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International Forum for
Francophone Africa
**Infant Feeding and
Child Survival**

September 9-13, 1991
Lomé, Togo

Conference Report

A.T.G.N.

Togolese Nutrition Association

PRITECH

NCP

Nutrition Communication Project

**INTERNATIONAL FORUM FOR FRANCOPHONE AFRICA
INFANT FEEDING AND CHILD SURVIVAL**

**September 9 - 13, 1991
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CONFERENCE REPORT

Sponsored by
The United States Agency for International Development

in cooperation with
**Nutrition Communication Project
Technologies for Primary Health Care
Togolese Nutrition Group**

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LIST OF ABBREVIATIONS

A.I.D.	Agency for International Development
AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infections
CDD	Control of Diarrheal Diseases
EPI	Expanded Program on Immunization
FAO	Food and Agriculture Association
IBFAN	International Baby Food Action Network
IEC	Information, Education, and Communications
KAP	Knowledge, Attitudes, and Practices
MCH/FP	Maternal and Child Health/Family Planning
NCP	Nutrition Communication Project
PHC	Primary Health Care
PRITECH	Technologies for Primary Health Care
RENA	Réseau pour l'éducation nutritionnelle en Afrique (African Nutrition Education Network)
UNICEF	United Nations Children's Fund
VITAL	Vitamin A Field Support Project
WHO	World Health Organization
WINS	Women and Infant Nutrition Support Project

OVERVIEW

During the week of September 9-13, 1991, nearly 50 Francophone African researchers, decision makers, scientists, health personnel, and program implementers gathered together with representatives of international donor and advocacy groups to discuss infant feeding and child survival. West African physicians and behavioral scientists who had recently mounted research on feeding practices, diarrheal disease control, and breastfeeding presented their findings to their peers. In addition, participants reviewed a collection of the most compelling French language literature on infant feeding, as well as selected technical documents and articles translated from English for this conference (see Appendix Five). These scientific materials were complemented by participant discussions of programmatic issues in their countries, as well as international donor policies and perspectives.

Certain issues posed problems, either because of the lack of credible data from the region to support immediate change, or because of the tremendous efforts required to change widely prevalent practices. Nonetheless, participants agreed on a number of thorny issues. They agreed that exclusive breastfeeding from birth through the age of 4 to 6 months provides the best chance of survival for children. Exclusive breastfeeding during these first months not only meets all needs for nutrients and fluids, but functions as an effective method of birth-spacing.

They agreed on the following definition of exclusive breastfeeding: An exclusively breastfed infant begins breastfeeding within the hour after birth, is fed only breast milk, including colostrum; and is fed frequently and on demand, day and night. Breast milk meets all need for fluids during the first 4 to 6 months of life, making water supplements unnecessary. In fact, water brings with it risk of diarrhea due to contamination.

They also agreed that breastfeeding promotion should continue even in areas with a high prevalence of HIV infection. The danger of transmission of the virus through breastfeeding is far outweighed by the highly protective effect of exclusive breastfeeding against morbidity and mortality from diarrhea and respiratory infections. Milk substitutes are an expensive and often dangerous option, as clean water and clean bottles are often unavailable.

After 4 days of examining the scientific evidence and debating its application, the participants endorsed the *Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding*, and prepared their own document charging African governments, health authorities, and the international donor community with taking specific concrete actions that would assure its implementation in each of their countries. While this document is produced in its entirety at the end of the report, highlights of consensus reached during plenary and small group discussions may be found on the following page:

- Countries need to formulate clear national policies in the areas of infant feeding and nutrition.
- Countries must enact or enforce legislation which supports maternal and child health during and after pregnancy, and which promotes breastfeeding through maternal leave policies and control of breast-milk substitutes.
- Health authorities must institute good pre- and in-service training of health workers if health workers are to support mothers and promote breastfeeding and improved infant feeding.
- Countries and donors must carry out region-specific operational research on breastfeeding and weaning practices in order to develop culturally appropriate interventions.
- Health authorities must give high priority to information, education, and communication campaigns to promote improved maternal nutrition, breastfeeding, and improved infant feeding. The messages should be targeted not only at mothers, but at fathers, grandmothers, government officials, and traditional authorities.
- Health authorities should ensure integration of nutrition-promotion activities into family planning and other primary health-care services.

In response to the conference themes and debate, country teams prepared action plans outlining steps they wished to take to improve infant feeding and child survival in their countries. They had the opportunity to discuss these plans with other country teams and international participants. These plans and discussions have already begun to bear fruit in the form of concrete actions. For example, one country has already formed a national breastfeeding task force and is working on a national breastfeeding policy. Having heard the research results from their neighbors, many country teams expressed enthusiasm for carrying out similar practical research in their own countries and are hard at work preparing proposals for such research. Follow-up visits by international organizations are already planned for many participating countries.

The importance of infant feeding to children's survival can no longer be ignored. Participants in the Lomé conference will ensure that child feeding and maternal nutrition are given new priority in the countries of West Africa and in the activities supported by international organizations. This will be the legacy of the International Forum on Infant Feeding and Child Survival.

INTRODUCTION

This conference, sponsored by the United States Agency for International Development (A.I.D.), was held in response to the growing understanding that infant-feeding practices and maternal nutrition are of key importance to the survival of children. The conference was jointly organized by the Office of Nutrition's Nutrition Communication Project (NCP) of the Academy for Educational Development, and the Office of Health's Technologies for Primary Health Care (PRITECH) Project, of Management Sciences for Health. The conference was hosted by the Togolese Nutrition Association (ATGN). All logistical arrangements were made by Creative Associates International, Inc. (CAII).



Opening Ceremony, On the Podium, (left to right): Dr. Ananivi Doh, Director, A.T.G.N.; Mr. O. K. Alabi, Translator; Ms. Hope Sukin, Bureau for Africa, A.I.D.; Dr. Sarah Clark, USAID Representative, USAID/Lomé; The Honorable John Kirby, U.S. Ambassador to Togo; Mr. Paul Ihou, Togolese Minister of Health; Dr. Liliane Barry, WHO Representative to Togo; Ms. Margaret Parlato, Director, NCP; Dr. Eunyong Chung, Office of Nutrition, A.I.D.; and Dr. Martita Marx, Assistant Director for Research and Development, PRITECH.

The overall objective of the conference was to exchange ideas and experiences on improving infant feeding and maternal nutrition among key African specialists in the areas of maternal and child health, nutrition, control of diarrheal diseases, and family planning. These deliberations would lay the foundation for concrete action plans to reduce child morbidity and mortality related to diarrheal disease and malnutrition in Francophone Africa.

Participants included decision makers, researchers, program implementers, scientists, health personnel, and other representatives of ministries of health and private institutions from Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Niger, Senegal, Togo, and Zaire. In addition to these national teams, international participants included speakers from Gambia and Rwanda, technical advisors and program implementers from the World Health Organization (WHO), the Food and Agriculture Organization (FAO), UNICEF, the International Baby Food Action Network (IBFAN), the African Nutrition Education Network - "Réseau pour l'éducation nutritionnelle en Afrique" (RENA), and A.I.D.-funded health projects including the Georgetown Institute for Reproductive Health, the Nutrition Communication Project (NCP), PRITECH, the Vitamin A Field Support Project (VITAL), Wellstart, and the Women and Infant Nutrition Support Project (WINS).

Specific conference objectives were as follows:

- To learn about the nutritional status of West African children and the current programs designed to improve this status in each participating country;
- To compare internationally recommended practices for optimal infant feeding with practices in the field, in order to reevaluate the extent of the breastfeeding problem in the region;
- To review and discuss technical data and program ideas relating to maternal nutrition, breastfeeding, weaning, and diarrheal disease control;
- To learn about successful strategies and programs and to encourage their wide adoption; and
- To identify concrete activities and projects related to the themes of the forum.

This report is intended to serve as a brief summary of the main conclusions and actions of the conference. It is organized by broad topical themes and summarizes both plenary and working group presentations. The plenary presentations featured individual and panel speakers on a given topic. The working group discussions summarized here will begin with the recommendations presented by each group to the conference participants. These are complemented by highlights from the discussion stimulated by each working group presentation. The conference agenda and a list of participants are attached as appendices.

THEMES

THEME I: PROGRESS IN CHILD SURVIVAL AND OUTLOOK FOR THE 1990s



Child survival in Africa: Review of the last 10 years and outlook in the area of nutrition

Dr. Baba Traoré, Head, Family Planning Division (CERPOD), Mali

Mortality in children under 5 in developing countries has decreased considerably over the last 20 years. However, in sub-Saharan Africa, progress has slowed during the last decade. While the region experienced a decrease in under-5 mortality of 18 percent between 1968 and 1977, it saw a decrease of only 10 percent between 1978 and 1987. During this latter period, the rate of decline in mortality accelerated in North Africa, as well as in Latin America and Asia. Today, under-5 mortality in the sub-Saharan region is the highest in the world. The current poor socioeconomic situation in the region, resulting from weaknesses in health programs and unfavorable structural adjustment policies, is the primary reason for this lack of progress.

Diarrheal disease is one of the principal causes of child morbidity and mortality, killing 4 million children under 5 each year. WHO recommends breastfeeding promotion as the most important preventive measure against diarrhea. Although

more than 90 percent of African mothers initiate breastfeeding at birth, many add supplements to their children's diets too early, while others delay the beginning of supplementation past the recommended 6 months. While the former practice brings with it risks of disease and malnutrition for the infant and reduces the beneficial child-spacing effect of exclusive breastfeeding, the latter practice also leads to malnutrition and possible death.

Children's nutritional and health status can be improved through the following actions: increasing the level of mothers' education; encouraging mothers to use modern health services; lengthening the time between births; and increasing the supply and demand for basic preventive health services such as prenatal care, sanitation, breastfeeding promotion, control of diarrheal diseases (CDD), vaccination, and family planning.

Brief overview of interventions related to the improvement of breastfeeding practices and control of diarrheal diseases

Prof. Mandy Kader Kondé, Director General of Public Health, Ministry of Health and Population, Guinea

An important recent trend in many countries has been the integration of activities to improve nutrition into primary health care (PHC) programs. This trend within PHC programs began with the 1978 UNICEF/WHO *Alma Ata Declaration*. The *Declaration* established the concept that accessibility to health services is a fundamental human right that should be made available at the community level. This became the foundation for the goal of providing "health for all by the year 2000." Typical PHC programs include prevention and treatment of disease, family planning, vaccination, provision of essential drugs, sanitation and provision of safe drinking water, and promotion of good nutrition.

In 1987, the Regional Committee for Africa of WHO adopted the *Bamako Initiative*. The *Bamako Initiative* puts an even greater emphasis on bringing primary health care to the local level and puts priority on the needs of women and children. Typically, health activities are divided into three categories: curative, preventive, and promotional. An important emphasis in this strategy is seeking community resources to assist in the provision of health care, often through a system of cost recovery for essential drugs. In Guinea, this strategy has led to an increase in the accessibility and efficacy of health services, has limited the cost of care, and has assured the continuance of care in a country with extremely limited government resources.

How do feeding and nutrition fit into this framework? Mothers need to be monitored and counseled before, during, and after birth. Special consideration should be given to teenaged mothers who often are at higher risk both physically and socially. The recommendations of the *Innocenti Declaration on the Protection, Promotion,*

and Support of Breastfeeding (see Appendix Three) should be publicized and adopted in order to promote optimal infant feeding. Efforts should be made to understand the attitudes of the population so that harmful notions such as "bad" or "insufficient" breast milk can be overcome. Health workers also need to learn to communicate better with mothers and to reach out to the community if their advice is to be heeded. The preventive role of growth monitoring and the use of health cards to record and gather information must be emphasized. Countries should work to promote a policy of food self-sufficiency and should have clear national and regional nutritional policies.

Innocenti Declaration: International recommendations on infant feeding

Dr. Joseph Anáoh, Head of Pediatrics, CHU Treichville, Côte d'Ivoire

Due to its importance to this forum, the *Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding* was distributed to each participant and read aloud. The *Declaration* was adopted at the 1990 conference, "Breastfeeding in the 1990s: A Global Initiative," which was sponsored by WHO, UNICEF, A.I.D., and SIDA (Swedish International Development Agency). It calls for promotion of exclusive breastfeeding until the age of 4 to 6 months and for continued breastfeeding until at least the child's second birthday. It includes specific operational objectives both for countries and for international organizations if these goals are to be reached.

COUNTRY PRESENTATIONS: Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Niger, Senegal, Togo, Zaire

To provide a better understanding of the regional context, representatives of the nine country delegations gave brief presentations on the situation of maternal and child nutrition and health in their countries. Information presented included background statistics, notably health indicators and information on nutritional and feeding practices; activities in the areas of research, training, treatment, and information, education and communication (IEC); and strategies and constraints related to the integration of interventions to improve infant feeding into PHC services such as CDD, acute respiratory infection programs (ARI), immunization programs, and maternal care.

An important subject of the presentations and subsequent debate was the necessity of integrating broader health-care services into disease-specific health programs. Ideally, a child who enters a health center for diarrhea will also be weighed, given needed nutritional advice, and checked for vaccination status. The child should also be referred to other services as appropriate.

Another more hotly contested point of controversy in the discussions centered on poor feeding practices. Participants disagreed over whether lack of resources is the reason parents do not provide appropriate or adequate food to their children, or whether cultural beliefs such as food taboos or family food-distribution practices result in inadequate feeding practices. The former point was supported by stories of mothers who were knowledgeable about appropriate feeding practices but were unable to provide adequate food for their children. Supporting the latter point was the argument that poor feeding practices persist even in areas where the food supply is adequate. These two forces may also interact, as in the case of Côte d'Ivoire where the taboo preventing pregnant women and young children from eating animal protein may be linked to the scarcity of this food source. Participants did agree that malnutrition in West African countries increased during the 1980s and that the structural adjustment policies of the 1980s have widened the gap between rich and poor in these countries. Poverty was cited again and again as a major constraint to improving health and nutrition. Despite this, participants underscored the importance and the potential positive impact of addressing the nutritional situation through concrete program activities.

A commonly noted problem was the inadequacy of current nutrition training in schools which prepare health workers. In-service training for health workers is also inadequate. IEC activities to reach the entire population should be integral components of nutrition programs and other PHC initiatives. Some participants observed that IEC in the area of nutrition is not a high priority in many countries, and that current IEC activities are either weak or not always carried out properly.

THEME II: SUPPORT OF WOMEN DURING PREGNANCY AND DURING THE POSTPARTUM PERIOD

Support of women during pregnancy and the postpartum period

Prof. Runesha Muderhwa, Nutritionist, Zaire National Nutrition Planning Center (Centre de planification nutritionnelle - CEPLANUT), Zaire

The pregnant woman has special nutritional needs which differ depending on her baseline nutritional status, her age, and her level of physical activity. A pregnant woman who has a good nutritional status and who is not engaged in heavy physical activity needs a supplementary 285 calories and 3.3 grams of protein each day. A malnourished pregnant woman needs further supplementation, or she may have a low-birth-weight baby. Pregnant women also experience an increased need for vitamins and minerals, especially vitamin A, iron, and iodine. Because of the high prevalence of anemia in West Africa, programs should consider recommending iron-rich foods and, where possible, consider giving all women iron supplements. The recommended amount of iron is 1,000 milligrams. Iodine deficiency can lead to serious side effects such as mental retardation, congenital defects, and stillbirth, and should be addressed before pregnancy if possible. During pregnancy, a supplement of 25 micrograms of iodine per day is recommended in iodine-deficient areas.

Breast milk is the most appropriate food for the infant through the first 6 months, including premature and low-birth-weight infants. Even mothers who are malnourished produce adequate milk to meet their infants' nutritional needs. Only in cases of extreme malnutrition is milk supply a problem. In the case of maternal undernourishment, it is better to supplement the mother's intake than to give the infant a breast-milk substitute.

The following actions should be implemented to support pregnant and postpartum women in the African context: help mothers reduce their level of physical activity; make sure they receive caloric supplements from the beginning of their pregnancy; fortify a staple food with iron, as is presently done with iodine in many countries; and properly train health workers so that they can fulfill their key role in promoting the health of pregnant women and their children.

Working Group: Nutritional intake and nutritional needs during pregnancy

Constraints to good nutrition among pregnant women include: lack of knowledge about their special nutritional needs; low rate of use of health services for prenatal care; reduction in the quality and quantity of food during pregnancy due to beliefs and practices; no lessening of physical activity during pregnancy; widespread belief that pregnancy should be hidden; variability in food supply; lack of support by men

for pregnant women; and little attention by health workers to the nutritional needs of pregnant women.

The recommendations to improve maternal nutrition during pregnancy were: publicize results of studies on nutrition during pregnancy; encourage further studies of the relation between nutrition and pregnancy, and between work and pregnancy, in Africa; implement IEC efforts targeted at heads of families, grandmothers, and administrative and traditional authorities; establish systems to locate pregnant women for prenatal care; encourage expectant mothers to eat snacks between meals and to be the first to eat during meals; train health workers to counsel pregnant women properly; and increase the availability of food.

During discussion of the recommendations, the appropriateness of recommending a 10 to 12-kilogram weight gain for African women was questioned. Studies are needed to determine normal, pre-pregnancy baseline measurements in order to make appropriate recommendations.

Working Group: Nutritional and social support for women during the postpartum period

Breastfeeding mothers should eat extra food. Since food supplementation programs have met with little success, encouraging women to increase consumption of local foods may be a better strategy.

The recommendations for improving support to women were: develop a clear definition of exclusive breastfeeding; undertake knowledge, attitudes, and practices (KAP) studies on breastfeeding; use social marketing to convince the population of the need to support mothers and of the importance of breastfeeding; institute the use of the *Ten Steps to Successful Breastfeeding* (see Appendix Four); enact supportive legislation, for example, a maternity leave of 14 weeks for working women, 6 of which would be taken before birth; encourage women to make postnatal visits to clinics where both breastfeeding and family planning are discussed; and train health workers and decision makers to support women and encourage breastfeeding.

During discussion, the issue of the reasonableness of the maternal leave recommendation within the African economic context was raised. It was suggested that some practices already do exist which allow the mother to rest during the postpartum period, such as the concept of "staying in" for the first month after birth. These traditions should be encouraged.

THEME III: IMPROVEMENT OF MATERNAL AND CHILD HEALTH THROUGH PROMOTION OF BREASTFEEDING

Improvement of maternal and child health through promotion of breastfeeding

Dr. Amsagana Boukar, Ministry of Health, Niger

Both colostrum and breast milk are suited to infants as no other food is. Breast milk provides the correct nutrients, protects the infant from disease, and stimulates the development of the infant's immune system. Lactation is maintained through a series of important reflexes in both the mother and the child. The quantity of milk the mother produces increases or decreases according to the frequency and number of feedings.

Studies have concluded that there is no clinical syndrome of "maternal exhaustion" which results from breastfeeding. However, poverty and heavy physical work can result in a high nutritional cost to a breastfeeding mother. Research has shown that except in cases of severe malnutrition, the nutritional status of the mother does not affect the quantity or quality of her breast milk. In general, the positive effects for both the mother and the child of exclusive breastfeeding through 6 months of age far outweigh the short- and long-term nutritional costs to the mother. The best approach with an undernourished mother is to encourage her to continue breastfeeding while supplementing her diet or reducing her workload.

With the advent of AIDS, new questions have arisen concerning the safety of breastfeeding. The AIDS virus can be transmitted from mother to child prenatally, during birth, or postnatally through breastfeeding. Most infants born of seropositive mothers are not infected. It has been estimated that transmission by all three routes combined occurs at an average rate of 25 to 30 percent. A recent study from a high-prevalence area of Rwanda followed 212 mother-infant pairs who were seronegative at birth. Of the 212 mothers, 16 seroconverted after delivery. It can be confirmed that four of these mothers' infants became infected postnatally, presumably through breast milk. This risk is still far outweighed by the highly protective effect of exclusive breastfeeding against morbidity and mortality from diarrhea and respiratory infections in the developing country setting. Milk substitutes are an expensive and often dangerous option, as clean water and clean bottles are often unavailable and breast-milk substitutes are often diluted.

WHO-representative Dr. Isabelle de Zoysa confirmed that WHO stands firm in its support for the continued promotion of breastfeeding, even in countries with a high prevalence of AIDS. In fact, *even if* transmission through breastfeeding occurred in 100 percent of cases in which the mother was seropositive (which it does not), the number of child deaths due to AIDS would still be lower than if bottlefeeding were

to become the norm in developing countries. In the case of a woman who is known to be seropositive, alternatives should be examined, but if no safe alternative feeding method is available, breastfeeding should be recommended. WHO will be developing further operational recommendations soon.

Definition of exclusive breastfeeding

Dr. Ekoe Tétanyé, Chief, Pediatrics Unit, Yaoundé Central Hospital, Cameroon

By definition, an exclusively breastfed infant begins breastfeeding within the hour after birth, is fed only breast milk, including colostrum, and is fed frequently and on demand, day and night. Infants should be exclusively breastfed for the first 4 to 6 months. At 4 months, most infants are physiologically ready to eat other foods. However, in the African context, exclusive breastfeeding should be encouraged through the first 6 months, as breast milk is a safer and nutritionally better source of food than other foods given to the child at this age.

Supplementary water is not necessary during the first 4 to 6 months because breast milk meets all need for fluids, even in hot climates. Water also often brings with it the risk of contamination. Exclusive breastfeeding has been shown to have an extremely strong protective effect against morbidity and mortality from diarrheal and respiratory diseases. Partial breastfeeding also has a significant, but smaller, protective effect. Breastfeeding prevents an estimated 7 million deaths from these diseases each year.

Breastfeeding and child spacing

Ms. Kristin Cooney, Deputy Director, Institute for Reproductive Health, Georgetown University, U.S.A.

One of the benefits of breastfeeding is its effect on child spacing. The risk of child mortality increases when the space between children decreases, especially when a mother has two children within 2 years. In many countries, breastfeeding practices currently contribute as much to child spacing as does the use of all other types of family planning. At the Bellagio meeting in 1988, experts agreed that breastfeeding provides 98 percent protection against pregnancy during the first 6 months postpartum if the mother is exclusively breastfeeding upon demand, day and night; and if her menses have not returned. A counseling algorithm based on the Bellagio guidelines, which describes the Lactational Amenorrhea Method (LAM), has been produced by the Institute for Reproductive Health and used with success in the field.

Breastfeeding initiatives and family planning initiatives should work hand in hand, as prevention of a new pregnancy allows the mother to breastfeed for a longer period of time. Health workers must listen carefully to the desires of mothers in order to help

them choose the most appropriate combination of breastfeeding and family planning methods. Non-hormonal methods of family planning are preferred for women who are breastfeeding. The preferred hormonal method for nursing women is a progestin-only method such as the mini-pill. Combined oral contraceptives (those containing estrogen and progestin) may have a negative impact on milk quantity and should only be used when other methods are unavailable and when lactation has been well established.

Health-worker attitudes toward breastfeeding: Cameroon

Dr. Jean Claude Lowe, Nutritionist, Ministry of Public Health, Cameroon

In Cameroon, 98 percent of infants under 12 months of age are breastfed, and bottlefeeding is not prevalent. However, a serious problem is the late introduction of nutritional supplements (after 6 months), leading to malnutrition. In the Extreme-North and West provinces of the country, the rate of child malnutrition is 20 percent above the national average. To provide further information on breastfeeding, a health-worker KAP survey was carried out in these two regions during 1991. Information was gathered through interviews and direct observation.

Positive findings from the study included a high level of knowledge among the health workers of the positive effects of breastfeeding on infant health (69.5 percent) and nutrition (76.5 percent), a high level of support for keeping the infant and mother together in maternity wards (rooming-in) (70.4 percent), a large proportion of health workers who encourage breastfeeding until 12 months of age (72.2 percent), and a high number who recommend that breastfeeding be continued or increased during diarrhea (70 percent). On a negative note, many health workers encourage mothers to give supplementary liquids to their children at birth (32.5 percent recommend water and 66.3 percent recommend sugar water). Many do not recommend exclusive breastfeeding (33.5 percent). Only 3.7 percent know of breastfeeding's contraceptive value. Visits to health facilities by firms selling milk substitutes are common.

A national breastfeeding strategy is urgently needed. Specific actions should include defining a national breastfeeding policy, training health workers and workers in other governmental sectors, educating the population through an IEC campaign, and developing and reinforcing legislation concerning maternal leave policies and the Code of Marketing of Breast-Milk Substitutes.

Breastfeeding knowledge, attitudes, and practices of health workers and mothers: Senegal

Mr. Abdou Fall, Nutritionist, PRITECH Consultant, Senegal

Previous breastfeeding studies in Senegal revealed that only 5 percent of infants under 5 months of age are exclusively breastfed, with 61 percent of this age group receiving supplementary water and 33 percent receiving food. To gather more information on breastfeeding, a KAP survey was conducted among health personnel and mothers in urban and suburban Dakar in early 1991.

Results indicate that mothers' attitudes and practices reflect those of the health workers. Only 28 percent of health workers recommend that breastfeeding begin within 1 to 2 hours of birth, while 34 percent recommend that mothers wait 24 hours, despite the fact that 81 percent think colostrum should be given to infants. Perhaps reflecting this finding, 34 percent of mothers breastfeed their infants for the first time 24 hours after birth. Sugar water and "holy" water are the fluids most commonly given to children before breast milk.

Fifty-five percent of personnel think that breast milk meets all of an infant's nutritional needs for the first 3 months, while 40 percent recommend no supplementary foods until 4 to 6 months. Sixty percent of mothers give their infants weaning foods within the first 4 months of life. Ninety-three percent think supplementary water is needed starting at 3 months. Principal reasons mothers gave for use of a bottle were work constraints and insufficient milk supply. Health workers cited insufficient milk as the most important reason for the use of a bottle. A proposed action plan includes training of health workers, social marketing of breastfeeding, and changes in legislation to help working mothers and to implement the Code of Marketing of Breast-Milk Substitutes in Senegal.

Working Group: Growth of exclusively breastfed infants

The recommendations to promote optimal growth were: develop a clear, operational definition of exclusive breastfeeding; recommend exclusive breastfeeding for the first 6 months due to its proven benefits; develop new reference data (growth curve) for exclusively breastfed children; and train health personnel to counsel mothers about breastfeeding. Breastfeeding should be continued even if a mother is infected with the AIDS virus before, during, or after the birth of the child, as recommended by WHO. Periodic updates should be provided to health workers as new scientific information on this subject becomes available.

Debate focused on the need for a special growth curve for breastfed children. It was accepted that in normal, breastfed infants, growth slows at 3 to 4 months and also differs slightly from the international growth curve currently used.

Working Group: Exclusive breastfeeding and women who work outside the home

The following factors discourage women from exclusively breastfeeding: concerns about physical appearance; effects of formula advertising on attitudes; fatigue; need to work; inappropriate advice from health workers; and illness. Constraints which particularly apply to women who work outside the home include: lack of time; separation from the child; working hours; and the belief that milk substitutes are more "modern." A constraint which particularly applies to women who work at home is the problem of overwork.

Solutions include: a maternal leave of at least 16 weeks; permission for women to combine annual vacation with maternal leave; better working hours for breastfeeding mothers; a campaign against breast-milk substitutes; national adoption and implementation of the International Code of Marketing of Breast-Milk Substitutes; training of health workers; public educational campaigns, aimed especially at fathers; promotion of exclusive breastfeeding; encouragement for the practice of expressing breast milk; creation of nurseries in the workplace; encouragement of night-time breastfeeding; promotion of self-help groups; promotion of community development interventions which lessen the burden on women; KAP studies; and finally, support for the promotion of exclusive breastfeeding at the governmental level.

Working Group: Ensuring that maternity wards respect the *Ten Steps to Successful Breastfeeding*

The following recommendations were addressed to public authorities and health personnel: define a national breastfeeding policy and ensure that it is implemented in both the public and private sectors; train social and health personnel by revising current pre-service training programs, producing a module on breastfeeding, and carrying out in-service training; and encourage the formation of support groups to which mothers can be referred. A last suggestion was the development of communication and counseling activities which will reach mothers directly, especially during prenatal and postnatal consultations.

Working Group: Promulgation of laws protecting the right of working mothers to breastfeed their children and elaboration of measures to ensure their application; putting the Code of Marketing into action

First, it was recognized that even mothers who work in the home often have so much work that they do not have time to breastfeed. Lack of information about the benefits of breastfeeding and methods to increase breast-milk production was also listed as a constraint to breastfeeding. Suggested actions to help mothers: adopt and promulgate national laws based on the Code of Marketing; create IBFAN groups or similar advocacy groups in each country; create a breastfeeding subsidy for mothers which would be financed by a tax on milk substitutes; promulgate laws forbidding the sale of baby bottles; revise or create maternal leave policies giving mothers 16 weeks of leave, 2 before and 14 after birth; allow women to combine maternal leave with vacation, with full pay; create incentives for employers who implement these policies; monitor to ensure that these laws are obeyed; integrate breastfeeding promotion into family-planning programs; encourage the development of women's self-help groups and the creation of nurseries.

During discussion, it was noted that a law forbidding the sale of baby bottles has been helpful in breastfeeding-promotion efforts in Kenya. Even premature infants can be fed expressed breast milk with a cup and spoon, making bottles unnecessary. In a clean container, expressed breast milk may safely be kept up to 6 hours, even at tropical temperatures.

THEME IV: INFANT-FEEDING PRACTICES IN THE PREVENTION AND TREATMENT OF DIARRHEA



Benefits and risks of water supplementation during breastfeeding: Cameroon

Dr. Ekoe Tétanyé, Chief, Pediatrics Unit, Yaoundé Central Hospital, Cameroon

Although many studies have shown that supplementary water is unnecessary to meet infants' hydration needs during the period of exclusive breastfeeding, this issue remains controversial in Africa. Therefore, a study was carried out in August 1991 to determine the benefits and risks associated with the practice of supplementing breastfeeding with water in the Extreme-North Province of Cameroon, an area with high temperatures (average of 28 degrees Celsius in the morning and 42 degrees at noon) and low humidity (average of 13 to 55 percent). In this region, there is widespread belief among mothers and health personnel that supplementary water is necessary beginning at birth.

milk (Group B). It was found that the average urinary output over a 10-hour period was comparable and well within accepted norms in both groups (44 milliliters \pm 17 in Group A and 34 milliliters \pm 18.6 in Group B). This was also the case for the specific gravity of the urine (range of 1.005 - 1.010 in Group A and 1.007 - 1.009 in Group B). In this study, 17 samples of drinking water used for the infants were examined, revealing that all were highly contaminated with enteropathogens, especially *E. coli* and *Klebsiella*. This study confirms previous studies showing that water supplementation provides no advantage to the infant and suggests that the bacterial contamination in the water puts them at considerable risk of diarrhea.

Nutritional case management of diarrhea

Dr. Youssouf Gamatié, Chief, Pediatrics Unit, National Hospital of Niamey, Niger

Diarrhea is a nutritional disease which has negative nutritional consequences for children. Nutritional intake is generally reduced during diarrhea for several reasons: reduction in the amount of food absorbed, loss of nutrients in the stool, the patient's lack of appetite (anorexia), and attitudes which discourage feeding, such as a belief that one needs to "rest the gut" and a fear of lactose malabsorption. Proper treatment of diarrhea should include both replacement of fluid losses and feeding. Feeding is an integral part of treatment which promotes healing and continued growth, and which may reduce severity and duration of diarrhea.

Breastfeeding should be continued during diarrhea. It helps rehydrate the child and reduces the duration and severity of diarrhea. In partially- or fully-weaned children, continued feeding should be encouraged to help restore the gut. Most locally available foods are well tolerated and well absorbed. Some vegetable diets have been shown to reduce stool output and duration of the diarrheal episode. In general, high-calorie, locally-available foods which are easy to digest, taste good to the child, are inexpensive and easy to prepare, and which are acceptable to the mother should be recommended. Vegetable oils, ingredients in many local diets, are a good source of calories and vitamin A. In the case of persistent diarrhea, which leads to the highest diarrheal mortality, proper nutritional management is especially crucial. Further studies are needed to determine the acceptability of various diets and their long-term effects in children with persistent diarrhea.

The great majority of children can tolerate cow's milk and other milks without any need for dilution. Patients showing signs of lactose malabsorption should be given milk which is mixed with cereal-based foods rather than with water, or given fermented lactose products such as yogurt. Lack of appetite can be overcome with small, frequent feedings and by offering the child his or her favorite foods. Force feeding should be avoided. The convalescent period after diarrhea is particularly important and often neglected. Special emphasis should be given to increased frequency of feeding and to adequate caloric content so that growth is not adversely

affected. For example, WHO recommends an extra meal each day for 2 weeks after diarrhea has stopped.

Working Group: The need for water supplements for the maintenance of hydration in infants during the first 4 to 6 months

Scientific evidence indicates that exclusive breastfeeding meets the hydration and nutritional needs of infants during the first 6 months, even in hot, arid climates. Water supplements provide no benefit and put infants at risk of infection in areas where hygienic conditions are poor and clean drinking water is not available. Supplementary water and food for mothers, on the other hand, should be encouraged to optimize their supply of breast milk.

In the case of diarrhea or fever, increased frequency of breastfeeding should be encouraged to prevent dehydration. In a dehydrated, exclusively breastfed infant, an oral rehydration solution should also be used.

Further studies are needed in the African context to underline the negative effects of supplementary water and to understand better why mothers give supplemental water. Exclusive breastfeeding should be promoted through IEC activities developed as a result of these studies, directed both at health personnel and the general public. Health workers can also be reached through dissemination of up-to-date technical information and pre- and in-service training.

Debate focused on the difficulty of changing entrenched practices, including the fact that health workers recommend supplementary liquids. One participant proposed suggesting "safe" liquids which mothers could give. This solution was rejected by the group. At the very least, mothers should be told to give the breast before they give anything else, but the focus should be on changing beliefs and behaviors so that no supplementary liquids are recommended or given during the first 6 months.

Working Group: Prevention and treatment of diarrhea

The following actions prevent diarrhea: exclusive breastfeeding for the first 4 to 6 months; beginning of food diversification at 4 to 6 months with local foods which provide sufficient nutrition for the infant; implementation of other health interventions such as growth monitoring, vaccination, sanitation, and provision of clean drinking water; design and diffusion of clear, correct, and culturally-appropriate health messages; and ensuring a true commitment of the government to preventive measures.

The following recommendations pertain to treatment of diarrhea: continue breastfeeding during diarrhea, accompanied by ORS when necessary, according to WHO recommendations; continue feeding children who already receive other foods and give extra food during convalescence; avoid the use of antidiarrheals; and use antibiotics only for dysentery or cholera.

During debate, the question of ORS use in exclusively breastfed infants was raised. If we are trying to promote exclusive breastfeeding, should we be telling mothers to give ORS, thereby introducing outside liquids? Giving ORS at home when the child has diarrhea has been a cornerstone of many CDD programs. Should we change this message? The final consensus was that in cases of dehydration, breast milk should be recommended as the main rehydrating solution, followed by ORS. Not as much ORS will be necessary if the infant receives sufficient breast milk. Breast milk is sufficient to prevent dehydration in most cases, but may not be enough to treat dehydration.

THEME V: INFANT-FEEDING PRACTICES DURING WEANING

Infant-feeding practices during weaning

Prof. Runesha Muderhwa, Nutritionist, Zaire National Nutrition Planning Center (Centre de Planification Nutritionnelle - CEPLANUT), Zaire

The three main problems that may occur during the weaning period (6 months to 2 years) are early provision of supplemental food, late provision of supplemental food, or provision of supplemental food which is nutritionally insufficient for the infant's needs. There are no universal behavioral or physiological indicators that indicate when supplemental foods should first be given. Age and growth of the child are the surest signposts. Because of the nutritional and protective benefits of breastfeeding, mothers should generally be encouraged not to add supplemental foods until 6 months.

Mothers should gradually introduce other foods, beginning with liquids, then semi-solids, and solids. The diet should progress from simple foods to double and multiple foods, to eating the family diet. Simple, local foods, with a cereal base, are the best. It is particularly important that foods have sufficient nutrient density and calories. The use of fermented foods should be encouraged as they generally have a more acceptable texture and taste and can be kept safely for a longer period of time. Foods prepared from germinated flour also have a reduced viscosity while maintaining nutrient density. During weaning, the breast should always be given first, and supplements second.

Illness in the infant or a new pregnancy in the mother are not contraindications to breastfeeding, as breast milk is an especially important nutrient during illness, and since pregnant mothers can generally continue breastfeeding.

During the discussion it was clarified that while the general norm is to continue breastfeeding until 2 years of age, there is no fixed age at which breastfeeding should be stopped completely. This depends on each individual mother and child. Vigorous discussion focused on reference to a Demographic and Health Surveys study which found more malnutrition in children over 12 months of age who were breastfed than in those who had been completely weaned. This indicates that longitudinal research needs to be done to determine the specific causes of such a phenomenon so that recommendations about a proper combination of breast milk and other foods can be formulated. It is likely that the increased malnutrition was due to factors such as inadequate quantity or quality of weaning foods rather than to the continuation of breastfeeding.

Panel Discussion: Research and Program Experiences in the Area of Nutrition

Improvement of traditional weaning foods: Niger

Dr. Colette Geslin, PRITECH Representative, Niger

Children under 6 years of age in Niger have an average of 6 or 7 episodes of diarrhea each year. Twenty-eight percent of infants who have had diarrhea in the preceding 2 weeks are malnourished, twice the rate of children who have not been ill, and diarrhea prevalence is higher among malnourished children. Because of this disturbing situation, one of the objectives of the Niger CDD program is to teach mothers to feed their children appropriately during and after diarrhea to help prevent resulting malnutrition and further illness. Therefore, the goal of a study conducted in early 1991 was to determine what and how mothers are feeding their children and to find culturally acceptable ways of enriching already existing weaning foods and/or changing mothers' infant-feeding practices.

In the two regions where study was conducted, Dosso and Konni, it was found that mothers most often give *koko* and *fura* as weaning foods. Neither of these millet-flour-based liquids is nutritionally rich enough to support the needs of a growing child, especially during and after illness. It was also found that although mothers do continue feeding their children during diarrhea, they do not encourage anorexic children to eat.

Through the study, four recipes for improved *koko* or *fura* and targeted recommendations for improved feeding practices were developed. These recipes and recommendations were tested with mother-child pairs during field trials and were found to be acceptable to the mothers in terms of time, cost, and ingredients. Seventy-three percent of mothers in the study prepared one of the recipes at least once per day. The next steps planned under this intervention include the integration of nutritional recommendations into diarrheal case management among health workers in a pilot area in order to improve feeding during and after diarrhea.

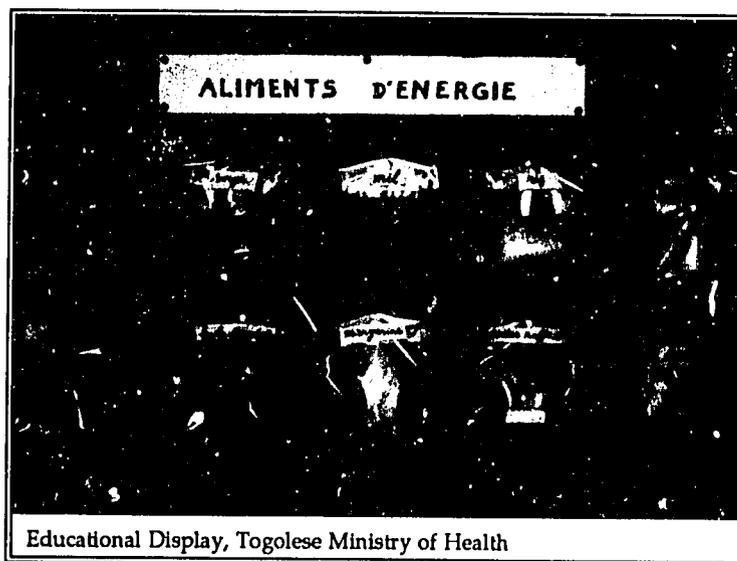
Improvement of nutritional case management of diarrhea: Nigeria

Dr. Eléonore Seumo-Fosso, Health Coordinator, CARE International, Cameroon

In Kwara State, Nigeria, the Dietary Management of Diarrhea Project (1985 - 1989) conducted research to improve nutritional case management of diarrhea. Preliminary ethnographic research found that mothers are concerned about the need for

continued feeding during diarrhea, as shown by the widespread practice of "forced feeding" of infants during illness. Mothers strongly believe that solid foods should not be given before 1 year of age, or children will become "heavy." The signs of "heaviness" they describe correspond closely to symptoms of kwashiorkor. The traditional weaning food, *eko*, is a watery, cereal-based pap of low nutritional value. Because of the strong belief against solids for infants, mothers would be more willing to fortify the pap than to introduce solid foods in order to improve their childrens' diet.

Research identified ingredients to add to this pap which were acceptable to the mother and not too expensive: red palm oil, sugar, and cowpea flour. Malt was also used to keep the mixture from becoming too thick. The new mixture, *eko ilera*, contains 85 kilocalories per 100 grams, a considerable increase over the traditional recipe which contains 25 kilocalories per 100 grams.



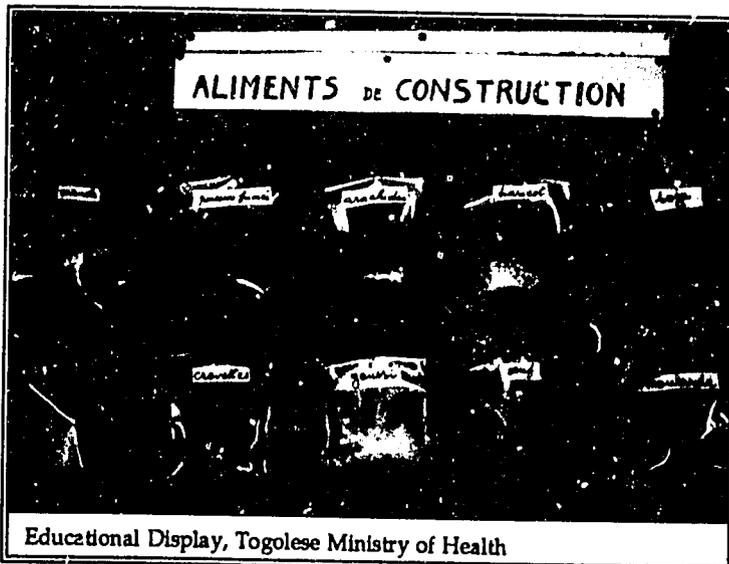
In a pilot intervention, health workers were trained to teach "teaching moms" to make the recipe. These mothers in turn taught other mothers in the participating communities. Evaluation of the intervention measured mothers' levels of knowledge, trial, and adoption of *eko ilera*. Most mothers found the recipe acceptable in terms of ease of preparation and time. The 17 percent adoption rate was higher than had been hypothesized for such a pilot intervention. The methods of face-to-face instruction, demonstrations, and songs conveyed information successfully. However, some mothers were concerned with the price of the ingredients. The results of this carefully designed study point to a number of issues to be further explored when the pilot activity is expanded. These include simplification of the recipe to reduce cooking time and training of existing *ogi* sellers to prepare the ingredients for the *eko ilera* and to help promote the new product to mothers.

Improvement of weaning practices: Cameroon

Dr. Eléonore Seumo-Fosso, Health Coordinator, CARE International, Cameroon

A 1978 nutritional survey showed that 22 percent of weaning-age children in Cameroon suffer from malnutrition, especially in the northern region. The goal of a

recent study (1986-1987) in the Extreme-North Province was to develop and implement nutrition-education activities designed to improve the nutrition and health of children 0 to 3 years of age. Background research on current practices identified the following problems: colostrum is generally withheld; most children are given water supplements by the end of the first month; weaning foods are of poor quality and are not generally given until the ninth or tenth month, and then are not given frequently enough or in great enough quantity; sick children are not encouraged to eat and generally eat very little. The target population was found to have low rates of visual literacy, literacy, and access to radio.



Specific feeding messages were developed for the following age-groups: 0 to 3 months, 4 to 9 months, 10 to 15 months, and 16 to 36 months. These messages addressed the correct age at which to introduce supplements, the type of supplements to give, and the correct quantity and frequency. In a pilot intervention, health workers were trained to carry out two major nutrition-education activities in participating villages: monthly weighing

sessions for children followed by individual nutritional counseling with the mothers, and monthly discussion groups followed by participatory cooking demonstrations showing how to use recommended ingredients to enrich the local weaning pap.

A follow-up study found that mothers participated regularly in the activities, that their knowledge had increased, and that their behavior had measurably changed. They particularly liked the attention of the individual nutritional counseling. To increase the impact of the program, the following actions are necessary: develop nutritional messages for pregnant and nursing women; put more emphasis on traditional



channels of communication; involve midwives in nutrition-education activities; and develop messages for fathers. This approach will be expanded into the greater northern region of Cameroon in the near future.

Ethnographic research on infant feeding: Gambia

Ms. Kinday Samba, Nutritionist, Gambian Feeding and Nutrition Association, Gambia



Ms. Kinday Samba

Discussion of a 1990 ethnographic survey from the Gambia on child-feeding practices focused on the methodology of four types of systematic data collection: free listing, pile sorting, triad sorting, and ranking. The goal of the survey was a better understanding of mothers' knowledge, attitudes, and behaviors related to weaning and weaning foods. This would help determine what supplementary ingredients could be used to improve the nutrient and caloric content of weaning foods.

In free listing, the respondent is asked to make a list of all the things in one category, for example, foods given to children under 1 year of age. In pile sorting, respondents are asked to group items which belong together. This can help determine which

foods mothers are willing to combine. Triad sorting is similar and complementary to pile sorting. Respondents identify the "thing that doesn't belong" out of a group of three items. Ranking determines the relative position of items within a category by asking respondents to place the items between two extremes, such as often and never, or best and worst. This method can be used to determine which foods are most likely to be added to a traditional weaning pap.

The study in the Gambia used these techniques in combination with key-informant interviews and direct observations to identify weaning foods traditionally given to children and to determine what foods mothers would be most willing to add to the traditional millet pap. The next step will be the trial of four to six improved weaning-food recipes using local ingredients.

Improving infant and maternal nutrition: Mali

Ms. Dandara Touré Kanté, Nutritionist, Nutrition Communication Project, Mali

In Mali, malnutrition often begins as early as the fifth month. Nutritional messages about adding beans or peanuts to the traditional millet pap have not been very successful at changing mothers' behavior. Therefore, a new nutrition-education strategy was needed. Initial ethnographic research revealed that people are generally unfamiliar with the nutritional value of different foods, and that they tend to classify foods by taste. Until the age of 23 or 24 months, children are generally given only breast milk and water. Pregnant women do not generally eat supplementary foods, and husbands do not see the need to buy supplements for their pregnant wives.

Based on the initial findings, messages were developed to encourage the giving of supplementary foods of sufficient quality and quantity to children starting at 6 months as well as to women during pregnancy; to encourage men to take responsibility for these needs of women and children; to teach mothers to teach older children to take better care of infants; and to teach health workers to encourage the use of locally-available foods during nutrition education. Specific vehicles for dissemination of these messages include a flip-chart in local languages for nutrition education of mothers, a newsletter for health workers, child-to-child teaching, mass media, and traditional oral routes of communication.

Infant-feeding knowledge, attitudes, and practices: Burkina Faso

Mr. Jean Parfait Douamba, Nutritionist, Family Health Division, Burkina Faso

During a KAP study on feeding practices carried out in several regions of Burkina Faso, interviews were conducted with nursing mothers, mothers of children 2 to 5 years of age, pregnant women, and fathers. When parents were asked what risks

children face if they do not eat well, the most common response was that they become ill. A smaller percentage said they do not grow properly. Most parents do not know the link between what they feed their children and the presence of marasmus or kwashiorkor, nor do they know how to prevent these nutritional illnesses.

About one-half of the parents start giving supplemental foods at 4 to 6 months, while about one-third give supplements too late, and the rest, too early. More than one-third feel that the father should receive the most food in the family; a majority feel that children do not need to eat meat; many feel that the father does not need to concern himself with his children's diet; and most parents have never discussed nutrition with a health worker. Half of the parents do not think children need extra water during diarrhea and half have never heard about ORS. On a more positive note, almost half of the mothers continue breastfeeding for over 2 years. A workshop is planned to develop a communications strategy based on this information in the hopes of improving feeding practices in Burkina Faso.

During the discussion following the panel presentations, it was noted that there should have been more time allowed for presentation of practical studies and programs such as these. It was also noted that much of the research has been sponsored by CDD programs rather than nutrition programs, highlighting the importance of linking these two programs.

THEME VI: INTEGRATION OF NUTRITION ACTIVITIES INTO OTHER HEALTH PROGRAMS

Panel Discussion: Integration of Nutrition Activities Into Other Health Programs

Breastfeeding promotion and child spacing

Ms. Kristin Cooney, Assistant Director, Institute for Reproductive Health, Georgetown University, U.S.A.

Breastfeeding has made an important contribution in the reduction of fertility in Africa. For example, in Senegal, breastfeeding contributes as much to child spacing as all other family planning methods combined. In an optimal program, family planning counselors and other health workers, including midwives, should be trained to promote exclusive breastfeeding for the first 4 to 6 months. Reaching mothers during the prenatal period to promote exclusive breastfeeding, as well as other appropriate family planning methods, can have an important positive impact on exclusive breastfeeding and contraception. In a pilot intervention in Ecuador, the knowledge and confidence about dealing with child spacing increased among health workers in four rural dispensaries after they were trained in breastfeeding promotion and family planning. The effect of the intervention on mothers is being measured.

Breastfeeding promotion and family planning

Ms. Margaret Parlato, Director, Nutrition Communication Project, Academy for Educational Development, U.S.A.

A pilot project in a hospital in Honduras focused on integrating breastfeeding and family planning. The goals of the intervention were to promote exclusive breastfeeding during the first 4 to 6 months and to complement breastfeeding with other contraceptive options. Emphasis was placed on training health personnel. Both a breastfeeding and a family planning clinic were established. Breastfeeding was discussed with mothers during prenatal visits and after birth in the hospital. They received free contraceptives on leaving the hospital, and follow-up appointments for both the breastfeeding and family planning clinics. The results were positive: the number of women breastfeeding at 3 months increased from 14 to 23 percent; the number breastfeeding at 6 months increased from 58 to 73 percent; and the proportion of women using complementary family planning methods at 6 months postpartum increased from 54 to 68 percent.

Breastfeeding promotion in health facilities: Côte d'Ivoire

Dr. Joseph Andoh, Head of Pediatrics, CHU Treichville, Côte d'Ivoire

Integration of breastfeeding promotion into health services in Côte d'Ivoire was discussed using the example of maternal and child services in Abidjan. Most infants are born in public facilities where they are given directly to the mother after birth and remain with the mother during her 12- to 48-hour stay. These children are generally breastfed from birth. Premature infants are put in a special newborn nursery where mothers come daily to express breast milk which is then given to the infant with a bottle or nasogastric tube. All children are then followed up in health centers through growth monitoring activities.

One of the major constraints to breastfeeding is the promotion of milk substitutes in health facilities. This is difficult to stop because the facilities do not have budgets to buy milk substitutes for infants who do need them and therefore must accept samples from companies. A second constraint is the practice of separating sick newborns from their mothers, and of separating healthy newborns from their sick mothers for care in a separate pediatric service. These children are often fed milk substitutes. In private clinics, infants are often separated from their mothers at night so the mothers can rest.

A major constraint in both private and public facilities is the lack of time, knowledge, and motivation among health personnel who are supposed to counsel mothers in breastfeeding. The result is the unnecessary use of sugar water and bottlefeeding. Needed equipment, such as breast pumps for expressing breast milk, are often lacking as well.

An advisory group has been created to develop solutions to these problems. The primary strategy developed in Abidjan is training of all levels of health personnel. During one-week training seminars, breastfeeding is integrated with training in other health interventions. Help from advocacy groups, such as IBFAN, may be needed to combat the negative influence of breast-milk substitutes.

Improvement of nutrition through CDD programs: PRITECH Project

Dr. Adama Koné, Deputy Director, Sahel Regional Office, PRITECH, Senegal

The PRITECH project has integrated nutritional activities into CDD programs in five ways. First, PRITECH has sponsored studies on child-feeding practices in order to develop strategies to improve feeding during and after diarrhea, and to improve weaning practices in general. WHO is developing a protocol focusing on the dietary management of persistent diarrhea. PRITECH hopes to apply the protocol in one or two pilot sites in the Sahel.

Second, in an effort to improve breastfeeding practices, PRITECH has sponsored studies and program activities to promote breastfeeding. Studies have been carried out on breastfeeding knowledge, attitudes, and practices among mothers and health personnel, including one on water supplementation in Cameroon (presented above). Program activities include the training of health personnel in lactation management and breastfeeding promotion, and the introduction of breastfeeding-promotion activities into diarrhea training units.

Third, PRITECH has supported studies of health-worker behaviors and counseling practices. PRITECH has found that health workers do little in the way of counseling mothers about feeding their children. Therefore, nutritional guidelines have been included in diarrheal treatment charts, technical handouts, and CDD curricula. Nutritional information is collected and recorded on health records.

Fourth, in one country, specific breastfeeding and feeding messages are included as part of all diarrheal treatment messages. Particularly innovative is the inclusion of specific breastfeeding and feeding messages on the ORS packet itself and in the ORS instructions.

Finally, nutrition modules are being developed both as part of a CDD curriculum for use in nursing schools in the Sahel and for use during continuing education. In addition, PRITECH has developed a "nutrition checklist" which outlines a series of actions CDD programs can take to incorporate nutrition promotion into program activities.

Improvement of nutrition and primary health care

Ms. Bibi Essama, Director, Women and Infant Nutrition Support Project, Education Development Center, Inc., U.S.A.

How can efforts to improve child feeding and nutrition be integrated into PHC programs? Operational research by Tufts University and UNICEF in Nicaragua and Nigeria focused on developing a new approach to growth monitoring. Initial research identified obstacles and constraints to breastfeeding and appropriate young child feeding. A communications campaign was launched to encourage mothers to participate in growth-monitoring activities. During growth-monitoring sessions, health workers use an innovative "age scale" as the primary tool for nutrition education. The age scale allows the mother and health worker to compare the developmental growth of the child with his/her actual age and thereby measure progress. It eliminates the need to plot a graph, as is required in traditional growth charts. During counseling, health workers use the concept of a "contract" to involve mothers more directly in decision making about specific nutritional practices they would be willing to change. Preliminary findings indicate that positive changes in breastfeeding and child-feeding practices have taken place.

In a collaborative pilot project in Jamaica, the Ministry of Health and the Ministry of Education successfully integrated nutrition education into the primary school curriculum. Children learned action-oriented nutritional messages while learning to read. Evaluation found that they retained many of the basic concepts.

Improvement of nutrition and primary health care: Guinea

Prof. Mandy Kader Kondé, Director General of Public Health, Ministry of Health and Population, Guinea

An overview of the obstacles and opportunities for integration of nutrition activities into PHC programs focused on the example of Guinea. Following the implementation of the *Bamako Initiative*, the operational emphasis has been placed on the local health centers. These centers must integrate curative, preventive, and promotional activities. Nutrition has not been given a high priority in this system and is primarily addressed only through growth monitoring. However, nutritional issues could also be addressed during prenatal consultations, at birth, and during postnatal visits.

Each center has a management committee made up of members of the community as well as the health team. Children are weighed and checked for vaccination status on all visits. Health cards for all mothers and children are kept at the health center in order to allow follow-up in the community. Integration of nutritional activities into this system must begin with a well-defined, national nutrition policy.

Working Group: Integration of activities which promote optimal child feeding into primary health care programs: MCH/FP, CDD, ARI, and EPI

Before integration of nutritional activities can take place, a well-structured nutritional policy must be developed on the national level. Since donors have not always been supportive of the integrated approach, they must be sensitized to the need for integration. An action plan should include the following strategies: training at all levels (in schools and in the field) using nutrition modules, with an emphasis on the importance of growth monitoring; operational research on local weaning practices, breastfeeding, and family planning in Africa; and social marketing of improved feeding practices.

On an operational level, the following actions will be needed: reorganization of health-care services (if necessary); clear directives; training of personnel; increase in and better distribution of personnel throughout the country, as well as improved mechanisms of reward and encouragement; integration of efforts to improve feeding

into CDD, EPI, growth monitoring, family planning, and women and development activities.

Working Group: Integration of activities which promote optimal child feeding into community nutrition programs

In recognition of nutritional activities which are already in place in various countries, as well as of the constraints to improvements in feeding practices, the following recommendations were made: involve women and the whole community in implementation of nutrition programs; develop appropriate educational materials and use traditional channels of communication; emphasize operational research at the community level; integrate nutrition into health-worker training in schools and in the field; institute rewards to motivate health workers involved in nutrition-promotion activities; promote revenue-generating activities at the community level to finance nutritional activities; decrease the workload for women; affirm the importance of nutritional activities for maternal and child health; and help the community take responsibility for nutritional activities.

Working Group: Revision of training programs for all health personnel, including doctors, nurses, midwives, and primary health care workers

Health workers are not generally well trained in the area of nutrition. To correct this situation, the following actions are needed: give more importance to nutrition during pre-service training using up-to-date information; make sure the training is practical and focuses on solving problems with the community; improve health workers' communication skills; ensure that health workers in the field receive systematic in-service training; assist health workers by ensuring the implementation of the Code of Marketing; emphasize regular supervision as the way to maintain and reinforce correct knowledge, attitudes, and practices.

Working Group: Integration of operational objectives to promote breastfeeding into national health and development policies

All countries should develop national action plans which promote and protect exclusive breastfeeding through the sixth month, with supplements beginning in appropriate cases at 4 months and in all cases by 6 months. Specific actions should include ethnographic studies on breastfeeding practices in order to develop IEC activities; pre- and in-service training for health and social-extension workers; and implementation of national codes of marketing of breast-milk substitutes.

COUNTRY PLANS

Before the country teams met to develop draft plans for the future, participating donors and advocacy groups⁷ gave presentations on their objectives with respect to infant feeding, in terms of policies, priorities, and types of programs they generally support. These groups met with the country teams upon request to answer specific questions. Eight country teams (Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Niger, Senegal, and Togo) deliberated and then presented individual country plans of action related to infant feeding. Some of these plans were very broad and general in nature while some proposed specific activities and timelines.

Commonly suggested activities to promote breastfeeding and improve maternal and child nutrition were:

- qualitative and quantitative research on breastfeeding and feeding practices within specific country contexts;
- development of national policies on breastfeeding and nutrition;
- formation of national intersectoral committees to plan and guide promotional activities;
- development of educational materials and training of health workers and other relevant government workers at all levels in breastfeeding and nutrition, with an emphasis on improving communication skills;
- development of educational materials and implementation of IEC campaigns to promote breastfeeding and improved feeding practices among the population; and
- integration of promotional activities into other health programs such as family planning and CDD.

Highlights from the country-team plans are outlined in the following pages:

⁷FAO, IBFAN, RENA, UNICEF, WHO, and the following A.I.D. projects: Georgetown Institute for Reproductive Health, NCP, PRITECH, Wellstart, and WINS.

COUNTRY FOLLOW-UP PLANS

Country	Highlights of National Plans
Burkina Faso	<ol style="list-style-type: none"> 1. Integrate breastfeeding into family planning training, curriculum, and educational materials development. 2. Perform national level study on diarrheal disease prevalence and practices as well as several operations research activities. These will lead to communications strategies for breastfeeding, weaning, and control of diarrheal disease (CDD). 3. Review the weaning food situation with the goal of improving infant feeding practices. Feasibility/ acceptability of commercially produced local weaning food to be explored, including production, promotion, acceptance and price. 4. A more specific nutrition action plan and strategy will result from workshop scheduled for January, 1992 to discuss results of maternal and child nutrition knowledge, attitudes, and practices (KAP) survey. 5. Create a national breastfeeding committee; write legislation against breast milk substitutes; make "crèches" available for professionals in government service.

COUNTRY FOLLOW-UP PLANS

Country	Highlights of National Plans
Cameroon	<ol style="list-style-type: none"> 1. (MOH/University) Perform applied research on infection risks from various food/fluid supplements. 2. (CARE/World Bank) Develop infant feeding communications and training. <ul style="list-style-type: none"> ◆ Assess current status. ◆ Perform formative research and pretesting. ◆ Train and implement information, education, and communication (IEC). 3. Develop national breastfeeding program. <ul style="list-style-type: none"> ◆ Train team at Wellstart. ◆ Improve hospital practices. ◆ Develop national breastfeeding policy and strategy. 4. Establish regional training center for West/Central Africa.
Côte d'Ivoire	<ol style="list-style-type: none"> 1. Create comprehensive infant feeding program. 2. Develop urban breastfeeding protection program. 3. Create national breastfeeding program.
Guinea	<ol style="list-style-type: none"> 1. Maternal and child nutrition, including optimal infant feeding, are a major priority of MOH.

COUNTRY FOLLOW-UP PLANS

Country	Highlights of National Plans
Mali	<ol style="list-style-type: none"> 1. Aspects of optimal infant feeding will be integrated into training programs currently established in nutrition, CDD, and family planning. 2. Nutrition communications currently stress exclusive breastfeeding and appropriate introduction of solids; CDD developing better ways of feeding kids recovering from illness, programs are integrated at level of MOH and USAID.
Niger	<ol style="list-style-type: none"> 1. Integrate optimal infant feeding research into nutrition programs (currently stressing increased consumption during pregnancy and lactation of Vitamin A rich foods) and CDD. 2. Link operations research efforts. 3. Train team at Wellstart.
Senegal	<ol style="list-style-type: none"> 1. Develop comprehensive infant feeding program: iron, vitamin A, low birth weight, weaning foods. 2. Develop breastfeeding/optimal infant feeding training modules. 3. Perform national breastfeeding program needs assessment.

COUNTRY FOLLOW-UP PLANS

Country	Highlights of National Plans
Togo	<ol style="list-style-type: none"><li data-bbox="483 437 1421 570">1. MOH most interested in linking growth monitoring/promotion (GM/P) and infant feeding counseling and training.<li data-bbox="483 614 1421 703">2. Improve service delivery, integrating MOH and Catholic Relief Services (CRS) programs.

The one delegate from **ZAIRE** who was able to attend prepared a comprehensive national breastfeeding promotion plan, however, this has not been presented to the MOH or USAID in country.

RECOMMENDATIONS OF THE FORUM

We, delegates from Burkina Faso, Cameroon, Côte d'Ivoire, Gambia, Guinea, Mali, Niger, Senegal, Togo, and Zaire, participants in the

INTERNATIONAL FORUM ON INFANT FEEDING AND CHILD SURVIVAL

have determined that deficiencies in infant feeding and a disturbing decline in breastfeeding pose a serious threat to child survival in Africa, resulting specifically in increased morbidity and mortality due to malnutrition and diarrheal disease.

While the widespread economic crises facing the African countries are partly to blame, the African states themselves also bear an unequivocal responsibility due to the:

1. Lack of clearly-defined, national health policies which give priority to nutrition as a major health problem among the population in general, and especially among mothers and their children;
2. Inadequacy of existing legislation for the protection of pregnant and nursing women;
3. Incomplete implementation of the provisions of the International Code of Marketing of Breast-Milk Substitutes;
4. Shortcomings among health personnel in the areas of nutrition and breastfeeding.

As an expression of our endorsement of the *Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding*, and in order to improve the deplorable situation described above and protect maternal and child health,

WE RECOMMEND

that AFRICAN GOVERNMENTS:

1. Immediately define and establish integrated, practical policies on feeding and nutrition, focusing particularly on breastfeeding promotion and child survival;
2. Change existing legislation governing maternal leave policies with the goal of truly promoting exclusive breastfeeding;

3. Take the necessary steps to ensure optimal nutrition for women in general, and especially for pregnant and nursing women;
4. Take the necessary steps to improve health-worker knowledge and practices in the areas of nutrition and breastfeeding promotion in our countries;
5. Ensure that structural adjustment plans, to which all our developing countries must adhere, allow for the promotion of optimal infant feeding and child survival, as set out in these recommendations;

that HEALTH AUTHORITIES

6. Promote exclusive breastfeeding from birth through the age of 4 to 6 months, recognizing that breastfeeding meets all of an infant's nutritional and hydration needs, and, in addition, serves as an effective birth-spacing method;
7. Ensure that weaning foods are introduced gradually and in sufficient quantity, that they are culturally acceptable, local foods of adequate nutritional value, and that they are first given at 4 to 6 months, with continuation of breastfeeding until 2 years of age or longer;
8. Ensure that, in case of diarrhea, breastfeeding is continued among nursing infants, and feeding is continued in children who are already weaned, in association with oral rehydration therapy;
9. Ensure that even in populations with a high prevalence of HIV infection, breastfeeding promotion continues in order to avoid the increased risk of mortality associated with a decrease in the practice of breastfeeding;
10. Ensure that these recommendations are implemented;

**and that INTERNATIONAL AND NON-GOVERNMENTAL ORGANIZATIONS
AND BILATERAL AID AGENCIES:**

11. Place more emphasis on national feeding and nutrition programs, especially in the area of applied research, in order to promote the survival of mothers and their children.

Lomé, September 13, 1991

APPENDICES

APPENDIX ONE

Conference Agenda

CONFERENCE AGENDA

Forum International pour l'Afrique Francophone

Alimentation du Nourrisson et Survie de l'Enfant

du 9 au 13 septembre 1991
Lomé, Togo

PROGRAMME

LUNDI 9 septembre

08h30 à 09h30

Séance d'ouverture

Formalités et allocutions

- Intervention de l'USAID
- Messages des organisations collaboratrices
- Allocution de son Excellence M. le Ministre de la Santé Publique

09h30 à 10h00

Pause Café

10h00 à 10h10

Présentation des participants

10h10 à 10h20

Détails de l'organisation et du matériel. *Mme Jeanine Daniels des Etats-Unis*

10h20 à 11h00

Présentation des objectifs de la Conférence. *Professeur Ananivi Doh du Togo*

11h00 à 12h00

Exposé I sur le thème: Progrès dans le domaine de la survie de l'enfant et perspectives pour les années 1990.

1. La survie de l'enfant en Afrique: Bilan des dix dernières années et perspectives en matière de nutrition. *Professeur Baba Traoré du Mali*
2. Bref aperçu sur les interventions relatives aux programmes d'allaitement au sein et de lutte contre les maladies diarrhéiques: (a) SSP (Initiative de Bamako), (b) LCMD, (c) Alimentation et Nutrition. *Professeur M. Kader Kondé de la Guinée.*

3. *Déclaration d'Innocenti: Recommandations internationales pour l'alimentation du nourrisson. Dr. Joseph Andoh de la Côte d'Ivoire*

12h00 à 12h30

Débat. *Professeur Ananivi Doh du Togo*

Déjeuner

(Ensemble)

15h00 à 17h45

Présentation des expériences et Discussion, I

Brèves présentations (15 minutes) de chaque délégation sur la situation dans leur pays en matière de nutrition et de santé maternelles et infantiles.

- I. Les principales activités de recherche, de formation, d'IEC et de traitement.
- II. Les approches et contraintes liées à l'intégration des interventions pour l'alimentation optimale du nourrisson dans les programmes de SMI/PF, notamment PEV, IRA, LCMD et contrôle de la croissance.

15h00 à 15h15	Burkina Faso
15h25 à 15h40	Cameroun
15h50 à 16h05	Côte d'Ivoire
16h15 à 16h30	Guinée
16h40 à 16h55	Mali
17h05 à 17h20	Niger

MARDI 10 septembre

08h30 à 08h45

Présentation du rapport des travaux du 1er jour.

08h45 à 10h00

Présentation des expériences et Discussion, II

08h45 à 09h00	Sénégal
09h10 à 09h25	Togo
09h35 à 09h50	Zaire

10h00 à 10h15

Pause Café

10h15 à 11h00

Exposé II: Soutien de la femme pendant la grossesse, optimisation de la santé de la mère et de l'enfant pendant la période post-partum. Professeur Runesha Muderhwa du Zaire

1. Apport nutritionnel et dépense d'énergie pendant la grossesse: prise de poids recommandée et répercussions d'un déséquilibre énergétique provenant, par exemple, de carences en fer et en iode.
2. Soutien nutritionnel et social pour les femmes post-partum.
3. Les enfants de faible poids à la naissance et les risques encourus.
4. Implications éventuelles.
5. Attitudes du personnel de santé vis à vis de l'allaitement maternel: **Cameroun. Dr. Jean Claude Lowe du Cameroun**

11h00 à 11h15

Discussion

11h15 à 12h15

Exposé III: Optimisation de la santé de la mère et du nourrisson. Dr. Amsagana Boukar du Niger

1. Lait maternel (qualité nutritionnelle, biochimie et immunologie) et la conduite de la lactation.
2. Réduction de l'épuisement maternel.
3. Implications.
4. Connaissances, attitudes et pratiques du personnel de santé et des mères en matière de l'allaitement maternel: **Sénégal. M. Abdou Fall du Sénégal**
5. L'allaitement au sein et l'espacement des naissances. **Mme Kristin Cooney des Etats-Unis.**

12h15 à 12h45

Définition des groupes de travail pour l'après-midi

Déjeuner

(Libre)

15h00 à 16h00

Exposé IV: Prévention et traitement de la diarrhée. Dr. Ekoe Tétanyé du Cameroun

1. L'eau et autres liquides supplémentaires donnés à l'enfant pendant les six premiers mois -- Présentation des recherches et des implications.
2. Etude de réplique: **Cameroun**

3. Traitement et gestion nutritionnels des enfants diarrhéiques. *Dr. Youssouf Gamatié du Niger*

16h00 à 18h00

Travaux de groupes¹: Les participants se répartiront en groupes de travail pour discuter des obstacles à l'application des nouvelles données scientifiques et identifier des moyens pour surmonter ces obstacles. Introduction: *Professeur Ananivi Doh du Togo*

Groupe 1: Apport nutritionnel et dépense d'énergie pendant la grossesse.

Groupe 2: Soutien nutritionnel et social pour les femmes post-partum.

Groupe 3: La croissance des nourrissons exclusivement allaités au sein.

Groupe 4: La femme qui travaille à l'extérieur et l'allaitement exclusif.

Groupe 5: Les besoins de suppléments d'eau pour maintenir l'homéostasie hydrique chez les nourrissons pendant les 4 à 6 premiers mois.

Groupe 6: Prévention et traitement de la diarrhée.

18h30 à 20h00

"Cocktail"

Exposition du matériel éducatif de chaque pays. *Dr. Etsri Akolly au Togo*

MERCREDI 11 septembre

08h30 à 08h45

Définition de l'allaitement maternel exclusif. *Dr. Ekoe Tétanyé du Cameroun*

08h45 à 10h00

Présentation du rapport des travaux du 2ème jour et du rapport des travaux de groupes.

10h00 à 10h30

Exposé V: Diversification alimentaire. *Professeur Runesha Muderhwa du Zaïre*

¹ Les rapporteurs pour chaque discussion seront nommés pendant la séance de travail. A la fin de tous les débats et discussions, les rapporteurs récapituleront les discussions et réactions des groupes.

1. Les besoins physiologiques chez l'enfant et les indices pour l'élaboration d'un horaire en vue de leur satisfaction. Mode de croissance des enfants uniquement allaités au sein, indicateurs de comportement (résultats de recherches et implications).
2. Problèmes d'une alimentation complémentaire tardive et insuffisante en nutriments.

10h30 à 10h45

Pause Café

10h45 à 12h00

Discussion guidée par un groupe d'experts: Recherches et programmes visant à encourager une bonne croissance et de bonnes pratiques de sevrage: expérience des pays. *Dr. Eléonore Seumo Fosso du Cameroun, Dr. Colette Geslin du Niger, Mlle Kinday Sumba de la Gambie, Mme Dandara Touré Kanté du Mali et M. Jean Parfait Douamba du Burkina Faso*

DEJEUNER ET APRES-MIDI LIBRE

JEUDI 12 septembre

08h30 à 08h45

Présentation du rapport des travaux du 3ème jour.

08h45 à 09h15

Définition de programmes d'action: Préambule. Vidéo: Préserver une ressource naturelle. *Mme Kristin Cooney des Etats-Unis*

09h15 à 10h30

Discussion guidée par un groupe d'experts: Intégration des activités de nutrition dans les programmes de PF, LCMD, SSP intégré, et dans les formations sanitaires. *Mme Kristen Cooney, Mme Margaret Parlato et Mme Bibi Essama des Etats-Unis, Dr. Joseph Andoh de la Côte d'Ivoire, Dr. Adama Koné du Sénégal, Professeur M. Kader Kondé de la Guinée.*

10h30 à 11h00

Pause café et constitution des groupes

11h00 à 12h30

Travaux de groupes: Les participants se répartiront en groupes de travail pour formuler des avant-projets de recommandation pour le renforcement des programmes complémentaires à l'alimentation optimale du nourrisson, notamment les soins prénatals et périnatals, la nutrition, les services de PF et la prévention et le traitement des maladies les plus courantes chez les mères et les enfants.

- Groupe 1: Intégration des activités pour l'alimentation optimale du nourrisson dans les programmes de SSP: MCH/PF, LCMD, IRA, PEV.
- Groupe 2: Intégration des activités pour l'alimentation optimale du nourrisson dans les programmes de nutrition communautaire
- Groupe 3: Assurance des prestations de maternité respectant les *Dix conditions pour le succès de l'allaitement maternel* (OMS/UNICEF).
- Groupe 4: Révision des programmes de formation destinés à tout le personnel de santé, y compris médecins, infirmières, sage-femmes et agents de santé primaire.
- Groupe 5: Intégration des objectifs opérationnels pour la promotion de l'allaitement maternel dans les politiques nationales de la santé et du développement.
- Groupe 6: Promulgation de lois protégeant le droit de la femme qui travaille d'allaiter son enfant et élaboration de mesures pour assurer leur application. Mise en vigueur du code de marketing.

Déjeuner

(Libre)

14h30 à 15h30

Rapport des travaux de groupes

15h30 à 17h00:

Présentation des bailleurs de fonds: intérêts, politiques et priorités. Exemples de programmes financés récemment.

- OMS
- UNICEF
- FAO
- IBFAN
- RENA
- USAID

L'Institut de la Santé Reproductive de l'Université de Georgetown, Washington, D.C., Etats-Unis

Formation de Spécialistes de la Lactation: Wellstart, San Diego

Projet de Soutien de la Nutrition Maternelle et Infantile (WINS)

Projet de Communication pour la Nutrition

PRITECH

- 17h15 à 18h30
- **Travaux en commission (par pays) sur les projets relatifs aux thèmes de la conférence.** (Moment où les équipes nationales discutent des plans de travail avec les bailleurs de fonds et les animateurs techniques.)
 - Travaux préparatoires pour les recommandations du Forum par le sous-comité.

20h00

Soirée "Voudou"

VENDREDI 13 septembre

- 08h30 à 09h00 **Discussion de l'allaitement maternel et HIV.** *Dr. Amsagana Boukar du Niger*
- 09h00 à 12h00 **Travaux en commission (suite)**
- Bailleurs de fonds et animateurs disponibles pour des discussions individuelles avec les éléments nationales, sur la planification des futures étapes et les possibilités de proposition/financement/assistance technique.
- Déjeuner** (Libre)
- 14h00 à 14h30 **Présentation du rapport des travaux du 4ème jour**
- 14h30 à 15h30 **Rapport des travaux en commission**
- 15h30 à 16h00 **Conclusions et recommandations du forum (en réponse à la Déclaration d'Innocenti)**
- 16h00 à 16h30 **Les actions proposées: Président**
- 16h30 à 17h00 **Séance de Clôture**
- 17h00 à 17h30 **Présentation finale et ratification des recommandations**
- 19h00 à 20h30 **Réception**

APPENDIX TWO

List of Participants



Liste des participants qui ont assisté au Forum
International pour l'Afrique Francophone
"Alimentation du Nourrisson et Survie de l'Enfant"
du 9 au 13 septembre 1991 à Lomé, Togo.



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APPENDIX THREE

*Innocenti Declaration on the Protection, Promotion,
and Support of Breastfeeding*

INNOCENTI DECLARATION

On the
Protection, Promotion
and Support of
Breastfeeding



1 August, 1990
Florence, Italy

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RECOGNISING that

Breastfeeding is a unique process that:

- provides ideal nutrition for infants and contributes to their healthy growth and development;
- reduces incidence and severity of infectious diseases, thereby lowering infant morbidity and mortality;
- contributes to women's health by reducing the risk of breast and ovarian cancer, and by increasing the spacing between pregnancies;
- provides social and economic benefits to the family and the nation;
- provides most women with a sense of satisfaction when successfully carried out; and that

Recent research has found that:

- these benefits increase with increased exclusiveness¹ of breastfeeding during the first six months of life, and thereafter with increased duration of breastfeeding with complementary foods, and
- programme interventions can result in positive changes in breastfeeding behaviour;

The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers' meeting on "Breastfeeding in the 1990s: A Global Initiative", co-sponsored by the United States Agency for International Development (A.I.D.) and the Swedish International Development Authority (SIDA), held at the Spedale degli Innocenti, Florence, Italy, on 30 July - 1 August 1990. The Declaration reflects the content of the original background document for the meeting and the views expressed in group and plenary sessions. It represents the general consensus emerging at the meeting but not necessarily the individual views of each participant.

WE THEREFORE DECLARE that

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

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

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

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

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

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

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

²World Health Organisation, Geneva, 1989.

OPERATIONAL TARGETS:

All governments by the year 1995 should have:

- appointed a national breastfeeding coordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations;
- ensured that every facility providing maternity services fully practises all ten of the *Ten Steps to Successful Breastfeeding* set out in the joint WHO/UNICEF statement² "Protecting, promoting and supporting breast-feeding: the special role of maternity services";
- taken action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety; and
- enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

We also call upon international organizations to:

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

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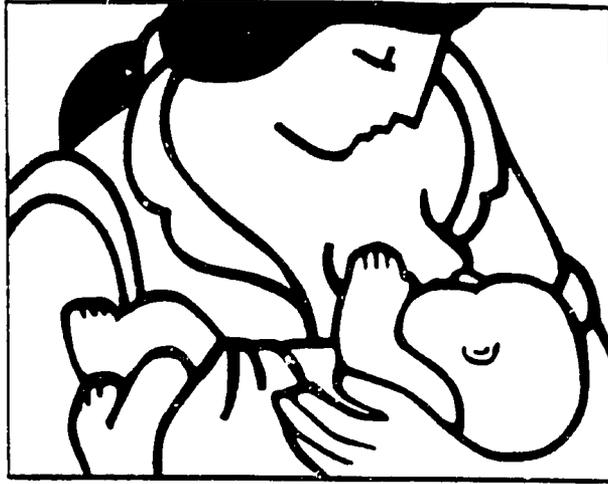
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APPENDIX FOUR

Ten Steps to Successful Breastfeeding



**Every facility providing maternity services and care
for newborn infants should follow these**

Ten steps to successful breast-feeding

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

From: **Protecting, Promoting and Supporting Breast-feeding: The Special Role of Maternity Services**
A Joint WHO/UNICEF Statement



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APPENDIX FIVE
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