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Updated report on Kenya infant feeding
situation

by

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INTRODUCTION

Since the 1983 Nyeri Workshop, several changes have taken place in Kenya in terms of breastfeeding, infant feeding practices, and weaning foods. This INCS consultant report sets forth much of the progress that has taken place in the areas of research, training, marketing, educational activities, and other programs and projects.

Although much progress has been made in terms of infant feeding practices, the consultant notes that there is a growing concern with the proliferation of glucose drinks, especially since they seem to fall outside the Kenya Code for the Marketing of Breastmilk Substitutes. The report also includes an analysis of the Kenya Breastfeeding Information Group (BIG), its progress, and changes incurred since its commencement. The description provides information useful to similar groups in other countries.

Ronald C. Israel
Director, INCS

March 22, 1985

WORK AGENDA

Date	Name, Title	Activity/Discussed
4 February '85 Monday	Mrs. Grace Mule Program Asst. USAID Mr. C. Mantione Chief, Nutrition USAID Dr. G. Merrit Chief, Population and Health USAID	Briefing on new proposal Initial itinerary Arrangements for Nyeri trip
5 February '85 Tuesday	Mrs. M. Kyenya IBFAN (A) Regional Coordinator Ms. H. Armstrong BIG Ms. R. Shompa Coordinator BIG	Briefing on new proposal Discussion on Kenya Code Update on BIG and other work since 1983 Review of last implementation meeting
6 February '85 Wednesday	Dr. J. Kigundu Chairman, Infant Feeding Implementation Committee Mrs. Kithinji Health Educator, National Family Welfare Centre Executive Committee Mtg. Breastfeeding Information Group (BIG)	Briefing on new proposal Discussion of training needs of MOH Collection of training agenda and curriculum development proposals Briefing on new proposal Request for materials to study BIG Discussion of current limita- tions and problems facing the group
7 February '85 Thursday	Mrs. Grace Mule Dr. C. Mantione Mr. F. Omoro Central Bureau of Sta- tistics	Progress report on activities to date Update on CBS activities related to infant feeding since 1983
8 February '85 Friday	Ms. J. Bradley BIG Mr. J. Owuor Ms. R. Shori Scientific Officers, Central Bureau of Statistics	BIG/Ford Foundation proposal for rural breastfeeding outreach Progress report on 1983 urban nutrition survey analysis
9 February '85 Saturday	B.I.G. monthly meeting	
11 February '85 Monday	Mrs. Grace Mule Dr. S. Kinoti Director, Medical Research Centre Mr. Agunda Director, Central Bureau of Statistics BIG Research sub-committee	Briefing on new proposal Discussion of training needs Briefing on new proposal Reworking of Ford proposal

Date	Name, Title	Activity/Discussed
12 February '85 Tuesday	Ms. H. Armstrong Dr. Bwibo University of Nairobi	La Leche League in Kenya NGO milk distribution and infant feeding Briefing on new proposal
13 February '85 Wednesday	Breastfeeding Seminar for Provincial Level Health Workers Dr. J. Kigodu	Briefing on progress
14 February '85 Thursday	Jim Collins Dr. C. Wood Dr. Popp AMREF Ms. Grace Mule Mr. C. Mantione	Briefing on new proposal Progress of training manual AMREF training on breast- feeding Briefing on progress
15 February '85 Friday	Mr. J. Vandemoortele ILO Economist BIG	Minimum wage & price changes on breastmilk substitutes since 1983 Preliminary sifting of BIG documents
18 February '85 Monday	Joyce Naisho Training Director, AMREF BIG weekly counselors meeting	Traditional birth attendant training Private sector health worker training History of and current coun- seling activities
19 February '85 Tuesday	Ms. Grace Mule Mr. C. Mantione Mr. S. Nyanzi University of Nairobi	Update on progress Further agenda planning Marketing of breastmilk substitutes
20 February '85 Wednesday	Ms. Margaret Kyenkya Mr. John Owuor	Planning of marketing interviews Sampling frame for interviews Interview form design Training of interviewers
21 February '85 Thursday	Ms. Katherine Olouch Ms. Vicky Quinn Mr. Alan Silverman UNICEF Mrs. Mwiti Training Program, AMREF	Kenya mass media efforts for GOBI UNICEF assisted breastfeeding promotion UNICEF distribution of emer- gency food aid The San Diego lactation management training
22 February '85 Friday	Dr. E. Lubulwa Pumwani Hospital Dr. F. Onyongo University of Nairobi School of Medicine	Milk sharing program The San Diego lactation management training

Update on Kenyan Infant Feeding

- I. Research
 - A. Sempebwa/Okello WHO Study
 - B. S. Nyanzi Study of Use of Artificial Feeds by Nairobi Mothers
 - C. Central Bureau of Statistics Child Nutrition Surveys
 - D. Food Commodity Distribution Study
 - E. Situation Analysis of Children and Women in Kenya
 - F. Marketing Interviews
 - G. CRSP Research in Embu
- II. Training
 - A. San Diego Lactation Management Training
 - B. Nairobi Health Worker Training
 - C. Nurses Breastfeeding Seminars
 - D. Nyeri District Health Worker Training
 - E. Provincial Health Worker Training, Nyeri
 - F. AMREF Traditional Birth Attendant (TBA) Training
 - G. AMREF Private Sector Health Worker Training
- III. Marketing
 - A. Imported Formula
 - B. Glucose Drinks
 - C. Packaged Weaning Foods
 - D. Infant Formula Price Increases
 - E. The Kenya Code for the Marketing of Breastmilk Substitutes
- IV. Media/Educational Materials
 - A. Health Workers Training Manual
 - B. Social Perspectives
 - C. Distribution of the MOH Directive
 - D. Distribution of Workshop Recommendations
 - E. Rainbow Magazine
 - F. GOBI Adult Literacy Materials
 - G. GOBI School Radio Programme
 - H. GOBI Pamphlet for Policy Makers
 - I. Voice of Kenya Air Time
 - J. BIG Radio and T.V. Interview
- V. Projects and Programmes
 - A. Pumwani Hospital Milk Sharing Programme
 - B. YWCA Breastfeeding Promotion Project
 - C. Commodity Food Distribution Programme
 - D. Proposed Mother to Mother Network

14

1. Research

A. Sempebwa/Okello WHO Study

The 1983 study done by two BIG members with WHO funding examined what mothers do with their children while they themselves are working outside of the home. The objective was to investigate this issue in light of how it affects breastfeeding, nutrition, and health care practices.

A field study of 1065 women of child bearing age was done in four different locations with four different groups of workers:

- 1) Cashew Nut Factory in Kilifi (Coast Province)
- 2) Delmonte Fruit Farmers and Cannery, Thika (Central Highlands)
- 3) Brooke Bond Liebig Tea Estate, Kericho (Central Highlands)
- 4) Atero Rice Irrigation Pilot Scheme (Lake Basin)

Some of the major findings:

- 1) Almost 40% worked more than 8 hours away from home
- 2) Roughly 25% left their children alone and another 25% left theirs with relatives or a neighbor; in 10% of the cases the child caretaker was under 10 years of age
- 3) Duration of breastfeeding was shorter for working than non-working women (reanalysis needs to be done using lifetable analysis)
- 4) The working mothers studied are more likely to use infant formula than their non working counterparts.

(Table of contents of report listed in Appendix 1; full report at INCS.)

B. S. Nyanza Study of Use of Artificial Feeds by Nairobi Mothers

The 1984 study by a University of Nairobi student looked at the use of breastmilk substitutes and weaning foods by 883 mothers of children 18 months or younger interviewed at well baby clinics held in 8 health centres and two private hospitals in Nairobi.

Analyses are done by whether or not the mother was working outside of the home or not and whether the mother was of African or Asian origin. Given the limitations imposed by the sampling procedure, useful information not included in the report could still be culled from the data set, especially on weaning foods and practices. Abstract of report included as Appendix 2; full report found in INCS Clearinghouse.

C. Central Bureau of Statistics Child Nutrition Surveys

The Third Rural Child Nutrition Survey 1982, published in December 1983, presents data from a national survey of 5,400 children aged 3 to 60 months from approximately 3,000 rural households. Data were collected on weight, height, age, mother's education and age, use of infant formula, weaning foods, morbidity, and several household amenities. Analysis of feeding patterns showed them to be somewhat similar to the Nairobi urban infant feeding study done in 1983. Many of the outcome analyses (stunting, wasting, morbidity, etc.) could not be analyzed by feeding practices because of the inability to control adequately for income. Table of contents included in Appendix 3. The urban component of the child nutrition survey, field data collected February-April 1983 is in the final draft stage.

D. Food Commodity Distribution Survey

An informal study of commodity food distribution programs has been done by Helen Armstrong of BIG to look at possible effects on breastfeeding of the distribution of powdered milk products to households with children under 2 years of age. The report is still being drafted, but preliminary analysis suggests that little thought has gone into this issue by most of the distribution agencies. In no program was a breastfeeding mother given an extra allotment of protein or calories to encourage continuation of breastfeeding and in some cases dry skim milk (DSM) is being distributed

with no warning as to its inappropriateness as a breastmilk substitute. One good practice noted was pre-mixing DSM with ground grains before distribution. This effectively limits their use to porridge and ensures that water used in preparation will be boiled. A more complete and systematic study of commodity food distribution and its effect on breastfeeding needs to be done. See section 5D on commodity food distribution programs.

E. Situation Analysis of Children and Women in Kenya

This 4 volume report produced by the Kenyan Central Bureau of Statistics and UNICEF was published in August 1984. The four volumes are titled:

1. Some Determinants of Wellbeing
2. Development Policies and Issues
3. The Roles and Situation of Women
4. The Wellbeing of Children

The summary contents for all four volumes are listed in the beginning of volume 1 (and are included as Appendix 4) and deal with population growth, basic needs, poverty, employment, the roles of women, and child health, nutrition and education.

F. Marketing Interviews

A series of marketing interviews were conducted using a random sample of low and low middle income clusters from the Kenyan Central Bureau of Statistics Nairobi sampling frame.

Questions were asked about the availability, price and weekly volume sold of infant and child feeding products from the following categories: fresh milk, tinned liquid milk, powdered dry milk, infant formula, liquid glucose drinks, dry glucose drinks, and bottle and teats. The full results are in Appendix 5 and are discussed in section 3.

G. CRSP Research in Embu

A longitudinal study to study the effects of mild malnutrition has been underway in Embu since 1982. Some of the data collected has been on infant feeding.

2. Training

A. San Diego Lactation Management Training

Three Kenyans, Mrs. S. Nakhisa, Dr. F. Onyongo, and Mrs. Mwiti, attended this INCS funded training held in San Diego in January 1984. Since their return, two of the participants (Mrs. Mwiti and Mrs. Nakhisa) have left government service for private sector health administration/training posts. All three participants have assisted in some of the training sessions listed below. A recommendation has been made that a lactation management training be held for Kenyans in Kenya so that more individuals could be trained at a lower cost and so that there would be more resource people available in Kenya for further training of Kenya health workers. Discussions were held with Dr. Onyongo and Mrs. Mwiti about how the San Diego training could be modified for a group consisting solely of Kenyans. These are presented in the recommendations section at the end of this report.

B. Nairobi Health Worker Training

This training was held at the National Family Welfare Centre in Nairobi as a joint venture of the Ministry of Health, Breastfeeding Information Group and the University of Nairobi Department of Paediatrics, in August 1984. Most of the participants were nurses. A copy of the programme was not available.

C. Nurses Breastfeeding Seminars

Two, five day seminars were held for nurses and nursing tutors in Nakuru (September 1984) and Mombasa (December 1984) to disseminate information on breastfeeding and to develop curricula for nursing education.

Participants came from area hospitals and both private and government nurses training programs. A proposed teaching curriculum drafted by seminar participants at the Mombasa workshop is included as Appendix 6.

D. Nyeri District Health Workers Training

This training session, held in October 1984, was undertaken to train district level personnel in Nyeri who would then be used as resource persons for two later training sessions for provincial level health workers to be held in Nyeri in the first half of 1985 (discussed below).

E. Provincial Health Worker Training, Nyeri

Two, five day training sessions are being held in early 1985 to train provincial level health personnel. Six health officials from each of 5 eastern and central provinces were called to Nyeri from 12-16 February 1985 for the first training session. The health workers involved included the Provincial Obstetrician/Gynecologist, Paediatrician, Matron, Hospital Secretary, Physician, and Health Officer. At a second session provincial health officials from the two western-most provinces and health workers from the country's six rural health training centres will be trained. The programme for the first Nyeri training is included as Appendix 7.

F. AMREF Traditional Birth Attendant (TBA) Training

Since the Nyeri workshop AMREF has conducted several courses in different areas of the country for traditional birth attendants and all of these have included information on breastfeeding and child nutrition. The woman who was responsible for organizing many of these courses went on sabbatical in August 1984 and since that time, AMREF's training of TBAs has been concentrated in the Kibwezi District area where they have an ongoing comprehensive health program. Approximately 50 women have been trained in programs involving local community nurses and follow ups have begun to assess the impact of the training. Community health workers

in Kibwezi have undergone similar training programs which are broken up by tasks such as adolescent girl training, antenatal care, delivery, post-natal care, child care, and family planning. An innovative community education approach has also been tried, training local shop keepers about the non-prescription drugs they sell and using the shops as distribution points for family planning information and contraceptives.

G. AMREF Private Sector Health Worker Training

This is a relatively new nine week program for private sector clinical officers, registered nurses, clinical nurses, and midwives. The main emphasis is the instruction of family planning methods, but the program also includes nutrition, child care and immunizations. Thirty-six health workers had completed the course in one of the 4 sessions held in 1984. Twenty-two trainees were in the clinical segment of the program at the time of my visit. Funding is provided by USAID and the John Snow Foundation.

H. Breastfeeding Information Group Training

BIG training work is discussed in the institutional profile section.

3. Marketing

A. Imported Formula

At the time of the Nyeri Workshop in 1983, very little infant formula was still being imported into Kenya in finished product form (production materials including dry skimmed milk were being imported by the principal domestic producer, Food Specialities Kenya (Nestles)). One of the 1983 Nyeri Workshop recommendations was to continue the listing of imported formula on the restricted list. The marketing interviews (Appendix 5) conducted in Nairobi in February 1985 found two Wyeth products, SMA and S26, available in all 4 of the large self service stores surveyed and Abbot Ross's ISOMIL available in 3 of the 4 large self service stores. These products were not found in any of the smaller shops around Nairobi

and it is not sure if this is because of a lack of demand or absence of a distribution system.

B. Glucose Drinks

The inappropriateness of powdered and liquid concentrate glucose drinks for infants is a growing concern of some members of the Workshop Implementation Committee because of the proliferation of new products in this category in the last few years, their increased advertisement (including some recent television and cinema ads showing babies), and the fact that they fall outside of the Kenya Code for the Marketing of Breastmilk Substitutes. The marketing interviews done in February (appendix) found more products in the liquid or powdered glucose drink category than in any other category studied. They were available in 86% of the shops surveyed and two-thirds of the shops surveyed stocked two or more brands. In shops stocking both infant formula and glucose drinks, and where "quantity sold" information was available, nearly 75% reported selling more units per week of the glucose drinks than they did formula.

These products are of special concern in light of the pattern of use of infant formula reported in the CBS study where it was shown that mothers use these products more as "dawa" or a tonic "to make their babies healthier" than as a food substitute. This belief creates a perfect niche for marketing very expensive powdered sugar to a susceptible audience. Health worker promotion of oral rehydration therapy may also wrongly influence the inappropriate use of these products.

C. Packaged Weaning Foods

The main change in the marketing of weaning foods is the introduction of the Nestles product NESTUM. This early weaning food consists of a combination of finely powdered cereal and dried milk. It is not clear if the product falls outside of the Kenya Code for the Marketing of Breastmilk

Substitutes. It has been marketed using pamphlets. Other than the general concern that the Nyeri Workshop expressed about these products being much more expensive than home-prepared weaning foods, finely ground commercial products allow preparation without boiling water. NESTUM was not widely available in the shops surveyed in the February marketing interviews.

D. Infant Formula Price Increases

Infant formula products have twice been allowed a price increase by the government since the 1983 Nyeri Workshop. At the same time the minimum wage has not increased. This means that the cost of feeding an infant exclusively with infant formula expressed as a percentage of minimum wage is even higher than that reported in the CBS Infant Feeding Practices Final Report and elsewhere in 1983.

E. The Kenya Code for the Marketing of Breastmilk Substitutes

The Breastfeeding Information Group has been unable to ascertain the current status of the Kenya Code from the Kenyan Bureau of Standards, who is responsible for gazetting it. If gazetted in its present form, it will still lack the monitoring and enforcement machinery necessary to make it very useful. The Breastfeeding Group has hired a Kenyan lawyer to prepare a brief on other ways in which such a code could be enacted within the structure of the Kenyan legal system. It is recommended that this topic be one of the main issues if a follow-up workshop is held.

4. Media/Educational Materials

A. Health Workers Training Manual

Helping Mothers to Breastfeed by Felicity King is in the page proof stage and should be ready for distribution at the end of March. The printing is being done by AMREF and as is their usual policy, the first 1,000 copies will be distributed free. Thereafter copies will be available from AMREF and through other commercial outlets for a nominal charge.

Discussions are being held to consider a translation into Kiswahili for distribution in Tanzania.

B. Social Perspectives

This publication of the Central Bureau of Statistics is produced for and distributed to Ministry policymakers to present the results of the Bureau's surveys in an easily understandable format. An issue devoted to the Kenyan Infant Feeding Practices Study, conducted by the Bureau in 1982, has been prepared and published with assistance from UNICEF. It is included as Appendix 8.

C. Distribution of the MOH Directive

In June 1983 the Ministry of Health issued a directive to all government, private and mission hospitals dealing with the issues of rooming-in, pre-lacteal feeds, institutional use of infant formula, etc. (mimeograph copy included as Appendix 9). The Breastfeeding Information Group has mail distributed copies of this directive to all the hospitals in the country. Copies have also been distributed by the Ministry of Health at all breastfeeding trainings and seminars.

D. Distribution of Workshop Recommendations

A booklet describing the agenda, participants and recommendations of the 1983 Nyeri workshop was produced with the assistance of INCS and printed by AMREF. A shortened version of this booklet containing only the summary recommendations was later prepared at the request of The National Family Welfare Centre. Those recommendations have been distributed in health worker training sessions and have been sent to all hospitals in the country by the Breastfeeding Information Group.

E. Rainbow Magazine

With the assistance of UNICEF, Rainbow Magazine, a children's publication distributed to 12,000 Kenyan schools, published a special edition

devoted to UNICEF's GOBI (growth monitoring, oral rehydration, breastfeeding, and immunizations) programme. The comic book format was so well accepted that a second printing and distribution was undertaken by UNICEF (Cover of Rainbow issue included as Appendix 10; entire issue found at INCS Clearinghouse).

F. GOBI Adult Literacy Materials

Four booklets in Kiswahili, one on each of the GOBI themes, have been prepared by UNICEF for distribution as teaching texts for adult literacy classes. It is hoped that these can be distributed by March, 1985.

G. GOBI School Radio Programme

Radio programmes are currently being produced by UNICEF on each of the GOBI themes. These will be created to run parallel to the new curriculum for standard 8 students on child care.

H. GOBI Pamphlet for Policy Makers

The Kenya UNICEF office has prepared a short pamphlet for Kenyan policymakers describing the UNICEF GOBI program and how it relates specifically to Kenyan issues and policy decisions (included as Appendix 11).

I. Voice of Kenya Air Time

The Voice of Kenya has been in touch with the Breastfeeding Information Group about the possibility of BIG producing some short radio spots to promote breastfeeding. Voice of Kenya has offered to provide free air time and minimal assistance with production of the spots. If the spots are successful free air time might also be provided for longer radio skits or plays on breastfeeding themes.

J. BIG Radio and T.V. Interview

Voice of Kenya has done interview programs with the Breastfeeding Information Group for both T.V. and radio.

5. Projects and Programmes

A. Punwani Hospital Milk Sharing Programme

Pumwani Hospital, part of the Nairobi City Council health care network, leads the country in hospital births with an average of 40-60 per day. For the last two years, the Newborn Unit which cares for underweight, premature, and infants with special problems has been operating a breastfeeding and milk sharing programme. Infants who are too small to breastfeed are fed expressed milk every 4 hours using either a tube or small cup for the feeding. Children with mothers unable to produce milk are fed using expressed milk from the other mothers. No feeding bottles are used. Infant formula is used only when the expressed breastmilk supply is inadequate (rarely) and is fed either by tube or with a small plastic cup.

B. YWCA Breastfeeding Promotion Project

This project, to begin in February 1985, has three main components: an infant day care centre operating out of the YWCA's downtown Nairobi location; a Home support for working mothers service offering training for child-minder and home-helpers; and family life, parenting and ante/post natal mothers classes. The project was just beginning at the time of my visit. The project publicity is included as Appendix 12.

C. Commodity Food Distribution Programmes

Shortfalls in staple production occurred in 1984 due to the failure of the long rains in April-May of that year. Several international agencies initiated commodity food distribution programmes to provide food to badly hit areas mostly in the North Central and Eastern parts of the country. A council of organizations providing this type of assistance was formed under the direction of one of the Kenyan ministries. By the time of my visit several of the temporary programmes such as those set up by UNICEF and AMREF were already being dismantled. This is due to the harvest of the late, but adequate short rain crop which is now taking place.

Large donor programmes like those run by the Catholic Relief Service and Freedom from Hunger Foundation have long been in place and will continue to serve various communities. The continuation or reconstitution of the emergency food distribution undertaken by other agencies will depend on the success of future local crop production. Some of the issues surrounding the effects of commodity food distribution on breastfeeding have been raised (see section 1.D) but remain largely unresolved.

D. Proposed Mother to Mother Network

The Breastfeeding Information Group is negotiating with the Ford Foundation for funding to start a mother to mother network to spread breastfeeding information and assistance to the rural areas. The mechanics of the programme are still under negotiation, but it appears that a pilot project will be started in a rural area of Kenya sometime in 1985. The proposal calls for a study to be undertaken in the pilot areas to establish mothers interest, knowledge, attitudes, problems, etc. and to determine what existing networks might be tapped for the distribution of infant feeding information. The original proposal and notes on subsequent discussions of the project are available in the INCS Clearinghouse.

1983 NYERI WORKSHOP RECOMMENDATION IMPLEMENTATION

<u>RECOMMENDATION</u>	<u>DISPOSITION</u>
1. Health Training	
1.1 Annual for Infant Feeding	In Press
2. Government Regulations and Strategies related to the marketing of breastfeeding substitutes	
2.1 Ratification and enforcement of the Kenya Code	Ratification uncertain
2.2 Reduction in local manufacturer/importation of feeding bottles	No action
2.3 Restriction on importation of infant formula in finished form	No action Importation has increased
2.4 Recommendations regarding donated breastmilk substitutes	No action Dry Skim Milk (DSM) distribution increased
2.5 Government should continue price control of breastmilk substitutes	Continuing
3. Policies and strategies to improve infant feeding through the health services	
3.1 Health facility practices: promoting, no prelacteal feeds, no feeding bottles, no commercial influences	MOH Directive of June, 1983 Distribution of same by BIG Some monitoring, mostly in Nairobi
3.2 Weaning recommendations including ban on promotion of commercial weaning foods	No action Large promotion of Nestles Nestum
3.3 Non separation of mother and infant when either is hospitalized	No action
3.4 Recommendations for women with insufficient milk	Stressed in training counseling
3.5 No oral or injectable contraceptives in first 4 months post partum When oral contraceptives are given they should not contain oestrogen	No action on injectable Combined oral pills not recommended for breastfeeding mothers Progesterone oral pills ordered
3.6 Pregnant mothers need no special foods Local breastfeeding groups should be encouraged	Included in breastfeeding courses/seminars BIG/Ford proposal

13

RECOMMENDATION

DISPOSITION

- | | |
|--|--|
| 4. Policies related to women in paid employment | |
| 4.1 Women should continue breastfeeding after they return to work | Included in breastfeeding courses/seminars |
| 4.2 Women be given 2 months maternity leave in addition to annual leave | No action |
| 4.3 Employers should provide time off or creches | YWCA Project
Sempebwa/Okello WHO Study |
| 4.4 Research on professional discrimination against women because of pregnancy | No action |
| 5. Programmes and policies related to public information and education | |
| 5.1 MOH guidelines based on health worker training manual | Action awaits availability of manual |
| 5.2 Committee standardize mass media messages | No action |
| 5.3 Requests to international donor agencies for financial assistance | UNICEF contributions/B.I.G. funds from various sources/
WHO contributions |

Institutional Profile of the Breastfeeding Information Group

A secondary purpose of this consultancy was to study the Breastfeeding Information Group (BIG) as a possible model for other similar groups in other countries.

Discussions were held in Nairobi with Margaret Kyenkya, Director of the Africa Regional IBFAN office, which is actively working to start and support organizations similar to BIG in other African countries.

In May 1984, IBFAN's first African Regional Conference was held in Swaziland. Participants included representatives from government agencies, health professionals and IBFAN groups from Botswana, Ethiopia, Kenya, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

The Conference was organized around four major themes:

- 1) Breastfeeding management in health care facilities,
- 2) Breastfeeding and the employed mother,
- 3) The International Code for the Marketing of Breastmilk Substitutes, and
- 4) The Code as a plan of action for promoting maternal and child health in Africa.

The conference summary is attached as Appendix 13.

According to Ms. Kyenkya, the following groups are currently active:

- 1) Botswana - a breastfeeding committee in the Ministry of Health
- 2) Ethiopia - Breastfeeding Information Group of Ethiopia, a registered N.G.O. in which each member represents an organization or ministry involved in maternal and child health and nutrition issues
- 3) Lesotho - a committee within the Ministry of Health but which is not yet registered as an N.G.O.
- 4) Mauritius - the Mauritian Action for the Promotion of Breastfeeding and Infant Nutrition

- 5) Swaziland - Breastfeeding Campaign Group, a registered N.G.O.
- 6) Uganda - Uganda Breastfeeding Association, a registered N.G.O. doing counseling work
- 7) Zambia - The Zambia Breastfeeding Action Group, a registered N.G.O.
- 8) Zimbabwe - The Zimbabwe Infant Nutrition Network, a registered N.G.O., and a branch of La Leche League.

BIG and IBFAN have each produced a mailing on how other groups can get started. They are attached as Appendix 14.

A. History

The Breastfeeding Information Group (BIG) started out as an informal organization of seven women interested in helping mothers who had problems breastfeeding. Interest and "membership" grew until in 1978 the group decided to formally register as a voluntary society. In the constitution approved at the annual general meeting in 1980, the objects of the organization were stated as follows:

- 1) to provide accurate information on breastfeeding
- 2) to encourage the practice of breastfeeding
- 3) to help anyone who wants assistance in breastfeeding.

It was also stated that the organization is "non-political" and "non-sectarian" and that additional branches will be formed when found necessary.

The organization has increased in activities, membership, budget, and influence over the last 7 years. This growth will be discussed in detail in the following sections on organization, activities, membership, and funding.

B. Organization

BIG is organized by its constitution using a committee system. Annually elected office bearers (Chairman, Vic-chairmen, Secretary, and Treasurer) sit on an executive committee with the elected Chairmen of each of the

sub-committees. The number of sub-committees and the issues that they deal with have changed over the years (usually expanded) and are listed in the 1984 annual report as follows:

- Counselling
- Education and Training
- Visual Aids
- Fund raising
- International Cooperation
- Kwangware
- IBA Conference

At other times there has been an active Research Committee, Kenya Code Sub-Committee, etc. How active a sub-committee is, or if one exists at all, is dependent on both the current needs of the group and the interest of members in serving on it. The system is feasible and directs the efforts of members to their areas of interest.

Monthly business meetings, while not specifically called for in the constitution, provided a regular opportunity for active members to meet as a whole group. Committees would give updates of their individual efforts and the executive committee would poll those present as to the group opinions on matters being addressed by the executive. In the early years of the organization the monthly meetings were well attended forums where many decisions were reached. More recently they have become much less well attended (there was no monthly business meeting held in December 1984, January or February 1985) and many more decisions appear to be made in either the executive meetings or in sub-committees.

The executive committee currently meets weekly and in addition regular office bearer meetings have started on a weekly or twice monthly schedule. There has been concern expressed by members of the executive committee

that the frequency of meetings places too much of a burden on office bearers and sub-committee chairmen.

Annual general meetings are held usually in October and include the election of office bearers and selection of sub-committee chairmen, consideration of the annual report, amendments to the constitution or by-laws, and any other new business. These meetings require a quorum of 10% of the registered active membership.

C. Activities

The activities of BIG are probably best discussed by sub-committee. The following has been taken directly from BIG materials describing some of their sub-committees for a project proposal.

1) COUNSELLING COMMITTEE:

This committee promotes breastfeeding through individual counselling and talks to groups of mothers in maternity hospitals and maternal child health clinics within Nairobi. They also do counselling by correspondence to mothers outside Nairobi. BIG now employs four full-time swahili speaking counsellors who visit 39 clinics and 6 hospitals twice a month.

2) EDUCATION AND TRAINING COMMITTEE:

Our two target groups are health workers, who receive in-service training in breastfeeding management, and existing women's groups in rural areas. Our goal with the latter is to establish a mother to mother network, and create awareness of the benefits of breastfeeding and proper weaning practices.

3) VISUAL AIDS AND PUBLICATIONS COMMITTEE:

In addition to advising mothers and organizing workshops,

we also distribute materials throughout the country. Our visual aids and publications committee is responsible for the design, writing and production of posters, informational booklets, leaflets and other printed matter.

When writing our materials, we try to respond to general needs and often use frequently asked questions as starting points. For example, many Kenyan men have asked what they can do to promote breastfeeding, so we produced a leaflet entitled "Please Help Your Wife to Breastfeed." This popular leaflet is also available in Swahili.

Our printed materials reach a wide audience and we consider them essential to our efforts. Some are used by our counsellors as handouts to mothers. Others are distributed by mail to health institutions, church groups and schools throughout Kenya.

4) NEWSLETTER COMMITTEE:

BIG publishes a bi-monthly, offset-printed newsletter, which is sent to all members in Kenya and abroad. Because of the newsletter's general appeal and professional appearance, we have recently decided to increase the press run and send copies to pediatricians, obstetricians and health institutions throughout the country. In this way we hope to attract new members and reach as many health professionals as possible - people who are in a position to promote breastfeeding through their daily work.

5) RESEARCH AND EVALUATION COMMITTEE:

Members of this committee carry out research in breastfeeding and infant feeding practices, as well as evaluation of our

own workshops. In 1981, BIG, in conjunction with the Ministry of Health undertook research on knowledge, attitude and practices of health workers with respect to breastfeeding.

The outcome of this study has been published and is now being used as the basis for developing an in service education curriculum for health workers.

Details of the activities of other sub-committees which have existed over the last 7 years are available in the BIG annual reports.

D. Membership

No formal study of membership was done for this evaluation although this information is potentially available from dues receipts. Recent materials made available by BIG as background information on the organization states that there are more than 250 local members and 50 overseas members and goes on to state that initially many BIG jobs "were frequently done by expatriate volunteers temporarily resident in Kenya."

This appears to have changed over the years with more local Kenyans taking an active role. One problem in involving Kenyan women is that many of those interested are health professionals who already are juggling full time careers and family demands. Whether expatriate or local the "active" members (presently estimated at about 40) are generally at least middle SES and almost exclusively female. Active members usually volunteer 5-15 hours per week. Recently there has been discussion around starting BIG branches in other areas of the country to attempt to attract rural women.

E. Funding

An analysis was made of the annual financial reports available for the years 1979 through 1983 in an effort to look at expenditures and income for the organization. While it was difficult to classify expenditures and income in constant groups over the whole period because of both

changing funding sources and the group's changing activities, the following generalizations can be made:

- 1) Real growth in budgets from 1979 to 1983.

First year expenditures were reported at KS 3,049/- compared with 1983 expenses listed as KS 593,061/-, an incredible rate of growth even considering inflation and the devaluation of the shilling against the U.S. dollar.

- 2) A general trend for income to come from international donor agencies instead of from Kenyan sources
- 3) A general trend (linked with 2) above) for funds to be for restricted use rather than general uses
- 4) Under-spending the budgetted funds
- 5) An increase in overhead (office expenditures) as a percent of total income (approximately 6% in 1979 vs approximately 12% in 1983)
- 6) The increase in the percentage of income used for salaries (from 0 in 1979 to approximately 30% of the 1983 expenditures).

Again, because of the changes in activities of the organization over the five year period examined, these trends probably need to be considered in context.

Recommendations

After meeting individually with many members of the Nyeri Workshop Implementation Committee, a group meeting was held on 26 February 1985 at the National Family Welfare Centre. From the individual discussions and the minutes of the 26 February meeting, the following recommendations emerged:

I. Lactation Management Training

The Implementation Committee recommends that a two week workshop patterned after the lactation management training done in San Diego in January 1984 be held in Nairobi for a group of approximately 25-30 Kenyan health workers. The objectives are to:

- 1) update knowledge using outside expertise
- 2) bring in materials not locally available
- 3) increase the competency/skills of local trainers.

A sub-committee consisting of the following implementation committee members was selected to follow up this recommendation including:

Mrs. Kithinji	National Family Welfare Centre
Mrs. Shompa	Breastfeeding Information Group
Dr. Stanfield	AMREF
Dr. Sandbladh	AMREF
Dr. Onyango	University of Nairobi (Paediatrics)

The implementation committee felt that as much as possible the workshop should be locally organized and that the new Kenyan breastfeeding manual for health workers be introduced in the curriculum. Discussions with participants from the San Diego training resulted in the suggestion that visual training materials be tailored to Kenya (slides be produced showing Kenyan mothers), that more information be included on appropriate weaning foods and practices, and somewhat less attention be given to promoting

initiation of breastfeeding (very high in Kenya).

II. An Infant Feeding Practices Workshop

A recommendation was made that a workshop be held similar in some ways to the 1983 Nyeri workshop for Kenyan policy makers interested in infant feeding. The objectives are to:

- 1) Present and discuss new research, or materials, or projects on infant feeding which have been developed since 1983 (including several mentioned in the update section of this report)
- 2) To discuss new implementation strategies for the Nyeri Workshop recommendations which have not been fully implemented (such as the Kenya Code)
- 3) To discuss new developments in Kenyan infant feeding issues (such as glucose drinks, commercial weaning foods and the distribution of dry skimmed milk in commodity food programs)

It was further suggested that this workshop be held just before the training discussed in I. above.

III. Research/Evaluation

To provide information for the discussions proposed in recommendation II, it is recommended that:

- 1) an evaluation of compliance with the MOH directive on hospital practices be carried out on a national sample of government, mission and private hospitals.
- 2) in conjunction with the hospital survey, a series of marketing interviews patterned after those done in Nairobi in February 1985 (Appendix 5) be done in the same areas at the same time.

IV. Media Support

The Breastfeeding Information Group requests assistance in the prep-

ation of radio spots and radio plays promoting breastfeeding for broadcast on The Voice of Kenya. It was further suggested that a local consultant be hired who knows Kenyan radio marketing and production.

Marketing Interview Study

In February 1985 a series of marketing interviews were done in Nairobi to look at the availability, price and volume of sales of items in the following categories: fresh milk, tinned liquid milk, powdered milk, infant formula, weaning cereals, liquid glucose drinks, powdered glucose drinks, and bottles and teats. This was done to assess changes in marketing patterns since the last systematic marketing study of infant and children's foods done in connection with the 1982 Kenyan Infant Feeding Practices Study, and to investigate a new area of concern voiced by some workshop implementation committee members - the growing availability and marketing of glucose drinks and their consequences for infant feeding.

A sample of 18 cluster areas was randomly selected from approximately 40 low and low-middle income cluster areas from the Kenyan Central Bureau of Statistics sampling frame. Interviewers were instructed to choose the first shop of any size that they encountered in a cluster area and conduct the interview. They were then instructed to ask the shopkeeper for the location of the nearest shop of a different size (a self-service store if they had just interviewed a kiosk owner and the reverse). If this type shop was within 5 minutes walking distance (distance limit to prevent overlap of interviewing in densely clustered areas) they would proceed there for the next interview. If this was not possible, they were to choose another nearby shop at which to interview.

Using this procedure a total of 36 shops were visited (35 small kiosks and 1 large self-service). Because many kiosk owners stated that many of their customers now shop at the large self-service shops in the city center, 8 shops were interviewed there in a separately chosen sample.

The availability of the different products found are presented (as percent of interviewed shops stocking each item). A short summary of analysis results by product category follows.



	<u>% shops stocking (n = 36)</u>		<u>% shops stocking (n = 36)</u>
Any fresh milk	92	Any liquid glucose drink	69
KCC 250	22	Ribena	56
KCC 500	83	Lucozade	64
UHT	8	Trufu	3
		Cremex	6
Any tinned liquid milk	8	Haliborange	22
Safariland	8	Other	3
Cowbell	3		
Lita	3	Any glucose drink (dry & liquid)	86
		Any dry glucose drink	81
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Nan	67	Flambo 1	3
Lactogen	78	2	6
SMA	3	3	33
S26	3	Dextrosol 1	3
Isomil	3	2	3
Prosobee	0	Flambo energy drink	3
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Nestum	8	Glass bottle	6
Cerelac 500	81	Teats	47
Cerelac 1 kg	17		
C & G rusks	3		

Availability of Infant Feeding Products by Product Category

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- * KCC 500 ml generally standardized at gov't. reg. price of 2/75
- * KCC 250 ml price more variable. This size originally only for free distribution to schools
- * One duka owner while complaining about a general decrease in business noted that "the heart of a duka owner's business was bread and milk"

TINNED LIQUID
DRY POWDERED Generally unavailable at time of interview

FORMULA - AVAILABLE IN 78% OF SHOPS

- * All shops stocking any formula stocked a Nestles formula
- * 86% shops stocking any formula stocked both Nestles products
- * Lactose free formula available in none of the dukas/only available in self service & chemists
- * Prices almost always exactly the allowed maximum price for Nestles products

WEANING FOODS - AVAILABLE IN 82% OF THE SHOPS

- * All small shops stocking any weaning cereal stocked a Nestles product
- * New Nestles product "Nestum" (part cereal, part milk for use as earliest weaning cereal) not widely available
- * Most Cerelac 500g size (most widely available product) sold at or just below maximum controlled price
- * Except for what appears to be old stock Cow & Gate baby rusks available only in the 1 self-service shop sampled. No other products available in this category except Nestles
- * In shops stocking both Nestles formula and Nestles cereal for which sales/week information was available. 37% (7 of 19) were selling more weaning cereal than formula
- * Other products mentioned by shop keepers as weaning foods include weetabix, sorghum flour, and maize meal

LIQUID GLUCOSE DRINKS - AVAILABLE IN 68% OF SHOPS

- * Market dominated by Ribena and Lucozade - only one shop stocking any liquid glucose drink did not stock either Ribena and/or Lucozade
- * Haliborange available in approximately 1/3 shops stocking any liquid glucose drink
- * Prices for all 3 products vary little from shop to shop

POWDERED GLUCOSE DRINKS - AVAILABLE IN 82% OF SHOPS

- * Market dominated by Glucolin - 81% of shops having any powdered glucose drink stocked one or more size of Glucolin
- * Glucolin's best selling sizes are 250 and 500 g
- * Flambo's glucose is the only real competitor and holds most of the market for the 100g size
- * Prices for all products and sizes vary little from area to area

ANY GLUCOSE DRINK - AVAILABLE IN 86% OF THE SHOPS

- * Of the 35 small shops surveyed, 20% stocked only 1 type/brand; 46% 2-3 types/brands; and 20% 4 or more types/brands
- * More shops stocked powdered glucose drinks than liquid ones
- * More shops stocked glucose drinks than stocked infant formula
- * In all shops carrying both infant formula and any glucose drink and for which "quantity sold" information are available (n = 15) 73% report selling more units of glucose drinks than formula

BOTTLES AND TEATS

- * Glass bottles difficult to find
- * Bottle prices range widely with some plastic bottles more expensive than glass ones
- * Teat prices range widely (\approx 4/- to \approx 8/-)

CITY CENTER SAMPLE

- * Large self-service stores stocked more brands for each category
- * Prices for formula and most glucose drinks very close to those in sample survey
- * Very few chemists stock any of the survey items
- * Many surveyed shop owners from outside city center blame their decreasing business on the popularity of city center self-service stores

APPENDICES

APPENDIX 1
Breastfeeding
Information
Group

P.O. Box 59436 Nairobi, Kenya



Dear *Karin*

No. 57 UNIT OF WOMEN INFANT FEEDING STUDY.

We are pleased to forward to you the first draft report of the above study. However the section of "Recommendations" has not been written. We are now requesting you to kindly read through this draft and give us your opinion.

We shall also be most grateful for any suggestion you may come up with to go under the section on recommendations.

Please do this by February 29 1984 at the latest as WHO in Geneva have waited long enough for this report.

Let us know through BIC office box number your opinion on the report even if you have no other contribution.

Yours sincerely,
Margaret Ogello
M. Ogello
Esther Serengebu
E. Serengebu

STATUS OF WOMEN, INFANT AND YOUNG CHILD FEEDING
(A Case Study Of Social Support Measures In Kenya)

*by Esther Nyonyintono Sempebwa

Margaret Okello

Breast feeding Information Group,

Nairobi, Kenya.

1983

CONTENTS

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	Page
A. Background	1
B. Introduction to The Study Area	3
C. Sample Selection	7
D. Interviewers	8
E. General Characteristics Of the Women	10
F. Employment	12
G. Child Care	14
H. Breastfeeding	16
I. Maternity Leave	19
J. Support Measures	21
K. Conclusions	25
L. Recommendations	29

APPENDIX

A. Table 1: Religion	1
B. Table 2 : Ethnic Groups	1
C. Table 3 : Professional Training of Women	2
D. Table 4 ; Employment Categories	2
E. Table 5 : Distribution of Employment by District	3
F. Table 6 : Total Hours of Work	3
G. Table 7 : Total Hours of Work by District	4
H. Table 8 : Present Employment by Total Hours of Work	4
I . Table 9 : Person Caring for Children	5

.....Contd.....

CONTENTS (Contd.....)

	Page
J. Table 10 : Age of Person in Charge of Children	5
K. Table 11 : Education of People in Charge of Children ...	6
L. Table 12 : Relationship of Person in Charge of the Children and the Mother	6
M. Table 13 : Meals and Children	7
N. Table 14 : Reason for Terminating Breastfeeding	7
O. Table 15 : Exclusive Breastfeeding by Job Category ...	8
P. Table 16 : Length of full breastfeeding by Job Category	8
Q. Table 17 : Total Hours of Work Versus Reason For Stopping Breastfeeding	9
R. Table 18 : Total Hours of Work Versus Length Of Full Breastfeeding	9
S. Table 19 : Breast Milk by Total Hours of Work	10
T. Table 20 : Length of Rest Before Delivery	10
U. Table 21 : Reason For the Rest Before Delivery	11
V. Table 22 : Reason for Not Taking Maternity Leave	11
W. Table 23 : Length of Leave Taken after Last Delivery	12
X. Table 24 : Norminal Maternity Leave	12
Y. Table 25 : Length of Leave Taken after the Last Child versus Total Hours of work	13
Z. Table 26 : Benefits From the Employer	13
Z1. Table 27 : Attendance to MCH Clinic	14
Z2. Table 28 : Why No Clinic	14
Z3. Table 29 : Ways Employer Makes it Hard to Breastfeed and Childcare	15
Z4. Table 30 : Items of Expenditure	15
Z5. Table 31. Help from Family and Relatives	16.
Diagram 1	17

BREASTFEEDING AND THE USE OF BREASTMILK SUBSTITUTES

AMONG URBAN MOTHERS IN NAIROBI:

BY STEVEN NYANZI

ABSTRACT

A study has been conducted among urban mothers attending well-baby clinics with infants less than one and a half years old. The study revealed that the majority of the urban mothers (83%) start supplementary breastmilk within the first three months of childhood. The type of baby food used for supplementing breastmilk greatly depends on the income class of the mother. The use of breastmilk substitutes such as Nan, Lactogen, Isomil, S-26 and SMA is mainly limited to mothers from the middle and upper income groups. A comparative study of breastfeeding habits between African and Asian mothers further showed that although most of the Asian mothers (84%) are non-working breastfeeding is not popular at all among the Asian mothers and the majority of Asian mothers (99%) interviewed do not breastfeed beyond 6 months unlike their African counterparts. The study shows that there is a widespread exposure of infants (below 4 months) to a variety of baby foods from several sources.

PUBLISHED COURTESY OF

UNICEF

BOX 44145

NAIROBI

KENYA



REPUBLIC OF KENYA

THIRD RURAL CHILD NUTRITION SURVEY 1982

CENTRAL BUREAU OF STATISTICS
Ministry of Finance and Planning

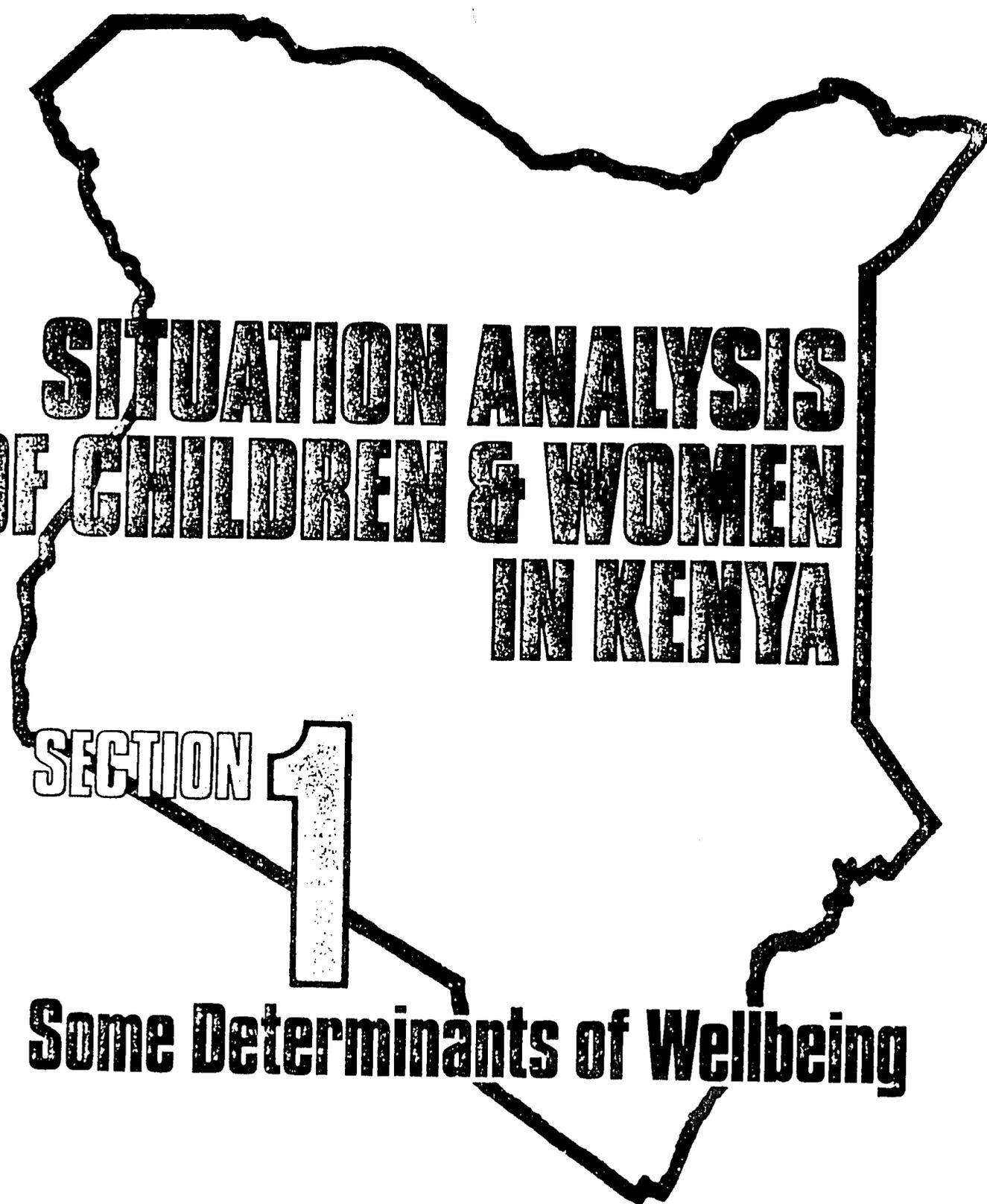
NAIROBI, KENYA

DECEMBER, 1983

23

TABLE OF CONTENTS

	Page No.
FOREWORD	
SECTION 1 - Introduction	1
SECTION 2 - Methodology	4
Differences between the 1977, 1978/79 and 1982 surveys	4
Equipment used and measurements made	5
Training of Survey staff	7
Supervision, Validation and Editing of the Data collected	7
Sample Design	8
Limitations and Caveats of the Data	9
Selection of Reference Standards and Calculation of Nutritional Indices	11
SECTION 3 - Characteristics of the Sample	13
SECTION 4 - National 1982 Estimates of Nutritional Status	16
SECTION 5 - Trends in Nutritional Status - 1977, 1979, 1982	22
SECTION 6 - Provincial and District Level Profiles	31
SECTION 7 - District Level Description of Household Amenities, Feeding Practices and Morbidity Patterns	41
SECTION 8 - Investigation of Selected Factors Affecting Nutritional Status.	44
Household Amenities	45
Demographic Characteristics of the Mother	48
Feeding Practices	50
Morbidity	59
SECTION 9 Conclusions	64
NOTES	66
REFERENCES	67
APPENDIX A - Survey Questionnaires	68
APPENDIX B - Rankings of Nutritional and other Indicators by District	70
APPENDIX C - District Level Tables	71
APPENDIX D - Frequencies of Feeding Patterns by Age (3-36 months)	76
APPENDIX E - Tables Comparable to NS2 Report	77



SITUATION ANALYSIS OF CHILDREN & WOMEN IN KENYA

SECTION 1

Some Determinants of Wellbeing



REPUBLIC OF KENYA

CENTRAL BUREAU OF STATISTICS
Ministry of Finance and Planning


united nations children's fund

SUMMARY CONTENTS

ALL SECTIONS

SECTION 1: SOME DETERMINANTS OF WELLBEING

1. THE LAND AND THE PEOPLE
2. POPULATION GROWTH, DENSITY AND REDISTRIBUTION
3. URBANIZATION
4. LIVELIHOOD
5. POVERTY
6. BASIC NEEDS SERVICES

SECTION 2: DEVELOPMENT POLICIES AND ISSUES

7. DEVELOPMENT POLICIES
8. DEVELOPMENT ISSUE 1 - POPULATION GROWTH
9. DEVELOPMENT ISSUE 2 - AGRICULTURAL PRODUCTION
10. DEVELOPMENT ISSUE 3 - THE PERFORMANCE OF THE ECONOMY
11. DEVELOPMENT ISSUE 4 - EMPLOYMENT
12. DEVELOPMENT ISSUE 5 - GOVERNMENT EXPENDITURE, POLICIES AND BASIC NEEDS

SECTION 3: THE ROLES AND SITUATION OF WOMEN

13. WOMEN AS WIVES AND BEARERS OF CHILDREN
14. WOMEN AS CHILD CARETAKERS, FOOD PROVIDERS AND CARRIERS OF BURDENS
15. WOMEN AS HEADS OF HOUSEHOLDS AND FARMS
16. WOMEN AS PRIMARY SCHOOL PUPILS, SECONDARY SCHOOL GIRLS AND TERTIARY LEVEL STUDENTS
17. WOMEN AS PARTICIPANTS IN THE LABOUR FORCE
18. WOMEN AS PARTICIPANTS IN COMMUNITY AND MUTUAL SELF-HELP ACTIVITIES

SECTION 4: THE WELLBEING OF CHILDREN

19. CHILD POPULATION
20. MORTALITY
21. CHILD HEALTH
22. NUTRITIONAL STATUS OF YOUNG CHILDREN
23. EDUCATION

REFERENCES (SECTIONS 1 - 4)

Note: Page numbers in each Section start from page 1, whereas sub-sections and paragraphs continue consecutively throughout all four Sections.

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BREASTFEEDING SEMINAR - FROM 2nd - 8th DEC, 1984

AT

OCEANIC HOTEL-MOMBASA

CURRICULUM DEVELOPMENT

SUBJECT: - TOTAL HOURS - 14.

Broad Objectives: The Student will be able to:-

1. Acquire knowledge and skills towards breast-feeding.
2. To develop positive attitude towards breast-feeding.
3. To promote breast-feeding.

Specific Objectives: The Student will be able to:-

1. Describe the Anatomy and physiology of the female breast.
2. Describe the Biochemistry and immunology of the human milk.
3. Describe effects of drugs and hormonal contraceptives on lactation.
4. Discuss advantages of breast-feeding and disadvantages of breast-feeding and disadvantages of breast-milk substitutes and bottle-feeding.
5. Describe the proper management of breast-feeding and provide appropriate care (management).
6. Identify the problems which affect breast-feeding and provide appropriate care (management).
7. Describe the proper weaning practices.
8. Educate the community on Breast-feeding.

TOPICS.

1. Anatomy and physiology of female breast - 2 hours.
2. Biochemistry and immunology of the breast milk. - 2 hours.
3. Effects of drugs and hormonal contraceptives on lactation. 1 Hr.
4. Advantages of Breast-feeding. - 1 hour.

.... / 2

5. Disadvantages of Breast milk substitutes and bottle-feeding. - 1 hour.
6. Proper management of breastfeeding. - 2 hours.
 - ante-natally
 - Intra-pentally
 - Post-natally.
7. Problems/Factors which affect breast-feeding and their management. - 2 hours
8. Proper weaning practices in the Community - 2 hours
9. Counselling the community on breast-feeding. - 1 hours

13 Hours

MINISTRY OF HEALTH, MCH/FP PROGRAMME

SEMINAR ON BREASTFEEDING PROMOTION EDUCATION FROM 12TH FEBRUARY TO 16TH FEBRUARY 1985 - IN NYERI

DAY	TIME	SUBJECT/TOPIC	RESOURCE PERSON
Tuesday 12/2/85	4 - 6pm	Arrival	1. Dr. J. Kigodu-Director, MCH/FP Prog. 2. Dr. F. Onyango-Snr. Lect. Univ.-K ^{WH} 3. Dr. J. Githiari-Prov. Obgy. Central Province
Wednesday 13/2/85	8.30 - 9.30am 9.30 - 10.30am 10.30-11.00am 11 - 12 noon 12 - 1pm 1 - 2pm 2 - 4pm 4 - 4.30pm 4.30 -5pm	Registration of Participants Official Opening T E A B R E A K Trends in Breast Feeding in Kenya Anatomy & Physiology of Lactation L U N C H Biochemistry T E A B R E A K Film Show	Mrs E. Kithinji Dr. Kigodu - Director - MCH/FP Prog. Dr. Ritho - Nyeri Dr. Ochieng (Mrs) - Nyeri Mrs. R. Shompa - B.I.G
14/2/85 Thursday	8.30 -9.30am 9.30-10.30am 10.30-11am 11 - 12noon	(Nutrition of pregnant & Breast-feeding mother) Proper management of Breast feeding T E A B R E A K Proper weaning practices	Dr. J. Githiari - Nyeri, MCH Mrs. E. Nderitu - Nyeri Mrs. R. Shompa - B.I.G

Appendix 7

GA

DAY	TIME	SUBJECT/TOPIC	RESOURCE PERSON
Thursday 14/2/85	12 - 1pm	Effects of Hormonal Contraceptives and drugs on the Breast.	Dr. J. Kigundu - N.F.M.C.
	1 - 2pm	L U N C H B R E A K	
	2 - 3pm	Common problems of Breast feeding	Mrs. M. Bwire - Nyeri MATERNAL & CHILD HEALTH CENTRE
	3 - 4pm	Small group discussion on how to promote Breast feeding	Dr. Turkish - K.N.U. University.
	4 - 4.30pm 4.30 - 5pm	T E A B R E A K Small group reporting on how to promote Breast Feeding.	Dr. Turkish - K.N.U. University
Friday 15/2/85	8.30 - 10.30 am	Advantages of Breast-feeding and Disadvantages of artificial feeds.	Mrs. Kithinji - N.F.M.C.
	10.30-11.00 am	T E A B R E A K	
	11.00 - 1pm	Recommendations of the seminar	Dr. J. Kigundu - Chairperson
	1 - 2pm	L U N C H B R E A K	
	2 - 4pm 4 - 5pm	Prov. G. Hospital Nyeri MCH/FP Tour Official Closing Ceremony	Dr. J. Githiari - Nyeri P.M.C. CENTRAL PROVINCE
Saturday 16/2/85	Departure		

4/6



Social Perspectives

CENTRAL BUREAU OF STATISTICS MINISTRY OF FINANCE AND PLANNING GOVERNMENT OF KENYA

INFANT FEEDING PRACTICES IN NAIROBI, KENYA

Summary of Findings

A survey of 980 low and middle income Nairobi women who had given birth in the previous 18 months showed a common pattern of almost universal successful and prolonged breastfeeding overlaid with widespread supplementation with infant formula especially in the first six months of life. The high prevalence of formula use could not be explained by data collected on either women's employment outside the home or by difficulties in breastfeeding. There is a widely held misconception that infant formula given in addition to breastmilk is preferable to breastmilk alone. This belief may be partially explained by promotion of breastmilk substitutes and by health care facility practices.

The negative results of this unnecessary use of breastmilk substitutes include a drain on family income, shorter intervals between births, and increased child morbidity. Measures taken to protect, support and promote breastfeeding would benefit Kenya by saving foreign exchange spent on breastmilk substitutes, by decreasing child illness, and by increased birth spacing.

I. Introduction

This issue of *Social Perspectives* is based on the results of the Kenyan Infant Feeding Practices Study (IFPS). The cross-sectional survey described here was conducted by the Central Bureau of Statistics (CBS) on 980 low and middle income Nairobi women who had given birth in the previous 18 months. Sampling was conducted using the CBS national sampling frame based on the 1979 census and the data were collected between March and June 1982. These data only represent low and middle income women who had recently given birth in Nairobi and should be considered accordingly.

II. Household and Demographic Data

The typical household from the sample consisted of 5-6 people living in 1-2 rooms. The water source

1. The Kenyan Infant Feeding Practices Study was undertaken by the Central Bureau of Statistics of the Ministry of Finance and Planning, the African Medical and Research Foundation and a U.S.-based consortium of Cornell and Columbia Universities and the Population Council. Funding was provided by the United States Agency for International Development.
2. This paper is taken from the Final Report of the Kenyan Infant Feeding Practices Study by T. E. Heath and J. Kikuyiri and is available at the Central Bureau of Statistics Library.

was piped to a point outside the house. The house had no electricity and cooking was done on a jiko or over a wood fire. The family used a pit latrine. The typical household head was a male, educated 7 years or less and working at the time of the interview.

The typical mother was 24 years old, married, and Kikuyu, Luo or Luhya. She had a primary school education or less and had spent most of her life in rural areas, having moved to Nairobi only in the last five years. The index child was her first or second, and at the time of the interview, she was not using any method of birth control.

Forty-nine percent of the index children were female and 51% male. The ages were distributed quite evenly over the range of 0 to 18 months. Sixty-five percent were born in a government clinic or hospital, 23% at home, and the rest in private hospitals or clinics. Seventeen percent of the children had been hospitalized overnight for an illness since birth. Ninety-seven percent had at some time been breastfed and 77% were breastfeeding at the time of the interview. Just less than 8% of the children were below 70% of their expected weight for age.

III. Infant Feeding Practices

Children were classified by what they were being fed at the time of the interview into one of seven possible feeding patterns created from combinations of breastmilk, breastmilk substitutes (cow's milk or infant formula) and food supplements as shown in Table 1. These seven feeding patterns are strongly related to the child's age. Exclusive breastfeeding (pattern 1) starts at 76% of the children less than one month of age and quickly declines as either food supplements and/or breastmilk substitutes are added to the diet (patterns 2-4). Exclusive feeding with breastmilk substitutes (pattern 3) was very rare in any age group. The number of children being fed exclusively on food supplements, solids and semi-solids (pattern 6) is very small until after one year of age when more children have been weaned and fewer are receiving formula or cow's milk.

In figure 1, these data are regrouped into three categories: those children receiving breastmilk in any combination, breastmilk substitutes in any combination, or food supplements in any combination. One striking feature of this figure is the almost universal initiation of breastfeeding and continued breastfeeding by more than half the

mothers for 12 months or longer. Ninety-seven percent of the women interviewed started breastfeeding, and 85% and 50% were still breastfeeding at 6 and 15 months, respectively.

A second interesting finding is the very early introduction of breastmilk substitutes and other supplemental foods. By two months of age 55% of the children and by four months 82% had been given these foods. Since exclusive breastfeeding is generally recommended as the best way to feed a child for the first 4 to 6 months of life, this pattern of early introduction of solids and semi-solids is unnecessary and potentially harmful.

The use of breastmilk substitutes which is fairly stable across age groups in figure 1 is quite different if use of cow's milk is examined separately from infant formula use. Cow's milk is considered a normal part of a child's or adult's diet and over the first 18 months of life between 30% and 40% of the children in each age group consume it. Infant formula use is very different with a peak use at three months (more than 45%) which then steadily declines to near zero at 18 months. More than half of the study infants had at some time received infant formula. The resulting picture is the unusual pattern of almost universal prolonged and successful breastfeeding overlaid with widespread supplementation with infant formula especially in the first 6 months of life.

This unnecessary supplementation with infant formula is especially disturbing in light of the household and demographic data presented earlier. Most of the women interviewed did not have the necessary facilities or skills for the safe preparation of formula feeds, and less than 1 in 5 were using any method of birth control.

IV. Determinants of Formula Use

The survey data were analyzed to determine the factors associated with the observed feeding patterns and especially with the use of infant formula. Breastfeeding problems are often suggested as explanations for the use of infant

formula. When asked about breastfeeding problems, only 11% of the mothers reported having any problem and half of these women reported that the difficulty was engorged breasts. Only 4% of the mothers or 36 women reported having insufficient milk and when asked to characterize their overall breastfeeding experience as "pleasant," "unpleasant," or "neither," 95% of the women chose "pleasant." These responses along with the overall picture of nearly universal prolonged breastfeeding suggest that breastfeeding problems are not an important determinant of formula use.

Paid employment which separates the mother and child for long periods of time each day is another common explanation suggested for formula use. Among the low and middle income women in this sample, only 11% worked outside the home and only 5% of the sample were not able either to take the child with them or visit her or him during the working day. This suggests that paid employment resulting in separation of mother and child does not account for the widespread use of formula.

Another set of possible explanations for the use of formula centers on knowledge and attitudes. Mothers were asked if they agreed with, disagreed with, or had no opinion on the following statement:

"A child will be healthier if it receives infant formula in addition to breastmilk in the first 2 months of life." Eighty-five percent of the mothers agreed. This mistaken belief, then, may explain much of the inappropriate formula use.

V. Influences on Feeding Practices

In light of the determinants found, the data were analyzed to investigate influences affecting feeding practices in general and the mistaken belief in the superiority of infant formula in particular. The two important influences arising from this analysis are the health care system and marketing practices.

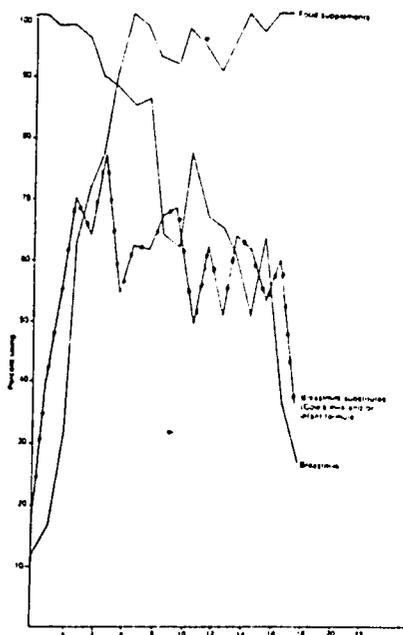
While 60% of the women surveyed had received some sort of antenatal care, only 40% recall being told anything about infant feeding. Of this 40%,

Table 1. Type of Feeding by Age of Index Child

Age in Months	Breastmilk Only		Breastmilk and Breastmilk Substitutes		Breastmilk Substitutes Only		Breastmilk Substitutes and Food Supplements		Breastmilk and Food Supplements		Food Supplements Only		Breastmilk Substitutes and Food Supplements	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1	51	76	5	7	1	1	4	7	3	5	0	0	0	0
1 to 2	16	53	21	67	0	0	5	14	5	14	0	0	0	0
2 to 3	19	33	29	54	1	2	17	31	8	14	0	0	0	0
3 to 4	3	9	11	33	0	0	16	47	9	22	0	0	1	3
4 to 5	5	13	7	16	0	0	11	24	11	24	0	0	2	3
5 to 6	3	4	12	16	0	0	11	14	11	14	2	9	6	10
6 to 7	1	1	4	5	1	2	10	13	29	41	1	4	6	9
7 to 8	0	0	0	0	0	0	10	11	11	12	0	0	5	5
8 to 9	0	0	1	1	0	0	14	12	11	14	1	1	5	11
9 to 10	2	3	4	4	0	0	14	12	15	14	4	4	11	10
10 to 11	2	6	1	3	0	0	9	24	11	30	0	0	11	28
11 to 12	1	3	0	0	0	0	11	11	19	14	2	4	8	18
12 to 13	2	5	0	0	0	0	19	14	16	10	2	4	15	18
13 to 14	2	4	2	5	1	3	9	23	15	15	5	12	16	22
14 to 15	0	0	2	4	0	0	13	16	11	14	5	11	11	28
15 to 16	0	0	0	0	0	0	12	27	10	22	3	8	18	42
16 to 17	1	4	0	0	0	0	9	30	9	31	4	13	7	23
17 to 18	0	0	0	0	0	0	5	18	3	12	7	29	10	40
18 to 19	0	0	0	0	0	0	5	14	4	11	8	21	7	22

46

Figure I
Percent Current Use of Breastmilk, Breastmilk Substitutes and Food Supplements by age of Index Child



one-quarter of the women reported being given the misinformation that either exclusive formula feeding or a mixture of formula and breastfeeding was best for their baby.

The results of the questions on information given at the time of delivery show that while 77% of the women had given birth in a health care facility; only 14% recall receiving any information on infant feeding at that time, and half of this 14% report being wrongly told that exclusive formula feeding was best for their child. These findings are disturbing.

Marketing practices were also investigated in the survey and mothers were asked if they could recall ever having heard or seen television or radio advertising for infant formula, and if so, for which brands. Even though the companies claim to have stopped using mass media advertising techniques for their products eight years before the study was done, more than one-third of the mothers recalled advertising for the currently most widely used brand, and more than half the mothers recalled advertising for one or more of the brands currently on the market.

With the move away from mass media marketing of infant formula, more promotion is now done through the health care system. Seventeen percent of the women delivering at health care facilities reported that their child was fed infant formula at the facility where they delivered, and more than half of these women (58%) could recall the brand of formula that was used.

VI. Consequences of Formula Use

Study data were analyzed to determine what effects if any the unnecessary use of infant formula had on the families, mothers or children studied. At the family level the obvious negative consequence of unnecessary formula use is the drain on family finances. Calculations made using current (March 1983) formula prices and minimum wage levels show that, depending on brand, between 32% and 67% of the urban minimum wage is necessary to exclusively formula feed one infant over the first 6 months of life. While very few children are being exclusively formula fed, the expense for families where the mother is either mixed feeding or sporadically bottle feeding can still cause a serious and unnecessary strain on family budgets.

Concerning mothers, an important issue is fertility. While the current study was not designed fully to analyze this aspect, much documentation is available on the effect of exclusive breastfeeding on birth spacing. Breastfeeding is known to reduce fertility because of hormones produced in response to sucking by the infant. Partial or total replacement of breastfeeding with formula feeds results in lower hormone levels and an earlier return of menstruation, ovulation and fertility. This is especially important because only 18% of the women surveyed reported using any method of birth control since the birth of the index child. The contraceptive effect of breastfeeding was recognized by the mothers themselves. Seventy-five percent agreed with the statement, 'At 6 months mothers still breastfeeding are less likely to become pregnant than women who stopped breastfeeding at 3 months.'

For the child, two issues addressed by this study included child morbidity and growth. Seventeen percent of the mothers reported that their child had at some time been hospitalized for an illness, and 44% reported that their child had been ill in the previous two weeks. When been ill in the previous two weeks when hospitalization is analyzed by feeding pattern, the data show significantly fewer exclusively breastfed children as ever having been hospitalized. This result may be confounded by age, since exclusively breastfed children tend to be the youngest children in the study and have thus had less opportunity to have been hospitalized.

When reported illness in the previous two weeks is analyzed by feeding pattern, the age effect is removed and the data show the same picture. Exclusively breastfed infants had a significantly lower incidence of reported illness in the previous two weeks than did other infants (Chi squared statistic significant at the .01 level).

Child growth was analyzed for all children below 90% of expected weight for age against feeding pattern and no significant relationship was found. Further analysis needs to be done to control for age and income factors.

VII. Conclusions

The infant feeding patterns observed in the low and middle income women sampled in Nairobi have important implications for Kenya. Many trends which begin in urban centres later move into rural areas and there is little reason to believe that the

feeding patterns observed in Nairobi are different from those in other Kenyan urban settings

Even excluding these other unsampled urban areas and the possibility of these patterns spreading to rural areas, implications of the use of breastmilk substitutes, and especially infant formula, by Nairobi residents alone are important. Increased health care costs associated with formula use and the loss of foreign exchange spent on unnecessary infant formula both negatively affect the national economy. A decrease in the contraceptive effect provided by breastfeeding would decrease birth spacing and increase Kenya's already high birth rate.

At least as important as these economic factors, is the fact that physicians, research scientists and even infant formula manufacturers recognize that exclusive breastfeeding for the first 4-6 months of life provides the best possible diet for an infant. Continued breastfeeding after 4-6 months supplemented by locally produced semi-solids and solid foods is the best regimen for infants and young children in the period following exclusive breastfeeding. Policies which foster breastfeeding are sound not only for economic reasons but also in terms of the effect on population increase and because this will help promote optimum infant nutrition.

A recent paper by Ted Greiner, "Infant Feeding Policy Options for Governments" (Draft report for the USAID-funded Infant Feeding Consortium, D.N.S. Cornell University, November 1982) breaks policy options into three categories of activities on behalf of breastfeeding as follows: (1) protection of breastfeeding, (2) support of breastfeeding, and (3) promotion of breastfeeding. Protection of breastfeeding refers to activities which guard women already breastfeeding from forces which would influence them to do otherwise, support of breastfeeding refers to providing assistance to women who are motivated to breastfeed but who find themselves facing conditions which make this difficult, and promotion of breastfeeding refers to convincing women who are not motivated to breastfeed that they should do so.

Because the survey data show the Nairobi women studied to be prolific, enthusiastic and well motivated breast-feeders, protection for them against forces which discourage breastfeeding seems to be the best policy option for Kenya. Two important issues to consider are the promotion and availability of breastmilk substitutes.

The promotion of infant formula in Kenya has moved from the mass media advertising of the last decade to more subtle promotion through health care facilities. This promotion includes free supplies of formula to institutions, posters, booklets, hospital visits by milk nurses, and in some cases giving free samples to mothers at delivery. The implementation of the recommendations include in the WHO BRIDGE Code for the marketing of infant formula which the Kenyan government supported in Geneva in 1981 would go far to curb these abuses.

The survey data show infant formula to be widely available to even the poorest and least well-educated mothers in Nairobi and that the marketing of these products is not being targeted only to those who can afford them and have the education to use them safely. Infant formula use was reported by over

half of the women interviewed in the cross-sectional survey. The pattern of use is as a supplement to breastmilk and very few of the women studied formula fed exclusively. Clearly policies to decrease the availability of infant formula through restrictions on importation, production or distribution would improve infant feeding practices in Kenya.

The most commonly used purveyor of breastmilk substitutes from the survey was the feeding bottle. Bottles are used for the mother's convenience, so that the baby can "feed itself" in spite of the fact that the safest and most sanitary way to feed either cow's milk or infant formula is with a cup and spoon. Feeding bottles, especially plastic ones most often used in Kenya, are difficult to clean and to sterilize, especially so taking account of the kitchen facilities and water sources seen in the study areas. The purchase of imported feeding bottles is also a drain on foreign exchange. Government restriction of their sale would not only encourage breastfeeding (as a more convenient alternative to cup and spoon feeding) but would promote the safest means of feeding breastmilk substitutes in the cases where their use cannot be avoided.

Supporting breastfeeding, according to Greiner, consists of helping motivated mothers to overcome circumstances which make breastfeeding difficult for them. Two important issues which are often stated to raise difficulties are employment away from home and problems that mothers experience in breastfeeding itself. The survey data show that in the women studied maternal employment outside the home was not now an important constraint to breastfeeding. Employment outside the home and physical separation from the mother may be a more common problem for higher income women, or may become a more serious problem as more women enter the labour force.

Kenya's current two month maternity leave policy helps ease this constraint and the policy in some agencies of allowing annual leave to be added to the maternity leave period helps even more. The latter should be supported. Innovative policies for on-site day care facilities where mothers can breastfeed during breaks and at lunch, job sharing, and extended unpaid leave should all be considered to meet this anticipated growing need.

Maternal morbidity and breastfeeding problems also appear not to be an obstacle to breastfeeding for most of the Kenyan women interviewed. Support to mothers with these kinds of problems should be made available through health personnel, and facilities as well as women's groups and facilities as well as women's groups and organizations like the Breastfeeding Information Group, which currently provides counseling for breastfeeding mothers as well as other educational programs.

Finally, there is the question of breastfeeding promotion. Eighty-five percent of the women sampled expressed the view that babies are healthier if given infant formula in addition to breastmilk in the first four months of life. This widespread misconception suggests that lack of resources, and not desire, have helped contain formula use to its current levels. This in turn indicates a need to reeducate women concerning the financial advantages and health benefits derived from exclusive breastfeeding for the first 4 to 6 months of the infant's life.

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Encouraging breastfeeding, according to Greiner, requires helping motivated mothers to overcome the obstacles which make breastfeeding difficult. The most important issues which are often cited are employment away from home and problems that mothers experience in doing so. The survey data show that in the studied maternal employment outside the home is not now an important constraint to breastfeeding. Employment outside the home and separation from the mother may be a more serious problem for higher income women, or may be a more serious problem as more women enter the labor force.

A recent two month maternity leave policy is a constraint and the policy in some countries allowing annual leave to be added to the maternity leave period helps even more. The latter is supported. Innovative policies for on-site facilities where mothers can breastfeed at work, and at lunch, job sharing, and paid leave should all be considered to meet anticipated growing need.

Illness and morbidity and breastfeeding problems do not seem to be an obstacle to breastfeeding for the Kenyan women interviewed. Supportive policies with these kinds of problems should be provided through health personnel, and as well as women's groups and organizations. The Breastfeeding Information Group, which actively provides counseling for breastfeeders as well as other educational

There is the question of breastfeeding. Eighty-five percent of the women expressed the view that babies are given infant formula in addition to the first four months of life. This widespread misconception suggests that lack of information and not desire, have helped contain breastfeeding to its current levels. This in turn needs to be reeducated women concerning the advantages and health benefits derived from exclusive breastfeeding for the first 4 to 6 months of the infant's life.

Greiner argues that breastfeeding promotion activities involving motivating or reeducating mothers are both cost and labour intensive, and where resources are scarce, should be deferred in favour of activities aimed at breastfeeding protection and support.

In our Nairobi sample most women had contact with health workers either during antenatal care or at the time of delivery, and yet few of these women recall being told of the importance of exclusive

breastfeeding for the first 4-6 months of their child's life. This contact seems to be an underutilized opportunity to promote breastfeeding, as well as a forum for teaching mothers to delay feeding supplemental foods at least until after 4 months of age.

In addition, efforts of the Ministry of Health, the media, and organizations such as Maendeleo Ya Wanawake, and the Breastfeeding Information Group should be supported in their continued work to promote breastfeeding.

APPENDIX 4

MINISTRY OF HEALTH

Telegrams: "MIMONALITE", Nairobi

Telephone: Nairobi 27381

When replying please quote

Ref. No. MIS/12/4/106 Vol. VII/(114)



AFYA HOUSE

CATHEDRAL H

P.O. Box 30016, NAIROBI

15th June 1963

All Provincial Medical Officers
All Medical Officers of Health
The Protestant Churches Medical Association
The Catholic Secretariat
The Muslim Council of Kenya

INFANT FEEDING
PRACTICES

Considering the importance of correct infant feeding on the health of children and mothers, and the decline in traditional infant feeding practices, I have found it necessary to draw to your attention my concern of some growing negative influences of health workers and health institutions with this regard. These influences prompt me to request you to take more interest in infant feeding. You are hereby directed to implement the following:-

- 1) Infants should be breastfed as soon as possible following birth. All healthy infants should be breastfed within the first six hours after birth depending on the condition of the mother and that of the baby.
- 2) Mothers should have full and unrestricted access to infants through rooming-in arrangements from birth onwards. All hospitals should allow normal newborns to stay with their mothers.
- 3) Pre-lacteal feeds given shortly after birth - either traditional (e.g honey, etc) or modern (glucolin, water type) should be prohibited in all but exceptional cases under the direction of a doctor.
- 4) No supplementary feeds of water or other substances should be given to normal infants in maternity facilities. Mothers should be informed that this should apply even at home up to 4 months of age. This should only be done on the advice of a doctor.
- 5) Mothers in maternity facilities should be encouraged to breast feed babies on demand. Maternity ward timetables should be arranged to suit the mother's and baby's needs and not institutional staff.
- 6) The use of breast feeding substitutes companies' posters and distribution of free samples of breastmilk substitutes of any kind in health institutions should be discontinued forthwith.


W. KOINANGE
DIRECTOR OF MEDICAL SERVICES

52

Rainbow

MAZINGIRA   INSTITUTE

Child Health and NUTRITION



World Environment Day Special Issue!

COMPETITION PRIZES!

On June 5, we celebrate World Environment Day. It's a day when all of us around the world should think about the importance of our environment — the world we

live in. To take care of our environment, we first need to take care of ourselves. This issue helps us to care for babies and growing children.

Best Available Document

Immunization. The current immunization average coverage rate of about 45% in Kenya means that more than a half of children born in this country are unprotected against the six immunizable childhood diseases: Measles, tetanus, whooping cough, diphtheria, poliomyelitis and tuberculosis. Apart from the risk of death and maiming the effect of these diseases is compounded by the serious malnutrition that follows infections leading to setback in normal growth.

The Kenya Expanded Programme of Immunization launched in 1982 is to be operational in 24 districts by 1986 with a target of over 70% of children to be immunized.

The target set for immunization coverage could be achieved if parental education, community involvement, money management, organisation and training are provided. But more important still is the mass mobilization and involvement of every possible means of communication in order to bring all parents to the point where they demand immunization for their children and understand that they must complete the full course of injections.



OTHER MEASURES TOWARDS IMPROVED CHILD SURVIVAL

As well as the four simple technologies listed above it has been demonstrated that the following measures will also increase Child Survival.

Improved Child Nutrition: Adequate balanced diets and carefully prepared weaning foods will reduce the incidence of poor growth.

Family Planning: Spacing of births and reduction of the number of children per mother ensures better care for each child, enables better distribution of available resources and affords the mother time to rest between births and to improve herself and her family.

Female Education: Research studies have demonstrated that the education of a mother is one of the most important determinants of a child's welfare and survival. Basic education for girls and mothers through primary education, literacy and Maternal Child health programmes need to be accelerated to achieve this aim.

Environmental Health and Sanitation: A general improvement of a family's living environment will ensure fewer infections and promote better health. Programmes to improve water supplies and sanitation, to control malaria, intestinal worms and upper respiratory tract infections will go a long way to improve family health.

WHAT NON-GOVERNMENTAL ORGANISATION AND INDIVIDUALS CAN DO TO ADVANCE CHILD SURVIVAL AND DEVELOPMENT

You and your organisation can advance the survival and development of children through -

- Advocacy and Promotion:** "Spreading the word" by
- Production of media programmes for public consumption on "GOBI" activities
 - Training in "Child to Child" health programmes for Schools and youth groups
 - Public information using pamphlets, meetings, posters, person to person campaigns
 - Engaging in nutrition education especially to change poor habits of child feeding
 - Advocating acceptable methods of Family Planning to colleagues, friends and members of your family
 - Supporting the practice of prolonged breast feeding by
 - improvement of working conditions for program

- and lactating women e.g. provision of breast feeding places and breaks
- job security and paid maternity leaves for mothers
- education on pregnancy, lactation and weaning changes in hospital maternity procedures
- introduction of technologies to lessen women's work-loads

Promoting Community Self-Reliance by:

- Helping communities and groups organise for Primary Health Care
- Giving community organisations confidence through training of leaders and project implementers
- Training of members of health communities, and Community Health promoters such as nutrition scouts in schools and youth groups
- Organising community groups to advance Child Survival and Development through provision of basic services such as clean water, health, sanitation and environmental hygiene basic education, and food
- Organising income generating projects



FOR FURTHER INFORMATION

Consult your nearest clinic or National Family Welfare Centre
P.O. Box 43319, NAIROBI.

Appendix II

TOWARDS ACCELERATED CHILD SURVIVAL AND DEVELOPMENT IN KENYA



"I believe that Children are
our most precious resource"

His Excellency, President
Daniel Arap Moi

CHILD SURVIVAL AND DEVELOPMENT REVOLUTION

Children are a family's and indeed a nation's most precious resource. Yet 125 of every 1000 children born in Kenya die during the first year of life. Many more are repeatedly sick or malnourished or disabled by diseases which could be prevented. This tragic loss could be drastically reduced if new steps are taken in the improvement of health for much larger numbers of children. The new measures do not require highly specialized medical care based on sophisticated technology, but on a system of Primary Health Care which relies on active communities backed by well trained community health workers and a well organised health programme.

Accelerated Child Survival and Development can be achieved through a partnership between government workers and the community, voluntary contributions and involvement of trade unions, religious organizations, secular voluntary agencies, women's organisations and youth movements. Many of these agencies are now adopting development as their goal. The combined efforts of all the above could speed up the growth of communities' self reliance in organising for their own health and improving child nutrition by making better use of available resources.

The Ministry of Health and the United Nations Children's Fund (UNICEF) is committed to work with these agencies to achieve such development for the improved welfare of mothers and children towards reduction of high Infant Mortality Rates.

POTENTIAL ACTIONS TO REDUCE INFANT DEATHS

UNICEF and the World Health Organisation (WHO) are promoting 4 simple technologies that could lead to drastic reductions in infant deaths if adopted by most families. The letters GOBI have been used to stand for the four practices described hereafter:

Growth Monitoring of an infant using a weight chart which shows the mother whether or not her child is growing normally. The weight of the child is plotted monthly on a graph to indicate whether it falls within the normal development path as compared to other children of the same age, from the same cultural group. Mothers are taught how to interpret the graphs of their children and notice the danger signals caused by effects of diseases or poor feeding.



Oral Rehydration Therapy. Diarrhoeal diseases of young children are often caused by poor sanitation and improper feeding habits especially during weaning from breast milk. The dehydration that results from excessive loss of vital body fluids unless arrested quickly leads to death. Such deaths can however be prevented by restoring the lost fluids through oral rehydration using an inexpensive solution of sugar and salt administered by the mother at home. Mothers can be taught how to mix the solution using boiled water and pre-measured quantities of Oral Rehydration Salt distributed or sold in sealed packets. If administered immediately at onset of diarrhoea and at regular intervals whenever motions are passed, the solution aids quick absorption of fluids to restore those lost. A number of countries have encouraged families to use fluids available at home such as tea, coconut water, porridge or fruit juice (e.g. orange and mango) or to make a solution with water, salt and sugar according to simple but precise instructions. Commercial outlets, clinics and community distribution of the prepared packets of Oral Rehydration salts when backed by widespread education through mass media and interpersonal communication have been known to achieve good results in the use of Oral Rehydration Therapy.



Breast-feeding. Prolonged breast feeding was practiced for periods longer than 2 years in most parts of Kenya, until the effects of aggressive commercial advertising of brands of dried milk powders. In 1978 it was estimated that only 45% of mothers breast fed their babies beyond 12 months. A high incidence of diarrhoeal and upper respiratory tract infections as well as malnutrition afflicts bottle fed babies especially during early weaning. This problem is more acute in poor families where mothers resort to the use of commercial formulae which they do not need, cannot afford in adequate quantities and do not know how to use safely when they adopt bottle feeding.

National campaigns are required to convince mothers of the advantages of prolonged breast feeding and to give them confidence that they can successfully breast feed; to persuade them that breast feeding gives a baby all the food it needs during the first 4 months; it protects a baby from infections and forms a bond between the baby and mother; reduces the likelihood of pregnancy and the milk is inexpensive, clean and always available. Such a campaign could be carried out by community groups, religious organisations, trade unions, the commercial community, employers, women's association, political parties, primary and secondary schools, the mass media, government services and particularly by men to encourage all lactating women to breast feed.

Kenya is one of the countries which has adopted and is in the process of applying the International Code on the Marketing of Breast Milk Substitutes.



YOUNG WOMEN'S CHRISTIAN ASSOCIATION

World motto: "Not by mighty, nor by power, but by my spirit, saith the Lord."

Kenya motto: "By love serve one another"

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YOUNG WOMEN CHRISTIAN ASSOCIATION

BREAST-FEEDING PROMOTION PROJECT

1. INTRODUCTION TO THE KENYA - Y.W.C.A.

Young Women Christian Association of Kenya is a voluntary organisation whose main objective is to promote community service among all people. Y.W.C.A. facilitates the endeavour to meet this objective through formation of fellowships of Christian women and young girls or Y-teens. The members are committed to their ideals through their faith as Christians and the motto of Y.W.C.A., 'to serve one another in love!'

Y.W.C.A. has four branches in Kenya - Nairobi, Mombasa, Kisumu and Meru.

Each branch of the Y.W.C.A. carries activities which are centred around the different needs of women and young girls. The hostels for girls is one of its oldest and best known service and is the Y.W.C.A.'s chief source of income for running other different programmes and projects.

The other services of Y.W.C.A. comprise adult literacy classes, nursery schools, day care centres, commercial courses, different types of nutrition projects, home industries & leadership training through conferences, seminar/workshops and conventions.

The Y.W.C.A. projects and programmes are financed through the income received from the hostels, the Parkview Flats in Nairobi, membership fee, grants from willing donors and public fund raising from members and friends.

2. THE Y.W.C.A. BREAST-FEEDING PROMOTION PROJECT:

This is the youngest nutrition project of the Y.W.C.A. whose planning started in 1979.

With financial assistance from UNICEF, Y.W.C.A. is planning to open the above stated project at its National Headquarters premises on Nyerere Road, opposite the Uhuru Park in Nairobi in February 1985.

The planned services of this project will comprise different activities aimed at promoting child and family health, family life and responsible parenthood as briefly explained here:-

2.1 Breast-Feeding Promotion:

This service will be offered to both the expectant and the nursing mothers and will comprise both information and education and technical support on breast-feeding, including infant-feeding in general.

Please Note:

The need to breastfeed a newly born baby has been given a lot of publicity through the media most of this year and will continue to get publicity. This is because of its many advantages which cannot be met at all by the artificial milk.

The publicity was initiated by UNICEF and the World Health Organisation and our Government has accepted that Kenya needs to also do something about it in order to be able to save many of our children's health and lives through controlling the very well organised publicity and marketing of the different brands of artificial milk as a result of which many mothers have abandoned breast-feeding and resorted to bottle-feeding.

Among the many advantages of breast-feeding besides the economic and birth spacing factors are its ability to destroy bad germs that cause the fatal types of diarrhoea and respiratory infections in the new born. It also helps in avoiding allergy conditions which are caused by artificial milk. The other very special advantage is the emotional security it creates in the child, which is essential for normal mental and social development.

Among the most impressive researches carried out to prove the superiority of breast milk over artificial milk, is the one reported to the Canadian Medical Association in 1979 by J. Ellestad Sayed. In that report, it was noted that artificially fed babies were admitted to hospital with different infections including diarrhoea ten times more and spent ten times longer in hospital. This is a good proof that breast-feeding enables children to acquire very high resistance against infections.

In another research in Central Indonesia reported in the Journal of Tropical Paediatrics in 1979 by D. Surjono, three quarters of the samples taken from feeding bottles amongst waiting mothers at a Child Health Clinic, had bacterial density in excess of 10,000 per ml. while a properly mixed sample contained a density of only 100 per ml. A third of the samples taken were also less than half of the correct strength of artificial milk - in other words, they were overdiluted, probably for economic reasons, or due to ignorance.

This is just a demonstration of how dangerous bottle feeding is and the degree of health risk children are placed under due to ignorance about the dangers of artificial feeding and the advantages of breast-feeding. The risk is highest amongst the poor illiterate communities who also lack basic sanitation, health-care and health-education facilities.

2.2 Breast-feeding Support Services for Working Mothers:

This will comprise a Child Day Care Centre or a Creche where mothers who would like to breastfeed regularly in order to maintain their milk flow as long as possible will leave their babies under the care of professionally trained Community Nurses and assistance of Child-Care Minders/Working Mother-Home Helper Trainees.

A mother-to-mother-networking forum where experienced mothers will share supportive ideas and actions on parenthood with inexperienced mothers will also be created and run on a regular basis as a free service.

2.3 Home-Support Service For Working Mothers:

This will comprise mainly training of mothers substitute or child-minder/home-helpers in child care, home management and employer/employee relationship. The working mothers or the employers will be involved in the planning of the training programme and in its implementation to suit their different needs, living styles and socio-economic backgrounds. An Emergency Day Care Service when a working mother-helper runs away will also be considered on special membership basis.

2.4 Family Health, Family-Life and Responsible Parenthood

Promotion Service:

These will comprise the following:

- (i) Information and Education Service: This will cover different topics of special interest to young mothers and couples, youth and families through an open education forum and different publications.
- (ii) Before and After Birth Exercises and Lectures on Parenting, Health and Beauty: These will be provided regularly by qualified experts and experienced renowned parents at a small fee.
- (iii) Creative Ideas and Action Forum & Exhibitions: This will be open to all family members interested in sharing ideas that work on different self-development artistic activities e.g. drawing, painting, sewing, singing, acting, dancing, cooking, etc. and will be organised and run by the members themselves.

This service is hoped to act as a very exciting incentive in self-development of its members and as a source of income for both the project and the members.

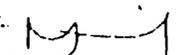
Please Note:

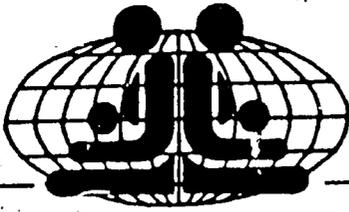
- (i) The different services additional to the creche will be developed one at a time starting with what will be in greatest demand.
- (ii) Enquiries about the different activities of the project by potential customers, educators and advisors will be entertained from the beginning of January, 1965 through the Breast-feeding Promotion Project Coordinator, Mrs. K. T. Kanari through telephones 335794 and 338689 and Post Box 40710 or through a personal visit to the YWCA National Headquarters.
- (iii) The promotion of breast-and-infant feeding is also being carried out by the Breast-feeding Information Group (B.I.G.) whose telephone is 749899 and Box number 59436, and the Government National Infant-Feeding Practices Steering Committee through its Chairman who is also the Director of the National Family Welfare Centre, P.O. Box 43319 and telephone No. 3345211, Nairobi.
- (iv) Planning discussions with working mothers on training needs of child-minders/home-helpers or Ayah/house-girls and other child care and responsible parenting needs will take place daily at lunch time from 1 p.m. to 1.45 p.m. at the YWCA National Headquarters, Nyerere Road from Monday to Friday; and will start on Monday 11th of February and continue until further notice.
- (v) Professional experts in any of the stated different services and activities of the Project who are interested to serve either on advisory capacity or in any of the actual forums, should get in touch with the Project Coordinator in writing as early as possible in February 1965, stating whether they would like to serve on a voluntary basis or for payment of a specific fee, for consideration.

CLOSING REMARKS:

YWCA would like to publicly express their gratitude to UNICEF for making the launching of this project in Nairobi and so in Kenya, possible.

YWCA looks forward to welcoming many mothers and volunteers in the new year, hopefully having had a very enjoyable Christmas.


K. T. KANARI (MRS.)
PROJECT COORDINATOR
NATIONAL GENERAL SECRETARY



IBFAN Africa

INTERNATIONAL BABY FOOD ACTION NETWORK
P.O. BOX 34308 NAIROBI-KENYA

**Summary Report on
IBFAN AFRICA REGIONAL CONFERENCE
1—5 May, Swaziland**

**Strategies for Breastfeeding Support Promotion
and Protection in Africa**

:

IBFAN POLICY ON SOUTH AFRICAN GROUPS

The International Baby Food Action Network (IBFAN) recognises the worldwide concern over the policies of apartheid practiced by the South African Government, and therefore has no official working relations with the South African Government or any of its institutions.

IBFAN, however, also recognises that inappropriate infantfeeding practices are prevalent within South Africa -- practices which affect the health and economies of infants and families in all sectors of the society. IBFAN also recognises that many transnational corporations and national companies involved in the manufacture and distribution of products related to artificial infant feeding operate from South Africa and export some of their products and aggressive marketing practices to neighbouring countries in Africa, thereby endangering infant health in those countries.

IBFAN, therefore, considers it essential that strong pressure be brought to bear on these corporations and their activities to ensure that they follow, as a minimum, the International Code of Marketing of Breastmilk Substitutes in all countries.

Accordingly, IBFAN maintains informal links with concerned individuals and non-governmental organizations within South Africa that are working on issues of infant and maternal health. From time to time, representatives from such organizations may be invited to attend, as observers, meetings, seminars or workshops which are organised by IBFAN.

May 1984.

61

ACKNOWLEDGEMENT

We deeply appreciate the support in all forms received from IRFAN Africa members and friends everywhere to enable this conference to happen.

We look forward to growing co-operation among us all towards implementation of the plans formulated.

SUMMARY REPORT OF THE 1ST IBFAN AFRICA REGIONAL CONFERENCE

Swaziland, May 1984

Theme: Strategies for Breastfeeding Promotion and Protection in Africa

Overview

More than 50 participants from 10 East and Southern African countries attended IBFAN's first Africa Regional Conference held at the Swaziland Institute of Management and Public Administration (SIMPA) in Mbabane, Swaziland, 1-5 May 1984. These included representatives from government agencies, IBFAN groups and health professionals in Botswana, Ethiopia, Kenya, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. (Angola, Lesotho and Mozambique were invited, but unable to come.) There were two observers from non-governmental organisations concerned with infant and maternal health from South Africa. Representatives from the World Health Organisation and UNICEF also participated. The host organisation was the Breastfeeding Campaign Group of Swaziland, in consultation with the Swaziland Nutrition Council.

Conference Agenda

Conference organisers, participants and organisations were introduced at an informal meeting on the evening of 30 April. Professor Lydia Makhubu, Pro-Vice Chancellor, University of Swaziland, officially opened the conference on 1 May. In her address, she lamented the fact that breastfeeding, a natural and culturally accepted practice in Africa, had now to be a subject of international conferences. She also highlighted governments' failure to recognise women's dual roles as workers and mothers and to provide them with adequate facilities to perform these roles with some ease. She castigated the baby food companies for pressuring the public to use their products when the consequences were disastrous.

The rest of the conference was organised around four major themes:

- Breastfeeding management in health care facilities
- Breastfeeding and the employed mother
- Analysis of the International Code of Marketing of Breast-milk Substitutes
- The Code as a plan of action for promotion of mother and child health in Africa.

For each theme there was a presentation, a panel and plenary discussion and a workshop. Participants also gave detailed reports on the infant feeding situation in their countries, and what both government and non-governmental agencies were doing to improve it.

1. Breastfeeding management

In dealing with this theme, the conference sought to identify the real problems that interfere with successful lactation and the kind of help or management techniques that ensure women will breastfeed successfully for long enough and that will diminish their chances of developing later "problems" like insufficient milk, cracked nipples, engorged breasts or breast refusal.

We had a number of nurses in charge of newborn units and maternity units and medical doctors who frequently dealt with pregnant and lac-

tating women. The chief speaker was Dr Felicity Savage King, paediatrician and co-author of Breastfeeding in Practice (Oxford University Press, 1982).

The group provided a rich exchange between health professionals who knew how to help mothers, those who did not yet know and wanted to learn, and mothers' own experiences in the health care system. Non-medical breastfeeding counsellors shared knowledge about breastfeeding benefits and management techniques and counselling expertise.

By the end of the conference, participants agreed that having breastfeeding counsellors was crucial to dealing with and preventing breastfeeding problems. In addition to mothers' groups, each country planned to identify a group within the health care system that would be trained as breastfeeding counsellors. Mother support groups present (La Leche League) offered to impart their knowledge and skills to other network members. Health professionals themselves undertook to organise the necessary seminars for their colleagues. IBFAN co-ordinators offered to assist in identifying resources for these training seminars as well as printing and publishing the visual aids and literature essential for such an exercise.

2. Breastfeeding and the employed mother

What might be adequate facilities enabling employed women who spend long hours away from home to breastfeed successfully? Sociologist Dr Catherine Robins presented a paper which outlined research findings in Kenya and other countries, detailing conditions under which women work and the provisions of the 1952 ILO Convention on maternity protection. Under this Convention, all women should have 12 weeks paid maternity leave, a daily one-hour nursing break when they return to work, and protection against job loss and other discrimination due to pregnancy. ILO members are supposed to ratify this Convention.

An analysis of records showed that very few countries in Africa had ratified the Convention. This was corroborated by participants' reports on the maternity protection laws in their countries. Zambia, Lesotho and Botswana have three months paid maternity leave. Swaziland and Zimbabwe have one month's paid leave with forfeiture of annual leave. Yet for optimum health, a baby should be exclusively breastfed for at least four months.

In studies carried out in Tanzania and Kenya among working mothers, it was found that work alone was not a significant reason for women to stop breastfeeding. In Tanzania, socio-economic status seemed to be the decisive factor.

Some of the constraints that interfered with successful breastfeeding included long hours of separation of mother and child, lack of reliable information, illness of mother and child, lack of family or community support, pressure from advertising, hospital practices, cultural taboos and mothers' attitudes stemming from misinformation. At a panel discussion, the group came up with suggestions of long- and short-term approaches to overcome these problems.

3. Analysis of the International Code

Annelies Allain presented this session and illustrated her points with examples of what the different articles in the Code aimed at controlling, and why. Participants also saw examples of how companies managed to continue promoting their products without necessarily violating the International Code in its present form. For this reason, the need to have stronger national codes was emphasised. Almost all the participating countries aired their concern over products harmful to the health of infants and children which as yet remain uncovered by the International Code and are actively promoted.

A one-day training exercise on how to monitor compliance with the

International Code was conducted. For practical experience, participants visited a government hospital, a private hospital and a shopping centre. Most had also done monitoring prior to the conference and the results were displayed at each country table. (A complete report of this exercise is attached as an appendix.)

4. The Code as a plan of action

The fourth theme focused on action based on the different articles of the Code which give specific recommendations on different aspects of breastfeeding promotion and protection.

Andy Chetley led off with a detailed historical presentation of how aggressive marketing and advertising of breastmilk substitutes had led to the creation of an artificial demand for the products. Their use had brought about widespread and unnecessary deaths which so alarmed health professionals and consumers that a campaign had begun to halt the harmful marketing practices of the baby food industry. The campaign was unco-ordinated until the late 1970s, when NGOs working with the international agencies on the issue formed a network -- IBFAN. The difficulties and successes of the campaign to date were related.

Emphasised was the fact that we need to work together to find solutions to the problems created by the continuing promotion of breastmilk substitutes and the decline in breastfeeding, as there were no pre-determined solutions. In spite of the achievements realised, the campaign had only just begun.

Brief reports were given on what international agencies were contributing towards the implementation of the Code. Representatives of WHO, UNICEF, the Commonwealth Secretariat, mother support groups, nutrition institutes and IBFAN Africa all outlined what their organisations were doing at international, regional and national levels, how they co-ordinated with the others and what skills and resources they were able to offer to governments and NGOs.

Country delegations then spent time developing national Action Plans to promote and protect breastfeeding. The Plans included network building, breastfeeding promotion, Code implementation, monitoring and research, hospital practices and fundraising. Country delegations planned to present these Action Plans to colleagues and relevant authorities on their return home.

General

Throughout the Conference, the need for regional and international co-ordination was emphasised, particularly in:

- Training of breastfeeding counsellors
- Identification of consultants or guest speakers to help boost national campaigns
- Correspondence to facilitate sharing of information between participants
- Organisation of workshops and seminars at all levels
- Country visits and exchange visits between groups
- Monitoring and ensuring that monitoring reports were shared by all.

Conference Close

In her evaluation of the Conference, Dr Felicity King felt there had been a good exchange of ideas on how to get started nationally.

The Conference was closed by Dr Friedman, Swaziland M.P., who congratulated IBFAN and other international agencies for having taken up the promotion and protection of breastfeeding, whose importance could not be overemphasised.

65

IBFAN AFRICA REGIONAL CONFERENCE REPORT 4

Conference Recommendations

Reproduced below is the "Mbabane Memorandum" released by the Conference on 5 May 1984.

The participants at the first African Regional Conference of the International Baby Food Action Network (IBFAN), held in Mbabane, Swaziland, 1-5 May 1984;

Recognising that inappropriate infant feeding practices are a major health problem and a serious obstacle to social and economic development;

Further recognising that breastfeeding is the natural and ideal way of feeding infants and the unique biological and emotional basis for child development;

Recommend:

- That all efforts be made to reduce infant mortality and morbidity by the active protection, promotion and support of breastfeeding.
- That health care facilities which cater for women and children should have a special responsibility to promote and support breastfeeding, including the provision of counselling.
- That pressure be put on all Ministries of Health to take account of new knowledge about lactation management, both in the practices permitted in health care facilities and in the basic and continuing training of all health workers and relevant community workers.
- That appropriate actions be taken at the national level to create public awareness of the content and correct interpretation of the International Code of Marketing of Breast-milk Substitutes.
- That the minimum requirements of the International Code be strengthened, made law, and be fully implemented and enforced at the national level.
- That systematic monitoring of the International Code be undertaken by both non-governmental and governmental organisations in order to stop marketing practices from interfering with the establishment and maintenance of appropriate infant feeding.
- That pressure be exerted on governments to enact and enforce legislation to ensure that all women in paid employment be provided with adequate paid maternity leave, guaranteed job security, creche facilities and nursing breaks to enable them to maintain successful breastfeeding.
- That governments and health care systems should, as a priority measure, emphasise the improvement of the health and nutritional status of pregnant and lactating women.
- That national IBFAN groups undertake a co-ordinated programme of action to exert pressure on governments, corporations and health care systems to act in the best interests of infant health.

(A full conference report is available from the IBFAN office in Nairobi.)

10/8

IBFAN Africa Regional Conference Outline

Dates: 30 April to 5 May 1984

Venue: Swaziland Institute of Management and Public Administration (SIMPA), Mbabane, Swaziland

Organised by: IBFAN Africa Regional Coordinator, Nairobi; with the Breastfeeding Campaign Group, Swaziland, in consultation with the Nutrition Council, Swaziland and the IBFAN Coordinating Council

Host Organisation: The Breastfeeding Campaign Group, Swaziland

Contact Persons:

Ms Margaret Kyenkya IBFAN (A) Regional Coordinator PO Box 34308 Nairobi, Kenya	Ms Fiona Duby Chairperson Breastfeeding Campaign Group PO Box 1051 Manzini, Swaziland
Tel: 62781/2, 62537 ext 9 Telex: 22953 DAAD Attn: Eva/Kyenkya	Tel: 53586 (Office) 83078 (Home)

Participating Countries: Botswana, Ethiopia, Kenya, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe

Countries invited but unable to participate: Angola, Lesotho and Mozambique

Participants: (approximately 50 participants)

IBFAN group representatives
Selected nurses and midwives active in PHC
Government officials

Opening Address: Professor Lydia Makhubu, Pro-Vice Chancellor, University of Swaziland

Closing Address: Dr Friedman, MP, Swaziland

Resource Persons:

1. Chief Conference Speaker: Dr Felicity Savage King, Paediatrician, Senior Lecturer at Tropical Health Unit, Institute of Child Health, London; co-author of "Breastfeeding in Practice: A Manual for Healthworkers", OUP, 1982
2. Dr Catherine Robins, Consultant Sociologist, Nairobi (formerly of University of Nairobi)
3. IBFAN Coordinating Council (IBCoCo) members

Resource Materials:

Films and slide shows
Visual aids from several African countries
WHO and UNICEF materials
IBFAN Resource Guides and material from coordinating offices
Materials by Teaching Aids at Low Cost, London
Materials from other international agencies concerned with infant feeding: ECA/ATRCW, Commonwealth Secretariat, LLLI, etc.

Agenda Content:

1. Breastfeeding Management Techniques: How health workers can better help breastfeeding mothers
2. Breastfeeding and the Working Mother: How can we utilise and improve on available facilities and help overcome practical problems?
3. Analysis of the Code: What is the best for each country (including legal text analysis, plugging loopholes, monitoring)
4. The Code of Marketing of Breast-milk Substitutes as a Plan of Action to Promote Mother and Child Health in Africa: How can we implement it?

Conduct:

Presentations to plenary sessions
Workshops on major themes, with recommendations for action presented to plenary sessions
Meetings of country representatives to draft national action plans

Expected Outcome:

1. Greater awareness among participants of the issues involved in breastfeeding promotion and protection
2. Plans of action for each participating country
3. Acceptable guidelines for regional coordination

Participants are expected to give concise presentations of their national situation (government action, NGO action, particular problems). These presentations are to be coordinated among participants from the same country, prior to the conference.

February 1984

SUMMARY ACCOUNTS

(All figures in US \$)

Item	Contribution Assistance from UNICEF	IBFAN (A) Direct Funds & Cash Travel	Country offices	Total Conf. Cost
1. Travel: (Tickets and other costs)	19,062	6,491		
2. Food and accommodation	2,179			
3. Conference Administration	983	402		
a) Stationery/publication /photocopy				
b) Local transport				
c) Telecommunications				
d) Secretarial services				
e) Baby care facilities				
4. Consultancy fees	891			
5. Monitoring: Data collection	1,601			
Publication and distribution of report	1,521			
6. Educational & Promotional	362			
7. Miscellaneous	17			
TOTAL:	26,616	6,893		33,509

Specific Donations to cover the costs
in the first column came from:

CMC, Geneva	920
Terre des Hommes, W. Germany	1,105
IOCU/UNICEF	1,500
IBFAN Africa fund from ICCO/ECN/NORAD	23,091
Total:	26,616

A WOMEN'S GROUP IN LATIN AMERICA
(CEFEMINA) SENT US THESE 'HINTS'
ON STARTING A GROUP. I HOPE
THEY WILL BE HELPFUL.

M KYENKYA, REGIONAL
CO-ORDINATOR

The following series of ideas can be helpful to grass roots organizations that work with very little money and have many plans to accomplish. These ideas come from the experience of a feminist group that was founded in 1976 and has never gotten any kind of grant to carry out its work. We have been working on several issues in a developing country, but we hope that our experience in fund raising will be useful for groups anywhere.

1. When working on a permanent basis becomes quite difficult because the group does not have an office, the time has come to look around the city or neighbourhood in order to see what facilities are available. We have found that universities, schools, churches and community centres are ideal places to meet. Sometimes it is possible to agree with the staff of any of these places on some kind of permanent arrangement so that the group has an office without paying anything. Cefemina for example, shares one of the offices of the Student Body of the University of Costa Rica. We meet there, have a desk and a filing cabinet. So, far an office is the problem, and the group cannot afford one, find a place of this sort. People would be amazed to know how easy this can be, if they talk to the right persons and justify well enough the need for an office or a meeting place.

We understand that this kind of arrangement does not work on the long run, but it can be a good thing to do if the group does not have enough means to provide for an office.

2. Any group needs to be able to work with some kind of permanent budget. We have learned that there are several ways of making this possible:

(a) Membership fees - The fee does not necessarily have to be a fixed one. The members can agree on a minimum fee and try hard to contribute with more than that on a monthly basis. Also, some members can pay more than the minimum and others cannot pay anything at all. So, each case has to be dealt with individually.

(b) The group must try to extend this kind of contribution to people outside. There are many persons that share the ideas of the organization or just like the work it does, even though they are not interested in becoming members. Such persons can be reached and asked for a monthly contribution. It is an idea that works. We have tried it very successfully.

(c) The following ideas can be included in a third group as things to be done on a campaigning basis in order to complete the budget or pay debts:

The group sets up a goal and a very strict timing and launches a fund raising campaign that will reach individuals and other organizations. Every person that contributes can get a receipt or a leaflet.

The raffles (of money or things) are also a very good idea, easy to carry out at the community level. Some people love to buy the tickets and wait anxiously to see if they become winners. And it is a lot of fun too!!!

Another great idea is to pick up a film that has something to do with the work of the group (or not) and organize a debate after it. The tickets should be sold before hand to make sure that the activity is a real success. The rent of the Cinema and of the film itself can be quite cheap if the group chooses the morning or the afternoon (when the Cinema is normally closed).

At the community level, the number of things that can be done is really amazing. The group can go together house by house, telling people of its work and why any help is so important. We have raised thousands of colones in this kind of activity. It is also a way of inviting other people to work with the group.

The group can organize its own local fair and sell food, all kinds of old stuff, hand made things and so on. If this kind of activity is well organized, it can raise a lot of money. Also, this can be done by joining in the local fairs that all towns have through the year.

All the places where people meet are good places to fund raise: Open market, bingoes, exhibitions, etc. If the group sets up a small table with leaflets and information, the results can be surprising.

Dances, balls, coffee parties and that sort of thing can be organized by the group with little effort and great results.

Generally speaking, the idea is to take advantage of all the activities and events that happen in the town. If the group keeps its eyes open and really puts a lot of imagination into it, the money can come easily without having to strain itself.

Obviously, the ideas noted above are useful for any group, whether it has any kind of external aid or not.

3. Some final ideas.

Instead of buying subscriptions to magazines and publications, the group can offer to exchange materials as well as information. It works!

When the group organizes "action days", somebody should take care of using activity to make some funds too. Sometimes we forget about money because we are too busy with other things. Money should always be a main worry but not so much so that becomes the most important. Funds are just a tool to carry on our work, but a tool without which the group cannot do very much.

We have found that activities directed to children can also be a good way of raising some funds as well as a lot of fun. Parents love to have their children entertained for a whole afternoon as long as they do not have to pay very much. This can be done with the help of universities, theater groups for children, schools.

Contact: IBEAN Africa
P O Box 59436, NAIROBI
Kenya

July 1983

11

HOW DO WE GET STARTED?

By the International Cooperation Committee,
Breastfeeding Information Group, Box 59436, Nairobi

We have been asked by various people how they can get a breastfeeding promotion group under way in their countries. The Breastfeeding Information Group of Kenya can only speak from its own experience, and circumstances elsewhere may be quite different. But here are some suggestions:

Getting started.

It does not take many people to start. We were seven! If you can collect about five people who are interested, get them together for coffee every two or three weeks, and ask them to bring someone else along. After a few such meetings, you will find that you have a nucleus of concerned and committed people, willing to work on the effort. They may be health workers, mothers, nutritionists, or just those who care for any reason.

Analysis.

Use the early meetings to discuss what you know of breastfeeding in your country, and to start defining what needs to be done. Pass around reading matter on what is being done elsewhere, as it can be inspiring or usable. But focus first of all on your local needs, which may be different from those in any other country or region.

Self-education.

We found it useful in early meetings to have members give short talks on different aspects of breastfeeding, e.g. nutrition, or family planning, or hospital management of new mothers. In this way we were learning from each other's areas of experience. We also started to collect books and articles for a small library.

Registration.

To register with the Kenya Government as a society was possible as soon as we had ten committed members. This permitted us to actively recruit other members, to establish and collect dues (kept very low so as not to keep people from joining), to rent a mail box, and also to open a bank account and raise funds from donors.

Find out from your country's Attorney General's office of any body concerned with registration of societies and how you can go about this. They may advise you helpfully on adopting a constitution, and generally getting effectively organised.

Activities.

The activities we undertook initially were:

- to print materials in English and Swahili such as posters and leaflets.

We started with sample posters done by a blueprint process, but these when tested in clinics were not very successful. When we felt we had a better design, we had poster printed and distributed them as widely as possible.

An article written for Kenya Woman magazine provided us with our first printed leaflet inexpensively. We asked the magazine to make us reprints of the article, which was a series of questions and answers about breastfeeding, and this was an inexpensive way of doing it as the magazine had already paid for the typesetting and the plates.

Distributing this and all subsequent leaflets as widely as possible has been our goal. We give them to individuals, clinics, doctors, women's groups -- anyone who asks and who will use them.

- to give breastfeeding talks in hospitals and clinics, and to women's groups.

- to publish a newsletter six times a year, which helped to keep members informed. We have been fortunate in finding organisations which allow us free use of Gestetner machines; we pay for paper and ink only.

This was more than enough to undertake! We never seem to have enough people to do the work which we feel is needed. Nevertheless, we have as time goes on included some other activities:

- to run monthly discussion classes for breastfeeding mothers
- to develop a slide show the coordinated tape in English and Swahili
- to do research on breastfeeding issues
- to cooperate in a community-based health centre with a strong component of breastfeeding support
- to train more counselors from among our members
- to provide in-service training for health workers
- to do some radio and TV programmes
- to act as IBFAN coordinating body for Africa region, through our International Cooperation Committee
- to attempt to affect government policies regarding infant feeding.

Usually we have so much work to do that we do not go out looking for it in most cases. When we are asked, we try to respond, whether with a display for the Ministry of Health stand at the Agricultural Show, or a talk to women church leaders, or counselling on the maternity wards of a hospital. We look forward to the day when we are big enough in active membership to need to seek more work.

Volunteers.

We could never do any of this without the work of our many volunteers, known as "active members." In the beginning, all our efforts were on a voluntary basis; even now our two half-time salaried staff members do only a fraction of the work of the group, concentrating particularly on distribution of printed materials and on counselling in Swahili.

Much of the volunteer time is donated by women who also have full-time employment of their own, and yet who feel strongly enough about breastfeeding to work with us. We schedule our monthly Business Meetings, and our Executive Committee meetings, for late afternoon following the working day, as many of our most valued members cannot attend daytime meetings. Daytime volunteer work, such as hospital counselling, is often contributed by women who for one reason or another do not have full-time jobs.

Most non-governmental groups like ours start out on an entirely voluntary basis. However, once the group is clearly a going concern, with a constitution, officers, proper financial procedures, and some accomplishments to its name, it may well find a funder for a paid staff member or two. Most of the work still remains voluntary.

Volunteers provide use of telephones, use of cars, and in the first years, use of their house space as office space. It is complicated to have the files in one place, the posters in another, the printed leaflets stored under someone's bed, etc. However, we found that renting office space was not truly necessary at first. We still do not have a telephone line of our own.

It should be emphasized that volunteers who have not themselves breastfed nevertheless have much to contribute to such a group. Although we use mothers to work directly with other mothers, we also have valued active members who are single women, or men, or women who failed to breastfeed happily for lack of support and thus recognize the need for help to other new mothers.

Fund Raising.

Initially, use your own knowledge of local organisations to contact in order to raise funds. Our first poster was printed with the aid of a foreign women's club here; our first article paid for out of our group dues but then sold at a slight profit to pay for more printing.

You might approach your local UNICEF office to get materials printed for you, and you can then distribute them for educational and fund-raising purposes. We found great interest in this kind of work among both local and international sources of funds. In our case, church organisations, UNICEF, OXFAM, and the Scandinavian aid agencies have all provided major help. Other funding has come from a family planning agency and from Kenya's National Council of Women. The Ministry of Health have provided printing facilities, meeting places, and other valuable assistance.

Once you have a group that is legally constituted in your country, write out what you plan to do, and what it will cost, and discuss it with funding agencies. You may find them eager to help, or at least informative about other possible sources to approach.

We have found it easier to raise money for printing and distribution of written materials than for recurrent expenses like salaries and office rents. We have found it helpful to the morale of volunteers to have some funds to reimburse them for transport or telephone expenses arising from work for the group, even though their time and energy cannot be paid for.

Group Organisation.

Is it necessary to note that conscientious officers are needed? The accounts must be kept carefully, although amateur methods are good enough at first. The letters must be answered. The meetings must be chaired responsibly and decisions followed up and put into action.

We have been fortunate in having many excellent officers. These positions rotate through annual elections by all members who attend the Annual General Meeting. We have taken care to avoid a situation where the Breastfeeding Information Group may come to be seen as a personal power base for one or two individuals, since in the long run this becomes destructive of morale and would mean that many potential leaders remain frustrated.

Through our several sub-committees (publications, fund raising, counselling, newsletter, international cooperation, etc.) we can give a position of responsibility to almost any member who has the will to take it on. This has greatly strengthened the group.

What keeps it going?

Finally, it is deeply satisfying to work with mothers and children and know that our efforts help to build a strong and healthy nation. We hope many members of the IBFAN-Africa network are discovering these satisfactions as they come to know colleagues who share their interests and will work with them.

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