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
World Health Organization
WHO Library Cataloguing-in-Publication Data


ISBN 92 4 159120 X (NLM classification: WS 120)

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Printed by the WHO Document Production Services, Geneva, Switzerland
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Infant and young child feeding is a critical component of care in childhood. It is a major determinant of short- and long-term health outcomes in individuals, and hence of social and economic development of communities and nations.

Unfortunately too many children still suffer from malnutrition worldwide as manifested in stunted growth, wasting and micronutrient deficiencies. The deficits acquired during the first years are difficult to redress later in life, resulting in reduced school performance and productivity.

Knowledge about the factors that affect infant and young child feeding and interventions to address them has been increasing steadily over the past decades. The importance of exclusive breastfeeding in particular has been recognised and its promotion has received more attention, resulting in focused programmes to improve breastfeeding practices in many countries.

The Innocenti Declaration1 and the Baby-friendly Hospital Initiative2 launched in the early 90s have been landmark events that set a new pace of global action. Considerable progress has been made since in raising awareness and changing caregiver practices to exclusively breastfeed their young infants.

Infants from 6 to 18 months are especially vulnerable to developing malnutrition. To sustain the gains made by promoting exclusive breastfeeding for the first six months of life, interventions need to extend into the second half of infancy and beyond, to enable caregivers to appropriately feed their children with safe and adequate complementary foods while maintaining frequent breastfeeding.

Protecting, promoting and supporting infant and young child feeding is essential for the healthy growth and development of children. The World Health Assembly and the UNICEF Executive Board unanimously endorsed the Global Strategy for Infant and Young Child Feeding in 2002. The Strategy aims to revitalise world attention to feeding practices that have an impact on the nutritional status, growth, development, health and thus the very survival of infants and young children.

The Strategy was developed at a time when the interest and investment in interventions to improve child nutrition was slowing down. In spite of strong and accumulating evidence demonstrating their feasibility and effectiveness, few countries are implementing comprehensive, large-scale programmes to improve infant and young child feeding practices as well as maternal nutrition. The Strategy is a guide for action, and provides the overarching framework of actions that are necessary to protect, promote and support infant and young child feeding. It identifies interventions with a proven impact and explicitly defines the obligations and responsibilities of governments, international organizations and other concerned parties.

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).
Objectives

The Global Strategy defines operational areas and describes a core of activities that governments and partners should implement in order to ensure adequate feeding, nutrition, health and development outcomes of children worldwide.

The operational areas refer to:

- developing and implementing a comprehensive policy on infant and young child feeding;
- strengthening the capacity of health services to support appropriate infant and young child feeding; and
- strengthening community-based support for infant and young child feeding.

Important lessons have been learned from the promotion of breastfeeding during the past decade. It is clear that sustainable implementation of interventions to support infant and young child feeding requires a comprehensive policy, a coordinator and multi-sectoral committee to implement the policy, promote interventions to strengthen health system and community support for feeding, and advocate for the enactment of relevant policy instruments such as the International Code of Marketing of Breast-milk Substitutes, ILO Maternity Protection Convention and Recommendation, and relevant standards of the Codex Alimentarius.

With this in mind, participants were asked to:

- discuss appropriate ways for achieving progress in the operational areas defined in the Global Strategy for Infant and Young Child Feeding;
- reach a common understanding on a generic planning framework to facilitate the implementation of the Global Strategy for Infant and Young Child Feeding in countries;
- identify tools available to support implementation, as well as those that need to be developed; and
- agree upon priority developmental and research needs and mechanisms to coordinate future work.

In working through the agenda (Annex 2), participants considered all aspects of the programme cycle, including advocacy and creation of political commitment, qualitative and quantitative assessment of the existing situation, design of interventions, planning of an appropriate intervention mix, monitoring of progress, and evaluation of outcomes. Details about the sessions can be found in the summaries of presentations and group work in Annex 3. The conclusions and recommendations of the meeting are summarized below.
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.
Enacting legislation to protect the breastfeeding rights of working women

The new ILO Convention and Recommendation on Maternity Protection updated requirements to protect the breastfeeding rights of working women and it is important for governments to ratify this as a legally binding instrument. While about half of all nations in the world have legislation providing some sort of protection to breastfeeding women, implementation remains a problem for a variety of reasons including the family’s desire to re-establish income earning capacity of mothers as soon as possible after delivery. In contrast to the situation for the International Code of Marketing of Breast-milk Substitutes, there is no strongly organized international lobby advocating for the enforcement of the right of the mother to adequate maternity protection.

To accelerate the ratification and enactment of the ILO Convention 183 on maternity protection, concerned partners should:

- take a more prominent role in assisting governments to ratify the ILO Convention on Maternity Protection and monitor the implementation of its regulations by all concerned parties;
- document successful experiences and develop materials to guide relevant parties in the adoption and enforcement of national policy for maternity protection;
- conduct a cost-benefit analysis of the economic gains that can be made by consistent implementation of maternity protection measures.

Using the Convention on the Rights of the Child as a legal instrument to protect, promote and support infant and young child feeding

The right to adequate nutrition is a basic right embedded in the Convention on the Rights of the Child (CRC). The CRC is a legally binding document that has been ratified by almost all countries worldwide. It provides a framework through which governments are responsible for protecting, promoting and supporting infant and young child feeding, and can be held accountable for actions by their own citizens and the international community. The CRC is therefore a useful legal instrument to facilitate and accelerate investment in infant and young child feeding interventions.

Governments, international organizations and civil society should use the regular reporting process of the Commission on Child’s Rights to draw attention to national situations and the actions that are necessary to remedy any deficiencies in nutritional status of infants and young children.

Applying relevant standards of the Codex Alimentarius to ensure adequate and safe nutrition of infants and young children

As the international body responsible for execution of the joint FAO/WHO Food Standards Programme, the Codex Alimentarius Commission can play a crucial role in protecting the health of infants and young children, by developing appropriate guidelines and standards for infant food products. The Codex Alimentarius Commission should be fully informed about global recommendations for appropriate infant and young child feeding and use this information to update guidelines and standards. WHO in particular can play a crucial role in sharing the relevant information and evidence base for it, and spearhead consultative processes to address unresolved questions.

Governments, international organizations, civil society and private enterprises should use the Codex as a tool to support implementation of global recommendations for optimal breastfeeding and complementary feeding, ensuring adequate labelling and quality of products intended for consumption by infants and young children.
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 were 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
breastfeeding. The Integrated Management of Childhood Illness (IMCI) strategy provides tools for training first-level health workers which integrate feeding counselling into the case management process for major childhood diseases. The 40-hour breastfeeding counselling course and the 24-hour complementary feeding counselling course are available to train a cadre of counsellors to whom mothers can be referred to deal with more complex problems. Thus a package of tools is available to meet the needs of various target groups and build a system for adequate feeding support.

Whether for in-service or pre-service training, the need to build-up teams of experienced trainers is critical in most countries. There are excellent examples of countries that have been able to implement breastfeeding counselling training nationwide, by systematically building the capacity of district managers and senior clinicians to plan for and conduct the training. It is important to define precise quality criteria for training, including the ratio of classroom versus clinical practice sessions. Continuous monitoring is needed to maintain quality of training.

Newly trained health workers need support to make the necessary changes to their working environment and start implementing new knowledge and skills. They may also encounter problems they cannot handle and for which they need extra support. Thus, at least one follow-up visit within 4-6 weeks after training by an experienced and skilled supervisor should be mandatory for all newly trained health workers seeing mothers and infants.

In addition to in-service and pre-service training approaches, alternative methods should be explored for communicating essential breastfeeding knowledge and skills. For example, distance learning, continuous education during monthly review meetings of facility-staff, and peer-supported learning are all options that should be considered when designing a training plan.

Necessary conditions to ensure sustainable implementation and expansion of training in a country include: a clear infant and young child feeding policy; coordinators at state, provincial, and district levels; teams to lead the activities that include representatives from various disciplines and levels (national and district); strict criteria for selection of trainers and trainees, monitoring of the quality of training and follow-up.
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 Model1 (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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New developments and work in progress

Updated guidelines on complementary feeding

The Guiding Principles for Complementary Feeding of the Breastfed Child1, published in follow-up to a WHO global consultation on complementary feeding in 20012, provide updated guidance on feeding children 6-24 months of age. The document describes ten principles of appropriate complementary feeding and the evidence for each. It provides a useful guide to programme planners in defining locally appropriate feeding recommendations and gives tips about potential assessment needs and actions. Based on the Guiding Principles, an international partnership of agencies led by WHO has established a process for defining indicators to assess complementary feeding, as a pre-requisite to sustainable programme action. WHO is also finalizing a three-day course on complementary feeding counselling for first-level health workers.

Feeding infants and young children in especially difficult circumstances

HIV and infant feeding: A broad partnership of UN agencies adopted a framework of priority action on infant and young child feeding3 for settings where HIV is present. The framework recommends that governments take action to develop a comprehensive national infant and young child feeding policy; implement the International Code, protect, promote and support appropriate infant and young child feeding practices; support HIV positive women in their chosen method of feeding; and promote research in infant and young child feeding. A number of specific tools on HIV and infant feeding are available to support the implementation of the framework.

Feeding low-birth-weight infants: The low birth weight (LBW) baby poses a special challenge to adequate feeding. WHO is developing practical guidelines for feeding the LBW baby based on a review of evidence. The review has demonstrated that maternal milk is the food of choice for LBW babies – not only for nutritional reasons but also because of the strong associations between mother’s milk and a reduction of infection and the possible association with improved neurodevelopment in premature infants.

Infant feeding in emergencies: natural disasters and complex emergencies pose a major threat to infant and young child feeding, and an increasing number of families are falling victim to these conditions. A partnership of concerned agencies is developing guidelines4 on how to protect and support infant and young child feeding in emergency situations, filling a void in guidance and promoting intensified investment on the part of relief agencies and governments to prepare for and implement appropriate actions.

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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 BASICS1, the WHO/UNICEF BFHI assessment tool2, the WHO Common Reference and Evaluation Framework (CREF) for assessing implementation of the International Code of Marketing of Breastmilk Substitutes3, and PROFILES developed by BASICS4.

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.

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Integrating infant and young child feeding interventions into ongoing programmes and activities for monitoring progress

To achieve comprehensive and sustainable action, the Global Strategy should not be moved forward in isolation, rather activities should be integrated into existing programmes and activities to the extent possible. Important in this respect are national programmes on immunisations, maternal and child health, nutrition and HIV/AIDS prevention and control.

Two approaches deserve special attention. The WHO/UNICEF Integrated Management of Childhood Illness strategy combines management of common childhood illness with preventive actions, including feeding counselling. IMCI is being implemented in over 100 countries and provides a unique avenue for building basic knowledge and skills on infant and young child feeding among health workers, community workers and families.

The Essential Nutrition Actions (ENA) approach promoted by BASICS and LINKAGES promotes key nutrition actions associated with improved health outcomes at the most relevant points of health service delivery contact1. ENA has been successfully incorporated into national action plans in several countries, including in combination with IMCI.

Other sectors can also play an important role in creating conducive conditions for improved infant and young child feeding. For example it is important to involve:

- education and learning to build a culture that adopts the current recommendations for appropriate infant and young child feeding as the norm among young people;
- agriculture to increase access to high quality foods and to disseminate knowledge about feeding;
- labour to enforce maternity entitlements;
- industry and commerce to ensure production, labelling and distribution of food products within the scope of provisions defined in the International Code of Marketing of Breast-milk Substitutes and the Codex Alimentarius

While integration is critical, it should also be recognized that there is a need for some specific activities, such as the BFHI, monitoring of Code implementation, increasing access to counselling clinics or points of contact with feeding counsellors. Moreover, integration does require the presence of a strong national coordinator and team concerned with infant and young child feeding, that is capable and available to move activities forward and accountable for results.

Monitoring and evaluation

There are very few examples of programmes that have successfully and sustainably integrated monitoring and evaluation into plans and activities. While some tools are available, there are large gaps in routine monitoring and supervision that need to be solved rapidly. The development of indicators for assessing complementary feeding is one area being taken forward at international level to facilitate assessment of the national situation, progress in the implementation of interventions, trends and international comparisons.

1 The seven ENA points include: 1. exclusive breastfeeding from birth to 6 months; 2. appropriate complementary feeding starting at 6 months along with breastfeeding up to 24 months or beyond; 3. appropriate feeding of infants and young children during and after illness; 4. adequate nutrition of women; 5. control of vitamin A deficiency; 6. control of anaemia through iron supplements and de-worming of women and children; and 7. control of iodine deficiency disorder.

The six key points of health delivery contact include: 1. antenatal; 2. delivery; 3. post-natal/family planning; 4. immunizations; 5. well-baby clinic; and 6. sick child visits.
Options
Specifically, participants of the meeting recommended that WHO, UNICEF and their partners at international and national levels take action to move forward the following areas:

- **Develop and adopt a common framework** for planning the implementation of the Global Strategy for Infant and Young Child Feeding, describing important steps and activities such as the orientation, assessment, prioritization of future actions, monitoring, evaluation, and advocacy.

- **Develop a package of advocacy materials** for various target audiences that describe the gains that can be made by investing in infant and young child feeding, considering human, social and economic perspectives.

- **Collate experiences from various countries** that have developed a comprehensive policy on infant and young child feeding, and derive a model policy to guide national authorities in the process of policy development.

- **Develop case-studies** of good practice models of Code implementation and disseminate them widely.

- **Make an inventory of tools** that are available to support the implementation of the Global Strategy and distribute this widely.

- **Create mechanisms and opportunities for regular exchange of experiences** among concerned national and international partners, including review of progress and design of innovative solutions to challenges.
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List of participants
## Agenda

### Monday, 10 February

<table>
<thead>
<tr>
<th>Time</th>
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| 09.00 - 09.45 | Welcome (Dr Tomris Türmen, Executive Director, Family and Community Health Cluster)  
- Objectives of the meeting, introduction of the agenda and participants (Dr Jose Martines, Team Coordinator, Department of Child and Adolescent Health and Development (CAH)) |
| 09.45 - 10.30 | Global Strategy for Infant and Young Child Feeding: objectives, operational targets, and current situation  
- The strategy as a tool for mobilizing global action  
(20 min - Ms Randa Saadeh, WHO/NHD)  
- The strategy as a tool for mobilizing global action  
(15 min – Dr Miriam Labbok, UNICEF/HQ) |
| 10.30 - 11.00 | Tea/coffee |
| 11.00 – 11.15 | Introduction of the preliminary inventory of tools to support the implementation of the Strategy  
(Dr Carmen Casanovas WHO/CAH) |
| 11.15 - 13.00 | Strengthening national policy to protect, promote and support appropriate infant and young child feeding  
(20 minutes – Mr James Akré WHO/NHD, Mr David Clark UNICEF/HQ)  
Discussion  
- Strengthening national measures for maternity protection  
(15 minutes – Ms Catherine Hein ILO/HQ)  
Discussion  
- Codex Alimentarius – what is Codex , current issues under discussion , and national implementation  
(10 minutes – Mr James Akré)  
Discussion |
| 13.00 – 14.00 | Lunch (Display of available tools) |
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 Vallenas, 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)
Discussion
- Improving complementary feeding practices
- Guiding Principles for Complementary Feeding of the Breastfed Child
  (10 min - Dr Chessa Lutter WHO/NUT/AMRO)
- Complementary Feeding Counselling course
  (10 min - Ms Randa Saadeh)
- Development of indicators for IYCF
  (10 min – Dr Marie Ruel, IFPRI)

Discussion

13.00 – 14.00 Lunch

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

14.00 – 15.00
- Introduction
  (Dr Bernadette Daelmans WHO/CAH)
- Assessing the current situation
  (7 min – Ms Randa Saadeh WHO/NHD)
- The Essential Nutrition Action approach: A way forward to operationalize the Global Strategy for IYCF at all levels
  (30 min – LINKAGES: Dr Agnes Guyon; BASICS: Dr Serigne Mbaye Diene)
- Building partnerships with other sectors
  (10 min – Dr Victoria Quinn)

15.00 – 15.30
- Regional strategy for moving forward the implementation of the Global Strategy for IYCF
  (15 min - Dr Charles Sagoe Moses, WHO/IMCI/AFRO)
- Strengthening national programmes for infant and young child feeding - Experiences from a country
  (15 min – Dr Rosanna Agble, Ghana)

15.30 – 16.00 Coffee/tea

16.00 – 18.00 Group work

- Group 1: Establishing community-based support for infant and young child feeding – lessons learned and recommended steps
- Group 2: Developing a comprehensive national policy and establishing a coordinating body for infant and young child feeding – lessons learned and recommended steps
- Group 3: Conducting a national assessment, identification and prioritization of interventions – lessons learned and recommended steps
- Group 4: Integrating interventions in ongoing programmes and activities and monitoring quality - lessons learned and recommended steps
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
Opening presentations

Welcoming address
Dr Tomris Türmen, Executive Director, Family and Community Health Cluster.

Dr Türmen welcomed the participants, stressing that it is the infants and young children who bear the brunt of malnutrition and suffer the highest risk of disability and death associated with it. She noted that inappropriate feeding practices are a major cause of malnutrition in young children and reminded participants that both exclusive breastfeeding for the first six months of life with appropriate complementary foods after six months and continued breastfeeding for at least the next 18 months are critical for infant health and survival.

Dr Türmen indicated that in a careful two-year participatory process, governments of all WHO Member States and international and intergovernmental organizations reviewed the latest scientific and epidemiological evidence and developed The Global Strategy for Infant and Young Child Feeding. Designed to be a concrete guide for action, it identifies interventions of proven positive impact and defines the obligations and responsibilities of all concerned parties. The challenge is: putting knowledge and policy into action to ensure that infant and young child nutrition are among the top priorities on the global public health agenda and that families have the necessary support to adequately care for their children’s nutritional needs.

Objectives of the meeting, introduction of the agenda and participants
Dr Jose Martines, Team Coordinator, Neonatal and Infant Health and Development, Department of Child and Adolescent Health and Development (CAH)

Dr Martines cited a series of consultations and technical meetings over a three-year period, leading up to the current meeting and outlined the way in which the Global Strategy differs from all previous efforts to improve infant and young child feeding. It brings together the critical operational areas in which investment is needed, in order to ensure that all mothers, caregivers and families receive the support they require to optimally feed their infants. And because it also defines obligations and responsibilities of concerned parties, it is an instrument that can be used to invigorate action, to sustain past gains, and to build future achievements.

He suggested an action framework for the three-day meeting which would explore ways to make progress in the operational areas related to policies, strengthening the health system and community-based support for infant and young child feeding. Technical updates on low birth weight infants, complementary feeding, HIV and emergencies would complete the background work and provide a foundation for planning interventions, building upon past achievements and prioritising the actions that are most critical to take forward.
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
with the appropriate tools for each phase of the implementation process are missing. Finalising such a matrix and summarizing information on each of these tools would be one major outcome of this meeting to be made available in both hard copy and as a CD-ROM.

Achieving progress in the operational areas defined in the strategy and tools available to support this

Mr James Akré WHO/NHD, Mr David Clark UNICEF/HQ

Mr James Akré presented an overview of national action on the Code in the two decades since the Thirty-fourth World Health Assembly adopted it in the form of a recommendation. Member States are asked to report annually to the Director-General of WHO on progress on implementing the Code. The Director-General reports to the World Health Assembly on this progress in even years. Since the adoption of the International Code in 1981, 162 Member States – 85% in all – have reported to WHO on action taken to give effect, in whole or in part, to its principles and aim (83% of Member States in Africa, 97% in the Americas, 80% in South-East Asia, 63% in Europe, 95% in the Eastern Mediterranean, and 96% in the Western Pacific).

The International Code states that governments should take action “as appropriate to their social and legislative framework”. Among the approaches used by Members States to give effect, in whole or in part, to the International Code and relevant subsequent Health Assembly resolutions have been:

- The adoption and periodic review of new legislation and regulations.
- Preparation and updating of related guidelines, e.g. for health workers, manufacturers and distributors, and retail outlets.
- Negotiation and updating of agreements with health workers and infant-formula manufacturers.
- Establishment of committees responsible for monitoring and evaluating implementation of national measures adopted to give effect to the International Code.

Some Member States have broadened the scope of their legislation to include other products (e.g. follow-up formula) and a wider age range (e.g. all children to age three) and/or have strengthened monitoring with publicity and/or sanctions, regulations on providing infant formula for precisely defined social purposes (i.e. orphans) and prohibition of product samples.

With the endorsement in 2002 by the World Health Assembly of the Global Strategy for Infant and Young Child Feeding, the International Code was again highlighted as one of nine operational targets. National governments were asked to give consideration to new legislation or other suitable measures to give effect to the principles and aim of the International Code and of subsequent relevant Health Assembly resolutions. However, governments alone cannot ensure that the Code is fully implemented. Manufacturers and distributors of products within the Code’s scope are responsible for monitoring their marketing practices and for taking steps to ensure that their conduct at every level conforms to the Code.

Nongovernmental organizations, professional groups, institutions and individuals have the responsibility of drawing the attention of manufacturers or distributors to activities which are incompatible with the Code and for informing the appropriate governmental authority about violations of the Code. Among the nongovernmental organizations most active in discharging this responsibility, Mr. Akré cited the International Baby Food Action Network (IBFAN),
Mr David Clark emphasized that implementation of the Code means achieving effective national legislation. Seventy-seven countries have adopted all or some of the Code as law; another 16 have drafted measures waiting final approval and additional 25 countries are studying the possibilities for implementation.

Because the Code is a global recommendation, the burden is on nations to enact effective, enforceable legislation. For those countries party to the Convention on the Rights of the Child, the Code is more than a recommendation. Under article 24(e) which calls for governments to take “appropriate measures” to ensure that everyone has knowledge of the advantages of breastfeeding and is supported in the use of this knowledge, implementing the Code is an obligation.

While legislation will be adapted to each country’s needs, there are some common elements. It should include all provisions of the Code and relevant subsequent resolutions. Provisions on implementation and enforcement should identify the independent body responsible for monitoring, the person to whom violations should be reported, a forum for adjudication and effective sanctions that act as a deterrent.

Major obstacles standing in the way of Code implementation include lack of awareness among policy makers, health care workers and the general public, an overburdened legislative agenda, lack of expertise and drafting capacity and pressures from commercial interests.

A strong emphasis on the Code as a human rights instrument, accelerated training and raising awareness will be central to UNICEF’s efforts in the near future.

**Strengthening national measures for maternity protection**

Ms Catherine Hein ILO/HQ

For close to a century, the International Labour Organisation (ILO) Conventions have been powerful tools to protect the maternity and breastfeeding rights of employed women. Ms Catherine Hein outlined in broad strokes the protections involved and the progress to date in implementing them. At the heart of the Conventions are direct health protection, maternity leave, cash and medical benefits, employment security and non-discrimination. The ILO Convention 183, passed in 2001, extended the period of maternity leave and emphasized that all employed women, including those in atypical forms of dependent work, were covered.

Fundamentally these protections mean that while pregnant or breastfeeding a woman is not obliged to perform work prejudicial to her health or that of her child, that she should be entitled to 14 weeks maternity leave, including six weeks of compulsory postnatal leave (more in the case of illness, complications or the risk of complications) and cash benefits (no less than two-thirds of a woman’s previous earnings) that ensure that the woman can maintain herself and her child in proper conditions of health and with a suitable standard of living. Eligibility requirements for cash benefits should be able to be met by most women. Prenatal, childbirth and postnatal medical care should routinely be a part of the medical benefits available to every pregnant and new mother. Where necessary, hospital care should also be included.

Employment security, including protection from dismissal during pregnancy, maternity leave, leave for maternity-related illness or complications and for a period after the woman returns to work is also essential. Breastfeeding
breaks or a reduction in working hours to accommodate breastfeeding complete the picture. These breaks are in addition to any other breaks provided to all employees, are to be counted as working time and should be remunerated accordingly.

While some countries have enviable maternity legislation, there are a great many gaps. Still needed are ratification of the ILO Convention in all countries, national legislation reflecting the terms of the Convention, widespread campaigns to inform employers and the women they employ about these entitlements and the extension of protections into all employment sectors.

**Codex Alimentarius – what is Codex? Current issues under discussion and national implementation**
Mr James Akré

The Codex Alimentarius is the international body responsible for the execution of the Joint FAO/WHO Food Standards Programme. Its aims are protecting the health of consumers and facilitating international trade in food. Volume 4 of the Codex Alimentarius concerns foods for special dietary uses, including foods for infants and children.

Development of these standards is the responsibility of the Codex Committee on Nutrition and Foods for Special Dietary Uses, which meets annually in Germany.

Codex standards cover infant formula, canned baby foods, processed cereal-based foods for infants and children and follow-up formula. There are also Codex guidelines for formulated supplementary foods for older infants and young children with advisory lists of mineral salts and vitamin compounds that may be used in these foods as well as a code of hygienic practice. The Codex standards for infant formula and processed cereal-based foods for infants and children define the products and their scope and cover composition, quality factors, food additives, contaminants, hygiene, packaging, labelling and methods of analysis and sampling. Currently, both standards are under revision.

**Strengthening health systems to protect, promote and support infant and young child feeding**

**The Baby-friendly Hospital Initiative – achievements and future directions**
Mrs Randa Saadeh and Dr Miriam Labbok

Mrs Saadeh reviewed the rapid expansion of BFHI in its first decade, creating in 16,000 hospitals worldwide a health care environment where breastfeeding is the norm. BFHI has proven itself an effective model for achieving change, not only in maternity care. Some countries have built on and expanded this model to paediatric care, to neonatal clinics, to traditional birth attendants and home delivery and even beyond the borders of health care settings to work sites (Myanmar), universities (Nicaragua) and broad areas of the country (China, Viet Nam).

The impact of BFHI can be seen in national legislation, in capacity building and training, in greater public awareness, in increased rates of exclusive breastfeeding and breastfeeding duration, in decreased rates of infant morbidity and mortality and in cost savings to the health sector. But there has been some slippage. The Global Strategy is an opportunity to reiterate earlier commitments, reverse this slippage and sustain the progress already made.

Dr Labbok indicated that the UNICEF review of BFHI focused on achievements and challenges to sustainability. Exclusive breastfeeding rates have increase in all regions. In some regions these gains are quite modest (ROSA
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 Vallenas, WHO/CAH

Dr Vallenas 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.
Improving the skills of health professionals through in-service training – case study
Mrs Rufaro Madzima, Zimbabwe

Mrs Madzima presented the case of Zimbabwe, a country that has a strong commitment to improving the skills of its health care professionals through in-service training. This training is grounded in national policies including exclusive breastfeeding from 0-6 months; the naming of both national and provincial infant feeding coordinators, 13-weeks maternity protection and strong governmental commitment to support training. Breastfeeding training has been linked with other in-service training including IMCI and HIV/AIDS. BFHI training has been increased from 18 to 22 hours to include a component on infant feeding and HIV. A full six-day integrated course teaches breastfeeding, infant feeding and HIV counselling.

Participants, trainers and directors are drawn from a wide field. The aim is both regional and professional balance (tutors, nurse midwives, nutritionists, dieticians, health education officers) involving those with backgrounds in breastfeeding and infant feeding counselling, BFHI and HIV issues. Government funding at national, provincial and district levels provides a basis for this extensive training.

The importance of dedicated coordinators and trainers and the need for quality control have become clear from experience. Central to the entire effort is building on previous achievements, ensuring that all counsellors and trainers have the basics – breastfeeding management and infant feeding counselling skills, familiarity with BFHI – before going on to more specialized areas such as HIV/AIDS.

Integrating infant and young child feeding into pre-service education – case study
Dr Agnes Guyon for Madagascar

Dr Guyon reported on integrating infant and young child feeding in pre-service education in Madagascar. Madagascar is a country with 15 million inhabitants, high infant and child mortality and high prevalence of nutrition problems.

Until the mid 1990’s there was very little in the way of nutrition policy and programme coordination. Few people were trained; there was poor understanding of the nature of malnutrition, its causes and its solutions. With the introduction of the Essential Nutrition Actions programme (ENA) in 1996 all this began to change.

ENA focuses on seven behaviours: breastfeeding, complementary feeding, women’s nutrition, sick childcare, vitamin A supplementation, anaemia prevention and iodine supplementation. Six entry points – pregnancy, delivery, postnatal and family planning, immunization, well child visits and GMP (growth monitoring programme) and sick child visits are targeted for introducing the ENA strategies. IMCI is used to help care for children with the primary childhood killers – malaria, diarrhoea, respiratory infections, measles and malnutrition – at home in primary level health facilities and at first-level outpatient health facilities.

Critical to adequate coverage was the integration of these programmes into pre-service education. This came at an opportune time when the entire medical school teaching programme was being revised. Interdisciplinary workshops at the paramedical and medical schools developed common ENA lesson plans. Simultaneously a major effort was mounted to revise lesson plans ensuring that the entire curriculum was scientifically up to date and that it was integrated into basic and clinical sciences, paediatrics and public health. Some 238 teachers and tutors were oriented and/or trained in ENA and IMCI. Clinical practices were evaluated and a strategy was devised to improve and maintain “quality” sites. Most promisingly, new criteria were developed to validate paediatrics, public health and gynaecology (BFHI) rotations based on successful practices and treatment of children including in the community.
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.
The programmes in Ghana and Madagascar came to similar conclusions: both a consensus on child feeding and a “critical mass of advocates” and key practitioners are essential if change is going to come about. The approach needs to be community-based and comprehensive, geared to the interests of everyone involved – children, their families and their health-care providers.

**Establishing and sustaining a cadre of lay and peer counsellors**

Dr Rukhsana Haider, WHO/NHD/SEARO

Dr Haider reported on a programme in Bangladesh. Randomised controlled trials of home visits by lay/peer counsellors, during pregnancy and after delivery showed a significant effect on exclusive breastfeeding rates at the end of five months (70% vs. 6% in the control group), confirming the experiences reported on from Brazil, Mexico and the USA.

Initially, peer counselling in Bangladesh was designed as a research project to see if it could increase counselling and support capacity for exclusive breastfeeding, growth and development and family planning. Women selected for training had at least five or six years schooling, ideally had successful breastfeeding experience themselves, were respected in their communities and were motivated to give their time to help mothers. They were trained for 10 days, four hours a day on the essential relevant information for mothers during the last trimester of pregnancy, within 48 hours of delivery and during monthly home visits. Considerable time was given over to practising both individual and group counselling, through role play and actual counselling, first of mothers of hospitalised babies, then pregnant women, newly delivered mothers and mothers of infants from 1-5 months.

With proper training, community counsellors provide appropriate information, skilled help and support both for breastfeeding and complementary feeding, but sustainability is an issue when counselling is voluntary. When funding ran out for this project, demand from the community to continue services was so strong, that the project directors established a trust – in part using their own personal funds – to provide the necessary funding – including for honoraria – to keep the project going.

**Updates on work in progress at global level**

**HIV and infant feeding – update on available tools and implementation issues**

Dr Peggy Henderson, WHO/CAH

Dr Henderson indicated that HIV is a heart-breaking epidemic from many perspectives, not the least of which, is its effect on mothers and infants. The HIV virus can be transmitted from an HIV-infected mother to her child during pregnancy, labour or delivery. Between 5% and 20% of infants may become infected through breastfeeding where it is prolonged. On the other hand, not breastfeeding increases the risk of infectious disease mortality. Current guidelines call for exclusive breastfeeding for six months when the mother is HIV negative or her status is unknown. For HIV-infected women, when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding is recommended. Otherwise exclusive breastfeeding is recommended for the first months of life.

Within the Global Strategy on Infant and Young Child Feeding, a framework of priority actions to be considered, has been developed to ensure an environment that encourages appropriate infant and young child feeding while reducing transmission of HIV through breastfeeding.
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
feeding practices and should contribute to the consistency of young child feeding messages and sustainability of activities in health facilities. With similar terminology and structure it complements existing courses (BFCC, IMCI, HIV/IV) or it can stand alone.

- **Development of indicators for IYCF**
  Dr Marie Ruel, IFPRI

Indicators for IYCF are crucial tools for the implementation of the Global Strategy. Dr Ruel outlined the process of developing these tools.

WHO and PAHO are working together on tools for assessing complementary feeding of the 6 to 23 month old child. At their joint meeting in December 2002 the document was reviewed, research and validation needs were identified and a plan of action was developed. Three working groups – on breastfeeding, energy and nutrient content of complementary foods and responsive feeding – were established to identify existing data, develop research proposals, identify field testing sites and raise funds to carry out the research.

Among the areas to be validated before reliable indicators can be established are the variables in energy intake from complementary food, micronutrient intake, standardization of measurements and ensuring safe preparation and storage. Two especially challenging areas are feeding low birth weight infants and IYC food security in emergencies.

There was considerable discussion following this session and many questions were raised. The importance of achieving a balance between being very prescriptive and recognizing that there is biological variability among children was stressed, as was the need for some clear indicators for complementary feeding. Some participants suggested that this new course be integrated with the others into one comprehensive course. Many countries do not have time to give several courses and are not doing a good job of integrating the available ones. WHO plans to have an integrated course ready in 2004.

- **Feeding low birth weight infants**
  Dr Karen Edmond, consultant WHO/CAH

Dr Edmond gave an update on the progress of developing guidelines for the low birth weight infant. A recent technical review examined the development of feeding ability in LBW infants from birth to 37 weeks, the nutritional requirements of LBW infants in their first 12 months of life and an assessment of the efficacy, safety and feasibility of interventions to improve feeding of LBW infants in their first 12 months.

Evidence clearly shows that maternal milk is the food of choice for LBW babies - not just for nutritional reasons, but also because of the reduction of infection in premature infants as well as a possible improved neurodevelopment.

Supplementation of mother’s milk is controversial. Current recommendations are for:

- phosphorous supplementation for infants < 1.5 kg
- vitamin D until the infant reaches 2 kg
- a one-time dose of Vitamin K IM at birth (all infants)
- oral iron supplementation for infants < 2.5 until they are 6 months old and possibly
- zinc for SGA and preterm infants until 6 or 12 months.
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.
The framework proposes a process that involves stakeholders, advocates for best IYCF practice and develops and strengthens policies. Stakeholders are varied and include national policy and decision-makers, programme managers, health-care professionals, educators, trainers and researchers, community-based organizations, international agencies.

The framework uses the life cycle approach as a leading principle and places support for infant and young child feeding in the context of a larger set of actions necessary to improve the nutritional status and health of girls and women in particular.

The key questions that guide the process throughout are: What is already in place? What are the strengths and weaknesses (internal)? What are the obstacles and opportunities (external)? What is the gap between adopted recommendations and current situation? What improvements are needed?

All three operational areas – legislation and policy, improving health systems and improving family and community practices – are essential to promoting, protecting and supporting appropriate IYCF practices.

In most settings, there will be a need to develop or strengthen policies in the areas of maternity protection at work, the Code, Codex Alimentarius and HIV and infant feeding as well as other areas.

There are often many areas within the health care system that need improvement if IYCF practices are to be implemented.

Family and community practices can also be improved through public awareness of the importance and benefits of IYCF, lay and peer counselling, breastfeeding support groups, community support to HIV+ mothers, elimination of adverse commercial influences and misinformation, and improvement of workplace support.

Combined with the answers to some further questions, a foundation is laid for developing a realistic plan for essential actions:

- What resources (human, financial, managerial, and technical) are available or could be mobilized?
- How can actions be integrated with other initiatives?
- How can we build on what already exists? And, most importantly
- Who will do what, by when?

There are a wide variety of guidelines and tools that can be used to support planning and implementation of interventions.

Within the health system there are a number of entry points that can be used for strengthening the system. Pre-service education lays the groundwork in preparing health professionals for their tasks. Efforts should be made to integrate essential knowledge and skills into the curricula. In-service training is useful for professionals who are already practising and a range of courses are available to improve their feeding counselling skills, including Integrated Management of Childhood Illness (IMCI), breastfeeding (BFC) complementary feeding (CFC) and HIV and infant feeding (HIVC). Specialised training courses on the management of severe malnutrition and infant feeding in emergencies are available to address the needs of special situations.

The training courses mentioned above can also be used (with some adaptation) for training community counsellors. Guidelines for planning the establishment of a cadre of lay/peer counsellors are under development. IMCI also
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 fulfill 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
and children). Controlling iodine deficiency disorders is very simply managed by providing all families access to and ensuring consumption of iodised salt.

Behavioural change on the ground (within families) demands involvement of communities, health facilities and administrators and planners at district, provincial and national levels. It goes beyond health and nutrition to include agriculture, education and trade.

Where ENA has been integrated into pre- and in-service training programmes and community events, nutrition has been integrated into health policies, technical nutrition guidelines have been developed and access to and quality of nutrition services and household nutrition practices have improved.

Planning includes expansion in existing ENA participant countries and launching in new countries as well as robust advocacy for ENA to be promoted by governments, international organizations, NGOs and university nutrition training groups.

Building partnerships with other sectors
Dr Victoria Quinn, LINKAGES

Dr Quinn explored why building partnerships with sectors outside of health makes good sense. Malnutrition is not just a health problem, it is also an indicator of poor development with immense consequences for both human and economic development. Vitamin A deficiency reduces survival; protein-energy malnutrition reduces both survival and productivity; iron deficiency reduces both productivity and intelligence and iodine deficiency also reduces intelligence, which, in turn reduces productivity. Because many underlying causes fall outside the health sector – in agriculture, economics planning, education, trade and labour, it is crucial to convince decision-makers that nutrition matters for social and economic development.

The Millennium Development Goals (MDG), which include nutrition indicators, are one golden opportunity to integrate these goals into comprehensive programmes. The Poverty Reduction Sector Paper (PRSP) is another. To ensure adequate investment into IYCF and nutrition, these areas need to be integrated into the PRSP process using economic arguments and language that policy makers understand (money). AED has developed a Nutrition Policy Analysis and Advocacy Tool (Profiles) to achieve this. It is a science-based computer model that simulates the consequences of malnutrition in human and economic terms using spreadsheet models and survey data. Using Ghana as an example, the model identified three key nutrition problems – iodine deficiency, stunting and iron deficiency - with clear economic outcomes – costing in Ghana’s case some $72 million a year. Using a tool like Profiles to capture the attention of decision-makers can help guide the development of sectoral plans such as PRSP, provides an argument for greater investment in IYCF and nutrition based on economic, not altruistic grounds, and serves as a tool to monitor the achievement of IYCF and nutrition goals.

Regional strategy for moving forward the implementation of the Global Strategy for IYCF
Dr Charles Sagoe Moses, WHO/IMCI/AFRO

Dr Sagoe Moses looked at implementation of the Global Strategy from the regional perspective. He indicated that in November 2002, Harare hosted a regional planning meeting for the implementation of the Global Strategy on IYCF. Representatives from Botswana, Ethiopia, Ghana and Zimbabwe were joined by representatives of UNICEF, WHO, IBFAN, LINKAGES and SARA/SANA to identify key elements for inclusion in a national IYCF strategy, develop a framework for a detailed implementation plan and define measurable indicators for monitoring and evaluating the strategy.
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.
International Code of Marketing of Breast-milk Substitutes

This group reviewed the progress and the obstacles to implementation faced by the Code over its 23-year history, identified successful strategies and useful tools and made a number of recommendations.

While virtually all governments have agreed, in principle, that the Code is a good instrument, implementation has been slow for a number of reasons:

- lack of awareness of the importance of breastfeeding;
- lack of involvement of relevant sectors outside the area of health;
- daunting legal language;
- active commercial pressures;
- underfunding of Code advocacy;
- insufficient global leadership.

Nevertheless a number of successful strategies and useful tools have been used to move the Code forward:

- awareness of the obstacles and detractors is the first step to getting rid of barriers;
- building a strong multisectoral team of local experts provides a first critical mass of advocates to draft enforceable legislation, get it adopted, disseminate it widely and ensure that it is implemented;
- identifying national champions willing to promote the Code serve as its visible face raises the Code’s profile in a community;
- IBFAN has developed a range of useful tools from the weighty “Code Handbook” to “The Code in Cartoons”. Their “Health Workers’ Guide to the Code”, translated into numerous languages, is kept updated as new resolutions are passed and periodic “State of the Code” charts monitor progress on Code implementation at country and company levels. A Code Implementation Course has been run for many years and UNICEF has developed a Code Orientation Course.

It is an impressive armoury, but more is needed if the Code is to be fully implemented worldwide. The group recommended:

- utilising the international human rights system to call attention to governments’ legal obligations in Code implementation;
- developing a practical guide on the utilisation of human rights instruments to make progress on Code implementation;
- developing an attractive use-friendly brochure describing the rationale for investing in the Global Strategy and explaining why the Code is an integral part of it;
- preparing an advocacy document with country success stories;
- conducting an analytic review of Code implementation at national level to identify what is effective, the major challenges and best practice models;
- forging partnerships across governments, NGOs and international organizations for Code support in the context of Strategy implementation;
**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.
This working group **recommended** that:

- BFHI be integrated into current initiatives including the Millennium Development Goals (MDGs) and Poverty Reduction Strategies.
- There be a greater focus on advocacy and revitalization of advocacy materials.
- The focus be changed from BFHI as a project to BFHI as an integral part of the health care system.
- An international review of community mother support systems be undertaken to identify best practices and lay the groundwork for more effective implementation of Step 10.

**Building capacity of health professionals to support infant and young child feeding**

This group examined capacity building among administrators, hospital maternity staff, and primary health-care workers including paramedics. They looked at both in-service and pre-service possibilities to build sustainable capacity. Among their **primary recommendations were**:

- increasing the ratio of practice vs. classroom sessions in both in-service and pre-service training with a focus on community level work;
- ensuring consistency of messages and an enabling environment across all levels in the health care system;
- ensuring that national policies support curriculum revisions and local level actions and incorporate both private and public institutions;
- linking training and (continuing) education to certification of health workers.

*Identified as needing more research* were the questions of measuring performance quality in such areas as negotiation, counselling and supervision and determining the amount of time needed for real quality performance.

**Discussion:** Many new questions – some with answers - were raised during the discussion.

- What skills are necessary for sustaining breastfeeding?  (IMCI does this)
- Can a module be developed on sustaining breastfeeding?  What would be in such a module?  (Modules need more practical work and linkage with community activity)
- What do we need to achieve the desired feeding behaviour?  (Creativity.  We need to be talking a new language.)
- Who would be good allies for helping achieve this behaviour?  (Immunisation staff, family planning workers, paramedical workers.)
- What about mothers who have to be separated from their infants in the first six months of life?

**Establishing community-based support for infant and young child feeding**

Community-based support is usually the key to exclusive breastfeeding for the first six months, timely and appropriate complementary feeding and continued breastfeeding until the age of two. It is exactly this sort of support that is often missing. This working group looked at several *effective models of community-based support* – both group and individual - among them:

- mother-to-mother support groups;
- peer groups/peer counselling;
- “piggy-backing” on existing women’s groups;
- community health worker counselling (GP, health visitors);
- community volunteers;
- extended family members including men.
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);
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- BFHI assessment tool;
- CREF (to assess implementation of the Code);
- PROFILES.

Then, the gaps in IYCF implementation – micronutrients, fortification of complementary foods, integration into other programmes and maternal nutrition and ways to address them were discussed. Analysis of such a comprehensive programme requires:

- a public debate;
- communication of assessment results;
- quantification of the problems (e.g. via PROFILES);
- policy gap analysis;
- analysis of available opportunities.

Once analysed, the issues must be prioritised giving special consideration both to the very vulnerable groups and to the areas in which rapid progress might be expected. The whole process should be inclusive, involving the health sector, training and research institutions, policy-makers, managers, academics and NGOs. Together and publicly they need to assess the gaps in IYCF and set priorities for action.

**Discussion:** Availability of some other tools, such as SIF was raised

**Integrating interventions in ongoing programmes and activities and monitoring quality**

This group examined opportunities and modalities for integrating infant and young child feeding support into existing programmes. The group appreciated the essential nutrition action approach as a useful guide towards identifying essential actions and their possible entry points in the health system. Beyond this, planners would need to answer questions like: “What services are needed at each point of entry?” and “What skills are needed to deliver them?” This would enable planners to identify the tools that could be used for specific purposes.

Integration of IYCF practices, counselling, supervision and training of health workers can most effectively be fitted into programmes such as:

- Immunisation
- The Early Childhood Development movement
- IMCI (Integrated Management of Childhood Illness)
- Family planning and
- Integrated Management of Pregnancy and Childbirth (IMPAC)

Integration requires advocacy not only within the health sector but also with those sectors that impact on health and nutrition:

- Education
- Agriculture (i.e. WIC)
- Planning
- Finance
- Law and Justice
- Labour
- Food and Industry
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 practices 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?
Each group was asked to make three recommendations for strengthening collaboration and suggest three concrete next steps.

**Eastern Mediterranean and Europe**

These regions often lack both professional capacity and government commitment to/interest in the health sector. These factors, combined with weak or absent regulatory systems and aggressive marketing of inappropriate foods for IYCF, make change difficult. On the positive side, European countries have taken the lead in providing maternity entitlements; they have active trade unions and professional associations, vigorous broad-spectrum democracies and vocal media, all of which could be enlisted to encourage greater commitment to IYCF.

This group explored the possibilities of both traditional and non-traditional partnerships involving:

- Medical schools and postgraduate training
- First Ladies’ projects (US example: Laura Bush’s reading/cultural initiatives)
- UN agencies and other governmental (i.e. EU) and private donors
- Ministries of Health and health insurance companies
- Environmental groups

A concrete first step is planned for the EU meeting in Athens early in March 2003 when delegates will be educated on IYCF.

**Africa**

This group cited weak health systems, insufficient human resources and HIV/AIDS as major challenges to putting IYCF on the policy agendas of their countries. Communities were very much affected by these issues as well as by poverty, food insecurity, inappropriate feeding practices and inadequate awareness of the issues.

Nevertheless, it should be noted that African countries have shown considerable leadership compared to other developing regions and some industrialized countries in incorporating the International Code into their legislation, in providing maternity entitlements and in overall breastfeeding rates and duration.

This group recommended:

- Strengthening existing networks
- Planning a regional workshop to incorporate nutrition into poverty reduction programs
- Documentation and dissemination of country level successful experiences
- Active follow-up on the recommendations of the Harare Meeting in November 2002

**Western Pacific and South-East Asia**

This region shares many of the challenges of the other regions, most particularly the lack of awareness of the long-term importance of IYCF by the governments and other policy-makers as well as donors. Structural problems – no system for dealing with behavioural change and difficulty in implementing the Strategy because of the diversity of programmes – are additional issues.
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
at national level. IBFAN welcomes the emphasis on national Breastfeeding Committees that would include WHO, UNICEF and IBFAN as well as the clear delineation of the responsibility of commercial enterprises as noted in paragraph 44 of the Global Strategy.

The International Lactation Consultant Association (ILCA)

ILCA is the professional organization for International Board Certified Lactation Consultants (IBCLC). Every one of the 18,000 IBCLC has years of hands-on experience with breastfeeding mothers and their babies and has passed a six-hour written competency exam.

Lactation consultants are very involved in the Baby-friendly Hospital Initiative as trainers and assessors, but also, in some countries - Austria, Iraq, Italy and the USA - as national coordinators for the Initiative.

Through its representative to WHO, ILCA supported the Global Strategy at the World Health Assembly, which approved it in May 2002. Following this meeting, the Global Strategy will be presented to the ILCA membership with recommendations for implementing it in both policy and practice in their countries.

La Leche League International (LLLI)

The LLLI Mission is to help mothers worldwide to breastfeed through mother-to-mother support, education, information and encouragement, and to promote a better understanding of breastfeeding as an important element in the healthy development of the baby and mother.

The 6419 LLL Leaders in 64 countries are experienced breastfeeding mothers who have completed the LLLI accreditation process. LLLI has, in addition, trained 4700 breastfeeding peer counsellors (BPC) in 28 countries. Normally both Leaders and BPCs live in the communities in which they volunteer. Both share their own experiences and the resources of the organization. By listening actively and respecting the mother’s choices, they help empower other women and increase their ability to make their own decisions.

LLLI would welcome the opportunity to develop projects and collaborate on activities including development of indicators to assess effectiveness of mother support group meetings, utilization of LLL Leaders as trainers to assist in hospital-based training of health professionals, expansion of current on-line help and list services available to mothers through the Internet in various languages, with particular attention to making these resources available to women in low-income communities.

LINKAGES

LINKAGES, a ten-year project funded by USAID, works at country, regional, and global levels to help organizations put new emphasis on breastfeeding, complementary feeding, and maternal nutrition and to support initiatives such as the lactational amenorrhoea method (LAM) of family planning and the prevention of mother-to-child transmission (PMTCT) of HIV. LINKAGES, managed by the Academy for Educational Development, works with local partners in more than 15 countries. In each country LINKAGES develops strong partnerships, usually with the Ministry of Health, international agencies, non-governmental organizations, community service organizations and academic institutions. Comprehensive country programmes in Bolivia, Ghana, Jordan, Madagascar, and Zambia support the design and implementation of national-level advocacy, district-level programming, community-based counselling, and support groups to achieve measurable results in behaviour change.
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.