UNICEF
Innocenti Research Centre

1990 - 2005

CELEBRATING THE INNOCENTI DECLARATION ON THE PROTECTION, PROMOTION AND SUPPORT OF BREASTFEEDING

Past Achievements, Present Challenges and the Way Forward for Infant and Young Child Feeding

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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1990 - 2005

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Past Achievements, Present Challenges and the Way Forward for Infant and Young Child Feeding

November 2005

In collaboration with REGIONE TOSCANA

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The opinions expressed are those of the authors and editors and do not necessarily reflect the policies or views of UNICEF or of the other organizations associated with this publication.

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The UNICEF Innocenti Research Centre

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The Centre's publications are contributions to a global debate on child rights issues and include a wide range of opinions. For that reason, the Centre may produce publications that do not necessarily reflect UNICEF policies or approaches on some topics. The views expressed are those of the authors and are published by the Centre in order to stimulate further dialogue on child rights.

The Centre collaborates with its host institution in Florence, the Istituto degli Innocenti, in selected areas of work. Core funding for the Centre is provided by the Government of Italy, while financial support for specific projects is also provided by other governments, international institutions and private sources, including UNICEF National Committees.

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FOREWORD

In 1990 the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding set an international agenda with ambitious targets for action. Meeting in Florence, Italy, in July of that year, government policy makers from more than 30 countries adopted the Declaration, which was later endorsed by the forty-fifth World Health Assembly and the Executive Board of UNICEF. The Innocenti Declaration reflected both the spirit of the support that was being mobilized for breastfeeding, and the recognition of the right of the infant to nutritious food enshrined in the Convention on the Rights of the Child. It captured the commitment as well as the practical vision of those who gathered in Florence to launch breastfeeding onto a higher public plane.

A great deal has been accomplished in the past fifteen years. Patterns of breastfeeding have improved, and national governments and societies have taken numerous steps to promote and ensure the enjoyment of the right to breastfeeding. The world itself has changed as well, to one now symbolized by global communications and widespread political commitment to the Millenium Agenda and its Millenium Development Goals. At the same time, the intervening years have seen increased numbers of emergencies, particularly man-made emergencies, and the emergence and spread of HIV/AIDS and other infectious diseases. All of these developments reconfirm the need to highlight and support those behaviours and practices related to infant feeding that can help maintain health, development, and personal satisfaction and growth.

This publication reviews the context of the Innocenti Declaration and analyzes the achievements that have been realized towards the targets that were established in 1990. It describes the continuing and new challenges that exist to optimal feeding of infants and young children, and suggests a way forward towards the global aim of ensuring universal enjoyment of children's right to adequate nutrition. This document represents a consensus report brought together by many partner organizations and agencies, including governments, multilaterals, bilaterals and NGOs. It is intended to serve as a catalyst for increased action in support of the Innocenti Declaration and the Global Strategy for Infant and Young Child Feeding.

The UNICEF Innocenti Research Centre generates knowledge and analysis to support policy formulation and advocacy in favour of children; acts as a convener and catalyst for knowledge exchange and strategic reflections on children's concerns; strengthens the role of UNICEF as an intellectual leader and global advocate for children's rights, and supports programme development and capacity-building. Innocenti studies present new knowledge and perspectives on critical issues affecting children and the realization of their rights.

We hope that this publication, assessing accomplishments over the past fifteen years and the situation today, will contribute to renewed attention, advocacy and action in support of infant and young child feeding, building on the advances since the adoption of the Innocenti Declaration.

Marta Santos Pais
Director
UNICEF Innocenti Research Centre

INNOCENTI

On the Protection, Promot

RECOGNISING that

Breastfeeding is a unique process that:

• provides ideal nutrition for infants and contributes to their healthy growth and development;

• reduces incidence and severity of infectious diseases, thereby lowering infant morbidity and mortality;

• contributes to women's health by reducing the risk of breast and ovarian cancer, and by increasing the spacing between pregnancies;

• provides social and economic benefits to the family and the nation;

• provides most women with a sense of satisfaction when successfully carried out; and that

Recent research has found that:

• these benefits increase with increased exclusiveness[1] of breastfeeding during the first six months of life, and thereafter with increased duration of breastfeeding with complementary foods, and

• programme interventions can result in positive changes in breastfeeding behaviour;

The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers' meeting on "Breastfeeding in the 1990s: A Global Initiative", co-sponsored by the United States Agency for International Development (A.I.D.) and the Swedish International Development Authority (SIDA), held at the Spedale degli Innocenti, Florence, Italy, on 30 July - 1 August 1990. The Declaration reflects the content of the original background document for the meeting and the views expressed in group and plenary sessions.

WE THEREFORE DECLARE that

As a global goal for optimal maternal and child health and nutrition, all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively on breast milk from birth to 4 - 6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond. This child-feeding ideal is to be achieved by creating an appropriate environment of awareness and support so that women can breastfeed in this manner.

Attainment of the goal requires, in many countries, the reinforcement of a "breastfeeding culture" and its vigorous defence against incursions of a "bottle-feeding culture." This requires commitment and advocacy for social mobilization, utilizing to the full the prestige and authority of acknowledged leaders of society in all walks of life.

Efforts should be made to increase women's confidence in their ability to breastfeed. Such empowerment involves the removal of constraints and influences that manipulate perceptions and behaviour towards breastfeeding, often by subtle and indirect means. This requires sensitivity, continued vigilance, and a responsive and comprehensive communications strategy involving all media and addressed to all levels of society. Furthermore, obstacles to breastfeeding within the health system, the workplace and the community must be eliminated.

)ECLARATION

and Support of Breastfeeding

Measures should be taken to ensure that women are adequately nourished for their optimal health and that of their families. Furthermore, ensuring that all women also have access to family planning information and services allows them to sustain breastfeeding and avoid shortened birth intervals that may compromise their health and nutritional status, and that of their children.

All governments should develop national breastfeeding policies and set appropriate national targets for the 1990s. They should establish a national system for monitoring the attainment of their targets, and they should develop indicators such as the prevalence of exclusively breastfed infants at discharge from maternity services, and the prevalence of exclusively breastfed infants at four months of age.

National authorities are further urged to integrate their breastfeeding policies into their overall health and development policies. In so doing they should reinforce all actions that protect, promote and support breastfeeding within complementary programmes such as prenatal and perinatal care, nutrition, family planning services, and prevention and treatment of common maternal and childhood diseases. All healthcare staff should be trained in the skills necessary to implement these breastfeeding policies.

[1]Exclusive breastfeeding means that no other drink or food is given to the infant; the infant should feed frequently and for unrestricted periods.

[2]World Health Organisation, Geneva, 1989.

OPERATIONAL TARGETS:
All governments by the year 1995 should have:

- appointed a national breastfeeding coordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations;
- ensured that every facility providing maternity services fully practises all ten of the *Ten Steps to Successful Breastfeeding* set out in the joint WHO/UNICEF statement[2] "Protecting, promoting and supporting breast-feeding: the special role of maternity services";
- taken action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety; and
- enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

We also call upon international organizations to:

- draw up action strategies for protecting, promoting and supporting breastfeeding, including global monitoring and evaluation of their strategies;
- support national situation analyses and surveys and the development of national goals and targets for action; and
- encourage and support national authorities in planning, implementing, monitoring and evaluating their breastfeeding policies.

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INNOCENTI DECLARATION

On the Protection, Promotion and Support of Breastfeeding

1 August, 1990
Florence, Italy

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PREFACE

Towards the close of the last millennium, child malnutrition threatened to become a 'global embarrassment'[1]. In the new millennium, malnutrition continues to contribute to more than half of all child deaths. It is estimated that about 6 million lives are saved annually from pneumonia and diarrhoea alone due to current levels of breastfeeding,[2] and that optimal infant and young child feeding could save some 2 million lives more.[3]

In 1990 a group of world health leaders and technical advisers, concerned by the infant deaths lost from malnutrition and infection due to the lack of optimal infant and young child feeding, gathered at the International Child Development Centre, now known as the Innocenti Research Centre, located in the Spedale degli Innocenti in Florence. Over the course of two days of discussion and debate, they produced the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding.

In November 2005, Florence is again a gathering place, to assess progress over the past 15 years and to renew commitment to breastfeeding and all aspects of improving infant and young child feeding. This anniversary is being observed to:

1. Assess progress made in the protection, promotion and support of breastfeeding since 1990.
2. Call upon governments, civil society and donors to increase efforts to implement the targets of the Innocenti Declaration and the additional targets established in 2002 within the Global Strategy for Infant and Young Child Feeding.
3. Raise awareness of every child's right to adequate nutrition, and the corresponding obligations on all sectors of society to ensure that this right is realized.
4. Promote proven strategies, interventions and tools, with special focus on new policies developed in the areas of HIV and infant feeding in emergencies, and the action needed to encourage exclusive breastfeeding.

This document celebrates the progress made since the Innocenti Declaration, and describes the way to achieve the global goal: to empower women to breastfeed their children from birth, exclusively for six months, and then with responsive, age-appropriate complementary feeding and foods, for two years and beyond.

This publication is intended to raise the profile of breastfeeding and all elements of infant and young child feeding as key interventions for improving child survival, growth and development, and to bring this once again to the attention of governments and donors. In doing so it describes a chain of actions, events, documents and practices stretching forward from the Innocenti Declaration to the Global Strategy for Infant and Young Child Feeding,[4] building on the established International Code of Marketing of Breast-milk Substitutes.[5] It also examines the bases found in the Convention on the Rights of the Child, and the centrality of infant and young child feeding to achieving the aims of the Millennium Agenda and the Millennium Development Goals. All of the aforementioned milestones and documents address infant and young child feeding from different perspectives, but as elements of a set, reflecting mutually supportive goals and processes. So while this document is organized from the past to the present and on to the future – from the Innocenti Declaration to the Global Strategy, with the Code as a cornerstone – the underlying theme is of the deep interconnectedness and synergy among all of these elements, towards a common aim.

The process of preparing this publication also reflects interconnections of a different kind – the generous and creative cooperation among multilateral, bilateral, NGO and academic advocates for breastfeeding. Building upon draft reports of UNICEF and WHO on infant and young child feeding, with the addition of contributions from over a dozen individuals from organizations with differing perspectives, resources and working methods, this document stands as a testament to the strength and breadth of the breastfeeding movement, and its willingness to take on the related but broader challenges of infant and young child feeding.

Hence, this is not a policy document, but rather it is a consensus report brought together by representatives of many partner organizations and agencies, including multilaterals, bilaterals and NGOs.

It seeks to provide a contribution towards renewed efforts for the benefit of all the world's children.

Note

1 Jonsson, U., 'Children's Right to Nutrition: Food, care and a healthy environment', in *Implementing the Convention on the Rights of the Child*, J. Himes, ed., The Hague, Netherlands: Martinus Nijhoff Publishers, 1995.
2 Saadeh, R. et al., 'Breast-feeding – The technical basis and recommendations for action', WHO, 1993, p. 2.
3 Jones, G. et al. and the Bellagio Child Survival Study Group, 'How many child deaths can we prevent this year?', *The Lancet*, 2003; 362: 65–71.
4 WHO/UNICEF *Global Strategy for Infant and Young Child Feeding,* WHO, Geneva, Switzerland, 2003.
5 WHO/UNICEF *International Code of Marketing of Breast-milk Substitutes*, WHO, Geneva, Switzerland, 1981.

EXECUTIVE SUMMARY

Many studies have confirmed that breastfeeding behaviours will change when a comprehensive set of interventions are in place. Ensuring appropriate medical support and care, legal protection, maternal nutrition, health and survival, family and social support for provision of feeding and care are essential in the support of optimal feeding in the first two to three years of life. Breastfeeding alone provides the ideal nourishment for infants for the first six months of life because it contains all the water, nutrients, antibodies and other factors an infant needs in order to thrive. Breastfeeding also has many health and emotional benefits for the mother. For the child breastfed beyond 6 months, complementary feeding, or the nutrition given in addition to continued breastfeeding, is also a key to child survival and development.

The Innocenti Declaration

In 1990, a gathering representing 30 countries together with multilateral and bilateral partners decided that it was time to create a global action plan to reverse declining breastfeeding rates. There had been seven preliminary technical working meetings and expert papers over three years in preparation for this event, which was hosted by the Innocenti Centre and co-hosted and supported by WHO, UNICEF, the United States Agency for International Development (USAID) and the Swedish International Development Cooperation Agency (Sida). A collaboration of technical staff, known informally as the ad hoc Interagency Group for Action on Breastfeeding (IGAB), was the driving force. Two additional publications were also vital to the meeting: 'Protecting, Promoting and Supporting Breast-feeding: The special role of maternity services, A joint WHO/UNICEF statement, 1989' and 'Breastfeeding: Protecting a natural resource' and the associated video, supported by USAID. The meeting (30 July–1 August 1990) presented the conclusions and recommendations from all the technical meetings and papers. The outcome of the Florence meeting was the adoption of the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, later endorsed by the forty-fifth World Health Assembly (WHA) and the Executive Board of UNICEF. The Declaration was immediately incorporated into the Statement of the United Nations World Summit for Children.

The Innocenti Declaration established four operational targets. By 1995, all governments were to have achieved the following:

1. Appointed a national breastfeeding coordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, NGOs and associations of health professionals;
2. Ensured that every facility providing maternity services fully practises all 10 of the 'Ten Steps to Successful Breastfeeding' set out in the joint WHO/UNICEF statement, Protecting, Promoting and Supporting Breast-feeding: The special role of maternity services';
3. Taken action to give effect to the principles and aim of all articles of the International Code of Marketing of Breast-milk Substitutes and subse-

quent relevant World Health Assembly (WHA) resolutions in their entirety; and

4. Enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

Achievements since the Declaration

The Innocenti Declaration set the stage for breastfeeding programming approaches that were used throughout the 1990s and were reaffirmed in the Global Strategy for Infant and Young Child Feeding that was endorsed in 2002 by WHA and the UNICEF Executive Board. The Declaration inspired the establishment of the Baby-Friendly Hospital Initiative (BFHI). It called on all countries to implement the International Code of Marketing of Breast-Milk Substitutes and to follow the Ten Steps to improve maternity practices and ensure full support for mothers intending to breastfeed.

The human rights approach adopted in the Innocenti Declaration gained wide recognition as one of the best examples of the concept of shared responsibilities in support of individual and community-level efforts to promote the realization of the child's right to the highest attainable standard of health. Soon after, the Convention on the Rights of the Child (1990) further recognized the importance of the protection, promotion and support of breastfeeding.

Challenges

The targets of the Innocenti Declaration were extremely ambitious. Although they were not fully achieved by the projected date of 1995, or even by 2005, a great deal of progress has been made on each of them. According to the latest figures, about 80 countries have some form of national authority, about 19,000 hospitals have been certified and designated as baby-friendly in 150 countries, more than 80 countries have laws or regulations implementing the International Code of Marketing of Breast-milk Substitutes either fully or in part, and 59 countries have ratified at least one of three maternity protection conventions to support employed mothers.

Within 10 years of the adoption of the Innocenti Declaration, declining breastfeeding rates were reversed. Exclusive breastfeeding increased 15 per cent worldwide.[6] Today we recognize that breastfeeding is a mother's first life-saving gift to her newborn, and that breastfeeding is already saving about 6 million lives annually from common infectious diseases.[7] But that is not all. An estimated 13 per cent of the roughly 10 million under-five deaths, which occur in the 42 countries that account for 90 per cent of child deaths worldwide, could be prevented through exclusive breastfeeding in the first six months; and a further reduction of almost 6 per cent through better complementary feeding.[8] Optimal feeding in this manner has the potential to save an additional 2 million lives each year.

New directions: Implementing the Global Strategy for Infant and Young Child Feeding

It is now possible – in 2005 –to better protect, promote and support improved infant and young child feeding practices than it was in 1990, for the following reasons:

- Additional scientific evidence of the beneficial properties of breastmilk;
- Programmatic experience from large-scale, community-based, breastfeeding programmes showing the effectiveness of a combination of interventions to change behaviours;
- Availability of training courses, counselling materials, policy guidelines,; employment aids,; assessment, monitoring and evaluation tools, and other resources to support those promoting improved infant and young child feeding practices;
- Heightened visibility in the international health community of breastfeeding as a critical intervention for newborn and child survival, thanks in part to *The Lancet's* Child and Newborn Survival Series and articles in other journals.

The Innocenti targets were augmented throughout the 1990s by further agreements on the best means to protect the nutrition rights of infants and young children. The Global Strategy calls for urgent action on the part of governments, as well as other partners, to enact all four of the Innocenti targets, as well as five additional targets, with emphasis on support for the mother, community action, complementary feeding and special circumstances.

While complementary feeding was not a central focus, the Declaration clearly stated its importance, and it was understood to be a vital issue for the child breastfed beyond six months. Unfortunately, too many children still suffer from undernutrition worldwide, manifested in stunted growth, wasting and micronutrient deficiencies. The deficits acquired during the first years are nearly impossible to redress later in life, resulting in reduced school performance and productivity. And today obesity is also a growing concern.

Working Together

It has become clear that to achieve the global behaviour change and targets of the Global Strategy, a comprehensive, coordinated, health- and rights-based approach is needed. Many organisations have joined together to produce the Innocenti Declaration and the Global Strategy; many more will become involved if we are to achieve the goals envisioned. This will demand activities at the global advocacy level, at the level of national policy and standards, within the health sector as well as with involvement of education, agriculture, and other sectors that impact on normative behaviours, and, of course, at the community and family levels, so that together an enabling environment will be achieved.

The Way Forward

In spite of the vital role of appropriate infant feeding

practices in reducing child mortality, investment in interventions to improve infant and young child feeding has apparently decreased, and few countries are implementing comprehensive, large-scale programmes to improve breastfeeding and complementary feeding practices, as well as maternal nutrition.

The challenge is to learn from experience and use this knowledge to work for a global environment in which all children can thrive and achieve their full potential.

Note

6 Labbok, M. et al., 'Trends in Breastfeeding 1990–2000', *JHL*, in press.
7 Saadeh, R. et al., 'Breast-feeding – The technical basis and recommendations for action', WHO, 1993, p.2.
8 Jones, G. et al., op cit.

1

CELEBRATING THE INNOCENTI DECLARATION

Historical background

The Innocenti meeting and Declaration of 1990 were a response to existing conditions; the recognition of the need for change based on the increasing scientific and social rationale for breastfeeding was the impetus for action.

The development of breastmilk substitutes

By the beginning of the 20th century, food-processing industries were marketing sweetened condensed milk and processed cows' milk as breastmilk substitutes both in their own countries and overseas. Commercial infant formula companies were established as early as 1920. During the same era, maternity care was shifting from being a matter for the household to an event supervised by the medical profession, and physicians increasingly sought options for their clientele that they considered 'scientific'. While many continued to write about the importance of breastfeeding, others promoted practices that made breastfeeding difficult and reduced women's supply of breastmilk. Mistaken ideas and harmful practices, based on misinformation, misperceptions and poor scientific methodology, are still accepted and promulgated today, in part because many other factors contributed. For example, as women entered the workforce in larger numbers – during the 1940s in the United States, for example – the call for breastmilk substitutes grew, as it became virtually a civic duty to support the war effort. The increasing medicalisation of birthing created obstacles to breastfeeding initiation; manufacture and marketing of commercial formulas, with brand-name competition, expanded; memories and skills of how best to support breastfeeding were lost; and a social model of artificial feeding as the norm was established in many industrialized nations, spreading to communities worldwide. The perception in many countries that artificial feeding carries few risks persists to this day.[9]

In the decades leading up to the development of the International Code of Marketing of Breast-milk Substitutes, it was noted that companies manufacturing infant formula increasingly launched aggressive and direct marketing campaigns throughout the world. New media, such as radio and television, facilitated widespread and unrestricted promotion of many products. Infant formula advertisements at this time did not state the superiority of breastfeeding, and many suggested that the substitutes were equal to or better than a mother's own milk. The 1980s saw the rise of HIV, fear of transmission, and breastmilk bank closures, and at the same time fortifiers to adapt human milk for premature infants and 'specialty' formulas became increasingly available.

The growth of public awareness

In 1939, the renowned international public health paediatrician and epidemiologist, Dr. Cicely Williams, made a speech to the Singapore Rotary Club entitled 'Milk and Murder'. Dr. Williams condemned the unnecessary deaths of infants caused by the promotion of sweetened condensed milk. She declared: "Misguided propaganda on infant feeding should be punished as the most criminal form of sedition, and those deaths should be regarded as murder."[10]

In 1979, WHO and UNICEF jointly hosted an international meeting on infant and young child feeding that called for the development of an international code for ethical marketing. Representatives of governments, technical experts, NGOs – including the La

Box 1 - Protection provided by breastfeeding

- In addition to providing nutrition and nurturance, there are many additional well-recognized benefits of breastfeeding for full-term infants:[11]
- Current research suggests that human milk may especially benefit the preterm infant;[12], [13]
- Human milk provides nutrition, digestive enzymes, immunologic factors of many types, growth factors, hormones and other bioactive factors, with new components being discovered regularly;
- Preterm human milk contains higher concentrations of immunoglobulins, other anti-infective factors such as lysozyme, lactoferrin and interferon, and more anti-inflammatory and immunomodulating components,[14] thus providing some protection from infection to these vulnerable infants;
- Breastmilk-fed infants have a reduced incidence of necrotizing enterocolitis,[15] sepsis[16] and other infections such as urinary tract infections;
- Both fresh and pasteurized human milk help lower infection rates;[17]
- Infants fed breastmilk tend to have higher IQ scores,[18] and improved visual development, [19] with less retinopathy of prematurity; [20]
- Enzymes in breastmilk help immature infants absorb and utilize nutrients more efficiently;

Recent research indicates that breastfeeding is a cost-effective intervention to address the problem of childhood obesity.[21], [22]

Leche League International (LLLI) and the International Council of Nurses – the infant food industry and scientists working in infant nutrition attended the meeting. The International Baby Food Action Network (IBFAN) was founded at this meeting. The meeting led to the drafting of the International Code of Marketing of Breast-milk Substitutes and its adoption by all but two member States, an extraordinary precedent, and one of the key initiatives discussed in chapter 2 on the achievements since the Innocenti Declaration.

The scientific evidence

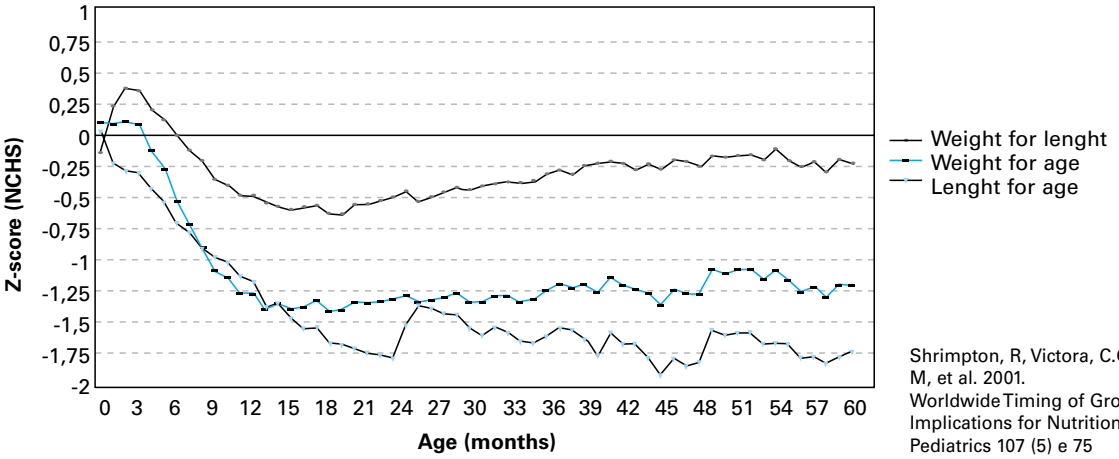
Breastfeeding

Many studies have confirmed that breastfeeding behaviours will change when a comprehensive set of interventions are in place. Ensuring appropriate medical support and care, legal protection, maternal nutrition, health and survival, family and social support for provision of feeding and care are essential in the support of optimal feeding in the first two to three years of life. In addition, encouraging adequate birth intervals will help ensure that there is enough time available to feed and care for their children and protect women's own health.

Breastfeeding alone provides the ideal nourishment for infants for the first six months of life because it contains all the water, nutrients, antibodies and other factors an infant needs in order to thrive. It constantly adapts to the needs and environmental challenges the child faces.

Breastfeeding also has many health and emotional benefits for the mother, including improved recovery following delivery, decreased blood loss postpartum, delayed return to fertility and decreased risk

Graph 1 - Global mean W/A, L/A and W/L



Shrimpton, R, Victora, C.G. de Onis, M, et al. 2001.
Worldwide Timing of Growth Faltering
Implications for Nutritional Interventions
Pediatrics 107 (5) e 75

Weight for length falters 0.9Z from 3 to 12 months and recovers 0.4 by 48 months
Global population weight growth falters 1.3Z between 4 and 12 months of life
Height growth drops a total of 1.6Z from birth to 24 months
Height and weight growth essentially normal after 24 months

of cancer of the breast and ovaries. Immediate postpartum breastfeeding helps the bonding between mother and child, decreasing desertion.[23]

Complementary feeding

Complementary feeding is clearly understood to be a vital issue for the child breastfed beyond 6 months. Growth reference analyses for developing countries consistently have shown falling off after the early months, while research has shown that little can be done for growth recovery after the first two to three years (*see Graph 1*). Hence, complementary feeding, or the nutrition given in addition to continued breastfeeding, is also a key to survival. According to *The Lancet's* Child and Newborn Survival Series, continued breastfeeding with appropriate complementary feeding could save about 600,000 lives annually.

The graph below shows the decline in mean weight for age, length for age and weight for length seen between the ages of 6 months to 2–3 years. This underlines the importance of continued breastfeeding with age-appropriate complementary feeding.

The Innocenti Declaration

In 1990, a gathering representing 30 countries together with multilateral and bilateral partners decided that it was time to create a global action plan to reverse declining breastfeeding rates. There had been seven preliminary technical working meetings and expert papers over three years in preparation for this event, which was hosted by the Innocenti Centre and co-hosted and supported by WHO, UNICEF, the United States Agency for International Development (USAID) and the Swedish International Development Cooperation Agency (Sida). A collaboration of technical staff, known informally as the ad hoc Interagency Group for Action on Breastfeeding (IGAB), was the driving force. Two additional publications were also vital to the meeting: 'Protecting, Promoting and Supporting Breast-feeding: The special role of maternity services, A joint WHO/UNICEF statement, 1989' and 'Breastfeeding: Protecting a natural resource' and the associated video, supported by USAID. The meeting (30 July–1 August 1990) presented the conclusions and recommendations from all the technical meetings and papers. The outcome of the Florence meeting was the adoption of the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, later endorsed by the forty-fifth World Health Assembly (WHA) and the Executive Board of UNICEF. The Declaration was immediately incorporated into the Statement of the United Nations World Summit for Children.

The Innocenti Declaration established four operational targets. By 1995, all governments were to have achieved the following:

1. Appointed a national breastfeeding coordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, NGOs and associations of health professionals;
2. Ensured that every facility providing maternity services fully practises all 10 of the 'Ten Steps to Successful Breastfeeding' set out in the joint WHO/UNICEF statement, Protecting, Promoting and Supporting Breast-feeding: The special role of maternity services';
3. Taken action to give effect to the principles and aim of all articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions in their entirety; and
4. Enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

Note

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2

ACHIEVEMENTS

Implementing the Innocenti Declaration

The visionary character of the Innocenti Declaration is evident in retrospect, as its five-year timeline was too ambitious for the targets established. Fifteen years later the vastness of the social changes necessary to fully support breastfeeding and young child feeding has become abundantly clear. Changing the world cannot be accomplished in 5 years – or even 15! But such comprehensive changes are, in effect, what the Innocenti Declaration demanded.

The Declaration introduced important new language into discussions of infant feeding. The conceptual framework underlying the Innocenti Declaration is the protection, promotion and support of breastfeeding. The distinctions between these three levels of activity are important.[24] **Protection** of breastfeeding shields women who are already breastfeeding from influences that might discourage the practice, such as the promotion of breastmilk substitutes. **Promotional** activities to try and persuade women to breastfeed their infants, often involve mass-media and re-education campaigns, but also include promotion and advocacy at all levels. Support activities help women to feed their infants optimally using appropriate techniques, and give them confidence in their breastmilk supply. **Support** includes help given by trained breastfeeding counsellors to overcome problems, and assistance to face conditions that make breastfeeding difficult, including unhelpful practices in health facilities, and conditions of paid employment. In sum, all women deserve protection, support and reinforcing information from many sources to help ensure that they can feed their infants optimally – not only those with an identified problem. Trained breastfeeding counsellors are an important means of support for breastfeeding mothers. The relative effort put into each of these depends on current conditions in the country concerned.[25]

The Declaration also continued the process of viewing breastfeeding and child feeding as human rights as they apply to both developing and industrialized countries. The impact on the rights discussion, as well as on behaviour, may be seen in the review of progress and lessons learned related to each of the four operational targets.

National breastfeeding coordinators and committees

Operational Target 1: Appoint a national breastfeeding coordinator of appropriate authority, and establish a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations and health professional associations.

Multisectoral national breastfeeding committees as described in this first target of the Innocenti Declaration are known to exist in many countries, and as part of this committee, or independently, a large percentage of countries have identified a national breastfeeding or infant and young child nutrition coordinator to provide oversight, guidance and coordination for their nation's breastfeeding promotion efforts. However, the number and level of activity has varied over the years.

In 1998, WHO reported on national committees and coordinators as seen in Figure 1[26]

Figure 1 - Numbers of National breastfeeding committees and coordinators by Region, WHO (1998)

	National breastfeeding committee	National breastfeeding coordinator
African Region	58	84
Eastern Mediterranean Region	65	71
European Region	74	76

A survey was carried out in 2005 and was sent to 127 key individuals in the 80 countries that had a contact on record at UNICEF headquarters.[27] Forty-three countries responded but five countries could not be included because they had no established national committees nor had they identified national coordinators. Twelve of the 43 responding nations were among the 30 nations present for the signing of the original Innocenti Declaration.

Twenty-eight of the responding nations reported that national breastfeeding coordinators had been appointed. In all but three countries where a national coordinator is in place, the national committee receives its major funding support from the government. While having a national coordinator in place is valuable to a national breastfeeding promotion effort, reports in this survey suggest that it has not been essential, as national committees without a coordinator in place also reported significant accomplishments.

The fact that the first Innocenti target urged all governments to develop multisectoral national committees to promote breastfeeding indicates that the sponsoring international agencies and the representatives of the 30 governments gathered in Florence in 1990 understood the complexities of promoting breastfeeding and the fundamental importance of accountability as well as comprehensive, multidisciplinary collaboration and cooperation if success was to be achieved. The Declaration appears to have been a major stimulus to national committee development in the decade that followed 31 additional committees were established, and 3 more countries reported setting up committees after 2000.

In the majority reporting, governments have a central influence and role in committee activities. Most were also involved in advising on policies and legislation and active in promotional campaigns. About half of the committees are active in the development of support groups and in working with employers to help employees continue to breastfeed after returning from maternity leaves. These efforts are more likely to be effective when officially supported by government.

Funding was universally reported as an area of continuing concern for sustainability. National committees responding to the survey are typically:

- appointed or endorsed by their governments;
- considered as the national breastfeeding authority;
- collaborating with UNICEF, where a UNICEF office exists, but are unlikely to have UNICEF as a formal member;
- responsible for overseeing and/or carrying out national BFHI activities (assessments, designations and reassessments);
- funded, at least in part, by their governments but are unsure of and worried about future support;
- active in the development of national policies and legislation, including the International Code of Marketing of Breastmilk Substitutes;
- playing or have played a significant role in helping to establish the Ten Steps and BFHI as a standard of mother-baby perinatal care in health facilities.

All report being involved in World Breastfeeding Week (WBW), and most develop or review informational materials. Some also participate in monitoring the marketing practices of manufacturers of infant foods. A significant number of responses indicated that promoting breastfeeding and the Global Strategy for Infant and Young Child Feeding should become a matter of **national policy**, including attention to national commitment to increasing the number of baby-friendly hospitals. Many included the importance of interagency and organizational collaboration to achieving long-term success.

In view of the contributions that national committees make to the protection, promotion and support of breastfeeding, it is essential to continue pursuing this Innocenti target, to continue supporting those committees currently in existence and to urge additional countries to appoint coordinators and develop committees. Today, it is appropriate that committee responsibilities be expanded to include the new objectives identified in the Global Strategy for Infant and Young Child Feeding and their functions be fully incorporated into national budgets to assure the continuation of their contribution to achieving optimal infant and young child feeding for all of the world's children.

Supportive maternity services

Operational Target 2: Ensure that every facility providing maternity services fully practises all 10 of the 'Ten Steps to Successful Breastfeeding'.

In 1989 WHO and UNICEF issued 'Protecting, Promoting and Supporting Breast-feeding: The special role of maternity services'. This document outlined 'Ten Steps to Successful Breastfeeding'. These steps were endorsed in the Innocenti Declaration and became the foundation of BFHI, inaugurated by WHO and UNICEF in 1991. The goals of BFHI were to:

- Improve breastfeeding practices within maternity wards in the health system;
- Educate all health workers who were trained in these facilities concerning the importance and basic skills of breastfeeding support; and
- Enforce within facilities the principles of the International Code of Marketing of Breast-milk Substitutes.

Box 2 - Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health-care staff.
2. Train all health-care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one half-hour of birth.
5. Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice rooming-in - that is, allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

BFHI placed breastfeeding on the health policy agenda of most countries worldwide. The BFHI approach has been shown to be extremely effective, increasing exclusive breastfeeding in many regions, even in the face of continued advertising of commercial infant foods and increasing HIV prevalence. According to the World Alliance for Breastfeeding Action (WABA): "The BFHI was clearly the right initiative at the right time. It galvanized numerous resources available globally and provided a focus and facilitated political will at the highest levels as never before."[28] BFHI continues to be a central component of strengthening breastfeeding support and early initiation, as well as health-worker training.

More than 19,000 facilities in 150 countries have been designated 'baby-friendly'. To receive this designation, a facility must go through an assessment process. Even where the designation is not achieved, the existence of baby-friendly hospitals may influence practices in the greater community as new health personnel are exposed to these skills, and as demand is created among women and families.

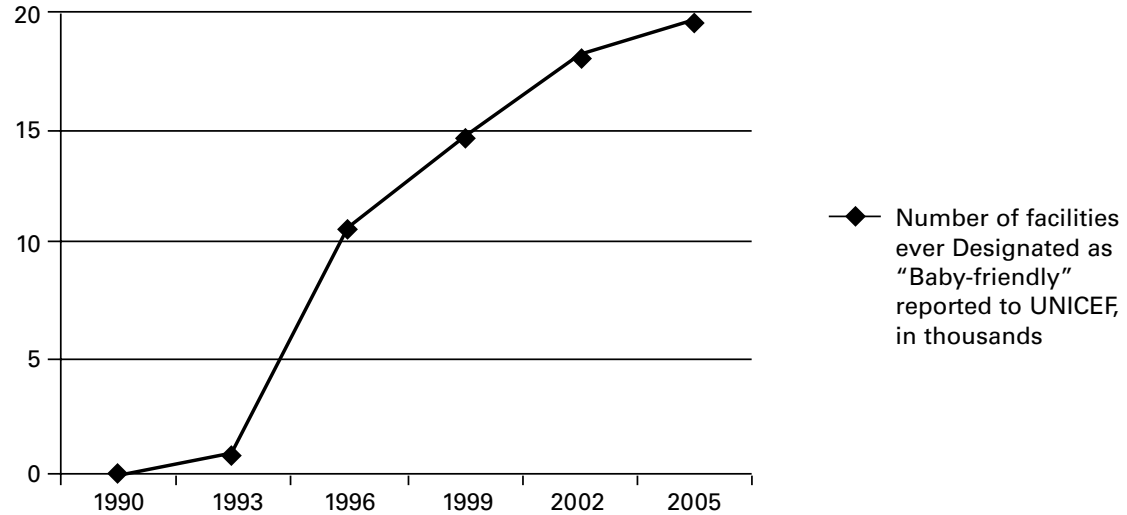
In 2000, UNICEF, in collaboration with Wellstart International and the USAID-funded LINKAGES Project, conducted several case studies of BFHI in different regions of the world.[29] These studies, for countries as wide ranging as China, Peru and Zambia, indicate that the Ten Steps are feasible, and illustrate the dramatic changes that occurred in concert with the initiation of BFHI.

Also in 2002, UNICEF conducted an assessment of country experiences in the implementation of the Innocenti target activities.[30] The assessment concluded that 'packages' such as the Ten Steps are easy to understand and appealing; the clear conclusion was, however, that for sustained behavioural change such packages are best applied as part of a comprehensive approach that includes policy and legislation, broader health system reform and community interventions.

Challenges

The assessment identified various challenges to BFHI implementation. These challenges will need to be addressed if BFHI is to evolve from a stand-alone ini-

Graph 2 - Cumulative number of facilities designated 'baby-friendly', in thousands (from UNICEF country reports)



tiative to a routine standard of care, fully integrated into standards of clinical practice. For this to happen, there must be sustained leadership at all levels; consistent and continuous commitment; time, human and financial resources; and accountability. Seven major challenges follow: commitment, compliance and quality control, cost, community, confusion and concerns regarding HIV, expansion of the continuum of care, and the integration of the baby-friendly concept with other initiatives.

1. **Commitment:** Staff turnovers, the departure of BFHI supporters, or competing issues have resulted in declining BFHI practices in some of the designated facilities.
2. **Compliance and quality control:** Many facilities once designated baby-friendly are no longer in full compliance. When oversight is weak or absent, quality suffers. Training is an important mechanism for maintaining the quality of BFHI activities but training is often brief and predominantly theoretical, and does not include sufficient practice of the skills needed to help mothers to breastfeed effectively. Improved training, including training of trainers and follow-up of skills practice, is needed to ensure that health workers in baby-friendly hospitals have good skills to support mothers.
3. **Cost:** Where BFHI is not a standard line item in national health budgets, it can easily be overlooked.
4. **Community:** Step 10 – community outreach – has not been actively implemented or maintained in many countries. All recognize, however, the need to strengthen community support for breastfeeding-related activities. Experience has shown that Step10 must build on established social-support networks if the support groups are to flourish. One effort to develop baby-friendly communities has been very successful. In the Gambia, for example, men's involvement sent out a clear and strong message that maternal and infant nutrition is everyone's concern. Many mothers run into real or perceived difficulties and give up breastfeeding in the first two to four weeks after delivery, even in baby-friendly hospital areas, because there is no one to give them skilled help and reassurance to overcome the common difficulties. Follow-up from health workers or from community members in the first few weeks is essential to ensure that breastfeeding is fully established.
5. **Confusion and concerns regarding HIV:** The HIV/AIDS pandemic has raised confusion and concerns about breastfeeding and related baby-friendly activities. (This subject is treated in more depth in chapter 3.)
6. **Extending the continuum of care:** Concern has also been expressed that BFHI does not provide a full continuum of care for all mothers and babies. The authors of *Impact of Birthing Practices on Breastfeeding*,[31] raise concerns that current maternity practices are detrimental to the maternal physical and emotional experience and can negatively affect breastfeeding outcomes as well. Extending the concept to include maternal care, as in 'mother-baby' friendly, might include continuous support to the mother by a birth companion during labour and childbirth, increasing a woman's comfort during labour, and pain management without medications.
7. **Mainstreaming/Integration:** The principles of mother-friendly and baby-friendly may also be integrated with other initiatives. To support the sustainability of baby-friendly hospital practices, full integration of these practices into all ongoing activities in support of Millennium Development Goals 1 (Eradicate extreme poverty and hunger), 4 (Reduce child mortality) and 5 (Improve Maternal Health)[32] is a way to ensure the maternal–newborn–child health continuum. In this way, all Ten Steps of BFHI are part of quality care of the newborn, along with immediate post-partum skin-to-skin contact and support for initiation of breastfeeding within the first hour after delivery.

Implementation of the International Code of Marketing of Breast-milk Substitutes

Operational Target 3: Take action to give effect to the principles and aim of all articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety.

The International Code of Marketing of Breast-milk Substitutes (the Code) was adopted by WHA in 1981 as a recommendation to member States to implement its provisions into national legislation, regulations or other suitable measures. (*For a summary of the Code, see Box 3.*)

The Code is a global recommendation that:

- Recalls that breastfeeding must be actively protected and promoted in all countries.
- Stresses that adoption and adherence to the Code is a minimum requirement.
- Urges all member States to translate the Code into national measures.

Specifically, the Code:

- Protects all babies whether they are breastfed or artificially fed.
- Regulates the distribution of breastmilk substitutes to help avoid a shift away from breastfeeding for babies who would benefit from it (protection from 'spillover').
- Protects artificially fed infants by ensuring that product labels carry the necessary warnings and instructions for safe storage, preparation and use.
- Aims to ensure that the choice of product is made on the basis of independent medical advice and not commercial influence.
- Ensures that the quality of breastmilk substitutes meets applicable standards recommended by

Codex Alimentarius and by the Codex Code of Hygiene Practices for Foods for Infants and Children.

The Code does not:

- Try to stop infant formula and other breastmilk substitutes under the scope of the Code from being made available, or being sold or used when necessary.

Prevent governments making breastmilk substitutes available to HIV-infected mothers, free or at a subsidized price, when the government has purchased them. But these should be reliable in the short term and sustainable in the long term.

The Code does, however, aim at preventing manufacturers from donating supplies of breastmilk substitutes, or providing them at a reduced price, to any part of the health-care system.

The actual text of the Code was a compromise agreed between governments, health experts, manufacturers and the NGO community; it thus contains some weaknesses, ambiguities and loopholes. WHA, however, has addressed issues related to the Code on numerous occasions since 1981, adopting a dozen resolutions that have clarified or strengthened matters of dispute. Because the Code itself was adopted as a WHA resolution, all subsequent resolutions regarding the Code have the same legal status and should be viewed as integral to the interpretation of the original text.

The Code was adopted as a minimum standard. Member States are expected to implement the basic principles and strengthen the provisions according to their society's need. They may make the Code stronger in any way they see fit in order to protect infant and young child health and survival, but they should not weaken it or omit any provisions.

The Code specifically addresses manufacturers and distributors, as well as other stakeholders, stating that they should comply with the Code independently of other measures. If a member State ignores the Code, companies are expected to implement it even when a government has not issued regulations or laws. The manufacturers involved in the drafting procedure agreed to this principle.

Code implementation since the Innocenti Declaration

At the time of the adoption of the Innocenti Declaration in 1990, only nine governments had adopted the Code into law. However, by 1991, IBFAN's International Code Documentation Centre (ICDC) launched a series of Code implementation courses to assist governments in drafting laws based on the Code and subsequent WHA resolutions. In 1995 UNICEF created a full-time post for a lawyer to provide technical assistance to governments on the implementation of the Innocenti legislative targets. UNICEF provided support to the IBFAN training courses, and by 2005 more than 60 governments had enacted legislation implementing all or many of the provisions of the Code and subsequent relevant WHA resolutions. Over 20 countries have draft laws awaiting adoption.

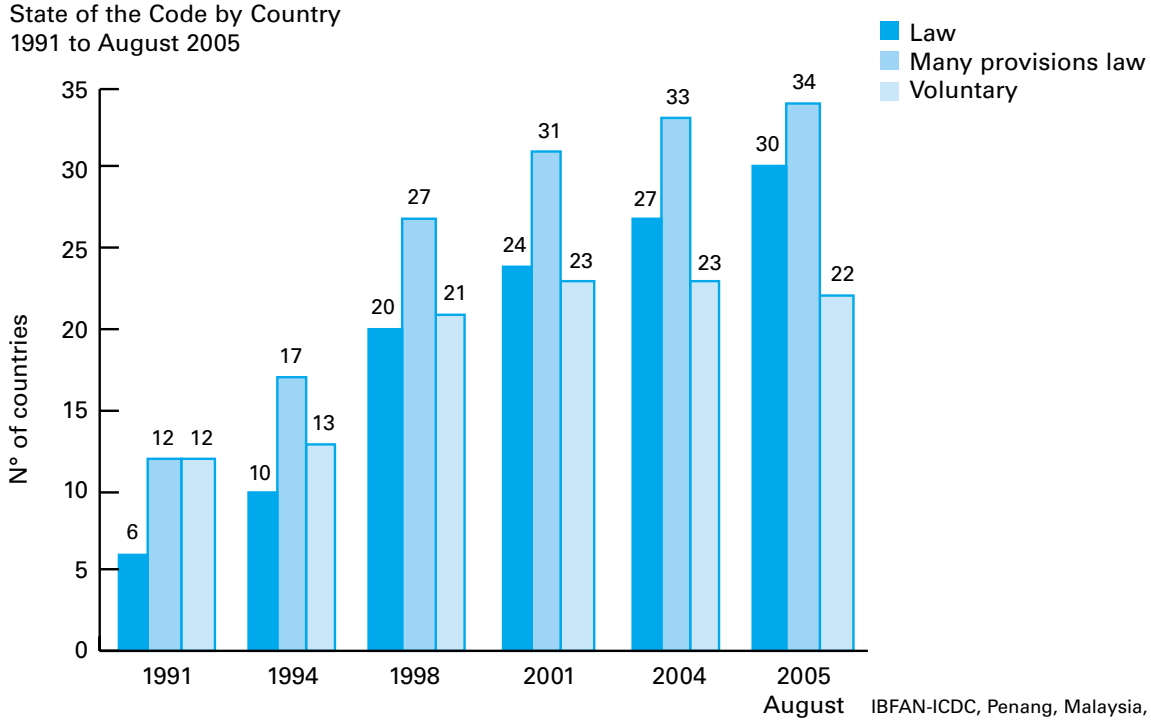
Key elements for successful Code implementation

Over the years, certain key elements have been identified as having contributed to the effective adoption, implementation and enforcement of Code legislation or regulations.

- **Creation of a critical mass of Code advocates through Code awareness training:** UNICEF began organizing three- or four-day awareness-raising

Figure 2 - Progress in Code implementation

State of the Code by Country
1991 to August 2005



IBFAN-ICDC, Penang, Malaysia, August 2005

workshops in 2000, which could then be replicated at national level to produce the strong advocates necessary to see the process completed.

- **In-depth training for policy makers and lawyers** including training on the drafting of Code legislation. The ICDC nine-day annual and week-long regional training courses have succeeded in encouraging some 70 nations to take action (*see Figure 3*). ICDC also offers country-level trainings.
- **Clearly drafted Code regulations** that incorporate all provisions of the Code and subsequent resolutions as a minimum standard and include the necessary implementation and enforcement provisions identifying an independent body responsible for monitoring, a person or body to whom violations should be reported, a forum for adjudication, and effective sanctions and regulatory processes to act as a deterrent.
- **Independent monitoring** free from commercial interests using standard protocols to document violations and maintain a global database.
- **Regular monitoring reports**.

Major obstacles to Code implementation include the lack of: a sufficient advocacy skill base, enforcement and monitoring skills by governments, awareness among policy makers, health-care workers and the general public, expertise and drafting capacity; and overburdened legislative agendas as well as pressures from commercial interests.

Resolutions adopted since 1981 have reiterated the urgent need for governments to implement the Code and subsequent resolutions at the national level. A resolution in 1986 pointed out that follow-up milks are not necessary, while WHA resolution 47.5 of 1994 clarified ambiguities in relation to free and low-cost supplies, stressing that such supplies of breastmilk substitutes, bottles or teats should not be allowed in any part of the health-care system. More recent resolutions have clarified the optimal duration of exclusive breastfeeding (six months) and urged that complementary foods are not marketed for or used in ways that undermine exclusive and sustained breastfeeding.

Other areas of concern addressed include calls to ensure that Code monitoring is carried out in a transparent manner free from commercial interest, and to ensure that financial support and other incentives for programmes and health professionals working in the field of infant and young child health do not create conflicts of interest.

Impact of the Code on promotion of breastmilk substitutes

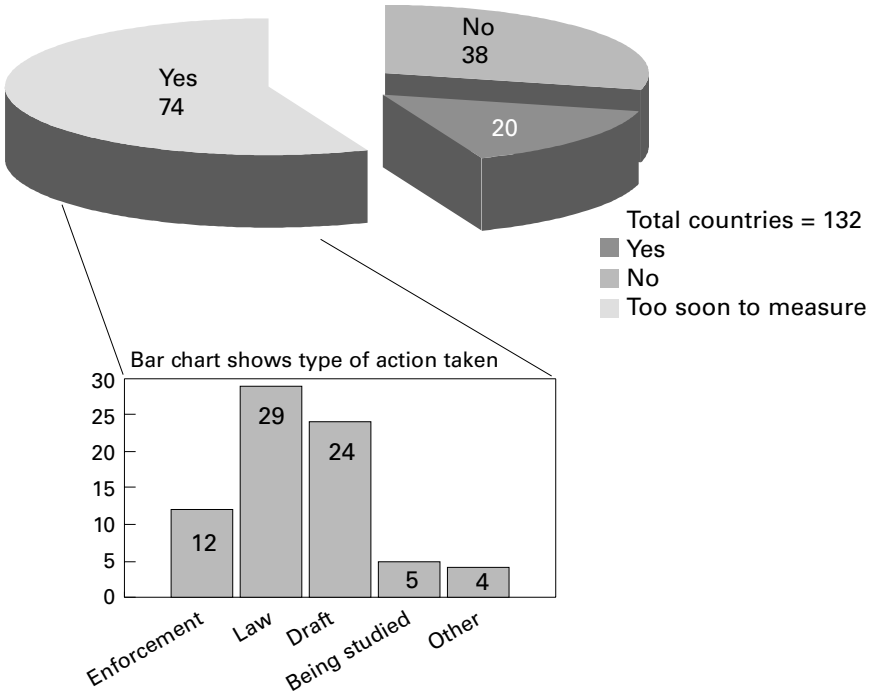
The adoption of the Code has been associated with major reductions in some forms of advertising and promotion around the globe. The changes are most visible in countries with strong legislation where government has enforced the regulations. India's strong laws have stopped much of the promotion of breastmilk substitutes, and Brazil has fewer violations than most countries, though inappropriate promotion of whole milks and sponsoring of health-worker associations are particular concerns.[33]

A four-country study was carried out by the Inter-agency Group on Breastfeeding Monitoring in 1996. Bangladesh, the only country studied that had laws governing the marketing of breastmilk substitutes, had the smallest number of free samples. Poland, on the other hand, had no legal or voluntary code governing any aspects of marketing of breastmilk substitutes, and Warsaw had the highest number of health

Figure 3 - ICDC training and Code implementation at the national level, 2005

This chart shows the 28 Code Implementation Training Courses held between 1991 and 2005 by ICDC

- Over 683 government officials from 132 countries were trained.
- The 28 courses were associated with Code implementation in 74 of these countries.



facilities in which information that violated the code was available to health professionals, as well as the highest proportion of health professionals who received free gifts.[34]

The Code remains even more relevant in the context of HIV/AIDS and emergency situations, where procurement may take place and the guidance provided by the Code is essential (*see chapter 3*). The issue of contamination of powdered formula has received more attention recently with the publication of a series of studies. A 1988 study reported recovery of bacteria from more than 50 per cent of 141 dry infant-formula powder products from 35 countries.[35] *E. sakazakii,* which is the cause of often severe and life-threatening illness, particularly for neonates in hospital settings or for immune-compromised children, was recovered from 20 of these products, that is, from 14 per cent of the samples. In 2003, the Codex Alimentarius Commission identified this contamination as a "known public health risk" having "high impact in terms of severity for a wide range of consumers and for specific sensitive populations."[36] In 2004, a study using a refined isolation and detection method concluded that the widespread nature of this micro-organism needs to be taken into account when designing preventive control measures.[37]

Given this knowledge, it is reasonable that both parents and caregivers receive warnings: "Powdered infant formula meeting current standards is not a sterile product and may occasionally contain pathogens."[38] FAO and WHO concluded: "Using current dry-mix technology, it does not seem possible to produce commercially sterile powder or to completely eliminate the potential of contamination."[39] In May 2005[40] a WHA resolution recognized "…the need for parents and caregivers to be fully informed of evidence-based public-health risks of intrinsic contamination of powdered infant formula and the potential for introduced contamination, and the need for safe preparation, handling and storage of prepared infant formula," noting that it is the responsibility of member States to decide whether to warn parents, caregivers and health professionals through explicit warnings on package labels.

Maternity protection

Operational Target 4: Enact imaginative legislation protecting the breastfeeding rights of working women and establish means for its enforcement.

Protecting the breastfeeding rights of working women was an ambitious target because of the diversity of work situations. Both breastfeeding and work use a woman's time and energy. It is necessary to make adjustments in the workload of mothers of young children so that they may find the time and energy for breastfeeding; this should not be considered the mother's responsibility, but rather a collective responsibility. Maintenance of breastmilk supply necessitates breastfeeding, or expressing milk frequency. Many worksites do not allow sufficient time for breaks or facilities to support this activity.

Both the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) provide a basis for this collective responsibility; the protection, promotion and support of breastfeeding are a means to fulfilling a child's right to the highest attainable standard of health, in accordance with CRC. CEDAW spells out a woman's right to be supported in carrying out her role as a mother and her right not to be discriminated against in the workplace on the basis of pregnancy or maternity. With the current concern for gender equality, some people object to the word 'protection'. Contemporary maternity protection refers to protection from discrimination on the grounds of pregnancy and maternity, a precondition of equality between men and women at work.[41]

The International Labour Organization (ILO) sets international standards for the workload adjustments needed by women in the formal workplace. There are three Maternity Protection Conventions (No. 3, 1919; No. 103, 1952; and No. 183, 2000) and two Maternity Protection Recommendations (No. 95, 1952 and No. 191, 2000). Several other ILO documents are also relevant to maternity protection, among them Conventions 156, Workers with Family Responsibilities, and 184, Health and Safety in Agriculture.

As agreed in the most recent ILO convention, C-183 (2000), maternity protection includes health protection, job protection and non-discrimination for pregnant, post-partum and lactating workers; 14 weeks of maternity leave with income replacement (at least two-thirds salary); and the right to one or more daily paid nursing breaks or a paid reduction of work hours for breastfeeding mothers after returning from maternity leave. Women employed in atypical forms of dependent work also come under the scope of C-183.

Although maternity protection has been a concern at ILO since 1919, progress towards meeting the ILO standards has been slow. Fifty-nine nations have ratified at least one of the three conventions; 11 have ratified C-183. Most countries in the world, however, have developed national legislation that ensures that women workers are granted a paid leave before and/or after birth (*see Figure 4*[42]).

Figure 4 - Status of maternity protection by region maternity leave, in weeks

	<12	12	13	14	15	16	17	>26
Africa (39 countries)	5	15		18	1			
Western Pacific (13 countries)	7	5		1				
South-East Asia (7 countries)	1	6						
Americas (31 countries)	3	18	3	1		2	1	3
Europe (28 countries)	2	4	1	3	1	9		8
Eastern Mediterranean (20 countries)	12	5		2		1		

Ideally, mother-baby separation for the purpose of work can be avoided or minimized by a range of options, including longer leaves, flexible or reduced hours of work while children are young, opportunities to work at home, availability of on-site or near-site childcare, or accommodations to have the baby visit and breastfeed at the workplace. If periodic contact with the baby cannot be arranged, then women need time and a place to express and store their milk while at the workplace.

The most challenging aspect of maternity protection is to find systematic ways of supporting the majority of the world's women who work in less formal work or workplaces. In recent years, the international trade unions and ILO have been looking for ways to extend benefits to women in the informal economy. The additional workloads due to gender-unequal roles embedded in cultural traditions that assign women the main responsibility of caring for home and family are not addressed, and these can also affect breastfeeding. Although some women's groups feel that putting a price on breastmilk is demeaning to women, ignoring it suggests that it has no economic value.43 Governments and societies will be more likely to invest in measures to support breastfeeding when it is recognized as productive work and seen as economically valuable. While the principle of collective solidarity or social responsibility is well accepted worldwide, the actual organization of a system that delivers reasonable maternity benefits to women is much more complex. ILO favours spreading the costs of maternity protection across the board; C-183 specifically stipulates that benefits should be covered by social security (public funds or compulsory social insurance) rather than by employers individually. Community-based insurance schemes have been proposed as a way for self-employed workers to join together for mutual aid. The community takes responsibility for itself, sets up a system to collect a premium from each member, and then disburses funds to community members in times of need. Creative alternative strategies are needed to support women at work and ease the load.

The Global Strategy singles out the heavy workload of rural women and the uncertain work opportunities for the urban poor as two major obstacles to proper feeding, and identifies childcare cooperatives and other childcare facilities specifically as important partners to protect breastfeeding.

The Maternity Protection Coalition (MPC)

Breastfeeding groups established an informal coalition to help make links with new partners, including the international trade unions. The Coalition produced an action kit to help breastfeeding groups understand maternity protection and give them materials for organizing a campaign to encourage their national governments to ratify the Convention, to improve maternity protection legislation, and to strengthen outreach to labour unions. The kit is available in English and Spanish, and has been used for training programmes in several countries.

A few suggestions for advocacy for maternity protection follow:

- Include the financial value of breastmilk in the gross national product (GNP) and the value of informal sector work to establish the economic importance of breastfeeding;
- Encourage men in all their roles to ease the workload of pregnant and breastfeeding women in the home and community;
- Include breastfeeding as a feminist issue and create links with women's groups;
- Give top priority to finding systematic and lasting ways to support women working in the informal sector;
- Foster links with the early childcare and education community to develop crèches that actively promote and support optimal infant feeding;
- Calculate the financial benefits of breastfeeding for employers, including reducing employee absenteeism and building employee loyalty;
- Design workplace benefits for mothers within a gender-neutral context of parental benefits or family-related benefits;
- Publicize mother-friendly workplaces that support their breastfeeding workers.

There are still many unanswered questions. Which laws are most effective in supporting working breastfeeding mothers in different settings? Are first-time mothers sufficiently empowered to negotiate for their breastfeeding rights? What protects breastfeeding women working in the most difficult situations: low-paid mothers who are heads of households, migrant women living alone, informal workers who have unsafe job positions with no legal benefits? The Global Strategy will enlarge the number of potential allies who can help answer these important questions.

Have the Innocenti Targets had an impact?

Estimating the impact of exclusive breastfeeding, considering different assumptions, it can be concluded that millions of children's lives have been saved due to the international commitment to infant and young child feeding expressed in the Innocenti Declaration 15 years ago. This impact can be attributed to the increase in the prevalence of exclusive breastfeeding in the first 6 months of life and increased birth spacing.

No group working to reduce infant and child malnutrition can focus on only one target; hence the need for an integrated approach, as proposed in the more comprehensive Global Strategy, which has added the related issues of continued breastfeeding with appropriate complementary feeding, maternal nutrition and health, and addresses present circumstances, including HIV/AIDS and emergencies.

Note

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3

CHALLENGES

The world of the new millennium is different in many ways from the world of 1990. This chapter explores some of the conditions that have shaped lives and policy-making in the decade and a half since the Innocenti Declaration was signed.

Infant-feeding decisions are not made in a vacuum, but are shaped by social, cultural, economic and political contexts. In a study citing trends, WHO recognizes that infant-feeding practices "…are underlain by a number of factors that are not the primary purpose of the present study such as premature cessation of breastfeeding and timing of introduction of complementary foods, poverty, food policies, political stability and environmental conditions."[44] Health systems and social sectors also have changed, and building breastfeeding protection, promotion and support into broader maternal and child survival and other health and nutrition activities is a policy and programme challenge.

This chapter introduces the climate at the time of the development of the Global Strategy and presents some of the challenges that it addresses. These challenges reinforce the need to act rapidly in support of infant and young child feeding.

HIV/AIDS and breastfeeding

In the 1980s it was revealed that the HIV virus could be transmitted through human milk; it is estimated that 5–20 per cent of infants born to HIV-positive women acquire infection through breastfeeding. However, avoiding breastfeeding may reduce the risk of HIV transmission, but it also increases the risk of death from other illnesses. For example, not breastfeeding during the first two months of life is associated in some countries with a six-fold increase in mortality due to infectious diseases. Exclusive breastfeeding provides even more protection against illness and death from common infections, and there is some evidence that exclusive breastfeeding during the first few months of life may also be associated with decreased HIV transmission via breastfeeding and higher levels of HIV-free survival when compared to mixed feeding.[45,46]

WHO/UNICEF policy for the woman who has been diagnosed HIV-positive is as follows:

- When replacement feeding is **acceptable, feasible, affordable, safe and sustainable**, avoidance of all breastfeeding is recommended.[47]
- In the absence of these conditions, exclusive breastfeeding is recommended for the first months of life.
- The HIV-positive woman who chooses to breastfeed should receive access to information and follow-up care and support, including family planning and nutritional support. Recent studies suggest that exclusive, rather than mixed, breastfeeding may significantly reduce transmission.[48, 49]

Also, for the vast majority of women who do not know their status or who have tested HIV-negative, exclusive breastfeeding for the first six months is recommended.

Only the mother, with proper counselling support, can decide what is going to be the best solution in her particular circumstances. She needs individual counselling and support to follow through with her decision. In order to test the feasibility of a counselling approach for preventing mother-to-child transmission, UNICEF supported governments that

requested assistance in providing infant formula to HIV-positive mothers by procuring generically labelled formula for use in pilot project sites.

Decision-makers and governments must consider all risks and benefits. In this consideration, attention must also be given to the problems that have been identified with the provision of infant formula.[50] These include:

- Lack of adequate knowledge and skills on the part of counsellors led to mothers being advised to feed formula without their circumstances being taken into account.
- In some places, women were not shown how to prepare the formula safely or were unable to do so. In one site in Durban, South Africa, where well-educated women received preparation instructions, 64 per cent of the milk samples collected from the mothers contained *E. coli* and 26 per cent *Enterococci.* A large proportion was also over diluted.
- Logistical problems meant that many women were unable to obtain a constant supply of formula, leading to inferior replacements or mixed feeding. Other reasons for mixed feeding included practical difficulties in preparing formula at night.
- Lack of proper counselling meant that many women who chose breastfeeding failed to understand the importance of exclusive breastfeeding and mix fed their infants.
- Social pressures to breastfeed resulted in some mothers starting out giving formula, but later switching to mixed feeding.
- Other untested mothers did not breastfeed or breastfed for a shorter time, or mix fed, due to fears about HIV. This is referred to as 'spillover'.
- The provision of free infant formula caused bias in maternal decisions since no equivalent subsidy was given for the diet of mothers who opted to breastfeed.

Based on these findings and those from other case studies, it is now widely agreed that the issue of HIV and infant feeding needs to be addressed in the context of promoting appropriate feeding for all infants and young children.[51] The promotion of exclusive breastfeeding as the gold standard would encourage the best possible start to life for the majority of infants who are born to HIV-negative mothers. But it would also result in less risk to the health and survival of those babies whose mothers do not know their HIV status, and for whom prevalent mixed feeding patterns would be the worst option, whether or not the mother is HIV-positive.

The 'HIV and Infant Feeding: Framework for priority action' presents key actions related to infant and young child feeding that cover the special circumstances associated with HIV/AIDS. Nine United Nations organizations have endorsed the Framework: Food and Agriculture Organization of the United Nations (FAO), International Atomic Energy Agency, Joint United Nations Programme on HIV/AIDS (UNAIDS), Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), UNICEF, World Food Programme (WFP), WHO and the World Bank. The aim is to create and sustain an environment that encourages appropriate feeding practices for all infants, while scaling up interventions to reduce HIV transmission.

The five priority actions are as follows:

1. Develop or revise (as appropriate) a comprehensive national infant and young child feeding policy, which includes HIV and infant feeding.
2. Implement and enforce the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions.
3. Intensify efforts to protect, promote and support appropriate infant and young child feeding practices in general, while recognizing HIV as one of a number of exceptionally difficult circumstances.
4. Provide adequate support to HIV-positive women to enable them to select the best feeding option for themselves and their babies, and to successfully carry out their infant feeding decisions.
5. Support research on HIV and infant feeding, including operations research, learning, monitoring and evaluation at all levels, and disseminate findings.

To support this, the Innocenti Target activities are being re-examined to ensure that they support both HIV-positive and HIV-negative mothers. For example, BFHI is being updated with HIV and emergencies in mind. Examination of the Ten Steps shows their relevance in the HIV context and the support they provide to HIV-positive mothers. A mother's right to information is met by having a publicly available hospital policy (Step 1), a trained staff (Step 2) and non-commercial information about breastfeeding during antenatal care (Step 3). All babies, breastfed and artificially fed, need the protection of strong bonding with the mother that is initiated by skin-to-skin contact from birth (Step 4) and rooming-in or bedding-in (Step 7). Baby-friendly hospital practices of feeding on demand (Step 8) and cup feeding (often provided as part of Step 9) may also benefit the full-term infant who is artificially fed.

Additional WHO/UNICEF/UNAIDS policy guidelines on HIV and infant feeding are designed to help reduce the risk of mother-to-child transmission of HIV (MTCT) while continuing to support optimal feeding for all. The guidelines consist of three main documents:

- 'HIV and Infant Feeding: Framework for priority action' (see above).
- 'HIV and Infant Feeding: Guidelines for decision-makers'.
- 'HIV and Infant Feeding: A guide for health care managers and supervisors'.

In addition to policy guidance, WHO has produced many reviews, training courses and other documents on this subject.

Emergencies and infant feeding

The world is facing even more severe conditions of instability and emergencies – both natural and man-made – in 2005 than was the case in 1990. For exam-

ple, more than 50 UNICEF country offices report that they expect some form of instability each year. Yet even in the context of war, hurricanes or tidal waves, infants and children have to be fed. A woman in an emergency situation is twice victimized if she must also abandon breastfeeding.

In natural and humanitarian crises such as the 2004 earthquake and tidal wave in Asia, disease and death rates among children under five are generally higher than for any other age group because of the increased incidence of communicable diseases, diarrhoea and soaring rates of undernutrition. Thus, in emergency and relief situations breastfeeding is of critical importance: It saves the lives of infants and young children.

Artificial feeding in these situations is difficult and increases the risk of malnutrition, disease and infant death. The basic resources needed for artificial feeding, such as safe water, a clean environment, and sufficient fuel and time, are scarce in emergency situations. It is impossible to ensure cleaning and sterilization of feeding utensils. Safe transport and storage of commercial infant foods cannot be assured, and this poses an additional threat to the food security of the infant. Furthermore, breastmilk substitutes donated as humanitarian aid often end up in the local market and can cause spillover of artificial feeding to babies that would benefit from breastfeeding in the host community.

While there is a common policy framework ('Operational Guidance for Emergency Relief Staff and Programme Managers', 2001), it has yet to be widely implemented. This document, now supported by more than 30 organizations, including UNICEF and WHO, is intended for all agencies, governments, national and international NGOs and donors. It provides a set of practical steps including how to minimize risks of artificial feeding through the procurement, management, distribution, targeting and use of breastmilk substitutes in compliance with the International Code of Marketing of Breast-milk Substitutes. Prevention of unsolicited donations of breastmilk substitutes is one of the key provisions of the Guidance.

The valuable protection from infection and its consequences that breastfeeding confers is all the more important in environments without a safe water supply and sanitation. However, there is a common misconception that in emergencies, many mothers can no longer breastfeed adequately because of stress or inadequate nutrition, and hence a need to provide infant formula and other milk products. Stress can temporarily interfere with the flow of breastmilk; however, it is not likely to inhibit its production, provided mothers and infants remain together and are adequately supported to initiate and continue breastfeeding. In fact, breastfeeding has been shown to reduce the stress levels of breastfeeding mothers.[52] Extra fluids and foods for mothers will help them breastfeed.

Humanitarian field staff and personnel of NGOs that support these efforts are often not aware of the crucial role of breastfeeding in emergencies, nor do they have the necessary knowledge and skills to protect, promote and support this practice. The Interagency Infant Feeding in Emergencies (IFE) Core Group composed of the Emergency Nutrition Network (ENN), IBFAN, Care USA, Terre des Hommes, UNICEF, UNHCR, WHO and WFP, took on the task of increasing capacity in this area. Its mandate included the development of two training modules.

Module 1 is a two- to three-hour course intended for all emergency relief staff, both international and local. It explains the crucial role that breastfeeding plays in the survival of infants and young children and provides basic knowledge and skills to respond to various challenges in emergencies. The first module was field tested, and a second version was prepared and distributed in early 2002 for further testing. More than 2,000 sets of this training module have been distributed to agencies and institutions wishing to train staff. Module 2, a four- to five-hour course intended primarily for health and nutrition service providers to give them increased technical knowledge and practical skills to support appropriate infant feeding in emergencies, has also been finalized. Health and nutrition staff should complete Module 1 before undertaking Module 2. A hard copy or CD-Rom with Modules 1 and 2 is available from ENN or at www.ennonline.net.

WHO, UNICEF, the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies have issued a joint statement to bring attention to these issues, and the risks related to importation of powdered milks and formulas for general distribution in emergencies (http://www.who.int/child-adolescent-health/Emergencies/IYCF_emergencies.pdf).

Empowering women

Breastfeeding is far from being only a children's issue; it is also about women and their world. The position and condition of women, including their nutrition, health and survival are major determinants of every child's welfare. Attention to women's health and nutrition benefits the entire family. Save the Children USA has developed a Mothers Index to document the link between the well-being of mothers and the well-being of their children. In addition, the gender-related development index (GDI) reflects inequalities between men and women using information on life expectancy at birth, adult literacy and estimated earned income. The gender empowerment measure (GEM) focuses on women's opportunities by measuring their political participation, economic participation and power over economic resources. This latter index is important because the Innocenti Declaration is the first international document to stress the **empowerment** of women to breastfeed rather than simply framing it as a duty. It states: "…efforts should be made to increase women's confidence in their ability to breastfeed. Such empowerment involves the removal of constraints and influences that manipulate perceptions and behaviour towards breastfeeding, often by subtle and indirect means…. Obstacles to breastfeeding within the health system, the workplace and the community must be eliminated."

Some of the challenges women may face when they breastfeed relate to their health and nutritional status. Women, as caregivers and nurturers of the family, are often the last to eat and eat the least, making them vulnerable to anaemia and malnutrition. About 450 million women in developing countries are stunted due to protein-energy malnutrition during childhood (World Bank, 1993), and 75 per cent of pregnant women in South Asia and 51 per cent in sub-Saharan Africa are anaemic.[53] In 1992, WHO reported that more than 50 per cent of the world's pregnant women were anaemic. A recent review of micronutrient programmes found that there was still a high prevalence of anaemia, generally higher than 40 per cent. Programmes to provide iron supplementation all depended on external funding.[54] With iron supplementation, however, some countries such as Thailand have seen a decline in severe anaemia among women. While women breastfeeding young infants often have high levels of anaemia, breastfeeding is actually a time when women's iron stores recover because breastfeeding, especially when exclusive and sustained, delays the return of menstruation.[55]

A mother's nutritional status at her birth, at age 2 and prior to her pregnancy are associated with the status of her newborn at birth; low birthweight (LBW) and poor nutrient stores result when mothers have not been well nourished. During pregnancy and lactation, mothers should have about 500 additional calories every day and consume additional quantities of all micronutrients. While studies show that undernourished women can breastfeed their babies adequately, mothers' nutritional status can suffer, especially when birth intervals are short. Breastfeeding, particularly exclusive breastfeeding, assists many women to lengthen the intervals between births. If a mother follows certain breastfeeding behaviours and pays attention to signs, she may use the Lactational Amenorrhea Method (LAM) for safe and secure delay of fertility and to know when to introduce another form of family planning.[56]

Early promotional messages in favour of breastfeeding often avoided discussions of maternal depletion because some infant food companies were reported to have exploited this argument to promote artificial feeding. More recent advocacy messages, as well as the Global Strategy, give prominence to the need for better nutrition and health among breastfeeding mothers without including the misinformation that women need expensive foods to be able to make good breastmilk. The welfare of the girl child and the adolescent girl, many of whom suffer from anaemia, continues to require attention. When breastfeeding advocates address women's health and nutritional needs, women's health groups and gender and development groups may be more likely to integrate breastfeeding advocacy into their programmes. See, for example, the materials developed by the LINKAGES Project on maternal nutrition.[58]

Other challenges include the fact that many women, especially those living in poverty, face obstacles such as low social status, violence, multiple work burdens, and lack of control over their reproductive lives. For example, in India, the government census of 2001 revealed that 1.5 million girls under 15 years were married, and of these 20 per cent or 300,000 girls had at least one child. Almost 2.7 million women under 24 years have already had seven or more children.[59] Evidence from nearly 50 population-based studies throughout the world shows that 10–50 per

Figure 5 - The Lactational Amenorrhea Method[57] for Family Planning

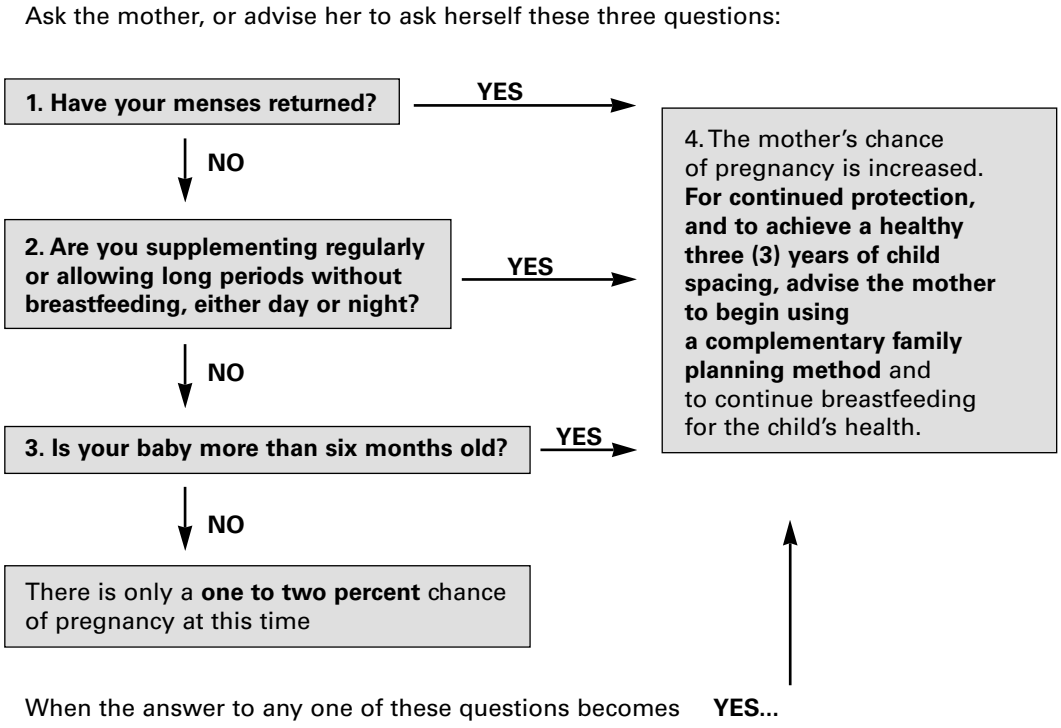
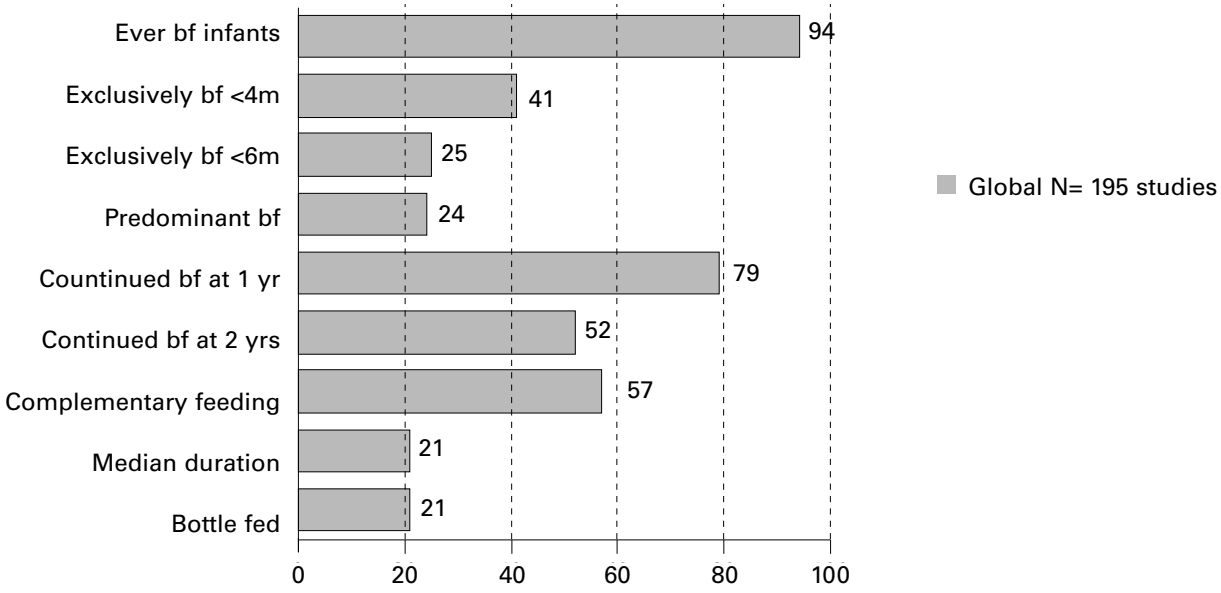


Figure 6 - WHO Global Data Bank 2004 Overview based on 195 Studies of infant feeding,



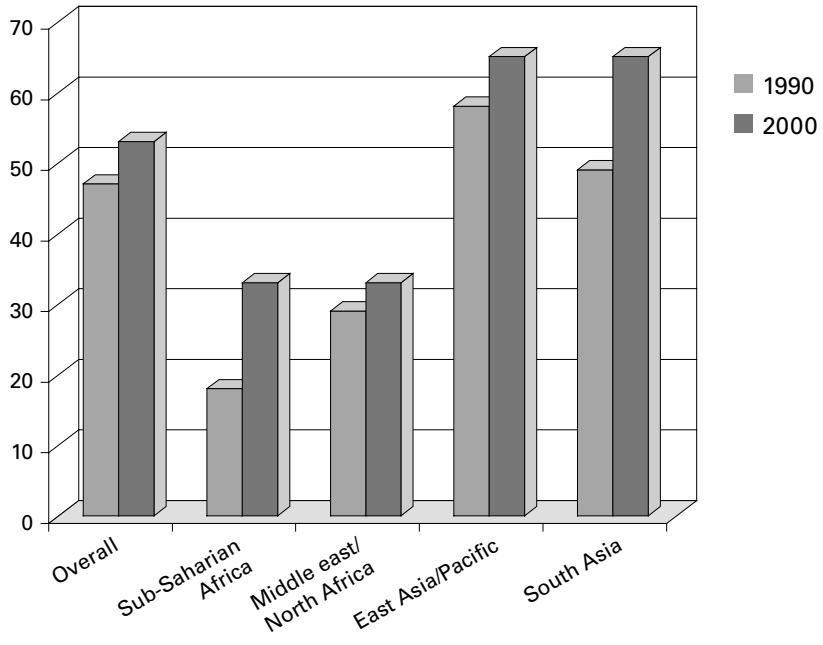
cent of women have experienced domestic violence, making this the most prevalent form of gender-based violence, followed by sexual violence.[60]

Breastfeeding advocates have begun to provide support for women survivors of violence or childhood sexual abuse who may face particular obstacles with breastfeeding.[61] Although addressing violence and other evidence of gender disparities is not the mandate of those concerned with infant and young child feeding, the Innocenti Declaration recognized that breastfeeding should take place in conditions of gender equality and that women be enabled and empowered in this context. This means that breastfeeding advocates may consider supporting initiatives that promote women's empowerment, be it in health, education, employment, or politics, and that put women in a better social and economic position. With this broad support for women's rights, women's groups are more likely to support infant and young child feeding initiatives, making outreach to women's groups more effective.

The state of infant and young child feeding today

Data have been collected on infant feeding for decades using a variety of national surveys and health information systems. Figures 6 and 7 provide an overview of the current situation. The global prevalence of both exclusive breastfeeding and timely introduction of complementary feeding increased

Figure 7 - Trends in Exclusive Breastfeeding (0<4 months of age) by Region (based on data from 38 countries covering 66 per cent of the developing world population)[63]



(Note: Insufficient number of countries reporting in South and Central America for presentation of trend.)

between 1990 and 2000/2004. Overall, analyses reveal that global prevalence of exclusive breastfeeding for the first six months increased from 34 per cent to 39 per cent, with the greatest increases seen in the early months of life, and in urban areas.[62] A 22 per cent increase was observed among the 0–1 month age group, while the rates remained approximately the same for infants aged 4–5 months. Increases in exclusive breastfeeding rates tended to be much greater in urban areas than in rural, with a 40 per cent increase in urban areas overall. No statistically significant differences were found in the trends of exclusive breastfeeding by gender of the infant, although the data point to increasing parity among the sexes over the decade.

These trends would seem to be reflective of the interventions in this decade to improve breastfeeding and complementary feeding such as BFHI, the Maternity Protection Convention and Maternity Protection Recommendation, the International Code of Marketing of Breast-milk Substitutes and the Global Strategy for Infant and Young Child Feeding. [64,65,66]. However, other concurrent issues may also have influenced national levels, including household food security, prevention and control of infections, unstable circumstances and poverty. An understanding of the individual and cumulative influence of these factors is important in interpreting the trends. The data necessary to show the precise nature of association between the observed improvement and the various interventions are limited.

Note

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4

NEW DIRECTIONS

The Global Strategy for Infant and Young Child Feeding: Inclusive of the Innocenti Targets – Providing a framework for the future

The Global Strategy for Infant and Young Child Feeding was developed over a two-year period, with comprehensive participation from many interested groups. It encourages the shift from pilot projects and limited interventions to full-scale programming whenever possible. The Global Strategy supports the view that feeding is not a separate issue, but a part of many other global interventions. 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.

Evidence of effective projects and new scientific research has provided a sound foundation for moving forward. Perhaps as a result, infant and young child feeding, especially exclusive breastfeeding, has been mentioned in the aims of the Millennium Agenda, WHA statements, HIV-related policy and UNICEF statements. But at the same time, resources for infant and young child feeding have not kept pace. It is unlikely that internationally agreed goals for child health can be achieved unless a substantial investment is made in interventions that support appropriate infant and young child nutrition in order to mobilize policy and decision makers to taking appropriate actions at national and international levels.

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

- To raise awareness of the main problems affecting infant and young child feeding identifying approaches to their solution, and provide a framework of essential interventions;
- To increase the commitment of governments, international organizations and other concerned parties for optimal feeding practices for infants and young children;
- To create an environment that will enable mothers, families and other caregivers in all circumstances to make – and implement – informed choices about optimal feeding practices for infant and young children.

The Global Strategy reaffirms the four targets of the Innocenti Declaration discussed in chapter 2, and adds five additional operational targets.

Comprehensive policy

Operational Target 5: To develop, implement, monitor and evaluate a comprehensive policy on infant and young child feeding, in the context of national policies and programmes for nutrition, child and reproductive health, and poverty reduction.

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 feeding is an essential aspect of childcare and can be integrated with efforts to prevent and manage childhood illnesses, to promote child development (including childcare) and to improve maternal nutrition. It is a stimulus to review what has been achieved since the Innocenti Declaration, strengthen ongoing work areas and activities, and initiate new activities as needed.

A national policy on infant and young child feeding is essential to provide the reason and context for implementation of interventions. Preparation of a multisectoral consensus in a national policy can take time, but this should not delay the implementation of interventions that are known to improve child nutrition.

Assessing the current situation and identifying future actions

Several tools are available to assist in national assessments. As a follow-up to the adoption of the Global Strategy, WHO in collaboration with the USAID-funded LINKAGES Project, developed a tool for assessing national practices, policies and programmes that specifically focuses on assessing progress in relation to the goals and targets defined in the Innocenti Declaration and the Global Strategy. In addition, there are other useful tools such as the district-level assessment tool developed by BASICS , the WHO/UNICEF BFHI assessment tool , the WHO Common Reference and Evaluation Framework (CREF) for assessing implementation of the International Code of Marketing of Breast-milk Substitutes, UNICEF checklists for action planning, and PROFILES developed by the Academy for Educational Development.

Optimal breastfeeding, with attention to supporting women in the community

Operational Target 6: To ensure that the health and other relevant sectors protect, promote and support exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require – in the family, community and workplace – to achieve that goal.

The Global Strategy stresses early breastfeeding as an integral aspect of exclusive breastfeeding, and adds the related issues of continued breastfeeding with appropriate complementary feeding, and maternal nutrition and health.

Early initiation of breastfeeding

Early initiation of breastfeeding, by placing the baby immediately post-partum skin-to-skin, allows the first feeding to be led by the baby with maternal support. This often results in a better initial latch, and is empowering in that the mother gains confidence in both herself and her baby. Studies have confirmed that this early contact is associated with better thermal regulation, and increased durations of exclusive breastfeeding and breastfeeding in general, and that health workers can readily acquire this knowledge and practices.[67,68,69] All other neonatal interventions, such as eye treatments, weighing, vitamin K, etc., can generally wait until after this essential first interaction.

Studies show a newborn, left undisturbed with skin-to-skin contact with the mother, will take an average of 55 minutes to begin suckling. So the recommendation now is to initiate breastfeeding within the first hour rather than within the first 30 minutes of birth (*see* BFHI News, *March/April 1999*). This initial contact is also associated with breastfeeding success,[70,71] improved thermal regulation,[72] improved blood glucose levels, reduced infant crying and summary scores of maternal affectionate love/touch.[73] Other studies have shown that, despite these findings, many practitioners are unaware of the importance of attention to this issue.[74]

Exclusive breastfeeding

Optimal infant and young child feeding includes six months' exclusive breastfeeding, starting at delivery, and continued breastfeeding with appropriate complementary foods and feeding for two years and beyond, as well as related maternal nutrition and care. There are benefits in delaying another pregnancy until the child is no longer breastfeeding and is able to eat independently, and the mother has recovered her nutrient stores.

During this period, one of the major policy changes based on evidence was the shift to a recommendation of six months' exclusive breastfeeding for optimal outcomes. While the Innocenti Declaration referred to six months of exclusive breastfeeding in the preamble, the text of the Declaration itself referred to four to six months. A 2001 expert panel reviewed all the findings for WHO and concluded that there was no evidence of any benefit in giving other foods besides breastmilk prior to 6 months.[75] This shift from a WHO recommendation of four to six months, to six months of exclusive breastfeeding, is expected to have considerable influence on efforts to sustain exclusive breastfeeding, as it increases by 50 per cent the age at which complementary feeding is considered appropriate.

The last 15 years have witnessed much success in increasing exclusive breastfeeding. In 1990, only about 34 per cent of mothers of children 0–6 months of age surveyed were seen to be exclusively breastfeeding. Extrapolating from those countries for which trend data are available, UNICEF analyses showed an increase to 39 per cent.[76] The latest data from all countries in *The State of the World's Children 2005* indicate a level of 38 per cent.[77] While overall increase in exclusive breastfeeding was about 5–6 per cent, some countries doubled, tripled and even quadrupled exclusive breastfeeding rates, especially in the most threatened urban areas, and levels of continued breastfeeding at about 2 years of age increased by about 5 per cent.

New evidence has become available about exclusive breastfeeding in this 15-year interval. Some of the research advances in recent years have been in the immunological components of breastmilk and in long-term health benefits.[78] Many studies have con-

Box 4 - Exclusive breastfeeding has additional benefits. Exclusive breastfeeding is associated with:

- Increased survival: Studies in developing and industrialized countries confirm the life saving benefits of breastfeeding, particularly in preventing diarrhoea, pneumonia and sudden infant death syndrome (SIDS) deaths..[79,80,81,82,83,84,85]
- Decreased morbidity: Infectious and chronic illness is reduced by exclusive breastfeeding, beyond the impact of breastfeeding alone.[86,87,88,89,90]
- Improved growth parameters: Exclusive breastfeeding helps overcome LBW and reduces stunting.[91,92,93,94,95,96]
- Reduced cardiac risk factors: Early breastfeeding, especially exclusive, is associated with reduced obesity and other factors related to heart disease..[97,98,99,100,101]
- Adequacy: Mean intakes of human milk provide sufficient energy and protein to meet mean requirements during the first six months of infancy. Since infant growth potential drives milk production, the distribution of intakes likely matches the distribution of energy and protein requirements. Some micronutrients are dependent on maternal stores.[102]

firmed that exclusive breastfeeding saves lives in the neonatal and post-neonatal periods of infancy and beyond. It would be impossible to review this extensive literature in this document; some of the most important areas of inquiry are highlighted in Box 4.

There is increasing scientific recognition of the importance of breastfeeding to survival growth and development of all children, with evidence mounting that exclusive breastfeeding may be even more important for LBW infants. Although not as well studied as mother's own milk, research is demonstrating that pasteurized donor breastmilk can provide many of the components and benefits of human milk while reducing the risk of transmission of infectious agents. While heat treatment by pasteurization (62.5˚C. for 30 minutes) may have an affect on immunologic factors, it also inactivates or destroys pathogens in the milk.[103] The nutritional components are altered somewhat, resulting in general in slightly slower growth in infants when compared to those infants fed non-pasteurised raw human milk.[104]

There is now both research and clinical evidence for feeding LBW babies with human milk, and increasing evidence for the importance of exclusive breastfeeding for the full-term, LBW baby. As survival rates for preterm and full-term LBW infants improve, more attention is being focused on improving the quality of survival through optimal nutritional management. Increasingly, both researchers and clinicians are recognizing that nutrition during critical periods in early life may permanently change the structure or function of organs and tissues.[105] A baby may need to be fed by naso-gastric tube rather than by mouth, but with feedings based on mother's milk, to decrease morbidity, shorten the duration of hospitalization and improve the overall health and long-term outcome of very low weight infants (VLW) infants.[106,107,108]

New research is also focusing on the management of breastfeeding for LBW infants, including how to support the establishment of a full milk supply for mothers of LBW and preterm infants, how to handle expressed milk safely, [109] how to make the transition in infants from tube feeding to full breastfeeding, [110] and how to maintain full, exclusive breastfeeding after discharge. Increasing use of Kangaroo Care (early skin-to-skin contact between infant and mother) is associated with an increased maternal milk supply and longer duration of breastfeeding after discharge,[111] as well as protection from infection.[112]

Physicians, nurses and other caregivers are increasingly recognizing that prior assumptions about breastfeeding LBW infants (for example, when oral feedings may begin) are based either on research on bottle-fed infants or on no research at all. It is now known that feeds may need to be more frequent and may take longer than with larger babies.

Today, the goals for exclusive breastfeeding have still not been reached, leaving millions of infants at unnecessary risk of illness and death. The map below indicates that few countries have reached 60 per cent exclusive breastfeeding. This goal would necessitate increased activity and intervention in most of the countries of the world.

New growth charts based on optimally fed children from different countries will become available in 2006. These new standards, developed by WHO, will confirm the growth patterns of exclusively breastfed children, and contribute to the recognition that early and exclusive breastfeeding is the reference standard for the optimal survival, growth and development outcomes for our children – our future.

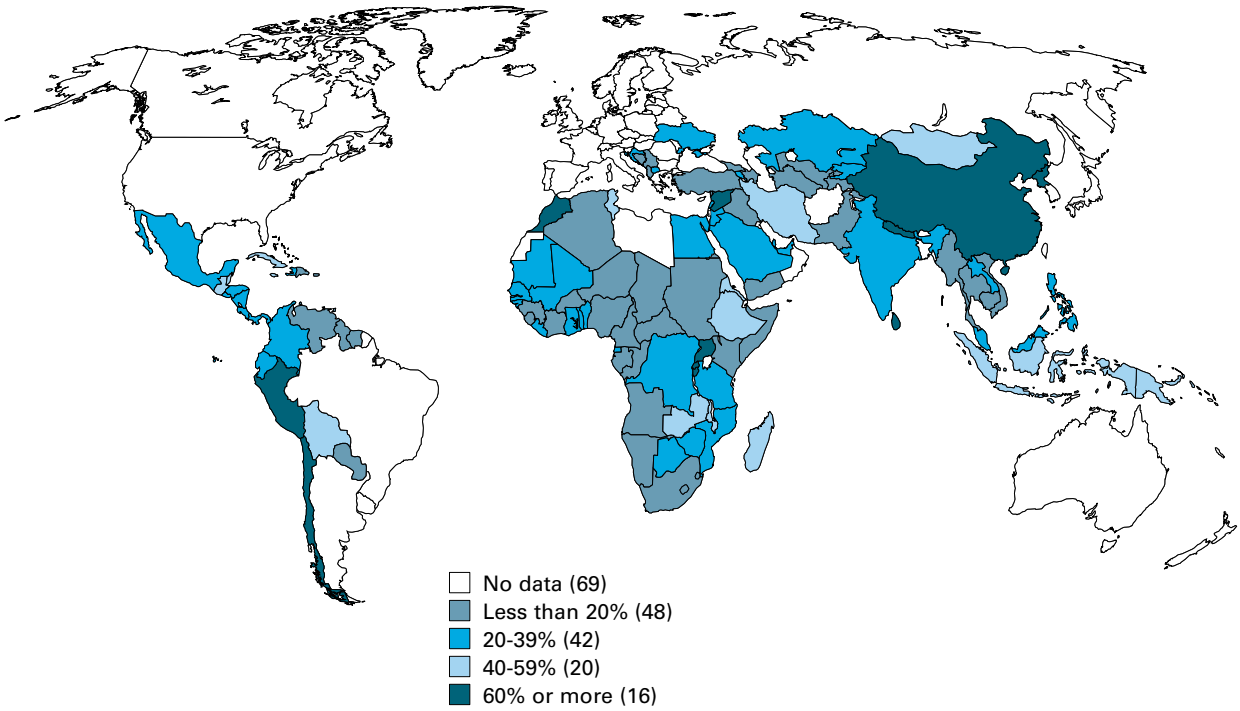
Revitalizing the Baby-Friendly Hospital Initiative

BFHI, reviewed in chapter 2, 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 BFHI to activities that go beyond the immediate post-partum period, and provide support in the home and community.

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

It is now time to mainstream the activity into the

Figure 8 - Still short of the goals: Levels of exclusive breastfeeding among children 0–6 months of age[113]



health system as an essential component of quality assurance and improvement of care, and ensure that national budgets include a line item for the cost of maintaining quality 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. Strengthening the existing community-based support groups is an important avenue to increase skilled and timely support for mothers in their communities.

Improving the skills of health care providers

While mothers and families are directly responsible for children's nutrition on a day-to-day basis, health workers also have an important influence through counselling and treatment of problems if they arise. The need for training in breastfeeding counselling is critically important but it is a nearly neglected area in the basic training of most health professionals worldwide; the BFHI course is not designed to prepare practitioners for the variety of problems that may emerge. 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 paramedical professionals is likely to be the most feasible and sustainable way to address the current knowledge gaps. But to lay the foundations for improved pre-service training, there is a need to increase the skills of health workers who are already in the health service.

WHO, UNICEF and other partners have developed a number of tools to increase the capacity and skills of health-care providers to protect, promote and support infant and young child feeding. BFHI, through the 18 (now 20) -hour course, is designed to achieve minimal requirements among maternity staff and provides only the basic knowledge and skills to support the timely initiation and establishment of breastfeeding. Alone, it does not provide skills to support the clinical competencies necessary for maintenance of exclusive breastfeeding. Additional training is needed to define precise quality criteria for training, increasing the ratio of clinical practice sessions and hands-on activities in communities versus classroom sessions. Continuous monitoring is needed to maintain quality of training. The 'WHO/UNICEF Breastfeeding Counselling: A training course', sometimes called the '40-hour course', fills these needs. It is appropriate for training all health workers who care for mothers and babies, giving them adequate breastfeeding counselling skills to enable all mothers to establish breastfeeding in the first several days, and to solve problems if they arise subsequently. It also trains trainers who can then teach about breastfeeding in other courses. New integrated courses are also available for regions with special needs to address HIV/AIDS counselling.

The Integrated Management of Childhood Illness (IMCI) strategy provides tools for training first-level health workers. These tools integrate a minimal level of nutrition counselling into the case management process for major childhood diseases. Thus, resources that have been shown to be effective are already available to help health-care workers provide good support for infant and young child feeding. But they are not yet fully implemented.

Newly trained health workers need support to make the necessary changes to their working environment and start implementing their new knowledge and skills. This means that their job descriptions must match their training and health policy, so that they are expected to spend time helping mothers. Often health workers themselves need support for

their own breastfeeding and young child feeding practices, as WABA's WBW theme on mother-friendly workplaces (1993) discovered.[114] They may also encounter problems that they have not learned to manage and need access to a more experienced worker for extra support. Thus, they need at least one follow-up visit by an experiences and skilled supervisor within four to six weeks after training. This should be a mandatory part of training, as courses are often too short to practise new skills adequately.

When designing a training plan for in-service and pre-service training approaches, alternative methods should be explored. For example, distance learning, continuous education and peer-supported learning are all options that should be considered. But nothing replaces practical hands-on learning in breastfeeding counselling. Whether for in-service or pre-service training, the need to build up teams of experienced trainers with clinical skills in breastfeeding promotion and support is critical in most countries. Some countries, including Brazil, the Philippines, Viet Nam and Zimbabwe, have been able to implement breastfeeding counselling training nationwide, by systematically building the capacity of district managers and senior clinicians to plan and conduct the training.

Building community skills and support

The Global Strategy includes strengthening community-based support for infant and young child feeding, something NGOs have been doing through WBW, and year-round through their community-based programmes. Families and communities are indispensable in the support of infant and young child feeding. Evidence shows that mother-to-mother support groups, lay or peer counsellors, and community-based workers can be very effective in helping mothers to initiate and establish exclusive breastfeeding and sustain breastfeeding up to two years or beyond. Building the skills and capacity of these supportive groups and individuals is an essential element of efforts to improve infant and young child feeding. The 40-hour breastfeeding counselling course can be adapted for less literate workers when necessary. These groups are also effective for creating and disseminating information and advice.

Individual infant feeding counselling is a key intervention that has been proven effective. It can be delivered by a well-informed peer, a well-trained health visitor, a community volunteer or extended family member if they have been trained in the necessary competencies. The counsellor needs to have accurate knowledge and skills, be equipped to negotiate a limited set of feasible actions, and be able to inspire a 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. The positive deviance approach, which identifies examples of good practice within the community, and facilitates the interaction between mothers whose children are thriving well with those mothers who have more difficulties in caring for their children, can also be effective.

Community-based infant and young child feeding support needs to be embedded in a larger context of communication activities that give 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 work through multiple channels and combine various methods, such as individual counselling by health facility and community-based workers, community group sessions and information sharing through mass media.

Reviews of community-based interventions show that they are most effective when they build on existing structures, integrate with the health system and involve partnerships with various sectors and groups. Interventions should complement 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. BFHI recommends the establishment of mother support groups as a requirement for each baby-friendly hospital. The Global Strategy moves further, aiming to address this problem by supporting community initiatives. One approach is to develop model national criteria for the designation of baby (and mother-baby) friendly communities.

In the Gambia, an effort was made to design a national plan for baby-friendly communities – communities that go beyond all applicable global criteria for BFHI (the Ten Steps). National initiatives would be based on community discussion of needs and include at least the following:

- Health system, or local health-care provision, designated baby-friendly, that actively supports both early and exclusive breastfeeding;
- Access to a referral site with skilled support for early, exclusive and continued breastfeeding available and approved by the community;
- Support for age-appropriate, frequent and responsive complementary feeding with continued breastfeeding;
- Mother-to-mother support system, or a similar back-up, in place;
- No practices, distributors, shops or services that violate the International Code as applicable in the community;
- Crèches and day-care centres with breastfeeding facilities.

A national decision to create an initiative for baby-friendly communities should highlight the inclusion of community, local government or civil society. Many interventions in communities reach mothers individually or in groups, often relying on volunteers. Events such as community theatre, health fairs, healthy baby contests, soap operas, radio call-in shows and nutrition certificates for families with optimally fed babies have also been effective.[115]

Improving infant feeding practices will not happen spontaneously, since they are integrated into the everyday lives of families in different societies.[116] Exclusive breastfeeding requires mothers to rely on

their own bodies and value their own milk production, trusting in breastmilk alone to end the cycle of infant malnutrition and death known to so many families. Shifts in thinking of this magnitude require family, community and government support, and they take time; hence the need for broad community-based programmes.

Some of the lessons learned from large-scale, community-based, breastfeeding promotion programmes include: the recognition that the promotion of breastfeeding through integrated rather than stand-alone vertical programmes can expand coverage and increase impact; multiple contacts, messages and channels of communication by different modalities are more likely to result in behavioural change; and effective advocacy and coalition building at the national, regional and district levels with a diverse group of nutrition or multisectoral stakeholders broadens the base of support for breastfeeding. Also, partnerships at the field level allow for rapid roll-out, reduced costs, extended programme reach and help sustain breastfeeding promotion and support. Role models and members of the mass media can be important partners in all these activities. The provision of short-term, practical training to large numbers of health workers and community health promoters ensures that communities are well supplied with breastfeeding advocates and helps create an environment where every mother feels supported and informed. It is also important to combine short-term and long-term strategies, to build on existing community groups or organizations to foster sustainability, and to regularly monitor activities with data collection to track progress in infant feeding for use in programme management.

In addition, community support has been achieved through national and international collaboration specifically for the promotion of infant and young child feeding.. For example, both the United States and the European Union have produced blueprints for action on breastfeeding. The European Union Project on Protection, Promotion and Support of Breastfeeding in Europe: A blueprint for action (2004) has reviewed breastfeeding interventions. Some of the lessons from Europe noted in the Project, as well as from U.S. interventions to promote breastfeeding noted in the National Guideline Clearinghouse (2003), include:

- Information, education, communication (IEC) is critical for re-establishing a breastfeeding culture in countries where artificial and mixed feeding have been considered the norm for decades;
- Use of printed materials alone on breastfeeding is the least effective of the interventions assessed;
- Workplace interventions are most effective when mothers have the flexibility to opt for part-time work;
- Programmes combining breastfeeding education with counselling are associated with increased rates of breastfeeding and its continuation for up to three months;
- Ongoing support for mothers through in-person visits or telephone contacts with counsellors increased the proportion of women continuing breastfeeding for up to six months.

Perhaps the most useful reminder in the European Union blueprint applies equally in both developing and industrialized countries: "Political commitment is more fundamental to the successful implementation of breastfeeding interventions than feasibility and cost issues."[117]

Continued breastfeeding and complementary feeding

Operational Target 7: To promote timely, adequate, safe and appropriate complementary feeding with continued breastfeeding.

The Innocenti Declaration promotes complementary feeding beginning at six months with continued breastfeeding for up to two years and beyond while receiving appropriate and adequate complementary food. The Global Strategy gives added emphasis to this recommendation.

Infants from 6 to 18 months are especially vulnerable to 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. These needs can usually be met with locally available foods, when properly prepared, and in some areas, with the addition of missing micronutrients.

In 1998, WHO brought together the best understanding of the new evidence in an important review article.[118] Some key findings include:

- Results of longitudinal growth studies and data from nutritional surveillance activities both indicate that growth-stunting occurs with in a fairly narrow 'age window' from several months after birth to about 2 years of age, the time when foods other than breastmilk are generally introduced into the diet;
- Observational studies and intervention trials indicate the importance of exclusive breastfeeding during the early months of life and the potential hazards of introducing complementary foods too soon;
- Quantitative data published recently on the adequate energy density of foods for young children provide useful guidelines on the proper formulation of complementary foods;
- The content and bioavailability of specific nutrients in the diet (dietary quality), may be more limiting to growth than energy intake per se in many populations;
- The attention and response to the child's needs (responsive feeding) by the caregiver, and the child's developmental readiness to handle food consumption are both exceptionally important.

Updated guidelines on complementary feeding

The 'Guiding Principles for Complementary Feeding of the Breastfed Child',[119] published as a follow-up to a WHO global consultation on complementary feeding in 2001/2002, provides updated guidance on feeding children 6–24 months of age. The document describes 10 principles of appropriate complementary feeding and the evidence for each, presented as Box 5. It provides a useful guide to programme planners in defining locally appropriate feeding recommendations and gives tips about potential assessment needs and actions.

According to the Global Strategy, complementary feeding should be timely, adequate and safe.. In order to achieve this, the Strategy recommends:

- Provision of accurate information and skilled support;
- Sound and culture-specific nutrition counselling for widest possible use of indigenous foodstuffs to ensure that local foods are prepared and given;
- Low-cost complementary food, prepared with locally available ingredients using suitable small-scale production technologies in the community setting;
- Industrially processed complementary foods also provide an option for some mothers who have the means to buy them and the knowledge and facilities to prepare and feed them safely. These foods must meet Codex standards;
- Food fortification and nutrient supplementations may also help;
- Emphasis is on local availability to help attend to the needs of those most vulnerable.

Responsive feeding, when there is active interaction between the caregiver and the child, has been shown to be the most effective in achieving growth and development.

Building on lessons learned and expanding breastfeeding protection, promotion and support into broader child feeding strategies is a policy and programme challenge. While support for breastfeeding at the policy and health system level has been very effective, complementary feeding programmes have not been as popular or successful. Piwoz, Huffman and Quinn[120] examine whether the same programmes that support continued breastfeeding can be engaged in supporting increased frequency and quality of complementary foods. WHO has established a process for defining indicators to assess complementary feeding, as a prerequisite to sustainable programme action, and is finalizing a three-day course on complementary feeding counselling for first-level health workers.

Today, new information is available on what is needed to complement breastfeeding in later infancy. New analyses show us the importance of continued breastfeeding and that energy needs are not as high as was thought. Other components, such as iron-rich foods, may be more necessary than formerly assumed. While efforts to improve complementary foods through fortification have been of international interest, sufficient frequency and variety of age-appropriate foods, fed in a responsive manner by an interested caretaker are the keys to improved growth and development. WABA's 2005 action folder features complementary feeding and may motivate breastfeeding groups to include more attention to complementary feeding in their programmes.

Infant feeding in exceptionally difficult circumstances

Operational Target 8:To provide guidance on feeding infants and young children in exceptionally difficult circumstances, and on the related support required by mothers, families and other caregivers.

HIV and infant feeding (see also chapter 3)

The risk that HIV can be passed by an HIV-infected mother to her child through breastmilk should not be allowed to undermine support for breastfeeding for the majority of mothers and infants whose health and chances of survival depend on it. The International Code of Marketing, subsequent relevant WHA resolutions and BFHI have become even more important in this context as a means to protect exclusive breastfeeding and ensure the proper use of breastmilk substitutes, when these are necessary, including when an HIV-positive mother makes an informed decision to use them.

Infant feeding in emergencies (see also chapter 3)

The Global Strategy on Infant and Young Child Feeding has given additional impetus to infant and young child feeding in especially difficult circumstances, such as emergencies and humanitarian crises. The Strategy states that health workers should have accurate and up-to-date information about feeding policies and practices, and the specific knowledge and skills required to support caregivers and children in all aspects of infant and young child feeding in exceptionally difficult circumstances. It also calls for NGOs to provide their members with accurate, up-to-date information about infant and young child feeding, integrate skilled support for infant and young child feeding in community-based interventions and ensure effective linkages with the health-care system.

WHA resolution 47.5 (1994) provides specific additional provisions related to emergency situations: "In emergency relief operations, breastfeeding for infants should be protected, promoted and supported. Any donated supplies of breastmilk substitutes, or other products covered by the scope of the Code, may be given only under strict conditions: if the infant has to be fed with breastmilk substitutes, the supply is continued for as long as the infant concerned needs it, and the supply is not used as a sales inducement."

Emergency guidelines supported by WHO, UNICEF, and many NGOs and bilateral organizations, recommended immediate protection of breastfeeding by creating safe spaces, or safe havens, for pregnant

and lactating women, so that they can receive special rations, as well as support for lactation and relactation. These skills should also be included in any feeding centre, whether therapeutic for moderate to severe malnutrition or for general food distribution.

In addition, these guidelines outline procedures regarding use of breastmilk substitutes in emergency situations include:

- Breastmilk substitutes should **never** be part of a general food distribution;
- Donations of breastmilk substitutes, bottles, teats and commercial baby foods should be refused. The Code prohibits donations to any part of the health-care system;
- If needed, breastmilk substitutes should be purchased by the organizations responsible for the nutrition programmes, based on a careful analysis and assessment of the situation at hand, (and only after approval) and together with the appointed emergency health/nutrition coordinating body and the most senior health/nutrition adviser at headquarters level;
- Purchased breastmilk substitutes should preferably be generically labelled;
- If breastmilk substitutes are distributed, their distribution and use should be carefully monitored, and infant health followed up by trained health staff;
- Distribution should only be to infants with a clear need of breastmilk substitutes, and for as long as the infants need them (until 1 year or until breastfeeding is re-established);
- Products should be labelled in accordance with the Code using the local language, instructions and messages, should comply with the standards of the Codex Alimentarius, and have a shelf life of at least six months from the date of distribution;
- Bottles and teats should **never** be distributed, and their use should be discouraged. Cup feeding should be encouraged instead.

Additional guidance is available concerning the use of unnecessary supplies, and the possibility of including them as a component, mixed with staples, of complementary foods, or foods for older children.

New legislation and other measures

Operational Target 9: To consider what new legislation or other suitable measures may be required, as part of a comprehensive policy on infant and young child feeding, to give effect to the principles and aim of the International Code of Marketing of Breast-milk Substitutes and to subsequent relevant World Health Assembly resolutions.

A comprehensive policy should also relate to existing policy instruments such as the International Code of Marketing of Breast-milk Substitutes, the ILO Convention on Maternity Protection, and the Codex Alimentarius, taking these and other instruments even further than the Innocenti Declaration. New policy could define 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, indicating how existing programmes can best be strengthened and incorporating actions in support of infant and young child feeding, specifying those interventions that are specific and require a focused implementation approach. Specifically, this operational target reinforces the original intent of the Innocenti Declaration to support development of comprehensive policy, but adds emphasis that there is a need is to examine **additional** measures that could strengthen Code-related and other relevant activities.

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5

WORKING TOGETHER FOR RESULTS

Coordination and integration

Since the Innocenti Declaration, many advances have taken place through partnerships that link United Nations organizations with governments and NGOs. Often groups with very different objectives have joined forces to improve infant and young child feeding. They share the recognition that achieving optimal child feeding is the most effective way to reduce the personal and global burden of child malnutrition, disease and death.

Following the Innocenti meeting, activities began to ensure that there would be coordination in all aspects of the Operational Targets, and WABA was created. WABA is an outcome of the Innocenti Declaration, and its aim became the mobilization of popular support for breastfeeding. Early participants in WABA included the American Public Health Association (APHA), La Leche League International (LLLI), the International Baby Food Action Network (IBFAN), the International Lactation Consultants Association (ILCA), the International Organization of Consumer Unions (IOCU), Wellstart International and the World Council of Churches. These organizations were later joined by the LINKAGES Project (managed by the Academy for Educational Development), and the Academy of Breastfeeding Medicine (ABM), while some initial partners left the network.

The following are some of the outcomes of collaboration and partnership that have occurred since Innocenti.

Social mobilization

Social and community mobilization have long been one of the central tenets of the support activity of a number of partners, and considerable activity has occurred over the last 15 years.

World Breastfeeding Week

WABA and its partners organized the WBW campaign in 1992 as their first social mobilization effort to raise awareness and stimulate action globally in support of breastfeeding. WBW has mobilized governments, various ministries, United Nations organizations, civil society organizations and the media in support of breastfeeding. Each year, over 100 countries hold many events during the Week, ranging from traditional activities such as conferences, seminars, information booths in public places, petitions and media coverage to more creative activities like street theatre, marches, dramas, poster exhibits in malls and subways and the launching of new breastfeeding laws and regulations. UNICEF has encouraged its country offices to use this as an opportunity to create action plans for implementation over the year.

WBW is celebrated in most countries every year from 1–7 August to mark the Innocenti anniversary on 1 August. The early years of WBW were dedicated to focusing public action on the Innocenti Targets. Year after year, even when the themes change, new groups continue to organize activities around BFHI during WBW. IBFAN created activities around the 1994 theme, UNICEF built an advocacy campaign – the Golden Bow – around the event, and WHO uses WBW to publicize new activities. Examples of the reach of WBW are seen in that, in 2004, Zambia had events in 72 districts, while in Brazil, a total of 1,000 cities were mobilized with over 100kinds of events organized throughout the 27 states in 1996. Examples of the breastfeeding themes include: 1992: BFHI; 1995:

Empowering Women; 1998: The best investment; 2000: Breastfeeding: It's your right; 2004: Exclusive Breastfeeding: Safe, Sound and Sustainable.

The different WBW themes have facilitated breastfeeding outreach to other issue groups by positioning breastfeeding within non-traditional themes such as ecology, economy, rights, development, globalization and peace. The 1995 theme on Empowering Women, for example, utilized the momentum of women's groups' preparation for the Fourth World Conference on Women, in Beijing, September 1995. This provided an opening for breastfeeding advocates to ally themselves with various women's groups. Other WBW themes such as Nature's Way and the Best Investment provided entry points for reaching out to environment and alternative economic development groups. LLLI, for example, initiated dialogue with Greenpeace International on supporting breastfeeding during WBW 1997. The WBW 2000 theme, Breastfeeding: It's Your Right, played a decisive role in revealing the complexity of bringing breastfeeding into discussions on human rights, deepening awareness about how breastfeeding can be understood as a human right, and how groups can support women's right to breastfeed. During that year, the Convention on the Rights of the Child and other supportive conventions were highlighted and subsequently better understood by the breastfeeding network.

WBW is a success story for several reasons, including outreach, impact, creativity and shared ownership; governments, and many local groups, all claim WBW as their own and have organized events and produced local materials over the years. The translation of WBW materials into more than 15 languages in some years is testimony to the popularity and spread of WBW. In 2004, up to 20 language versions were produced by different participating groups, although the WABA secretariat continues to support the production of key materials such as the WBW action folder, calendar and posters in four languages, Chinese, English, French and Spanish.

Golden Bow for advocacy

Exclusive breastfeeding is considered the gold standard for infant feeding. Recognizing its importance, UNICEF and WABA launched an advocacy campaign using the Golden Bow symbol, inspired by a similar symbol developed by the United States-based National Alliance for Breastfeeding Action (NABA), to be a visual image of the gold standard and to convey related messages, while calling upon all wearers to commit to action.

Additional information can be found at: http://www.unicef.org/programme/breastfeeding/bow.htm

Influencing global policy: Partnership of multilaterals, bilaterals and NGOs

The partnerships between multilaterals, bilaterals and NGOs have been instrumental in development strategy and policy. By participation in international meetings on women, population and development, food, environment and primary health care, for example, NGOs that support breastfeeding have worked closely with international agencies and donors to ensure that breastfeeding is well situated on these agendas. Breastfeeding advocates from multilaterals, bilaterals and NGOs lobbied to include a number of important statements on breastfeeding relevant to the theme of each of the following international conferences:

- The International Conference on Nutrition (ICN), Rome, 1992, adopted the World Declaration and Plan of Action for Nutrition which added the promotion of breastfeeding as one of its nine strategies and actions.
- The International Conference on Population and Development (ICPD) held in Cairo in September 1994. Concerted advocacy efforts at ICPD led the Conference to recognize breastfeeding as an issue of women's health, child survival, family planning and gender equity. ICPD is the first international forum where breastfeeding was recognized as more than a child health issue.
- The World Summit for Social Development (WSSD), Copenhagen, Denmark, 1995. Breastfeeding advocates were successful in inserting breastfeeding in the section on health of chapter III entitled 'Eradication of Poverty'. This inclusion in the WSSD document gives global recognition to breastfeeding as a healthy practice in the face of poverty.
- The Fourth World Conference on Women (FWCW), Beijing, China, 1995. A coalition of breastfeeding organizations – WABA with LLLI, ILCA, IBFAN, the Institute of Reproductive Health, ARUGAAN (a Philippine NGO), the Geneva Infant Feeding Association (GIFA, an IBFAN affiliate) and Wellstart International – lobbied for the inclusion of supportive wording on breastfeeding rights under two important chapters of the Platform of Action: Women and Health, and Women and the Economy.
- The World Food Summit (WFS), Rome, 1996. Efforts to broaden the global perspective on breastfeeding by including it as a food security issue continue. Breastfeeding was highlighted at several preparatory events, however, and reflected in the WFS Plan of Action.
- The ILO Maternity Protection Conferences, 1999 and 2000. The Maternity Protection Coalition lobbied for the adoption of the new ILO Convention 183 and Recommendation 191, recognizing breastfeeding as a working women's right, and strengthening several provisions.
- UNGASS 2002: The World Fit for Children. Its document included "Protect, promote and support exclusive breastfeeding of infants for 6 months and continued breastfeeding with safe, appropriate and adequate complementary feeding up to two years of age or beyond. Provide infant feeding counselling for mothers living with HIV/AIDS so that they can make free and informed choices."[121]

Advocacy, outreach and alliance building

WABA's mandate is to build alliances both within the breastfeeding movement and outside. As part of this

effort, WABA organized two global breastfeeding conferences, WABA Forum 1 in Thailand (Bangkok, 1996) and Forum 2 in the United Republic of Tanzania (Arusha, 2002) each bringing together several hundred participants to discuss breastfeeding issues in detail through plenary sessions, workshops and other creative events. The IBFAN Asia Pacific Conference on Breastfeeding, held in India (New Delhi, 2003) brought together over 500 participants from 38 countries and has led to widespread action. Some of these alliances are noted below

- Environment groups: Resulting in a joint statement and common communication strategy in raising public awareness on issues of contaminants in breastmilk in the lead up to the successful adoption of the Stockholm Convention.
- Women's groups: Although outreach to women's groups had begun with the ICPD and Beijing Conferences, a recent WABA activity has been the launching of a gender programme to sensitize breastfeeding advocates on the situation and needs of women, showing how they can more effectively link with the women's movement by situating breastfeeding within the women's agenda, specifically within the reproductive and sexual health rights framework.
- Men's groups: In 2002, the Global Initiative for Father Support (GIFS) was developed to focus on the need for men's involvement in supporting women in breastfeeding, birthing and childcare.
- Worker's groups and trade unions: The Maternity Protection Campaign continues to link with trade unions to promote the ratification and enforcement of the provisions of ILO C-183 while the Mother-Friendly Workplace Initiative (MFWI) stresses employed mothers' need for time, space and support.
- Birthing practices: The WABA Global Forum 2, held during the year (2002) when Healthy Mothers and Healthy Babies was the theme for WBW, helped initiate new links with the humane birthing practices movement and raised the issue throughout the breastfeeding network over the following years.
- HIV/AIDS groups: WABA and its core partners played a critical role in influencing the United Nations 'HIV and Infant Feeding: Framework for priority action'.

Integrating infant and young child feeding interventions into ongoing programmes and activities

To achieve comprehensive and sustainable action, the Global Strategy should not be an isolated effort. Instead, it should be integrated into existing programmes and activities as far as possible. Important in this respect are national programmes on immunization, maternal and child health, nutrition and HIV/AIDS prevention and control. For example, the WHO/UNICEF Integrated Management of Childhood Illness (IMCI) strategy combines management of common childhood illness with preventive actions, including nutrition 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 promotes key nutrition actions associated with improved health outcomes at the most relevant points of health service delivery contact. 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 the education, agriculture, labour and industry/commerce sectors.

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

Infant feeding, breastfeeding and human rights

Since the end of World War II, several international treaties, declarations and legal instruments have been adopted that represent the fundamental rights or entitlements of all human beings, whatever their age, sex, race, colour, culture, religion, economic or social background. "Human rights are legally guaranteed by human rights law, protecting individuals and groups against actions that interfere with fundamental freedom and human dignity. They encompass what are known as civil, cultural, economic, political and social rights."[122] Breastfeeding is at the intersection of many human rights that are addressed in many different international rights conventions.[123] These include the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (1966), the International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Elimination of All Forms of Discrimination Against Women (1979) and the Convention on the Rights of the Child (1989). There are numerous provisions on health, nutrition, education and information, environmental hazards, sanitation, work, and gender discrimination which, by extension, do have implications for breastfeeding rights and other related issues, such as day-care facilities. The Global Strategy links human rights specifically with infant feeding issues.

The Convention on the Rights of the Child (CRC)

The Convention was adopted in 1989. Since then it has been ratified by 192 States. One of its four basic principles is the child's inherent right to life, survival and development, as stated in article 6(1) and 6(2). The CRC Committee interprets this as placing a responsibility on States to reduce infant mortality, increase life expectancy and eliminate malnutrition, illness and epidemics. In article 24, the importance of breastfeeding in ensuring the child's right to the high-

est attainable standard of health is mentioned specifically. Article 24 builds on article 6, and its various provisions relate to the WHO definition of health: "…a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right…." Provision (e) is understood as States parties having the responsibility to disseminate positive information about breastfeeding and promote it through the health-care system, media and schools, as well as protecting the public from propaganda and misinformation through implementation of the International Code.[124]

Each State that has ratified the Convention is required to report on the current status of its implementation (an initial report two years after ratification, and subsequent reports every five years thereafter). This is a long-term process that is led by the CRC treaty body, the Committee on the Rights of the Child (18 elected child's rights experts from all regions of the world). Following each review, the Committee draws up a list of concluding observations – including the Committee's concerns and recommendations – that each State is expected to use as a starting point for its next review and report.

In 1997, representatives of UNICEF met the CRC Committee and clarified the infant and young child feeding issue, its implications for child health worldwide, and its consequences. IBFAN-GIFA began to develop a regular working relationship with the Committee, a relationship that has continued and progressed over the years. Through the presentation of 'alternative breastfeeding reports', GIFA began to act as an intermediary between breastfeeding advocacy groups in the countries under review (that prepare these reports) and the Committee (that uses them to question each government). IBFAN has taken advantage of the framework provided by the Convention to set up a 'breastfeeding' reporting system that is developing deeper roots. GIFA now presents and discusses updated information on infant feeding and health issues with members of the Committee, attends proceedings on a regular basis and reports back to national groups. A recent in-house evaluation demonstrated that this has led to the Committee's better appreciation of the importance of adequate infant and child nutrition, and subsequently to an increase in the number of recommendations made to States parties.

By 2005, in practically every state review (of industrialized as well as developing countries), infant and child nutrition was discussed. As a result, recommendations related to infant and young child feeding are now more numerous and more specific. Within the child rights movement, infant feeding has acquired visibility. At the national level, groups are acquiring expertise in using a 'rights-based approach' to infant nutrition, and are better equipped to use the Committee recommendations in their daily activities and advocacy.

There are, however, a number of challenges lying ahead for advocates working in the complex area of infant feeding, optimal health and child rights. In the broader context of human rights, the specificity of women's and children's rights are often not understood or appreciated, and thus overlooked. Hence the need to mainstream child rights into the wider human rights agenda. At the same time, within the child rights milieu, the importance of nutrition and breastfeeding are often not appreciated, and not high on their agendas. The result is that breastfeeding and related nutrition interventions – the most effective and efficient way to reduce infant and child malnutrition and mortality – often lose out to more costly and complex recommendations, policies and programmes.

A task force on Human Rights and Infant and Young Child Nutrition was established by the United Nations Standing Committee on Nutrition's Working Group on Breastfeeding and Complementary Feeding at its session in Brazil, March 2005. With membership from UNICEF, WHO and NGO partners, it would seem appropriate that this task force meet with the CRC Committee to present the most recent international policy developments on infant and young child feeding.

Last but very important, a rights approach requires a reconsideration of certain baby food companies that, through their marketing practices, impede the fulfilment of the right of the child to good food and nutrition and the highest attainable standard of health. In the words of Stephen Lewis, former Deputy Director of UNICEF: "Those who make claims about infant formula that intentionally undermine women's confidence in breastfeeding are not to be regarded as clever entrepreneurs just doing their job, but as human rights violators of the worst sort."[125]

Note

121 'A World Fit for Children: The outcome of the United Nations General Assembly Special Session on Children, UNICEF, 2002, p.30.

122 WHO, 25 Questions and Answers on Health and Human Rights, *Health and Human Rights Publication Series,* No.1, WHO, 2002.

123 Hofmeyr, A., *Breastfeeding and Human Rights: Towards a comprehensive rights approach*, 2002.

124 Hodgkin, R. and P. Newell, *Implementation Handbook for the Convention on the Rights of the Child.*: UNICEF, New York 2002.

125 'Malnutrition as a Human Rights Violation: Implications for United Nations-supported programmes, *SCN News*, No. 18, July 1999.

6

THE WAY FORWARD

In every country where breastfeeding and related complementary feeding have improved, some individual or group has made an active decision that saving children's lives is worth the time and energy involved. The political will was there to truly support women and families to make an informed and unbiased choice in feeding their children, and then to provide them with the support they needed to succeed. In some settings, the government led the way; in others, there was a gradual social revolution of behavioural change; in some cases, NGOs were the catalysts for these changes. In all cases, to achieve sustainable results, support for infant and young child feeding must continue, in order to keep and strengthen the improvements already made. The institutionalization of protection, promotion and support for child feeding into law, health and social norms will encourage real change, and allow the children of the world to achieve their full potential through optimal infant and young child feeding and care.

Fifteen years since the launch of the Innocenti Declaration, the time has come to state clearly the vision for the future:

"An environment that enables mothers, families and other caregivers to make informed choices about optimal feeding for infants and young children ***and to receive adequate support to implement them*** *in order to achieve the highest attainable standard of health and development."*

How can this vision be achieved in a practical, affordable and sustainable way?

These are the lessons learned over the past 15 years:

- Every mother deserves and should receive adequate support and counselling to make an informed infant feeding choice, and to succeed with her choice. When such support exists, optimal practices of infant and young child feeding are increased.
- Multisectoral and multiple contact approaches are necessary to achieve marked and sustainable improvements in infant and young child feeding, hence in child health, growth and development.
- Child survival strategies must include active promotion, protection and support of early, exclusive and continued breastfeeding with age-appropriate complementary feeding, since these practices will prevent up to 19 per cent of under-five deaths per year in the countries with the highest proportion of worldwide child deaths.
- Sustainable behavioural change is dependent on ongoing multiple contacts with the mother and community, and multiple approaches, including legal protection, health system support, and community and peer involvement, and this can be created in a manner that is affordable and sustainable.
- The HIV/AIDS epidemic need not interfere with the promotion of optimal breastfeeding practices. Support for exclusive breastfeeding in the general population also helps women with HIV who select exclusive breastfeeding. Further, programmes that support breastfeeding, such as baby-friendly hospitals, encourage optimal mothering and nurturance for both breastfed and non-breastfed infants.
- The Baby-Friendly Hospital Initiative (BFHI) can be expanded, modified and incorporated into other facilities, and it continues to be an important catalyst for breastfeeding action. Ongoing monitoring and quality assurance of these efforts is vital.

- The initiatives outlined in the Innocenti Declaration have been shown to work when countries have chosen to implement them. National rates of exclusive breastfeeding increase with a combination of interventions at the policy, health systems and community levels.
- Sustained efforts necessitate inclusion in national budgets as a permanent line item.

Great progress has been made since the Innocenti Declaration, but all the targets set in 1990 have not yet been met. Why can this vision be achieved now? Because there are opportunities now that did not exist at the time of the Innocenti Declaration, including:

- **Global Strategy for Infant and Young Child Feeding:** The Global Strategy re-examined the fundamental factors affecting feeding practices for infants and young children, and calls for renewed commitment to actions by all concerned partners, consistent with the Innocenti Declaration. The Global Strategy was unanimously endorsed by WHO member States at the fifty-fifth World Health Assembly, when governments agreed to revitalize efforts to achieve the Strategy's aim and objectives by guaranteeing the respect, protection and fulfilment of the rights of children to adequate nutrition and access to safe and nutritious food, and the rights of women to proper nutrition, to freely decide on the best method of feeding their children, and to full information and supportive conditions that will enable them to carry out their decisions.
- **Government and partner commitment to achieving the MDGs:** The aims of the Millennium Agenda include the Millennium Development Goals (MDGs), consisting of 8 goals, 18 targets and over 40 indicators. The United Nations General Assembly approved these as part of the Secretary-General's Millennium Summit Road Map. The Working Group on Breastfeeding and Complementary Feeding of the United Nations Standing Committee on Nutrition identified how early and exclusive breastfeeding, complementary feeding and related maternal nutrition, as defined by the Global Strategy, directly addresses seven of the eight goals. In sum, optimal infant and young child feeding and care:
- Reduces poverty and hunger;
- Increases gender equality by providing the best start for all;
- Prevents child mortality and undernutrition;
- Improves maternal health by impacting on post-partum blood loss and contributing to birth intervals;
- May reduce the rate of transmission of HIV during breastfeeding when breastfeeding is practiced exclusively; and
- Helps ensure environmental sustainability by reducing many forms of waste.

MDG 4, on the reduction of child mortality, can only be achieved with drastic improvements in child nutrition, since malnutrition is an underlying cause in 54 per cent of child deaths, and breastfeeding could directly save more than 1 million lives annually. In fact, the Millennium Development Project has declared action to increase exclusive breastfeeding as one of the potential 'quick wins' for child survival. By adopting the Millennium Development Goals in 2000, Heads of State and global leaders have made a firm commitment to combating child malnutrition.

These international strategies must be supported by accountability mechanisms, partnerships, and community involvement in health systems.

- **Accountability mechanisms**

Accountability mechanisms at international and national levels are vital, both for governments and all relevant stakeholders, to measure the extent to which **responsibilities** are met, e.g. through the development of laws, policies and programmes. The Global Strategy points out that governments, international organizations and other concerned parties should acknowledge and embrace their responsibilities for improving the feeding of infants and young children and for mobilizing the required resources.

- **Partnerships**

In order to follow up on international commitment to child health growth and development, national and international partners are forming alliances with the aim of accelerating coverage with effective interventions in countries with a high burden of child deaths. The global Partnership for Maternal, Newborn and Child Survival was created to facilitate coordinated and concerted actions among partners as well as for advocating increased resources flows and monitoring of progress.

- **Community involvement as an integral part of health system strengthening**

The last few years have reconfirmed that communities have a major role to play in improving infant and young child feeding, particularly when community members participate in the design of interventions and contribute to shaping the content and mode of delivery. Infant and young child feeding practices are part of the care that children receive at home. Evidence is rapidly growing to demonstrate that caregivers require skilled support, in the community and in health facilities, to develop or strengthen their skills of sensitivity and responsiveness that enable them to adequately perceive and respond to the child's needs. Recent studies have shown that working with communities and community leaders to develop a concentrated effort with multiple sources of contacts is a feasible and effective way to increase exclusive breastfeeding, improve complementary feeding practices, reduce childhood illnesses and improve growth.

One challenge is to maximize opportunities for their delivery so they reach all mothers and young children. Integration of support for optimal infant and young child feeding into all existing health services for mothers and children is essential for sustainability and access. The Essential Nutrition Action approach, developed by USAID/BASICS and the LINKAGES Project, identifies seven nutrition actions and six points of delivery. WHO and UNICEF have

been in the forefront in the development of strategies, such as Integrated Management of Childhood Illness (IMCI) and Integrated Management of Pregnancy and Childbirth (IMPAC), which combine clinical care with support for feeding and nutrition. Clinical guidelines are also being developed that promote attention to nutrition and child feeding as part of guidelines for prevention and care for HIV-affected and -infected families. Combined with the Baby-Friendly Hospital Initiative and intersectoral actions to increase food security and food quality, these approaches can go a long way towards improving children's health and nutrition outcomes.

In summary, these lessons learned confirm that there are well-established, effective, low-cost, low-technology interventions to improve infant feeding, outlined in the Innocenti Declaration, and expanded on in the Global Strategy.

It will be necessary to identify all challenges and turn them into opportunities. The finding that HIV can be transmitted through breastmilk threatened to wipe out years of work on the protection, promotion and support of breastfeeding. Increasing recognition of the balance of risks, however, is bringing together those with child survival interests and those with HIV-prevention interests in a new manner. With new knowledge on risk factors and rates of transmission in recent years, practices have been identified to lower the risk of transmission for women with HIV who choose to breastfeed. Hopes are high that antiretroviral treatment, either as a prophylaxis for the mother and infant, or as part of long-term treatment for the mother, will greatly reduce risks of transmission through breastfeeding in the future.

In addition, emergency response is receiving more attention; protection of breastfeeding in the first days of an emergency is a new challenge and opportunity.

It is hoped that new and creative planning and funding mechanisms, coupled with clarifying research, will lead to a sustainable, well-supported future for the proven interventions.

The way forward – Action now

To achieve the vision described above, the critical element is national commitment to improve infant and young child feeding through establishment of laws, standards, oversight and monitoring, and sustainability through establishment of a line item in national budgets to support these activities. The way forward is clearly outlined in the Global Strategy for Infant and Young Child Feeding, and complemented by the United Nations 'HIV and Infant Feeding: Framework for priority action' and WHO/UNICEF and Emergency Nutrition Network materials on immediate support for breastfeeding in emergency and unstable conditions, **all of which point to the need for skilled infant feeding counselling and support for mothers in varying circumstances, and the need to avoid aggressive marketing and excessive supplies of infant formula.**

Fifteen years after the Innocenti Declaration, fresh opportunities for action exist for improving infant and young child feeding practices and thereby nutrition outcomes and child survival. It should be recognized that accountability based on voluntary commitment may not be enough to move the infant and young child feeding agenda forward.

- Acceptance by governments of their legal obligations under ratified international human rights instruments, including the Convention on the Rights of the Child, and the associated responsibilities of the international system to assist governments in meeting their legal obligations, must be the basis for increased action in infant and young child feeding.
- Acceptance by the health professional community of their responsibility to 'do no harm' and their need to ensure high standards in clinical and social breastfeeding support are vital.
- Social and cultural acceptance that every child counts and every mother deserves community and political support is key.

The vision set out in this chapter, as well as the objectives and targets of the Global Strategy for Infant and Young Child Feeding, many of them based on the Innocenti Declaration, is being celebrated in 2005. What remains is for the international community, governments, health systems and society and families to take the actions described, and for all partners at all levels to actively support their efforts. The future of all children is at stake: Must more than 5,500 children continue to die each day because of inaction and inattention?

The world's children cannot wait. Their day is today.

List of Abbreviations

AIDS	acquired immune deficiency syndrome
BFHI	Baby-Friendly Hospital Initiative
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
ENN	Emergency Nutrition Network
FAO	Food and Agriculture Organization of the United Nations
GIFA	Geneva Infant Feeding Association (member of IBFAN)
HIV	human immunodeficiency virus
IBFAN	International Baby Food Action Network
ICDC	International Code Documentation Centre (member of IBFAN)
ICPD	International Conference on Population and Development
IMCI	Integrated Management of Childhood Illness
ILO	International Labour Organization
LAM	lactational amenorrhea method
LBW	low birthweight
LLLI	La Leche League International
MDG	Millennium Development Goal
MPC	Maternity Protection Coalition
MTCT	mother-to-child transmission (of HIV)
NGO	non-governmental organization
Sida	Swedish International Development Cooperation Agency
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VLW	very low birthweight
WABA	World Alliance for Breastfeeding Action
WBW	World Breastfeeding Week
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization

1990 - 2005

Celebrating the innocenti declaration on the protection, promotion and support of breastfeeding

Past Achievements, Present Challenges and the Way Forward for Infant and Young Child Feeding

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