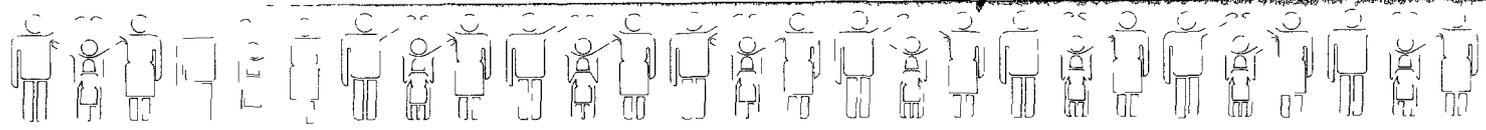


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**INSTITUTE ISSUES REPORT  
# 5**

**BREASTFEEDING POLICY: The Role of  
U.S.-Based International Organizations**

**Report of a panel presentation at the  
NCIH ANNUAL MEETING,  
June, 1989**

University of Pittsburgh, Graduate School of Public Health

Los Angeles Regional Family Planning Council

A

Institute Issues Report #5 Breastfeeding Policy The Role of U S -Based International Organizations May, 1990

Edited by John T Queenan, M D , Miriam H Lobbok, M D , M P H and Katherine Krasovec, Sc D , M A

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## FOREWORD

What could be more natural than breastfeeding your child? And yet in industrialized nations this practice is commonly thwarted and obstructed by manufactured formulas. In lesser developed countries, breastfeeding is even more important because of the widespread problems of poor nutrition, diarrheal diseases and need for promotion of child spacing.

We are in the midst of a worldwide enlightenment—the re-recognition of the importance of breastfeeding for the health of both the mother and the child. As international institutions based in the United States, we have a very special responsibility. We are one of the richest and healthiest nations in the world, but we are hampered by a very special handicap. In the United States, we have not as yet created a universal atmosphere that encourages and supports women in a decision to breastfeed. This creates a major question: How can we convince others to do what we have not yet succeeded in doing ourselves?

This panel on Breastfeeding Policy: The Role of U.S.-Based Organizations was brought together to address how we might proceed. I believe the content of this Institute Issues Report will be of interest to policy makers and program planners alike.

We invite your consideration and comments as we attempt to respond to the need for health for all. (See Page 50)

Miriam Lobbok, Georgetown University

## EVOLUTION OF POLICY RELATED TO BREASTFEEDING AT THE AGENCY FOR INTERNATIONAL DEVELOPMENT (A I D)

Melanie Marlett, Ph D  
Food and Nutrition Policy Advisor  
Bureau for Program and Policy Coordination, A I D

The "infant formula controversy" which emerged in the late 1970's and early 1980's brought about a heightened awareness on the part of people and governments of the issues related to breastfeeding. Scientific information was sought and opinions solicited. As a result of this controversy, policies on breastfeeding required conscious decisions. However, until recently, few developing countries had formal explicit breastfeeding policies. Health professionals lacked knowledge about breastfeeding and therefore continued with practices which were detrimental to the well-being of the child. Rapid urbanization, industrialization, and modernization were taking place, and breastfeeding practices were changing dramatically, especially in urban areas. As infants were deprived of the optimum nutrition and immunological benefits of breastmilk, morbidity and mortality increased. The contraceptive benefits of lactation were lost as well.

In response to these concerns, A I D strengthened its breastfeeding efforts. A I D breastfeeding policy has evolved from a number of different perspectives. The A I D Nutrition Policy paper (1982) explicitly states that, "It is the policy of A I D to support breastfeeding and proper infant feeding practices." Because breastfeeding has an effect on fertility, health and nutritional status, three different sectors have been directly involved in the formulation of breastfeeding policy within the Agency.

The breastfeeding policies and strategies for the Health, Nutrition and Population sectors all have the common goals of optimizing (1) child survival efforts, (2) the contraceptive effects of breastfeeding, and (3) the health of the mother. The summary of policies presented today is a summary of written policy and strategy statements which are supported by research from within and outside the Agency.

The aim of A I D breastfeeding policy is to incorporate breastfeeding into sector plans and to base programs on country-specific conditions. The A I D Child Survival Strategy incorporates breastfeeding into interventions in (1) the control of diarrheal disease, (2) nutrition, and (3) birth spacing. Breastfeeding interventions in the A I D strategy for nutrition in Child Survival include (1) supportive birthing and hospital practices, (2) improved information and support for health personnel and breastfeeding mothers, (3) integration of breastfeeding promotion with oral rehydration therapy (ORT), (4) integration of breastfeeding promotion with family planning programs, (5) community support, and (6) legislative and policy initiatives.

A I D policies are based on scientific knowledge and shared experience and have

resulted from open debate and discussion. AID strives to create breastfeeding policies and strategies based on a solid and up-to-date information base, with maximum participation of all interested groups, and stimulation of open debate on emerging issues.

The research which AID draws upon to formulate policies and strategies supports breastfeeding practices which reduce infant malnutrition, morbidity and mortality, contribute to longer birth intervals and enhance the psycho-social and physical health of mothers. The Nutrition Section of the AID Child Survival Strategy states that "Breastfeeding best conveys these benefits when done frequently, consistently, and exclusively (without additional fluids, semi-solids or solids) for the first 4-6 months. In the second six months of life and beyond, breastfeeding continues to provide a measure of benefits and should be continued with complementary foods." AID promotes these practices in conjunction with supportive services for working women. This will allow the mother to carry out breastfeeding while maintaining her normal activities.

A number of centrally-funded projects have been developed to support breastfeeding. These are: (1) the Science and Technology/Nutrition-supported projects include Women and Infant Nutrition, and Nutrition Education and Communication Field Support, (2) the Science and Technology/Health-supported projects including, HEALTHCOM, PRITECH, and MOTHERCARE, (3) the S&T/Population-supported projects including, Natural Family Planning Project, (4) the Bureau for Food for Peace and Voluntary Assistance-supported projects including, La Leche League, and MCH feeding program.

In terms of country field programs supporting breastfeeding, a review of the database indicates that there are 59 countries reporting long term AID projects with child survival activities. Of those 59 countries, 30 countries report 72 projects with a breastfeeding component. Of the 72 projects with a breastfeeding component, 47% are being implemented by local private voluntary organizations (PVOs). Of these 72 projects, 16 reported a national scope while 53 reported a less than national scope. Of the 53 projects with breastfeeding components reporting less than a national scope, 7 are located in urban areas, 14 in mixed urban-rural areas, and 32 in rural areas.

It is difficult to estimate the dollar value which can be attributed to AID breastfeeding promotion. In addition, there is no qualitative data on the impact of these activities at the prenatal, delivery and postpartum stages. Nor is there information on how these activities relate to other donor-supported or host government breastfeeding programs or policies. Little is known about the quality or the impact of AID-assisted projects with breastfeeding components. It will be necessary to evaluate a select number of these activities to determine their effectiveness and how they might be strengthened.

AID can look at strengthening existing field and centrally-funded projects which address or have the potential to address breastfeeding. In addition, the Agency can look at new initiatives. Suggested strategies for mobilizing resources to support increased activity are:

- strengthening current centrally-funded projects, and/or

- mobilization of nutrition, health, and population funds to formulate a "BREASTTECH" project which focuses on strengthening breastfeeding interventions

## ANNEX

### A. Excerpts from A.I.D Policy Papers

#### **Nutrition Policy Paper**

"It is the policy of A I D to support breastfeeding and proper infant feeding practices "

"Traditionally infants were breastfed for two or more years but now 'modern' women bottle feed their infants, often without knowing enough about the nutritional needs of infants. Babies fed barley water, cornstarch gruels, and diluted infant formulas, often prepared with unsafe water and contaminated utensils, may die before their mothers find out how to feed them properly. The more serious problem in rural areas is late introduction of complementary foods to breastfed infants. Proper complementary feeding of the weaning child is often a problem of dietary practices, home food preparation and preservation constraints, and other demands on women's time. A more multifaceted approach, going beyond breastfeeding promotion and food availability is therefore often required. Nutrition education, including encouragement of breastfeeding, improved child feeding practices, food fortification, and strong national nutrition policies, can avert these negative nutritional impacts "

#### **Population Assistance Policy Paper**

##### **Natural Family Planning**

"A I D missions have been informed of this legislative amendment and of A I D 's intention to see that natural family planning methods, defined to include all those methods which rely on periodic abstinence, are integrated into all relevant forms of population assistance, including research, training, service delivery and information programs, wherever this is appropriate to the culture and desires of the recipient population and its government "

"A I D gives preference in its funding to programs which provide a wide range of choices in family planning methods (excluding abortion) and strongly encourages such programs to include information and/or services related to methods of natural family planning "

##### **Health Assistance Policy Paper:**

"Children saved from death due to measles or diarrheal dehydration may succumb, however, to the next disease episode especially if nutritional status is low. Concurrent efforts to reduce malnutrition through a focused nutrition package including breastfeeding, feeding during and after diarrheal episodes, good weaning practices, a growth monitoring and supplementary feeding programs where appropriate can help prevent this 'replacement mortality' effect "

"Improved maternal health as a result of better nutrition also affects child survival through breastfeeding and the mother's ability to provide better child care "

"Improving nutrition in young children through adequate breastfeeding and improved weaning practices, growth monitoring, and targeted supplementary feeding (using PL 480 Title II resources and programs when available) "

## **B A.I.D Strategy Papers**

### **The A.I D Child Survival Strategy Statement.**

Background "A I D has been funding activities aimed at child survival for a number of years In FY 1985, additional funds appropriated by Congress for child survival and related health programs allowed A I D to accelerate its efforts to improve the health of children in A I D -assisted countries In FY 1986, Congress again appropriated additional funds for child survival For FY 1987 A I D requested a separate Child Survival account Funding for child survival also comes from many other accounts including health, population, economic support fund (ESF), agriculture, Sahel, and PL 480 In future years funding will continue to come from a variety of agency accounts reflecting the multi-disciplinary requirements of this strategy "

### **Selective interventions in the Child Survival Strategy which incorporate breastfeeding**

- 1 **Control of Diarrheal Disease** - "Appropriate nutrition interventions in addition to fluid therapy, especially dietary management of diarrhea (**breastfeeding**, feeding during episodes, refeeding) and appropriate hygiene interventions, especially sanitation education "
- 2 **Nutrition** - "Promotion of exclusive breastfeeding to 4-6 months to reduce the probability of infectious disease, diarrhea and associated weight loss " "Promotion of proper weaning practices including the introduction of solid foods between 4 to 6 months, with continuation of breastfeeding " (Editor's Note New guidance is being prepared by A I D at time of publication )
- 3 **Birth Spacing** - "Promotion of appropriate breastfeeding "

### **Nutrition Strategy for Child Survival**

The Nutrition Strategy for Child Survival states that breastfeeding provides (1) immunological protection for infants, (2) a complete, uncontaminated food for four to six months, (3) an excellent source of digestible protein and other nutrients for older infants and young children, (4) an ideal food during diarrhea which nourishes and reduces severity and

duration of episodes, (5) a significant cost savings over alternative milk for infants, and (6) more months added to birth intervals in the developing world than all modern contraceptives combined

"Breastfeeding best conveys these benefits when done frequently, consistently, and exclusively (without additional fluids, semi-solids or solids) for the first 4-6 months. In the second six months of life and beyond, breastfeeding continues to provide a measure of benefits and should be continued with complementary foods." AID promotes these practices in conjunction with supportive services for working women. This will allow the mother to carry out breastfeeding while maintaining her job

Interventions under the Nutrition Strategy for Child Survival are

- 1 Supportive birthing and hospital practices
- 2 Improved information and support for health personnel and breastfeeding mothers
- 3 Integration of breastfeeding promotion with ORT. Breastmilk is the single best food to promote for feeding during and refeeding following diarrheal episodes
- 4 Integration of breastfeeding promotion with family planning programs. Frequency, consistency, and exclusivity of breastfeeding for the first four to six months must be taught to mothers
- 5 Integration of breastfeeding promotion with immunization. Disease prevention properties of breastmilk are recognized in almost every culture, and research has confirmed these effects
- 6 Community support, including mother support groups and health systems support
- 7 Legislative and policy initiatives. Breastfeeding practices are affected by legislation and policies related to working women, marriage, urbanization, marketing of breastmilk substitutes, family planning, public health and hospital services and child welfare. Information dissemination, policy dialogue, and communication among representatives of various sectors can accelerate the process of institutionalizing policies and programs which protect breastfeeding

### **The A.I.D Child Spacing for Child Survival Strategy**

"Many women need to receive support for exclusive breastfeeding early in the postpartum period. Mothers need to know to breastfeed frequently, consistently and exclusively (without additional fluids, semi-solids or solids) for the first 4-6 months. Supportive birthing and hospital practices such as continuous contact between mothers and infants following birth (such as rooming in), immediate initiation of breastfeeding, and breastfeeding education are

associated with better and longer breastfeeding practice. A common rule is that women need to consider using some form of family planning by three to six months postpartum.

### **The A.I.D Diarrheal Disease Control for Child Survival Strategy**

Programs should stress efforts to promote proper dietary management of diarrhea in the home and in health facilities along with the promotion of proper fluid management. This should include breastfeeding continuation, feeding during episodes, and extra feeding during recovery.

## PRIVATE VOLUNTARY ORGANIZATIONS AND BREASTFEEDING POLICIES

Sandra L. Huffman, Sc D  
President, Center to Prevent Childhood Malnutrition

Policies affecting breastfeeding range from legislation authorizing funding levels for components of Foreign Aid activities to guidelines affecting hospital practices. Private Voluntary Organizations (PVOs) can affect policies through their role in education of Congress, support and evaluation of breastfeeding promotion projects, research on determinants and consequences of breastfeeding and information dissemination about breastfeeding programs.

### **Legislative Affairs**

Many PVOs, such as CARE and Planned Parenthood, have specific divisions responsible for legislative affairs. Other PVOs work through technical staff to educate Congress about the need for funding in particular areas. A good example of the ability of PVOs to influence legislation is the Congressional set asides for support for Vitamin A in the AID's Child Survival program. In FY 1988, \$8 million was set aside for programs to enhance Vitamin A consumption. PVOs, especially those involved with Vitamin A deficiency prevention programs, did an excellent job of educating Congress on the role of Vitamin A in reducing mortality.

PVOs were also effective in their advocacy of enhanced funding for child survival activities. This led AID to allocate over \$170 million on Child Survival activities in FY 1988. The distribution of these funds however, illustrates AID's perception of the role of various child survival activities in preventing mortality. Although the role of breastfeeding in preventing diarrhea is well acknowledged, AID's budget for ORT, primarily a treatment for diarrhea, was \$38 million in contrast to only \$2 million for specific breastfeeding promotion activities. This suggests that more needs to be done to influence policy makers on the role of breastfeeding in reducing child deaths.

As with the total Child Survival Program, PVOs can influence the intent of Congress in how AID should prioritize expenditures for health activities. This can be done through testimony given on Capitol Hill, letters sent to Congressional representatives (especially those serving on relevant Congressional committees such as the Foreign Operations Committee, Select Committee on Hunger, etc.), phone conversations with Congressional aids or better yet, the Senators and Representatives themselves. A problem faced by PVOs without specific legislative affairs offices is that of knowing who to call. An important resource is the annual Congressional Yellow Book, which gives a directory of members of Congress, the Committees they serve on, and the key staff aides.

## **Support and Evaluation of Breastfeeding Projects**

Many PVOs support projects that directly influence breastfeeding practices. Only through the evaluation of these activities, will information be available for policy makers to influence their decisions on what activities should be supported. For example, the PROALMA project in Honduras, run by a local PVO, was one of the few breastfeeding promotion projects that included a well planned evaluation and thus was able to show substantial increases in the duration of breastfeeding, and to measure hospital savings due to the program. This type of information is needed when policy makers make decisions on how best to distribute limited funds.

## **Research on Determinants and Consequences of Breastfeeding**

The World Health Organization is currently supporting strategies to increase breastfeeding as a component of the CDD (Control of Diarrheal Diseases Program) (WHO, 1988). This in part comes from the results of several recent research projects in Brazil, Peru and other countries illustrating the greatly reduced risk to breastfed infants compared to those also receiving supplements and those not being breastfed (Victora *et al* , 1986, Brown *et al* , 1989). The research on the effects of Vitamin A deficiency on mortality also illustrates the importance of research affecting policy. While we have known for years the effect of Vitamin A deficiency on blindness, it was the research showing the impact on mortality, that led to increased funding for vitamin A programs.

Research conducted as part of the Demographic and Health Surveys, the World Fertility Survey, and the many Contraceptive Prevalence Surveys, illustrate trends in breastfeeding and provide important information on where breastfeeding programs are especially needed. PVOs, through small scale surveys and through close contact with communities, can supplement the results of these studies with more information on practices and factors associated with those practices. The four country study conducted by the Population Council, led to programs to promote breastfeeding. For example, an important precursor to the development of the Bangkok Breastfeeding Promotion Project was a research project to assess determinants of breastfeeding in the Bangkok area (Winikoff *et al* , 1988). The study, funded by A I D , was conducted by the Population Council and implemented by the Mahidol University School of Public Health. The study concluded that health care providers played an important role in determining breastfeeding patterns in Bangkok. In response to the results of this study, the Bangkok Breastfeeding Promotion Project was implemented in 1984.

## Information Dissemination:

While most policy makers will acknowledge the benefits of breastfeeding, there has been little explicit emphasis given to the support of specific activities to promote breastfeeding. We have lessons to learn from the manner in which information is provided to policy makers on ORT (UNICEF, 1988) **IT WAS MADE SIMPLE**

*Diarrhea kills 5 million children each year through dehydration  
ORT prevents dehydration  
ORT can save 5 million children*

It does not matter that the distribution and use of ORT solution is not simple or in fact that not all diarrheal deaths are due to dehydration. What was and remains important is that it is perceived as an easy, do-able intervention with a high return.

We have not done this in the dissemination of information on breastfeeding promotion. We need to simplify the message in a similar way, for example:

*Malnutrition kills 5 million children each year  
Diarrhea kills 5 million children each year  
Acute respiratory infections kill 3 million children  
Breastfeeding prevents malnutrition, diarrhea and ARI  
Promoting breastfeeding can save 7 to 10 million lives*

It does not matter that there are competing risks of death, or that there is no single means to promote breastfeeding. If funds are made available, then within each country's individual context, appropriate breastfeeding promotion activities can be developed. But until policy makers come to accept breastfeeding (and thereby appropriate weaning practices) as an essential and equally important component of Child Survival and Primary Health Care programs, such programs will continue to be under-funded.

Thus, information needs to be focused on the types of information that policy makers can use. This means illustrating that breastfeeding promotion will save lives, that it can be done successfully (and has been shown to do so) and that it is cost-effective.

## Summary:

PVOs need to continue to support breastfeeding promotion projects, but they need also to ensure that adequate evaluations of these projects are conducted. Information on the impacts of such projects and their cost-effectiveness must then be disseminated to policy makers in the U.S. (including Congress) and within the individual developing country in a convincing manner. In this way, PVOs can affect child health beyond their impacts within their respective projects.

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## BELLAGIO CONSENSUS MEETING A MODEL FOR HEALTH POLICY DEVELOPMENT

Kathy I Kennedy  
Family Health International

It has been suggested that the Bellagio Consensus Meeting on the use of breastfeeding for family planning can be a useful model of the development of health policy. A discussion about the Bellagio consensus **process** and about the events that have occurred since the conference can take the form of 7 questions with responses oriented toward the development of policy.

- I What is the Bellagio Consensus?
- II Why did FHI organize the consensus conference?
- III How was the conference organized?
- IV What elements were key to the consensus process?
- V What attempts were made to change research into policy?
- VI How will we know that policies have changed?
- VII Was the consensus conference a success?

### I. What is the Bellagio Consensus?

In August, 1988, a group of 25 researchers from around the world was assembled in Bellagio, Italy. Their names, countries and affiliations can be found in the "Consensus Statement on the Use of Breastfeeding as a Family Planning Method," (Kennedy *et al* , 1989). These scientists had been studying the hormones involved in the recovery of ovulation following pregnancy in both developed and developing countries, in order to learn about how and when breastfeeding women become fertile again. The single purpose of the meeting was to see whether these people could agree on a level of protection from pregnancy provided to women by breastfeeding.

The group came to an agreement which stated that

*"During full or nearly full breastfeeding as long as the mother remains in amenorrhea, then for up to a full six months, she will have 98% protection from pregnancy."*

This is the essence of the Bellagio Consensus.

## II Why did FHI organize the consensus conference?

Many of the researchers who study breastfeeding and fertility are accomplished scientists, interested in sharing ideas and information. They share a degree of trust, which has led to a great deal of communication. These scientists were intimately aware of each other's work, and most of them had previously met.

A year before the conference it was clear that these colleagues had generated new data and were in the position to draw conclusions about the contraceptive effect of breastfeeding. Because of the openness among these researchers we knew what a lot of their conclusions were, even before they were published. Some conclusions were consistent across studies, some were not. We were certain that a plateau in the level of new information had been achieved. We could wait another 5-10 years for a generally accepted interpretation of all the studies to emerge from the literature or else we could facilitate that process. We chose to do the latter!

## III How was the conference organized?

FHI submitted a proposal to the Rockefeller Foundation to hold the week-long Consensus Conference at Bellagio, and our proposal was accepted. When assembling people from five continents any location will do, but importantly Bellagio, Italy was "home" to none of us. All participants were away from their offices and were our captive audience. We were to be assembled for one purpose only, and the objective was very clear. Fortunately our colleagues at WHO were also very keen on the success of this meeting, and WHO shared transportation costs. The remainder of the expenses were paid for by FHI with funds from AID.

There were months of behind-the-scenes work, both before and after the conference. Participants were asked to accept our invitation on the condition that they would continue to share information and to regard each other's data as confidential. There was a large volume of reading - of both published and unpublished data - which was required prior to the conference. In effect, half of the work of coming to consensus occurred before the meeting even began. With a common knowledge base, the group was then able to resolve whether there was enough consistency among these studies to make a generalization about contraceptive protection.

The consensus statement was drafted immediately following the meeting and the tedious process of obtaining the concurrence of the scientists began one week after the meeting adjourned. By mail, by phone and by FAX we crossed the t's and dotted the i's. In less than three months, the consensus was in print in The Lancet.

#### IV. What elements were key to the consensus process?

Several important factors have been identified thus far

- one, singular, very clear objective
- good rapport among the participants
- more cooperation than competition
- timeliness of the topic with respect to data collection
- endorsement of the importance of this concept by FHI, AID, WHO, and Rockefeller
- no interruptions or distractions
- intensive pre-meeting preparations, such as required readings
- rapid production of the consensus documents

Two additional elements can be introduced here, the consensus itself is **scientifically sound** and that the Bellagio recommendations are oriented toward **real** people, **real** programs and **real** problems

**Scientifically sound** In fact it is slightly disappointing that the consensus is really nothing new. We have known for almost 20 years that not more than 10% of women will conceive during lactational amenorrhea and that amenorrhea can last from two months postpartum to two years postpartum. If we modify this common knowledge with a restriction that a woman must be nearly fully breastfeeding and limit the period of protection to the first 6 months postpartum, then the 10% becomes a more acceptable 2%. The researchers at Bellagio come to **their** conclusions based on prospective studies measuring ovarian hormone levels to tell them when the first postpartum ovulation occurred. In a far more rigorous fashion, then, the Bellagio conclusion supports the earlier suggestions from studies with less rigorous study designs.

**Practical orientation** Not only is the consensus scientifically sound, but the Bellagio recommendations include respect for human rights and education because it calls for breastfeeding education to be a part of informed choice of contraception " women should be offered a choice and informed of how to use it " The recommendations embrace improvement in the status of women. The consensus also allows room for growth in terms of new research findings, creative ways of using the consensus information, and conditions for applying the consensus beyond six months. "Ongoing research should continue to measure a broad spectrum of variables so that these guidelines may be refined as new information becomes available. Local infant feeding practices, the average duration of amenorrhea and the ongoing changes in women's status and health practices should be considered in adapting these general guidelines. It is possible that these general guidelines can be extended for a period of beyond six months "

In sum, the consensus is scientifically sound, but there is also wisdom beyond the synthesis of numbers in the Bellagio recommendations. The scientists could see the practicality of their work and perceived the programmatic applications as well. Many of

them wore two hats - clinicians or administrators as well as researchers. They did not get lost in the details of their data, but focused on the practical utility of their research.

#### V **What attempts were made to change research into policy?**

There is often an abyss between clinical research and health policy. Researchers are not trained in how to convince politicians and others that certain policies should be endorsed. Instead what they try to do is to publish. Fortunately, many groups have been interested in publishing the consensus. They may be interested because the consensus is valid, because it is newsworthy or maybe because the use of breastfeeding for family planning was formerly taboo - so the consensus is also controversial. I feel certain that the association with, if not the endorsement of FHI, A I D , WHO and Rockefeller had something to do with the interest in the consensus shown by international health organizations.

The first and the official summary of the consensus was published in The Lancet. The Lancet is one of the most prestigious medical journals in the world, read in most countries in the world, with a circulation to 42,000 subscribers. Many of these subscribers are libraries, so the readership may be in the hundreds of thousands or more.

The official full consensus report was published in Contraception, an international journal with a circulation of about 1000. Again a large number of these subscribers are medical and population libraries here and in developing countries.

Both The Lancet and Contraception have given FHI permission to translate the documents into Spanish and French, and some have already been distributed. The consensus has also been covered as a news story in several newsletters of population or health organizations.

FHI's newsletter NETWORK has reached 9000 researchers, clinicians and policy makers, in three languages.

WHO's newsletter Progress carried the consensus as a cover story. The newsletter is relatively new, but 4,200 copies circulate in 124 countries.

The American Public Health Association has a Clearinghouse in Infant and Maternal Nutrition. They carried the Bellagio consensus as a feature story with a whole supplement on the topic in their newsletter. It is called Mothers & Children, and has a circulation in three languages of about 30,000.

The International Planned Parenthood newsletter People also carried an article about the consensus. Their circulation is highly relevant and about 22,000.

We recently gave a telephone interview to Contraceptive Technology Update, an influential newsletter in the U S with a circulation of about 1,700.

When professional organizations such as IPPF and APHA disseminated information on the consensus to their constituents, these were not endorsements. Yet recognition of the consensus through these groups still gives the consensus greater credibility.

The consensus information was also given at several relevant professional meetings. WHO's director of the Special Program in Human Reproduction was the first to publicly introduce the consensus and to encourage action on it. This was at the October, 1988 meeting of FIGO, the International Federation of Gynecology and Obstetrics. The consensus has been presented at at least a dozen more professional meetings, and the invitations keep coming.

One of the Australian participants has given 15 presentations about the consensus to medical and family planning professionals around Sydney. She has managed to change family planning counseling procedures and pamphlets at Westmead, one of the largest hospitals in the Sydney area.

One of the first principles of marketing is people are most likely to buy your product if they try a free sample. We have not yet figured out how to turn the Bellagio consensus into free samples, but the second principle is that if your product is relevant to a person, then he or she is next most likely to buy your product if they hear about it three times. That's why we see the same television commercials over and over. The same beer commercials are shown during Monday night football and the same detergent commercials during the mid-day serials. Likewise, it can be very effective if many of the same health and population professionals read or hear about the Bellagio consensus in more than one newsletter, conference or journal, in fact it maximizes the likelihood that they will "buy" it.

## **VI. How will we know that policies have changed?**

It is probably useful to distinguish among various levels of policy, such as international endorsement, national policies or legislation and operational policies, such as those that guide an organization or a hospital or clinic. International endorsement has been discussed and the support of UNICEF must be added. UNICEF participated in the meeting and actively encourages its members to use the Bellagio guidelines. On a national level, Indonesia has included instructions on the use of breastfeeding as a family planning method in its government family planning programs. At several international meetings of family planning and MCH program leaders the Consensus has been introduced and program implementation explored. Some examples are the meeting of all A I D Cooperating Agencies that work in family planning for the Office of Population. There were international breastfeeding promotion meetings sponsored by The Institute for International Studies in Natural Family Planning at Georgetown University and by NCIH. The Institute for International Studies in Natural Family Planning should be commended for its efforts to actualize operational policies to integrate breastfeeding into family planning programs. Westmead Hospital is an example that such changes in operational policy have already occurred.

Policies have changed, but perhaps more importantly, tools have been created to help people make policy changes. INTRAH, the Program for International Training in Health, has produced its 1989 Guidelines for Clinical Procedures in Family Planning and Sexually Transmitted Diseases (STDs). This is a comprehensive reference, a how-to book, for trainers. This procedure manual is widely used in several areas of the developing world. This means that the step-by-step instructions now exist about how to impart this contraceptive technology to real women. The Institute for International Studies in Natural Family Planning has developed "Guidelines for Breastfeeding in Family Planning and Child Survival Programs". These guidelines can be used by program managers to plan and to integrate a breastfeeding component into existing services.

Population Reports, published by the Population Information Program at Johns Hopkins University, is an authoritative compendium of important developments in the family planning field. Population Reports is read by researchers and administrators alike, and the most recent report on low dose oral contraceptives relied heavily on the Bellagio Consensus for its instruction on when lactating women should begin using mini-pills. Between this proliferation of the Bellagio recommendations and the anticipated inclusion in Contraceptive Technology, changes in many more operational policies are anticipated.

## VII Was the consensus conference a success?

It would appear that many people know about the consensus and some are acting on it. But are family planning professionals ready to **accept** the guidelines? Some are and some are not. Last year family planning providers would never have suggested that women rely on breastfeeding for family planning, even for six months. Now, we are asking people to **think** differently, and **act** differently, and that is a very difficult thing to do! In helping people to form their policies, the Bellagio Consensus has three major strengths: high visibility -- the message is in popular places, high credibility -- distinguished experts made a legitimate statement, and endorsement at high levels -- A I D , WHO and other important MCH and population groups.

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**INSTITUTE FOR INTERNATIONAL STUDIES IN NATURAL FAMILY PLANNING  
A UNIVERSITY-BASED ORGANIZATION'S ROLE IN BREASTFEEDING POLICY**

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The Institute for International Studies in Natural Family Planning (IISNFP) is entering its fifth year. Based in the Department of Obstetrics and Gynecology at Georgetown University, with collaborators at University of Pittsburgh Graduate School of Public Health and Los Angeles Regional Family Planning Council, IISNFP has been greatly involved in the promotion and support of Natural Family Planning methods. There is currently an increasing emphasis on breastfeeding as a natural method of fertility regulation. To this end, IISNFP has reformulated its strategy in breastfeeding to concentrate on three areas: policy change, health care provider development, and programmatic support for the introduction of the "lactational amenorrhea method" (LAM), derived from the Bellagio Consensus Statement.

First, as a University-based organization, we are in a unique position to interact with other universities worldwide and to enter into the technical dialogue that often precedes major policy and academic change. We are capitalizing on this position in research collaboration to demonstrate the feasibility and efficacy of breastfeeding intervention programs and to develop new curricula for health professionals that are promotive and supportive of, and compatible with optimal breastfeeding.

Second, IISNFP is participating in breastfeeding policy through the development, publication and dissemination of a series of Institute Issues Reports of interest to policy and program decision makers (see "Partial Listing of Planned Documents", p. 21). We also are collaborating with the IMPACT project in the development of a breastfeeding booklet for policy-makers entitled "Breastfeeding: Protecting a Natural Resource". The documents listed on p. 21 can be ordered from the IISNFP using the form provided on p. 30.

Third, we hope to create and support policy enhancement through our role as Technical Secretariat to the Interagency Group for Action on Breastfeeding (IGAB), which will be described in detail by Margaret Kyenkya. This group may be the catalyst for worldwide change in breastfeeding policy as it proceeds to develop an "International Breastfeeding Strategy for the 1990s". Also, we were active participants in the Interagency Group for Action on Breastfeeding meeting on Definitions for Breastfeeding. The definitional schema that was developed at that meeting allows a differentiation between levels of full breastfeeding and among levels of partial breastfeeding.

A University base has strengths and weaknesses, but a major benefit is that it confers a certain acceptability and recognition of academic excellence and open collegial exchange.

on our efforts in breastfeeding. We believe that this will help us in our strategy to improve breastfeeding policy through information and policy support.

## Partial Listing of Planned Documents

Institute Issues Report No 1	Outreach Strategies for Natural Family Planning
Institute Issues Report No 2	Cost-Effectiveness Analysis Natural Family Planning and Breastfeeding Programs
Institute Issues Report No 3	Report of the Working Group Meeting on Psychosocial Issues in Natural Family Planning
Institute Issues Report No 4 and IGAB Expert Meeting 1	Breastfeeding Definitions
Institute Issues Report No 5	Breastfeeding Policy The Role of U S -Based International Organizations
IGAB Expert Meeting No 2	Proceedings of the Interagency Workshop on Health Care Practices Related to Breastfeeding, <u>International Journal of Gynecology and Obstetrics</u> 31 (Suppl 1) 1-191, 1990
IGAB Expert Meeting No 3	Mother Support Groups

## Glossary of Natural Family Planning Terms

Breastfeeding Protecting a Natural Resource

Guidelines Series No 1 Guidelines for Breastfeeding in Family Planning and Child Survival Programs

Numerous scientific journal articles on Natural Family Planning and Breastfeeding

## THE INTERAGENCY GROUP FOR ACTION ON BREASTFEEDING DONOR TO DONOR COOPERATION FOR POLICY ENHANCEMENT

Margaret Kyenkya-Isabirye  
Infant Feeding Advisor, UNICEF

UNICEF, with its goals of GOBI (Growth Monitoring, Oral Rehydration Therapy (ORT), Breastfeeding and Immunization), has long supported breastfeeding. The development of a renewed international focus on breastfeeding began in 1984-85, and UNICEF continued its advocacy efforts in the development of national and international accord. Donor agencies also became acutely concerned that little programming and few resources were being directed toward breastfeeding. Since that time, there has been an increase in breastfeeding activities in the donor community. In 1987, UNICEF and WHO sponsored the first meeting of the Interagency Group for Action on Breastfeeding (IGAB). Participants included technical people, mainly from UNICEF, WHO, USAID, and SIDA, whose jurisdictions, or whose jobs, included nutrition, and who were concerned that they were not getting the support they needed from their agencies to promote breastfeeding.

The first meeting, in September 1987, was mainly a brainstorming session on "What do we do to bring breastfeeding back on the agenda of agencies and on the agenda of governments?" We agreed that there had been a great deal of focus on regulating marketing of infant formula. We also agreed that while we needed to continue to advocate international accord, it was also very important to review what had been done in other areas to promote breastfeeding. For example, did we know what activities had succeeded in promoting breastfeeding, both at global and national levels? Our review at the agency level found that there were numerous small activities with little financial support, usually being implemented by private voluntary organizations, that were having some impact on breastfeeding promotion. But the agencies themselves did not strongly support breastfeeding programs as mainstream activities.

Our next step was to undertake an interagency needs assessment. Our goals were to first decide what current resources were being utilized, and second, to determine how to coordinate and incorporate new resources and ideas. We decided that we should aim for a global event on breastfeeding, where we would present the assessments of various sectors, as well as strategies for the 1990's for each agency.

As a group, we were interested in understanding the reasons for limited success in breastfeeding activities in developing countries, given the great deal of commotion that had been made about breastfeeding in the 1980's. We determined that part of the problem was within our own agencies, since we had very few concrete examples of "success stories." What had been done was not documented, so it could not be used to influence policy makers or programmers or encourage other funders to provide additional funds for breastfeeding activities.

Another problem that we had was that the countries that we worked with were not convinced that breastfeeding was a problem, since by their statistics, 90-98% of women were breastfeeding. Yet researchers were expressing concern that the changing patterns and declines in breastfeeding could lead to major health, nutrition and fertility problems for many developing countries. We were faced with inadequate information with which to create policy awareness and policy change.

Therefore, a decision was made to define what we mean when we use the term "breastfeeding" before moving on to the task of determining what the donor agencies are doing in the breastfeeding arena. As a result of this decision, WHO developed their data bank on breastfeeding. In their review of the literature on breastfeeding, they found that breastfeeding was being defined differently by different researchers and by different organizations. There were no consistent definitions of breastfeeding behaviors. Miriam Lobbok has already described the work that IGAB has been doing to develop a consistent set of breastfeeding definitions. We hope to be able to use the schema and framework that has been developed to help clarify the findings of previous research and to better describe the range of actual breastfeeding practices that are taking place in developing countries in future surveys and research efforts.

The next task of the IGAB was to utilize this definitional schema within our own agencies in an attempt to assemble what Dr. Jim Shelton of AID called "the state of the art" in order to document whether breastfeeding promotion was, in his words, "do-able". We agreed that our objective should be to provide the support to empower a woman to choose to breastfeed, or, in other words, to convince her that breastfeeding is in her and her infant's best interest. But in order to start on the road to that objective, we first needed to compile descriptions of persons, and programs that have been successful in breastfeeding promotion in a number of countries.

In addition to its "do-ability", we also needed to demonstrate that breastfeeding can save lives. Why? Because in both AID and UNICEF, a major effort has been underway to reduce infant mortality. Even within governments, it is not very easy to prove that breastfeeding reduces infant mortality. To convince policy makers that breastfeeding is important we have to demonstrate that putting money into breastfeeding activities will reduce infant mortality. The meeting at Georgetown in December, 1988 on Health Care Practices Related to Breastfeeding brought together information on many programs which could be very useful in convincing policy makers that breastfeeding promotion efforts can reduce infant mortality. Yet, we have not yet succeeded in demonstrating this effectively to those who must decide. We need to inform our colleagues that data show that putting money into breastfeeding programs has reduced the rate of morbidity, reduced the incidence of diarrheal and respiratory disease and improved child spacing, all the things that lead to reductions in infant mortality. This is the information we need to make our case for promotion of breastfeeding.

We have begun to put together a series of significant documents: the *Proceedings of the Breastfeeding Definitions Workshop* and the *Meeting on Health Care Practices Related to*

*Breastfeeding*, Sandy Huffman's paper on *Breastfeeding and Infant Health*, the *Bellagio Consensus on Breastfeeding*, the *WHO/UNFPA/FHI/IPPF/GU-IISNFP Booklet on Breastfeeding and Child Spacing*, the *Joint Statement Protecting, Promoting and Supporting Breastfeeding*, and the *Ten Steps to Successful Breastfeeding*. We have started to distribute these documents to program people in our own agencies.

Yet we are faced with an additional problem, unless one can show concrete examples of what can be done and what the results will be, few resources will be made available on a country level for breastfeeding promotion activities. This problem can be illustrated from UNICEF's point of view. UNICEF supports country programs. The activities within country programs are determined on the basis of the situation of mothers and children in that particular country and the country's political priorities. Where statistics show that breastfeeding (undefined) is at a high rate and that infants are dying, there is no obvious link between breastfeeding rates and reducing infant mortality. Logically, no government will accept blindly whatever UNICEF or WHO or any outside organization may say. Even if they do, breastfeeding promotion will only receive token funding of about 1%.

Because of this problem, a review of countries whose breastfeeding trends have reversed was undertaken. This review was designed to assess how certain countries have managed to reverse the trends of declining initiation and shortened durations of breastfeeding in spite of the fact that there were no government level policies guiding them in this direction. In countries like Australia, the U.S., Sweden and Canada, there have been few government policies per se in support of breastfeeding, yet there has been a significant change in breastfeeding and related infant feeding practices. Some give credit to grassroots mother support groups, using the rationale that working directly with mothers in a one-to-one approach is most effective in initiating change. If this is the case, it needs to be documented and the technology transferred and made relevant for developing countries.

Although volunteer mother support groups may be extremely important, in developing countries we also must rely on existing health care services. One often hears the argument that health care services may not be optimally supportive in terms of breastfeeding promotion. Because of this argument, WHO and UNICEF decided to develop a *Joint Statement* concerning what should be done in relation to health care services. This statement should be useful for establishing policy at the global level and for targeting country level activities. To encourage health care services to begin breastfeeding promotion activities, a simpler *Ten Steps to Successful Breastfeeding* was developed. With the aid of these two documents, local level personnel can immediately begin discussion on what needs to be done for breastfeeding promotion. With these two documents, policy makers and program personnel have a concrete set of activities where they can put their support. And from these, developing a draft policy on breastfeeding becomes a relatively straight forward process.

The next focus of our efforts will be on training for health care workers so that they can implement breastfeeding policy. Implementation will not always be easy. Curricula may need to be modified, training structure may need reorganization, trainers of trainers will need to be

prepared, materials will need to be developed, etc. Eventually, the results of country programs will start to influence policy at an even higher level

The technical personnel who comprised the Interagency Group realized that we have to reach the high level policy makers. We have the information and the knowledge, but we have to reach the people who do not have the time to read documents, who have to be convinced that what we wish to promote will have an impact on their overall goals. Fortunately, all the activity of the last two years has led to a WHO and UNICEF Joint Committee on Health Policy. In 1989, one of the committee's tasks was to determine health goals for the year 2000. Within the ten goals that were established was the goal of empowering all women to exclusively breastfeed their children for 4-6 months and to continue supplemented breastfeeding well into the second year of the infant's life.

Now that UNICEF and WHO have a stated policy, the challenge is to implement it. Therefore, instead of simply working with the groups directly involved with IGAB (SIDA, USAID, UNICEF, or WHO) there is a need to involve all major organizations and agencies worldwide to assure dissemination of the existing information and policies, and to maximize networking in the breastfeeding arena. Information on breastfeeding must be moved out of textbooks and out of scientific publications, and be simplified and strengthened so that when it is presented to policy makers, they will be convinced to support our strategy.

## RESPONSE

Judith McGuire, Ph D  
Nutritionist, World Bank

I will try to respond to this rather convincing set of presentations this morning. In sum, I do not know why people are not buying it. But I think we can identify some of the elements that we should try to improve upon. From Kathy Kennedy's presentation, we understood the importance of organizing and of effectively communicating. She emphasized the need for a single clear purpose and for preparation of your participants. You must have a captive audience that is encouraged to be scientifically sound in dealing with issues relevant to real people, with practical advice. We have to keep these in mind as we are thinking about moving forward on breastfeeding, and I think the timing is right to move forward on breastfeeding. Of all the elements of nutrition, breastfeeding is the most marketable, in terms of scientific basis, in terms of its simplicity. The intervention is putting the breast in the baby's mouth, a magic-bullet intervention. It is not quite as complex as growth monitoring or even some of the other interventions such as supplementary feeding for older children.

There are a few obvious areas that come out in discussion that I think we could work on right away. At the legislative level, we need to talk about infant formula, obviously, that is an old-hat issue. We also need to think about maternal leave and employer-support for working women. An opportunity for introducing breastfeeding at the top level of the international community is at the International Meeting on Nutrition which will take place next year. This meeting, which WHO is organizing, is to be the summit on nutrition. And I think we would be severely remiss if we did not make breastfeeding one of the real keynote issues at that meeting.

In terms of operations, I think of breastfeeding as nutrition intervention. It is obvious from the presentations today that breastfeeding has become family planning, breastfeeding has become child survival, breastfeeding has even become safe motherhood. We must acknowledge this and build on it. Breastfeeding is also a food security issue. These are all buzzwords that are "hot" around Washington and other capitals, and we need to capitalize on them. We need to put together information material based on this, as Margaret Kyenkya-Isabirye says, it is do-able. We know what to do and we have a number of successful experiences that we can sell, certainly more than the ORT field had when it began. We have very effective social mobilization campaigns and very good hospital practice experiences. In mother support groups, as well, there are many successful experiences.

We need to work more on how to re-tool the health system. From my perspective, exposure to Western medical care is directly related to the fall of breastfeeding and that, in turn, is attributable to the training of health care workers. Everyone, from physicians to the auxiliaries, is not correctly trained concerning breastfeeding and there needs to be re-tooling. We need to be, in a social sense, the role models.

This applies to national leadership as well. I was pleased to hear that Benazir Bhutto breastfed, but I was distressed to hear that she did not fully breastfeed her child. I think this was a missed opportunity. If we do not have breastfeeding among prominent women, we do have an image problem that we need to address. Breastfeeding seems so often supported as traditional, rather than for the sophisticated, educated woman. This is one of the challenges before us, but we do have some problems in making this a "cause celebre" and in bringing it more into the fore. One problem is fad-fatigue, breastfeeding seems to be coming after child survival and after safe motherhood and the rest of our magic bullets. People are just sort of saying, "Yeah, yeah, I'll just wait for tomorrow's fad, I won't do anything on this one because I know there's a new one coming down the line." We do have to compete with this malaise.

Second of all, we have an unhealthy and unfortunate competition between the development of women as active economic members in society and the promotion of breastfeeding. I do not think this tension is necessary or real, but much work remains in advocacy to enhance both women's economic roles and women's mothering roles, and the promotion of their own and their children's health through breastfeeding.

Another challenge before us is making heard the economic arguments for breastfeeding. These arguments are quite strong, both from a foreign exchange point of view and from a sort of poverty/human resource/investment point of view. There are many things we could say about breastfeeding upon which we have been silent because the information has been primarily coming out of the medical community. We should get some of our economic colleagues to "buy in" and get on board.

Breastfeeding needs a champion, we really need to bring forth a leader. We need to get an institution to take the leadership role and we need to get an individual to take this on as her own cause. I do not know who that person is.

On the whole, I have been quite moved by this set of presentations. We should all take the need for support of breastfeeding quite seriously and each of us go back and work in our own ways to do something different. I hope that the Interagency Group for Action on Breastfeeding, of which the World Bank is not yet an active participant, will be able to serve at least as a clearinghouse/communications organization for building a successful new effort on breastfeeding.

## DISCUSSION

The discussion that followed included a lively interchange with many well known workers in the breastfeeding field, including N Baumslag, D and P Jelliffe, Jelliffe, and D Werner. The discussion extended well into the lunch hour. All present were thanked for their interest and participation. The following major issues and the panel's responses are summarized below.

- o What can we do to stop the misunderstanding of so many policy makers that breastfeeding is not a problem in their country?
  - Collect data in a manner that uses the Interagency Group for Action on Breastfeeding Definitions (Full, includes exclusive and almost exclusive, vs Partial vs Token) so that it might be properly interpreted
  - Emphasize that breastfeeding is high technology, even if it means that some less than fully useful studies must be carried out to define the elements and actions of breastmilk
  - Emphasize that breastfeeding is not a cottage industry but rather a thing of consequence and the consequences are costs and health
- o How can we get more funding for this field?
  - We need to convince policy makers to do more than give passing concurrence to a code. We need to see action plans
  - Part of the issue is to know what should be the first actions with the money now available, as well as to generate more. There are so many possible actions. The IGAB Strategy Meeting for the 1990's should help define a set of actions
- o How can we address the role of industry which has millions of dollars to promote a potentially deadly alternative?
  - This is a grave issue in that capitalism dictates selling, and successful selling includes promotion of products to increase sales. Social marketing for breastfeeding does not receive anywhere near the same level of financial support as does formula marketing
- o Even among those who recognize the importance of breastfeeding, we hear a great deal about insufficient milk, maternal depletion, and other maternal and child health conditions which are named as reasons to stop women from breastfeeding
  - "Insufficient milk" is a perception that generally occurs when unnecessary

supplementation has disrupted milk production or when a woman is unaware of the natural physiological changes that may occur over time. Maternal depletion is a complex and ill-defined phenomenon, most studies seem to show that women who breastfeed or do not breastfeed need about two to two and one half years to regain prepregnancy status. There are virtually no contraindications to breastfeeding, when conditions are severe, breastfeeding the infant and feeding the mother is the only acceptable approach.

- o Given all these arguments, what about the woman and her desires?
  - This is an excellent point. Clearly what must be done is to give each woman the information and support she needs to make the healthy choice. She must also be empowered to act on this choice within her cultural, family and work life contexts.
- o It is clear that breastfeeding is a safe motherhood issue as well. Women must be breastfed to assure health in infancy and long bone growth, women must be fed as adolescents and during pregnancy to be ready for safe delivery and to breastfeed their children. If these safe motherhood steps are taken, issues such as depletion can be prevented.
- o Several references have been made to the fertility impact of breastfeeding. Is there a way we can present this to women in a useful, efficacious fashion?
  - The Bellagio consensus has been developed into a set of guidelines (see Labbok) that are available upon request from IISNFP.

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