

To facilitate the implementation of the Global Strategy for Infant and Young Child Feeding, and assist governments in translating global recommendations into country-specific actions, WHO convened a technical meeting from 3 to 5 February 2003 in Geneva. The meeting brought together more than 45 participants representing governments, nongovernmental organizations, academic institutions and international organizations.

This report summarizes the conclusions and recommendations of the meeting including appropriate ways for achieving progress in the operational areas defined in the Global Strategy and steps for a planning framework to facilitate the implementation of the strategy at country level.

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**IMPLEMENTING THE GLOBAL STRATEGY  
FOR INFANT AND YOUNG CHILD FEEDING**

Geneva, 3-5 February 2003

**MEETING REPORT**



**Department of Child and Adolescent Health and Development  
Department of Nutrition for Health and Development**

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MEETING REPORT



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WHO Library Cataloguing-in-Publication Data

WHO Technical Meeting on the Implementation of the Global Strategy for Infant and Young Child Feeding (2003 : Geneva, Switzerland)

Implementing the Global Strategy for Infant and Young Child Feeding : report of a technical meeting, Geneva, 3-5 February 2003.

1. Infant nutrition 2. Breast feeding 3. Health plan implementation - standards 4. Guidelines I. Title.

ISBN 92 4 159120 X

(NLM classification: WS 120)

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Printed by the WHO Document Production Services, Geneva, Switzerland











By defining responsibilities and obligations for all concerned parties, the Global Strategy creates a unique opportunity for placing infant and young child feeding high on the public health agenda, considering nutritional status not merely as an output of investment, but also as an input into development.

To facilitate its implementation, and assist governments in translating global recommendations into country-specific actions, WHO convened a technical meeting on the implementation of the Global Strategy from 3 to 5 February 2003 in Geneva. The meeting brought together more than 45 participants representing governments, nongovernmental organizations, academic institutions and international organizations (Annex 1).





## Developing and implementing a comprehensive policy on infant and young child feeding

A national policy on infant and young child feeding is essential to provide a justification and context for implementation of interventions. The process of developing a policy is an opportunity to bring together all relevant partners, generate a common understanding about the problems and the possible solutions, and develop consensus about a common way forward making maximum use of all available resources. Preparation of a national policy can take time, but this should not delay the implementation of interventions. Once the policy has been agreed, it should be widely disseminated and promoted.

A comprehensive policy on infant and young child feeding places the health and development of children at its centre, and focuses on the multiple determinants that affect children's nutritional status. Action to improve food and feeding is an essential aspect of childcare and should be integrated with actions to prevent and manage childhood illnesses, promote childcare and development and to improve maternal nutrition.

A comprehensive policy should also relate with existing policy instruments such as the International Code of Marketing of Breastmilk Substitutes, the ILO Convention on Maternity Protection, and the Codex Alimentarius. It also defines in some detail the actions that will be taken to strengthen the capacity of health services and communities to care for the nutritional needs of infants and young children. A policy should indicate how existing programmes can be strengthened and incorporate actions in support of infant and young child feeding, and specify those interventions that are specific and require a focused implementation approach.

### **Taking measures to adopt and implement a national Code of Marketing of Breastmilk Substitutes as part of a comprehensive national policy**

Since the adoption of the International Code of Marketing of Breastmilk Substitutes by the World Health Assembly in 1981, many governments have taken action to adopt national measures to implement it. However, much remains to be done to enforce implementation. Lack of awareness about the public health rationale and relevance of the code is still widespread among policy makers, health professionals and the general public. While some countries are implementing the Code successfully, keys to success have not been analysed sufficiently. Nor do governments have easy access to technical assistance while drafting a national code and establishing the system for its implementation.

To accelerate the implementation of the International Code of Marketing of Breastmilk Substitutes, concerned partners should:

- strengthen advocacy about the relevance of the code and develop simple materials to convey key messages to policy- and decision-makers;
- prepare a document describing success stories from countries that are effectively implementing the code, summarizing the main steps that were followed and lessons learned;
- strengthen national and international partnerships for code implementation and monitoring, ensuring that adequate technical support to governments is available when so required and identifying and taking corrective actions when malpractice occurs.





## **Strengthening the capacity of health services to support appropriate infant and young child feeding**

Inadequate support for infant and young child feeding in health services is a main contributing factor to poor breastfeeding and complementary feeding rates worldwide. Health workers often do not have updated knowledge and skills to effectively support infant and young child feeding, and hospital practices and routines impede the initiation and continuation of appropriate feeding practices.

The evidence for effective interventions to support infant and young child feeding in health services has been accumulating rapidly, leading to major policy initiatives such as the International Code, the Ten Steps to Successful Breastfeeding, the Innocenti Declaration, and the Baby-friendly Hospital Initiative.

### **Revitalising the Baby-friendly Hospital Initiative**

The Baby-friendly Hospital Initiative (BFHI) has been an important catalyst for breastfeeding action in the past decade. Political will and strong advocacy have led to improved quality of breastfeeding care for mothers and babies in many countries. The challenge now is to increase and extend the BFHI to activities that go beyond the immediate post-partum period.

The basic principles of the BFHI are universally valid. They require some adaptation in the form of added guidance in settings where HIV is prevalent. Where hospitals have been certified as Baby-friendly, monitoring of quality is critical to ensure adequate standards of care and, deliberate efforts should be made to strengthen the reassessment component of the initiative.

The BFHI started as a project in many countries. However, it is now time to mainstream the activity into the health system as an essential component of quality assurance and improvement of care. This is feasible and can be achieved if BFHI is seen as one element in the range of activities that are needed to strengthen the health system and empower communities to provide adequate support to breastfeeding mothers and babies. As an area of particular interest, ways should be found to strengthen the establishment of community-based mother support groups as an important avenue to increase coverage of skilled support.

### **Improving the skills of health providers in first and referral level health facilities to give adequate feeding support**

Infant and young child feeding is a neglected area in the basic training of health professionals worldwide. It is therefore necessary to invest in improving knowledge and skills, through in-service and pre-service training. Including essential knowledge and competencies in the basic curriculum of medical and para-medical professionals is likely to be the most feasible and sustainable way to address the current knowledge gaps. Nevertheless while such efforts progress, there is a need to increase the skills of health workers who are already in the service.

WHO and UNICEF and other partners have developed a number of tools to increase capacity of health care providers to protect, promote and support infant and young child feeding. The BFHI, through the 18-hour course targeted at maternity staff, provides basic knowledge and skills to support the timely initiation and establishment of





## Strengthening community-based support for infant and young child feeding

Families and communities are indispensable resources in the support of infant and young child feeding. Evidence has shown that mother-to-mother support groups, lay or peer counsellors, and community-based workers can be very effective in helping mothers to initiate exclusive breastfeeding and sustain breastfeeding up to two years or beyond. Building their capacity should therefore be an essential element of efforts to improve infant and young child feeding.

Information and advice on feeding has been successfully promoted through groups specifically created for this purpose, such as mother support groups and lay or peer counsellors, as well as through existing groups. The Hearth Model<sup>1</sup> (or positive deviance approach) identifies examples of good practice within the community and facilitates the interaction between mothers whose children are thriving well with those that have more difficulties in caring for theirs.

Individual counselling is a key intervention and can be delivered by a peer, a health visitor, community volunteer or extended family member. The counsellor needs to have accurate knowledge and skills about infant and young child feeding, be equipped to negotiate a limited set of feasible actions, and be able to inspire the mother with confidence in her abilities. Home visits, group meetings, growth monitoring sessions and cooking sessions are all good opportunities for sharing information and for individual counselling.

Community-based feeding support needs to be embedded in a larger context of communication activities that disseminate consistent and relevant information to primary caregivers and their support structure repeatedly and frequently. Programmes and projects that have been successful in achieving behavioural change have been working through multiple channels and combining various methods, ranging from individual counselling by health facility and community-based workers, community group sessions and information sharing through mass media.

Essential steps in designing community-based interventions include defining the community and identifying vulnerable groups, conducting formative research to understand barriers and motivators for improved feeding practices, assessing human and material resources for behaviour change, and defining acceptable, feasible and affordable feeding recommendations.

Reviews of community-based interventions have demonstrated that they are most effective when they build upon existing structures, integrate with the health system, and involve partnerships with various sectors and groups. Interventions should extend the care that is provided within the health system to families in the home and mechanisms should be in place to refer mothers and babies with problems. With this in mind, the BFHI recommends the establishment of mother support groups as a requirement for each baby-friendly hospital.

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<sup>1</sup> Wollinka O, Keeley E, Burkhalter R, Bashir N. Hearth Nutrition Model: Applications in Haiti, Viet Nam, and Bangladesh. BASICS, 1997.





# A planning framework to facilitate the implementation of the Global Strategy for Infant and Young Child Feeding

Implementation of the global strategy for infant and young child feeding in countries will not be a new initiative, but rather a stimulus to review what has been achieved, strengthen ongoing work areas and activities, and initiate new activities as needed.

To make optimal use of the strategy as a framework for guiding action, several steps have been identified. They include:

- orientation to the strategy for a wide group of stakeholders in the country;
- assessment of the local situation focusing on policies, practices, and programmes;
- consensus on priority future actions based on the analysis of the assessment results, and identify and prioritise future actions;
- development of a plan of action involving all relevant stakeholders and integrating activities in ongoing programmes as far as possible and feasible;
- implementation of the plan;
- monitoring and evaluation of programme activities and outcomes.

Actions can be planned in four important areas strengthening policies; strengthening the health system; strengthening community-based support; and addressing the needs of vulnerable groups.

## Assessing the current situation and identifying future actions

Several tools are available to assist in a national assessment. As a follow-up to the adoption of the global strategy, WHO in collaboration with LINKAGES, has developed a tool for assessing national practices, policies and programmes which specifically focuses on assessing progress in relation to the goals and targets defined in the Innocenti Declaration and the Global Strategy. In addition, there are other useful tools such as the district level assessment tool developed by BASICS<sup>1</sup>, the WHO/UNICEF BFHI assessment tool<sup>2</sup>, the WHO Common Reference and Evaluation Framework (CREF) for assessing implementation of the International Code of Marketing of Breastmilk Substitutes<sup>3</sup>, and PROFILES developed by BASICS<sup>4</sup>.

The assessment should be a process that brings together stakeholders and helps to develop a common understanding of the gaps and the resources available to deal with them. It should involve all relevant partners, including policy makers, programme managers, representatives from training and research institutions, multilateral, bilateral and non-governmental organizations and implementing health staff in the field. Hence the usefulness of a consensus meeting to analyse the assessment findings as a basis for agreeing upon future actions.

<sup>1</sup> BASICS/USAID. *Program review of nutrition interventions: Checklist for District Health Services*. BASICS, 1999.

<sup>2</sup> WHO/UNICEF. *Global hospital assessment criteria for the WHO/UNICEF Baby friendly Hospital Initiative*. New York, UNICEF, 1992.

<sup>3</sup> WHO. *The International Code of Marketing of Breast-milk Substitutes: A common review and evaluation framework*. Geneva, World Health Organization, 1996.

<sup>4</sup> BASICS/AED. *PROFILES: a Data-Based Approach to Nutrition Advocacy and Policy Development*, Washington DC, AED, 1998.







## Recommendations

Appropriate infant and young child feeding is critical for human and economic development. Evidence of effective interventions has provided a sound foundation for moving programmes forward, while at the same time attention to infant and young child feeding has been dwindling in national and international public health arenas. Internationally agreed goals for child health cannot be achieved unless a substantial investment is made in interventions that support appropriate infant and young child nutrition in order to mobilize policy- and decision-makers to taking appropriate actions at national and international levels.

Participants of the meeting recommended that national and international partners concerned with infant and young child feeding should:

- **Consolidate and continually update the evidence-base** on the impact of feeding interventions on child health outcomes in the short and long-term, as well as their cost and effectiveness. This information needs to be presented in terms of human social and economic gains and disseminated widely.
- **Advocate for implementation of the Global Strategy** at local, national and international levels, creating a common understanding of the importance of working in the area. To this effect, key messages should be identified for various target audiences and materials developed to communicate these messages in an attractive and convincing manner.
- **Build partnerships and coalitions** at all levels, with the aim to develop a common language, pursue common goals, and harmonize approaches to improve infant and young child feeding. Only through joined forces and combined resources is it possible to make a substantial difference.
- **Facilitate the integration of infant and young child feeding support** into existing programmes and initiatives, involving various sectors and ensuring consistency in approaches. In the same vein, nutrition programmes should integrate aspects of other interventions to protect and promote child health, such as the prevention and management of childhood illness.
- **Build capacity of staff at all levels** to move forward the intervention areas described in the Global Strategy, focusing on in-service and pre-service training and ensuring the establishment of a small core group of key experts in every country to guide the efforts. Efforts to build capacity should not only involve service providers but also target policy makers and senior decision-makers with information suitable to their needs.
- **Promote the adoption of appropriate caregiver practices** by designing interventions that are complementary and can be delivered through multiple channels, leading to high coverage of information on small feasible actions and access to individual counselling for all mothers and babies when they need it.
- **Seize the opportunity provided by major health initiatives and projects** to incorporate feeding interventions and mobilize resources. Examples include the Poverty Reduction Strategy Paper, the Global Fund for Malaria, Tuberculosis and HIV/AIDS, Integrated Early Childhood Development initiatives, processes surrounding the achievement of the Millennium Development Goals, and the UN Development Assistance Framework (UNDAF).



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- 14.00 – 15.30      Strengthening health systems to protect, promote and support infant and young child feeding
- The Baby Friendly Hospital Initiative – achievements and future directions  
(20 min – Dr Miriam Labbok, Ms Randa Saadeh)
- Discussion
- Overview of approaches and tools to improve health workers' skills  
(10 min – Dr Constanza Vallenias, WHO/CAH)
  - Improving the skills of health professionals through in-service training – case study  
(15 min – Mrs Rufaro Madzima, Zimbabwe)
- Discussion
- Integrating infant and young child feeding into pre-service education – case study  
(15 min – Dr Agnes Guyon for Madagascar)
- Discussion
- 15.30 - 16.00      Tea/coffee
- 16.00 - 17.30      Group work
- Strengthening national policy to protect, promote and support appropriate infant and young child feeding
- Group 1: International Code of Marketing of Breastmilk Substitutes
  - Group 2: Other policy issues (maternity legislation)
- Strengthening health systems to protect, promote and support infant and young child feeding
- Group 3: Baby-friendly and beyond
  - Group 4: Building capacity of health professionals to support infant and young child feeding

**Tuesday, 11 February**

- 08.30 - 09.45      Feedback from groups
- Achieving progress in the operational areas defined in the strategy and tools available to support this (continued)**
- 09.45 - 10.30      Strengthening community-based support for infant and young child feeding
- Developing a system of community-based support for infant and young child feeding  
(30 min – BASICS: Dr Marcia Griffiths, Dr Serigne Mbaye Diene; LINKAGES: Dr Victoria Quinn)
  - Establishing and sustaining a cadre of lay and peer counsellors  
(15 min – Dr Rukhsana Haider, WHO/NHD/SEARO)
- 10.30 - 11.00      Tea/coffee
- 11.00 - 11.30      Strengthening community-based support for infant and young child feeding (continued)
- Discussion
- 11.30 - 13.00      Updates on work in progress at global level
- HIV and infant feeding – update on available tools and implementation issues  
(20 min – Dr Peggy Henderson, WHO/CAH)





**Wednesday, 12 February**

08.30 – 09.45 Feedback from groups

**Priority research and development needs and mechanisms to coordinate future work**

09.45 – 10.30 Group work: Identification of priority needs for research and development, and mechanisms to coordinate future work

10.30 – 11.00 Coffee/tea

11.00 – 12.00 Feedback from groups and consensus on responsibilities

12.00 – 13.00 Updates on work in progress at global level

- Feeding low birth weight infants  
(15 min – Dr Karen Edmond, consultant WHO/CAH)
- Infant feeding in emergency situations  
(15 min – Dr Sultana Khanum, WHO/NHD)

13.00 – 14.00 Lunch

14.00 – 15.15 Building partnerships for infant and young child feeding – the role of various partners and opportunities for coordination at regional and country levels

- BASICS
- CORE group
- IBFAN
- ILCA
- LLLI
- LINKAGES

15.15 – 15.45 Coffee/tea

15.45 – 16.30 Summary of conclusions and recommendations

16.30 Closing





## Overview of the global strategy

### Global Strategy for Infant and Young Child Feeding: objectives, operational targets, and current situation

Mrs Randa Saadeh, WHO/NHD

Mrs Saadeh indicated that with some 60% of the deaths among children under five associated with under-nutrition, the need to improve the feeding of infants and young children and increase the commitment of governments, civil society and international organizations to promote the health and nutrition of children is urgent.

Over the last decade there has been progress in meeting the operational targets of the Innocenti Declaration: National Breastfeeding Committees have been established in half of the countries in the African and Eastern Mediterranean regions and in three-quarters of European countries; 70% of the countries in these regions have named a national breastfeeding coordinator; 16,000 hospitals around the world have been designated “baby-friendly” and maternity leave entitlements have been increased in the first new ILO Convention in half a century. But despite improved policy and structure, practice lags behind. Breastfeeding rates have increased in a few countries, but have declined or stagnated in others. Only a small percentage of the world’s infants are exclusively breastfed at four months of age and complementary feeding often begins too soon or too late

The Global Strategy offers a novel, integrated and comprehensive approach – participatory, built on previous achievements and grounded in best available science and evidence – to address the challenges to full compliance with the operational targets set out in the Innocenti Declaration.

### The strategy as a tool for mobilizing global action

Dr Miriam Labbok, UNICEF/HQ

Dr Labbok addressed the question of how helpful the Global Strategy might be in turning policy into action. The results of some earlier high-profile interventions – the Baby-friendly Hospital Initiative (BFHI), the International Code of Marketing of Breast-Milk Substitutes, growth monitoring and micronutrient supplementation and fortification are encouraging. But with global exclusive breastfeeding at about 40% and the widespread growth faltering between 6 and 24 months there is clearly considerable room for improvement.

Dr Labbok suggested that the Global Strategy for IYCF, a comprehensive 52-point programme, has five basic objectives: multisectoral national commitment, legislation, health services and training reform, communications/community/social advocacy and special care for infants and young children in exceptionally difficult circumstances.

Many familiar programs fall within these objectives. Some linkage among the actions is needed and some additional actions to go beyond the goal of six months’ exclusive breastfeeding to include timely and appropriate complementary feeding and continued breastfeeding for two years or more. In a period of unprecedented “special circumstances”, the progress made depends on our ability to create behavioural change in target populations (families) and among decision-makers. The most efficient use of our time and efforts is building on what we have and strengthening programs that work, not replacing them.

### Introduction of the preliminary inventory of tools to support the implementation of the Strategy

Dr Carmen Casanovas WHO/CAH

Dr Casanovas outlined the current review and revision of the available tools - printed, visual and electronic - that address the components of the Global Strategy on IYCF. She noted that a comprehensive inventory and a matrix









5%, EAPRO 8%), but in others they have been quite dramatic (WCA/ESA 40%; MENA 48%). By the end of 2002, UNICEF had tallied some 19,000 hospitals with baby-friendly certification. Surprisingly, during a period of decreased financial support for the initiative (between 2000 and 2002), there was a 28% increase in designated facilities, a clear sign that the Initiative had developed a momentum of its own. Achieving sustainability without sacrificing quality is an overriding concern.

Two major issues for the future of BFHI are the implementation of Step 10 – a bit of a stepchild in BFHI, often implemented as an afterthought - and the effect of the HIV/AIDS pandemic on political will to continue supporting the Initiative. The HIV/AIDS pandemic should not be misunderstood as a barrier to BFHI. BFHI has always put the mother in charge of infant feeding decisions. In a baby-friendly setting, staff training should ensure the mother's right to accurate information and unbiased counselling. Practices routine in baby-friendly hospitals – skin-to-skin contact from birth on, rooming-in or bedding-in and feeding on demand – help all mothers bond to their babies and be aware of their needs.

Findings of recent pilot studies using replacement feeds for infants of HIV+ women have shown that the benefits are not as extensive as had been hoped. Early and exclusive breastfeeding remains the best advice for all population-level support and for the large percentage of HIV+ mothers for whose infants replacement feeding is neither a safe nor a sustainable option. When these mothers give birth in BFHI facilities, the breastfeeding management that they learn – most particularly proper positioning and exclusive breastfeeding – helps to minimize transmission by preventing nipple trauma and mixed feeding, both of which are associated with higher transmission rates.

#### **Overview of approaches and tools to improve health workers' skills**

Dr Constanza Vallenias, WHO/CAH

Dr Vallenias began with an overview: Implementation of the Global Strategy requires strengthening legislation, policies and the health care system and improving family and community practices.

Policy has been already been addressed by the International Code of Marketing of Breast-milk Substitutes and five subsequent relevant WHA Resolutions, the Codex Alimentarius, ILO Maternity Protection Conventions, the Convention on the Rights of the Child (CRC) the International Covenant on Economic, Social and Cultural Rights (CESCR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). These need to be ratified and implemented.

Major efforts have already been made to strengthen the health care system. BFHI is aimed at improving the quality of care in hospitals; a variety of training courses focus on improving health worker skills. All health workers need basic skills to support infant feeding and some health workers at both community and referral levels should have advanced skills. Building capacity within institutions to increase awareness among colleagues of the importance of infant feeding to improved health is also an important tool.

Maintaining quality while increasing coverage are serious challenges as scaling up is considered. Sustainability depends on imaginative use of financial and human resources including the development of an integrated approach for services to support infant feeding.





Monitoring and evaluation are the final pieces to pre-service education in Madagascar. Challenges to thorough, sustainable monitoring and evaluation include finding – or creating – a leading body to carry out evaluation and obtaining a baseline for IMCI and ENA. Additional issues are improving and maintaining the quality of the practicum, extending support to other teaching sectors, bringing curricula reform to other disciplines such as reproductive health and infectious diseases, ensuring funding and keeping momentum.

## **Strengthening community-based support for infant and young child feeding**

### **Developing a system of community-based support for infant and young child feeding**

BASICS: Dr Marcia Griffiths, Dr Serigne Mbaye Diene; LINKAGES: Dr Victoria Quinn

Dr Mbaye-Diene (BASICS II) indicated that Senegal and Benin tried integrated approaches to community support. Aiming to raise awareness of, provide a framework for, and increase commitment to essential interventions, the programmes in these countries worked with existing community organizations to link the health system and the community and build teams rather than relying on individual participation.

In Benin community and health care facilities analysed the situation, identified gaps and challenges and developed an action plan to achieve 80% coverage of the target population. After training with adapted IEC materials, the community mobilized to identify motivations and constraints to feeding practices, raised awareness of these feeding practices using trials of improved practice (TIPs) and used a multi-media approach to spread the word. Following the community campaign 80% of the mothers surveyed were able to cite key messages (early initiation of breastfeeding, giving colostrum to newborns and timely introduction of complementary feeding). Over a five-year period the rate of exclusive breastfeeding rose from 19% to 52%.

Senegal concentrated on exclusive breastfeeding and adequate complementary feeding combining BFHI promotion and an intensive home visiting programme beginning in pregnancy and carrying on through early childhood. Maternal nutrition, iron, iodine and Vitamin A supplementation were also central to the programme. Some 700 health-care workers were trained in counselling skills and complementary feeding practices. Over a two-year period, exclusive breastfeeding rates at 4 months climbed from 15% to 40%, which is clear evidence that community-based support brings results.

Dr Griffiths reported that in a programme in Honduras using growth as a key indicator of child well being within the national AIN (Atención Integral a la Niñez) programme, the IMCI protocol was expanded to include both child growth and illness recognition. The Food Box was adapted to set new national feeding norms and child feeding was moved to the first days of IMCI training to ensure that it underpinned all the rest. The new feeding practices were field tested (quick TIPs) and “sold” to health care workers, family decision-makers and the community at large. There was a dramatic jump in exclusive breastfeeding rates in those communities involved in AIN and these children too were much more likely to be fed appropriately (continued breastfeeding and adequate feeding frequency of complementary foods) in the risky period from 6 to 23 months.

Dr Quinn indicated that Ghana and Madagascar also developed community-based support for IYCF. After mainstreaming a package of IYCF Behaviour Change Communication interventions into existing nutrition, child survival, reproductive health and food security programmes, both countries saw improvements in the timely initiation of breastfeeding, exclusive breastfeeding and timely complementary feeding. Fundamental to this approach was inter-personal communication between families and health-care workers, mother-to-mother support groups and already existing groups. The media was involved and the whole community was mobilized to celebrate the successes of the programme.





Governments, international organizations, professional societies and NGOs all have roles to play in both policy-making and implementation. A number of tools are already available or in the process of development or revision to help with this difficult issue. Critical to finding a way forward is research – both formative and operational – on the relationship of breastfeeding and HIV transmission and the options available when the mother does not breastfeed.

### Improving complementary feeding practices

#### ■ **Guiding Principles for Complementary Feeding of the Breastfed Child**

Dr Chessa Lutter WHO/NUT/AMRO

Dr Lutter outlined for the participants the guiding principles for complementary feeding of the breastfed child. Even where breastfeeding practice is good, complementary feeding may pose a grave problem by being started too soon or too late or by being inadequate to the growing child's needs.

Reviews of the literature and technical consultations have made clear that mother's milk alone is usually adequate for six months or sometimes longer, that it is protective against gastrointestinal infections, prolongs lactational amenorrhoea and enhances infant motor growth. Because energy and micronutrients (iron, zinc and Vitamin D) may not be covered by breastmilk alone by the end of six months this is a good time to introduce complementary food – not to replace breast milk, but, as the term suggests, to complement it. Beyond a year, mother's milk continues to be a key source of energy, fat, vitamin A, calcium and riboflavin and to decrease the risk of morbidity and mortality in populations with high risk of contamination.

Like breastfeeding, feeding complementary foods is an active and responsive process. Infants need to be fed and older children assisted while they are eating and both their hunger and satiety cues should continue to be observed, as they were when they were breastfeeding exclusively. Critically important if complementary feeding is to enhance growth, development and health are good hygiene and proper handling of the food.

Small amounts of food – about 200 k/cal a day (130 k/cal in industrialized countries) – are all that is needed when complementary feeding begins. By the fourth quarter of the first year most children need about 300 k/cal and between the first and second birthdays it is around 550 k/cal in developing countries and a little more in industrialized countries, based on the average breast milk intake.

Small children need to have more than just three meals a day. If they are breastfeeding on demand, starting with two to three meals of complementary food a day is appropriate. By nine months that should be increased to three to four meals (with continued breastfeeding on demand) and by a year these meals should be supplemented with one or two nutritious snacks (self-fed, convenient, easy to prepare and nutritious foods offered between meals). Children especially need animal protein and Vitamin A-rich fruits and vegetables in their diets. During and after illness, their diets need special attention. This means more frequent breastfeeding and complementary feeding and gentle encouragement of the child to eat soft, varied and appetizing favourite foods so he/she can continue to grow.

#### ■ **Complementary Feeding Counselling course**

Mrs Randa Saadeh

Mrs Saadeh introduced the newly developed Complementary Feeding Counseling course.

With up-to-date knowledge on the nutrition of young children and suitable feeding techniques for this age group, this course can help health workers counsel caregivers about appropriate and effective complementary





Enteral feeds in the first 24 hours are associated with high mortality risks for the infant <1.5-kg. Current recommendations are IV fluids for the first 24 hours, then slow introduction of enteral or oral feeds. Research on the effect of cup feeding, room temperature, open cots/incubators, warm wrapping and kangaroo care are not yet available. HIV increases the infection and mortality risks; MCTC also appears to be greater for these infants. The risks of replacement feeding vs. breastfeeding remain among the questions with no clear answers.

Preterm and SGA infants need careful monitoring of vital signs, weight, blood biochemistry and gastric residual volumes as well as screening for metabolic bone disease and disturbances of neurodevelopment.

### **Infant feeding in emergency situations**

Dr Sultana Khanum, WHO/NHD

Dr Khanum looked at the effects on mothers and their infants of the increasingly common natural disasters and complex emergencies - increased malnutrition, increased incidence of communicable diseases and increased mortality. The problems need to be addressed in the context of weakening/dismantling of family and community structures leading to reduced capacity for care and change in breastfeeding practices, reduced access to health care services and reduced access to appropriate and adequate complementary foods.

Especially in the acute phase of an emergency, promoting optimal growth and preventing and treating malnutrition are major challenges that need to be addressed by optimal feeding and care of infants and young children. Guidelines and training modules are being developed to address these issues, e.g. Guiding principles for feeding infants and young children in major emergencies; Handbook on the management of nutrition in major emergencies; Training modules on infant feeding in emergencies; Operational guidelines on the ten principles for feeding infants and young children in emergencies.

Issues of particular concern that need to be dealt with are HIV and infant feeding in emergencies, management of severely malnourished infants under six months of age, controlling distribution of breastmilk substitutes and commercial complementary foods, and the practicality in emergency settings of improving infant nutrition with relactation or wet nursing. This latter intervention requires specialized skills and time – both of which are at a premium in the midst of a natural or man-made disaster.

## **A planning framework to facilitate the implementation of the strategy and tools available to support this**

### **Introduction**

Dr Bernadette Daelmans, WHO/CAH

Dr Daelmans introduced the discussion of planning framework. She indicated that WHO is working on a framework to assist governments and partners to strengthen activities to improve infant and young child feeding, translating the global strategy into country action. This framework is built around five steps:

- review recommendations and agree on the need for a comprehensive policy;
- assess and analyse the local situation;
- identify and prioritise essential actions;
- develop a plan for essential actions;
- implement and monitor.





provides a protocol that is useful in identifying local feeding practices, developing and testing appropriate messages and developing feeding recommendations.

The final step – implementing and monitoring – is never quite final because periodic evaluation remains important if IYCF practices are to be sustained.

### **Assessing the current situation**

Mrs Randa Saadeh, WHO/NHD

Mrs Saadeh looked at assessing the country's current situation for infant and young child feeding. She indicated that the first step in implementing the new "Global Strategy" is assessing practices, policies and programmes to identify their strengths and weaknesses in doing what they are intended to do – protecting, promoting and supporting appropriate feeding practices. From this assessment can come the determination of improvements needed to meet the aims and objectives of the Global Strategy.

WHO and LINKAGES together developed an easy-to-use national tool and field-tested it in Bolivia, Chile, Ghana, India, Indonesia, Russia, Sri Lanka, Thailand and the United Kingdom. It looks at three areas: infant and young child feeding practices, national infant and young child feeding policies and targets and national infant and young child feeding programmes. Once an indicator has been presented, the guidelines direct collection of data and assign scores and ratings to help identify achievements and areas for improvement. Trends and progress can be also be tracked and this information made available to fulfil reporting requirements to the World Health Assembly.

### **The Essential Nutrition Action approach: A way forward to operationalize the Global Strategy for IYCF at all levels**

LINKAGES: Dr Agnes Guyon, Madagascar: Dr Serigne Mbaye Diene, BASICS

Drs. Guyon and Mbaye-Diene discussed the Essential Nutrition Actions (ENA) indicating that this package was developed as an integrated concept involving infant and young child feeding, maternal nutrition and micronutrients. It is based on proven impact and is an action-oriented programme with clear guidance "Who should take what action when". It is linked with child survival on the one hand and reproductive health on the other, with breastfeeding at the centre of all. Messages are simple and doable, beginning with breastfeeding – early, frequently and exclusive for the first six months.

New messages build on the old ones. When it comes time to introduce complementary food, the breastfeeding messages stay the same. Mothers are encouraged to breastfeed at least 24 months while adding an ever-increasing number of complementary food meals.

This responsiveness to the child's needs and signals is even more important during and following an illness when both breastfeeding and complementary feeding should be increased.

The mother's nutrition during pregnancy and lactation needs to be as optimal as possible too. She needs to eat more often, have iron and folic acid supplementation and a vitamin A capsule after delivery.

Vitamin A rich foods, food fortification and child supplementation complete the strategy to control vitamin A deficiency. Anaemia is addressed with a combination of diet (iron-rich foods and fortification) and supplementation (for both women and children) plus disease-control measures (malaria control and deworming for both pregnant women





Eight features necessary to a national IYCF strategy were identified: situational analysis, use of the assessment tool (with some revision and expansion), advocacy, greater emphasis on the neglected areas of HIV and emergencies, coordination at all levels, integration into existing structures and programmes, systematic documentation and networking. Manageable monitoring and evaluation were determined to be key to the implementation of the strategy. This meant identifying a limited number of really useful process, outcome and impact indicators and setting a few operational targets.

Among the recommendations of the meeting were: revising the assessment tool, incorporating observations of the participant countries, implementing the IYCF strategy at national levels, networking among the four countries and training and capacity building. Currently, a similar meeting is being planned for francophone Africa.

### **Strengthening national programmes for infant and young child feeding - Experiences from a country**

Dr Rosanna Agble, Ghana

Dr Agble looked at strengthening national programmes for infant and young child feeding. She addressed the situation in Ghana as an interesting case study demonstrating how IYCF can be supported at all levels. Underweight and stunting declined over a 10-year period, but wasting increased by over 50%. Inadequate supplies of safe and nutritious food at household level to meet the physiological needs of all family members all year round is one major problem. Compounding this are inadequate sanitation in and around homes, unsafe water supply, unhygienic handling of food and inadequate health care for women and children. To cope with these problems, Ghana tackled both policy and practice.

In 1992, a National Plan of Action on Food and Nutrition (NPAN) was designed to ensure adequate food and nutrient intake for individuals and household food security, to sensitise policy-makers on food and nutrition issues and to strengthen coordination among agencies involved in those issues.

The Ghana vision for 2020 was that malnutrition among children and lactating mothers would be reduced and household food security improved especially in the poorest sectors. A five-year work programme by the Ghana Health Service supported this vision and the NPAN aims.

At the practical level, breastfeeding and complementary feeding initiatives blossomed, pre-service curricula were enhanced and a number of short courses on nutrition were developed. After a decade of action there have been successes, but there are challenges as well. The high attrition rate of health staff means continuous training and the high turnover of Ministers of Health has meant continuous advocacy. Revitalisation of key IYCF strategies – with greater attention to complementary feeding - is needed and the strategy needs to be more widely disseminated to the community, to NGOs and to the government.





Discussion: In the discussion that followed, the argument that certain trade treaties may prevent implementation of the Code was addressed. Consensus was that this is a bogus argument and might be countered by a document on common misperceptions about the Code. Enforcement was seen as a critical area for both research and action.

## Maternity legislation

Maternity protection is another area that has been difficult to realize in the formal employment sector – even when there are laws on the books - and especially in the informal sector in most areas of the world. This working group *identified several areas where research and/or work are needed* to combat the widespread resistance to implementing maternity protection legislation:

- lack of awareness of the importance not only to child health but also to the long-term well-being to a nation of having its infants and young children adequately and appropriately fed;
- widespread food insecurity in many regions;
- the up-front cost of maternity protection and its implications;
- resources for financing policy initiatives at local and national levels.

The group stressed the *need to reach those identified as decision-makers* in families, communities and governments – especially men - *and to mobilize public resources* to fold the Global Strategy into existing programmes, including insurance and income-generating schemes.

Discussion: The challenges of achieving comprehensive maternity protection elicited considerable lively discussion. Working mothers need time, space and resources if they are going to continue breastfeeding and, within the framework of the Global Strategy, they continue to need this care and protection until their children are two years old. This can be nearly impossible to achieve even for mothers in regular employment. It was suggested that the concept of “exceptionally difficult circumstances” might need to be broadened to include the employed mother.

Convincing employers that ensuring that their female employees can continue breastfeeding is also in their interests is not easy. Nor is it easy at the political level to mobilize public resources for helping employed mothers to achieve IYCF goals. Several participants in the meeting explored the possibilities of looking at this area holistically, seeing the Code, the ILO Conventions, the Convention on the Rights of the Child and other international agreements as an integrated policy framework from which the other arguments – nutritional, economic and human rights – flow. The Maternity Protection Coalition is finalizing a kit on maternity protections, which may be a useful tool for taking this holistic approach forward.

## “Baby-friendly” and beyond

This group made a number of *observations on the process of the Baby-friendly hospital initiative to date:*

- There is name recognition, but it needs ownership by the governments if it is going to be well integrated into health policy and programmes.
- Step 10 “never really happened”. There is just enough post-partum help to ensure that mothers are breastfeeding at discharge, but many mothers cannot attain the goal of six months exclusive breastfeeding without an on-going source of support in the community. This support is even more essential for achieving the other IYCF goals of timely and appropriate complementary feeding and continued breastfeeding through age two or beyond.
- The HIV pandemic has had a dampening effect on the support of BFHI because it is widely – and incorrectly - believed that this initiative is not relevant to the HIV+ mother.





*Critical to the success of all of these models are:*

- a communication style that establishes confidence in the counsellor;
- expertise and accurate information;
- the ability to negotiate feasible actions;
- empowerment of caregiver/mother/family to take action.

Any community-based intervention for IYCF must involve the community from the start. It is only in cooperation with the community that both the available and the needed resources, target groups and change agents can be determined. Together they can work out a practical plan that integrates child feeding into existing programmes (if they exist) and provide for training, supervision, monitoring and evaluation. Once such a plan has been worked out, donors can be approached to fund targeted action.

## **Planning framework for facilitating the implementation of the strategy**

### **Developing a comprehensive national policy and establishing a coordinating body for infant and young child feeding**

IYCF is not just about nutrition but rather about improving the health and development of children and thereby strengthening the human capital of a nation. This working group looked at the **preliminary steps** that have to be taken before an effective policy can be built:

- collecting evidence that there is a problem and that something can be done about it;
- identifying cost effective interventions to address the problem;
- identifying key allies and bringing them on board as advocates;
- identifying groups that may try to undermine the policy and having a strategy to minimize their negative impact;
- involving those who would be most affected by the planned policy.

*Evidence-based advocacy* needs to be done at all levels with influential policy-makers, with the press and with the community at large. Circulating the draft policy widely for comment while, at the same time, ensuring that commercial interests that might undermine optimal IYCF do not influence it, is one way to ensure that all relevant sectors feel involved.

Discussion: A concern was raised about the need to have a “model” of what should be in a national policy. Some material is available, for example:

- policy development material from Botswana, where the need to keep in mind that all elements are balanced and present throughout the process of policy development is highlighted;
- the documentation of agreement on steps to get policy guidelines at EURO.

### **Conducting a national assessment, identification and prioritisation of interventions**

A national assessment gives a snapshot of the IYCF situation on the ground and suggests interventions that might be useful in improving feeding practices. This working group first explored *the available tools*:

- national assessment tools;
- district level assessment tools (available from BASICS);





- Gender
- Culture
- Youth

The group touched on the importance of *monitoring and evaluation* as a critical area to support programme implementation. However, this is also a difficult area where limited experience is available to guide the development of approaches that can be implemented on scale. There are nevertheless a number of tools already available for monitoring progress within the context of BFHI, IMCI, and routine health system reporting systems in some countries. This group suggested that further work be done to *explore some other ways in which monitoring could be built into the system*:

- use of a mother and child health card that can be kept by caregivers and includes essential information on nutritional status and infant and young child feeding practices;
- including a few key indicators for infant and young child feeding into the routine monitoring system;
- establishing a system for implementation of key infant and young child feeding activities monitoring in other sectors (i.e. maternity entitlements in the Labour Ministry, Code and Codex in trade and industry).

While *integration* is essential for going to scale, it also *carries a risk of dilution of essential programme support*. The group emphasized that integration does not mean that there is no need for specific activities and support structures. For example, within a national plan for improving health worker performance, there is a clear need for supporting specialized training such as breastfeeding and complementary feeding counselling. Also, governments need to establish a coordinating body that has the authority to take implementation forward and is accountable for results. While the Global Strategy does not call for establishing a new programme, experience has shown that certain programmatic aspects as described above need to be honoured to ensure successful implementation.

*Efforts need to be carefully documented* to see what it takes to make programmes work on a large scale. This would include:

- documentation of best practises and lessons learned;
- inventory of assessment and supervisory tools for all areas;
- gaps in research and development (accessibility, indicators for adequate complementary feeding, documentation on successful integration in other sectors).

Discussion: Participants indicated that:

- it is important to consider small-focused group while seeking integration;
- there is a need to procure integration with other sectors at all levels;
- sharing of experiences in integration is important.

### **Priority research and development needs and mechanisms to coordinate future work**

Working in regional groups, participants were asked to *address the following questions*:

- What are the main challenges for moving forward the implementation of the strategy in the region?
- What are the key opportunities for building partnerships to implement the strategy and how can we make the best use of them?
- What are priority needs in terms of tools and research?





*Priority needs* identified were:

- Sources of funding
- High level commitment
- Evidence of the impact and cost effectiveness of the Strategy
- Indicators

*Recommendations* were very specific and ambitious:

- Organizing national coordination groups
- Consolidating partners within the groups
- Revising the National Nutrition Plan of Action
- Focusing on priority nutrition action including the ENA and IYCF

### **The Americas**

In common with the other regions, the Americas working group saw major challenges as *putting IYCF on the development agenda and identifying entry points* that are the focus of current investments (HIV, micronutrients, severe malnutrition). A primary goal was to *reposition child nutrition as a predictor and determinant* of cognitive development, risk factors for chronic diseases and the like rather than as an outcome.

This group *recommended* focusing on:

- Using existing networks to generate grassroots support and demand from civil society for IYCF
- Using the Millennium Decade Goals (MDG) to create demand from countries for funding
- Using the First Ladies' Fora
- Organising a launch of the IYCF Strategy with donors

Developing a Global Strategy press kit documenting how child malnutrition affects the interests in multiple sectors and that cost-effective strategies will make a difference.



## Description of partners

The role of various partners and opportunities for co-ordination at regional and country levels were discussed

### **BASICS II**

BASICS II has a USAID contract for Global Child Survival involving four technical areas: immunisations, community IMCI, neonatal health and nutrition. BASICS II works together with governmental and non-governmental coalitions in the countries where it is present, transferring expertise, helping to develop technical guidelines for country programmes, providing technical assistance for advocacy and policy development and building capacity.

In the area of nutrition, BASICS II developed Essential Nutrition Actions approach and tools (ENA), revitalised Community-Based Growth Promotion (CBGP) as platform for integrated health and nutrition, implemented vitamin A supplementation in Africa and strengthened capacity in countries in ENA (IYCF).

The focus of BASIS II is on scale, documentation and transfer of experience, technical guidelines for country programmes linking health services with communities, capacity building, policies and advocacy to support.

### **CORE group**

CORE group is a consortium of 35 US-based NGOs working in child survival with USAID funding. Both as a consortium and as individual NGOs, it can help advance the IYCF strategy through advocacy, sharing experience and knowledge, developing models and pilot projects, provision of both qualitative and quantitative data and active assistance with implementation. CORE uses a multisectoral approach involving the community, the health, agricultural and educational sectors, policy- and decision-makers and donors. For CORE to be able to make its resources available, it needs to be informed of and included in national and global plans, to know about existing and new materials and have ready access to them for dissemination in the field.

### **IBFAN**

IBFAN is a worldwide network of grass roots groups working to protect, promote and support breastfeeding. There are over 200 groups in more than 100 countries. IBFAN's key role is to protect breastfeeding against harmful commercial influences through the implementation and monitoring of the International Code and its Resolutions. IBFAN's core strategy is to advocate for strong national legislation. Close collaboration with governments is central to IBFAN's work and many IBFAN groups include members from government authorities. IBFAN's monitoring evidence provides baseline data for policy-making. IBFAN's International Code Documentation Centre in Penang, Malaysia organises training courses in Code implementation and IBFAN's biennial Code monitoring. To date, ICDC has held 16 training courses around the world and since 1997 alone, ICDC and IBFAN groups have worked with policy-makers in 18 countries, which have adopted new national laws or regulations.

IBFAN regional offices and national groups are already working with governments on plans to implement the Global Strategy. As a grass roots movement, IBFAN places enormous emphasis on capacity building and coordination





The major goals of LINKAGES' technical initiatives are to: inform decision-makers about the social, human, and economic costs of sub-optimal breastfeeding and promote appropriate policy and programme responses; promote scientifically-based guidelines on complementary feeding; raise awareness of the magnitude and impact of maternal malnutrition and women's special nutritional needs during pregnancy and lactation; increase recognition and acceptance of LAM as an effective, modern method of contraception by providing scientific and programmatic evidence to policy makers, programme planners, and family planning service providers; and interpret and disseminate scientific knowledge on infant feeding and HIV.



