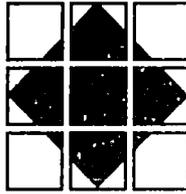


Report on the Technical Expert Meeting
Breastfeeding:
Global Opportunities for Intervention

November 3, 1989

THE PRAGMA
CORPORATION

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Established 1977

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Report on the Technical Expert Meeting
Breastfeeding: Global Opportunities for Intervention

Held at the American Public Health Association (APHA)
Washington, D.C.

November 3, 1989

Executive Summary

A meeting of technical experts in the field of breastfeeding promotion met on November 3, 1989 to discuss global opportunities for intervention. Discussion was based on review of A.I.D.'s draft "Strategy on Breastfeeding for Child Survival". Participants strongly endorsed the intentions of A.I.D, WHO and UNICEF to strengthen breastfeeding promotion within their international health, population and nutrition programs.

Consensus was reached that in addition to ongoing sectoral efforts to promote and support breastfeeding, a vertical program would provide the impetus and critical mass to ensure the needed changes to improve breastfeeding practices. In addition to a vertical approach to breastfeeding interventions, the integration of breastfeeding promotion into other programs should also be encouraged.

The goal of the strategy was suggested to be universal breastfeeding with all infants:

- 1) breastfed within 1 hour of delivery;
- 2) breastfed exclusively from birth through 4 to six months of age;
- 3) breastfed for one year or longer; and
- 4) fed appropriate complementary foods in addition to breastmilk at the end of six months of age.

The workshop strongly supported the setting of targets for breastfeeding at the country level based on the particular country situation, rather than a universal target.

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Report on the Technical Expert Meeting Breastfeeding: Global Opportunities for Intervention

Introduction

A meeting of technical experts in the field of breastfeeding promotion met on November 3, 1989 to discuss global opportunities for intervention. The background document was A.I.D.'s Draft Strategy on "Breastfeeding for Child Survival". The primary purpose of the meeting was to review the strategy. Special attention was given to: 1) the goal and indicators for the promotion of breastfeeding; 2) priority breastfeeding promotion activities; 3) methods to assess breastfeeding practices; and 4) research priorities. This report summarizes the proceedings of the meeting. The agenda and a list of the participants are found in Attachments 1 and 2, respectively. The meeting was organized by the PRAGMA Corporation.

General Review of the Strategy

Participants strongly supported A.I.D.'s intention to strengthen breastfeeding promotion within its child survival program, agreeing that the "twin engine" approach to child survival, that is oral rehydration (ORT) and immunization, over the last six years has been too limited. There is a large potential for greater reductions in morbidity, mortality, and fertility with enhanced breastfeeding. The distribution of a "Breastfeeding for Child Survival Strategy" throughout A.I.D. was thought to be an important step in the process of increasing support for the promotion of breastfeeding. Strategies for ORT, immunization, and child spacing have all been helpful in garnering central and Mission support for these interventions.

Several issues concerning the overall intent of the strategy were discussed. These included the importance of a vertical versus integrated approach, the selection of priority countries, a clarification of the factors affecting breastmilk output, and a general review of the sections on working women and breastfeeding, ensuring sustainability, and weaning.

Vertical versus Integrated Approach

There was much discussion on how breastfeeding could be best promoted, whether through integration with other health/nutrition/population activities, or through a vertical approach. Consensus was reached that there needs to be

a vertical program to provide the impetus and critical mass to promote the needed changes to improve breastfeeding practices. With this vertical approach as the central point of breastfeeding interventions, integration of breastfeeding promotion into other programs should also be encouraged. There is a need for both approaches to breastfeeding promotion, but having only the integrated approach, which is basically how breastfeeding has been supported in the current child survival strategy, is insufficient.

For example, the benefits of breastfeeding have sometimes been included within training programs for ORT programs. However the messages on how to promote breastfeeding have often gotten lost in the many other components of training. A recent Academy for Educational Development review of mass media approaches to promoting breastfeeding, found that the more successful programs were all vertically conducted, with breastfeeding as the central theme. Vertical breastfeeding promotion programs have been supported with limited funding for many years through A.I.D.'s Office of Nutrition.

One concern is that there is a huge body of technical information on breastfeeding but few health professionals specialized in the discipline. There is a critical need for more breastfeeding experts to work in ministries of health, to teach and to conduct research on breastfeeding. As with the field of diarrheal disease control, medical specialists have played a major role in promoting the needed policy changes for the use of oral rehydration instead of intravenous rehydration. Without the qualified technical specialists, it would have been much more difficult to make the needed policy reforms.

A concrete example of both integrated and vertical programs in the same country context was illustrated from Honduras. When breastfeeding was a single vertical program it succeeded in promoting changes in practices, with breastfeeding counselors carrying out the needed activities. However, when breastfeeding counselors were converted to MCH technicians with breastfeeding promotion as one of several responsibilities, they in fact emphasized MCH and not breastfeeding.

As put by Dr. Naylor, "when breastfeeding is everyone's business, it becomes no one's business". The evidence suggests that the critical input to getting changes made in other sectors has been a cohort of people within a country working on breastfeeding promotion and practical lactation management techniques. The consensus was therefore to support a focused breastfeeding intervention strategy, and work from that to strengthen breastfeeding in other health, population and nutrition programs.

It was acknowledged that while a vertical approach is needed, there is a need for integration, generally at the community

level. It also was emphasized that much can be done now through existing programs. In particular, many activities within child survival programs may have a negative impact on breastfeeding and need to be changed. Table 1 lists some of these.

Factors Affecting Breastmilk Output

The numerous factors affecting breastmilk output, such as maternal hormonal and neurological pathways, practices inhibiting these pathways, appropriate management of breastfeeding, and maternal nutritional status should each receive equal stress in the strategy. Poor maternal nutritional status should be mentioned in the same light as a low frequency of suckling, use of bottles, lack of confidence, mismanagement and incorrect procedures, stress and fatigue, etc., and not over-emphasized. It was cautioned that the way the strategy was written makes it appear that poor maternal nutritional status plays the main role in the insufficient milk syndrome, when in fact a number of other factors, as mentioned above, may be equally or more important.

Ensuring Sustainability

The expert group underscored the need for A.I.D.'s commitment to breastfeeding activities to be seen as a long term obligation. As with immunization activities, breastfeeding promotion needs to be continuous, with ongoing training provided to health practitioners, and support for breastfeeding given to new mothers. Since in the past, most donor funding has gone to short term projects to support breastfeeding, the group urged that breastfeeding promotion be seen as a strategy, equal in importance to immunization, with the continuity of adequate financial support essential to making these programs successful.

Another component of sustainability includes development of human resources. Training is essential if a program for breastfeeding promotion is to be maintained. Institutional sustainability should include both government and private institutions as well as universities.

Breastfeeding among Working Women

The issue of promotion of breastfeeding among working women was discussed at great length. The consensus was that there is a great need for a review of what has occurred in this area and for operational research to assess the effectiveness of interventions to support breastfeeding among working women.

**Table 1. Obstacles to Breastfeeding
in Child Survival Programs**

IMMUNIZATION PROGRAMS

- * Poor training and misinformation; e.g. "diminished response of oral polio vaccine among breastfed infants."
- * Missed opportunity for support of breastfeeding during vaccination visit.
- * Failure to promote colostrum as "first immunization" and to recognize its role in enhancing the infant's cell mediated immune response to BCG.

CDD AND ADJUNCT ORT

- * Poor training and misinformation: "Breastfeeding should stop during diarrhea"
- * Failure to promote exclusive breastfeeding from birth through 4-6 months to prevent early diarrhea.
- * Separation of breastfeeding mothers and infants in inpatient or outpatient wards during treatment.
- * Use of bottles and nipples to provide ORS to infants, exposing the child to pathogens if not sterile, and undermining the established breastfeeding relationship because of "nipple confusion".
- * Emphasis to mothers only on administration of ORS, so that mother may forget to breastfeed in between and milk supply diminishes.
- * Oral rehydration often given for cases of mild diarrhea without dehydration which can disrupt breastfeeding and expose child to pathogens, causing more harm than benefit.
- * Food-based ORS given to exclusively breastfed infants under 6 months of age may disrupt breastfeeding.

FAMILY PLANNING PROGRAMS

- * Poor training and misinformation: "No family planning until breastfeeding stops; breastfeeding has no contraceptive effect".
- * Use of combined oral contraceptives which contain estrogen, known to reduce breastmilk, instead of progestin-only contraceptives and non-hormonal methods.
- * Rewarding workers only for distributing contraceptives and not for promoting breastfeeding as a contraceptive.

Priority Countries

While a global strategy was seen as being indicated, it was also emphasized that there is a need to focus attention on those countries that currently have the most unfavorable breastfeeding practices. The selection of such countries will need to be made based on currently available data (such as the DHS) or a rapid assessment of practices. Once countries have been selected based on need, those in which A.I.D. chooses to work will depend on other data (such as anthropologic data on breastfeeding practices) available within the country, active organizations in the country, interest by other health sectors, etc.

Weaning

While it was emphasized that breastfeeding and weaning are interlinked, there is a need to have the breastfeeding strategy focus primarily on breastfeeding. The extent to which the strategy includes the issue of weaning as an important component of any breastfeeding promotion intervention appears to be sufficient. Promotion of weaning interventions will necessitate some of the same components as breastfeeding programs, however there will need to be substantially greater inputs to effect changes in the quantity and quality of weaning foods.

Goals and Indicators

It was suggested that the goal for the breastfeeding strategy be ideal and thus universal. The goal statement therefore should not mention a percentage of infants who should be breastfed or a date by which this should occur. Rather, targets (which should include such percentages and time limits) should be defined by each country as those levels of specific breastfeeding practices that the country would attempt to reach in a specific time period. Indicators were defined as measures to assess the success of program interventions toward achieving specific targets.

After slight editorial changes to A.I.D.'s draft strategy, the expert group supported the use of the following goal and indicators. It strongly supported the setting of targets for breastfeeding at the country level based on an assessment of the particular country situation.

A.I.D. Strategy Goal

Universal breastfeeding with all infants:

- 1) breastfed within 1 hour of delivery;
- 2) breastfed exclusively from birth through 4 to six

- months of age;
- 3) breastfed for one year or longer;
- 4) fed appropriate complementary foods in addition to breastmilk at the end of six months of age.

This goal is consistent with WHO/UNICEF guidelines with one exception, which is the initiation of breastfeeding within one hour of delivery per A.I.D. versus within 30 minutes per WHO/UNICEF. Concern was expressed that this difference might cause confusion. The initiation goal is oriented towards hospital deliveries, to ensure that infants are not separated from their mothers for long periods of time after delivery. However, it is also intended to overcome the common traditional practice of discarding colostrum for the first few days of life as is done in many communities around the world. Part of the dilemma was in defining an ideal initiation goal and in selecting a measurable indicator. It was deemed easier and more realistic to measure the timing of initiation of breastfeeding to within one hour after delivery, and thus the wording agreed upon for the goal and indicator was "within one hour."

Indicators

The global indicators to measure the goal, were similar to those originally proposed in the strategy, with some additions in the section on exclusive breastfeeding. They are described below:

- 1) Percentage of women breastfeeding by 1 hour following delivery
- 2) Percentage of infants fully breastfed at 4 (completed) months of age
 - a) Percentage of infants fully breastfed at 1, 2, 3, 4, 5, 6 months of age.
 - b) Mean months duration of exclusive breastfeeding
- 3) Percentage of infants fully breastfed at the end of 12 months of age
 - a) Percentage of infants breastfed partially at 0 months (thus showing ever breastfed)
 - b) Percentage of infants breastfed at each month of age (fully, partially) through 12 months of age
- 4) Percentage of infants over 6 months of age breastfed and fed complementary foods.

The term "fully breastfed" was used in the indicators rather than the term "breastfed exclusively" employed in the goal. Although exclusive breastfeeding (defined as no other liquids or solids given) is preferable to optimize the benefits of breastfeeding, often it is not practiced since a few sips of other liquids may

be given to infants. "Full" breastfeeding is more realistic and would still be considered to be practiced in the case of "almost exclusive breastfeeding" where water, juice or ritual foods are given not more than once per day, and for not more than 1-2 swallows. This is consistent with the definitions developed by the International Institute on Studies of Natural Family Planning. Thus, in the goal the ideal behavior, which is "breastfed exclusively", is emphasized whereas the indicators of actual behavior use the more realistic or likely to be encountered term, "fully breastfed."

Because of the need to assess improvements in duration of full breastfeeding that might not be observable if only the "percentage of infants fully breastfed at 4 (completed) months" was used, the percentage fully breastfed at each month through 6 months was added. For the same reason, the "mean months duration of exclusive breastfeeding (MEB)" was also included as an indicator.

There was considerable discussion of the advantages and disadvantages of the single "appropriate infant feeding" indicator currently used to score countries' breastfeeding and weaning practices as part of the A.I.D. Child Survival monitoring and evaluation system. This indicator summarizes into one percentage three "appropriate feeding criteria" for infants 0-12 months, which are:

- 1) breastfed throughout infancy;
- 2) no bottle feeding; and
- 3) exclusive breastfeeding if less than 3 months of age and receipt of other foods if six months or older.

However, the use of a goal and indicators which spell out four critical breastfeeding behaviors and thus focus attention on initiation, exclusivity, duration and weaning as enunciated in the goal statement in A.I.D.'s Draft Strategy on Breastfeeding for Child Survival was deemed more useful than a single summary indicator. An equal emphasis on each of the four essential breastfeeding behaviors for monitoring and evaluation as well as for identifying the problem points and practices in a particular country was deemed to be much more informative than one summary statistic which aggregates all of these practices.

An analogy to the recommended use of several indicators for breastfeeding rather than one combined indicator is the use of several indicators for immunization programs. For example, DPT 1 is often used as a measure of access and DPT 3 as a measure of coverage. Furthermore, coverage data are presented separately for measles, polio, DPT, etc. rather than aggregating the varying coverage rates into one indicator.

It was also felt that the term "appropriately fed", which has

been used in the A.I.D. Child Survival monitoring and evaluation system, is a misnomer since even if infants met all the appropriate infant feeding criteria previously listed and received other foods if six months or older, one cannot assume that adequate quantities of complementary food have been consumed. A child could be identified as "appropriately fed" based on breastfeeding practices but be receiving insufficient amounts of complementary food after six months, and thus be malnourished. The term "appropriately breastfed" should be used instead.

One situation in which a summary indicator might serve as a proxy for four separate indicators is in surveys in which small sample sizes do not allow the accurate assessment of each of the four critical behaviors. For example, if there were only 200 infants 0-12 months of age in a survey, there would be less than 20 at each month of age, and thus large errors could be introduced by chance alone for the percentage of babies exclusively breastfeeding at specific months. A summary indicator could be used easily if all infants are fed within 1 hour after birth and if each infant is evaluated based on its current age (e.g. if 0 to 4-6 months of age, fully breastfed is "appropriately breastfed", if 5-12 months, "appropriately breastfed" includes those breastfeeding and receiving complementary foods).

The problem with one combined indicator is that it does not show what type of breastfeeding problem exists. The percentage of children appropriately breastfed could be the same for populations as diverse as rural Bangladesh and rural Peru where most infants are breastfed within one hour of delivery and are breastfed for over 12 months. In Bangladesh, on average all infants would be "appropriately breastfed" during 0-6 months of age, but few would be "appropriately breastfed" from 7-12 months, because of failure to introduce complementary foods, giving the figure of 50% for the single indicator. In contrast in rural Peru, the score could be similar but for the opposite reason: early supplementation of nearly all breastfed infants in the first 6 months of life, but appropriate extended breastfeeding with complementary foods during the second six months of life. The aggregated indicator does little to illustrate country specific problems and what needs to be done, and may yield misleading information which in turn could give inaccurate feedback to policy makers and program managers. The consensus was for the use of several indicators on the four critical breastfeeding behaviors, except where sample size was too small to allow any assessment of breastfeeding practices unless a combined indicator were used. Furthermore, it was agreed that when simple summary statistics are needed as in reports to Congress, the four individual measures of breastfeeding practices could easily be aggregated into one indicator.

One reason for using a single appropriate feeding indicator in

the past has been due to limitations of sample size in prospective surveys, and doubts about the accuracy of recall data on breastfeeding practices collected in cross-sectional surveys. However, the group generally believed recall data on timing of initiation of breastfeeding, duration of full breastfeeding or total breastfeeding, and age at introduction of complementary foods are sufficiently accurate. Thus such recall questions can be asked to a large sample of mothers of preschool children in a cross-sectional survey, such as the Demographic Health Surveys (DHS), and need not be limited to small prospective surveys of infants.

Priority Breastfeeding Promotion Activities

Discussion on what the priority breastfeeding promotion activities should be centered on whether there is a need to expand beyond the formal health sector to the informal sector at the present time. The group's opinion was that the need to promote and support breastfeeding is so great within the formal sector, that efforts should be focused there first. The most acute problems with suboptimal breastfeeding practices are in urban/peri-urban areas in association with hospital deliveries and are influenced more by the formal health system than are breastfeeding practices in rural areas.

It was recommended that breastfeeding promotion and support efforts start in rural areas outside the health system but do so in parallel to more intensive efforts in the formal health sector. Expansion within the formal primary health care system may be the first way to penetrate into rural areas. This can be done through enhanced training of all levels of health workers in the management of breastfeeding, with care taken not to overburden workers at the lowest tier. Other mechanisms for expanding into the informal sector include utilization of agricultural extension workers, home economists, telecommunications, teachers, textbook writers, employers, and trainers of other workers for breastfeeding promotion.

Regional Training Centers

One option that was strongly recommended was the development of regional lactation training centers. Large countries, such as India, would need multiple centers within each country. The regional lactation training centers would train medical teams, as well as lower level health workers, from government, PVO, and private sector programs. People working outside the health system could also be trained at the regional centers. The regional lactation training centers would be differentiated from other regional health training centers, as they would focus exclusively on training in lactation management techniques and

dissemination of information on breastfeeding. This type of training would elevate the status of breastfeeding programs, as well as the study and management of breastfeeding.

Effort Focused on Professional Associations and Policy Makers

Regional lactation training centers could also work with associations of health professionals, donor agencies, and policy makers in order to get more visibility for breastfeeding and more support for the needed changes. Each of these centers would need a special targeted approach for presentations, materials, etc. such as that used by Wellstart. Methods of presentation used in population programs, such as RAPID or IMPACT, would be worth adapting for breastfeeding.

Support Groups

The development of informal or formal breastfeeding support groups seemed to be one of the major interventions proposed to extend breastfeeding promotion beyond the health system to the informal sector at the community level. The Thai "model mother" program was given as an example, where appropriate breastfeeding behavior is part of the requirement for being a model mother. Such women are respected within their communities and provide a model to emulate. These model mothers are given training by health workers on breastfeeding management among other aspects of proper infant nutrition and care.

Comprehensive Communication Strategy

A comprehensive communication strategy is key to establishing breastfeeding as a social norm. This strategy must make sure that information flows into both urban and rural areas and is sustained. Such a media approach would also help persuade decision makers within the country to support breastfeeding promotion.

As part of this communication strategy, there was much discussion with no consensus on whether an ICORT style meeting was warranted. Some stated that it was needed in order to focus international attention on the importance of breastfeeding, just as ICORT did on diarrhea and ORT. Others felt that there was a greater need for smaller, more focused workshops that would lead to plans of action within specific countries.

National Breastfeeding Groups

It was stated that national breastfeeding groups have often been

effective in coalescing interdisciplinary support for breastfeeding. It was suggested that the funding of such groups would be an important means to promote breastfeeding within a country.

Monitoring of Breastmilk Substitutes

Since a great deal of training is currently being provided by the infant formula industry, it was stressed that the activities of this sector be monitored. It would also be helpful to have data by year on imports and sales of infant formula and milk by individual countries. This would serve as an evaluation tool, illustrating to decision makers the vital role breastfeeding plays in reducing expenditures and the need for foreign exchange generated by such imports.

Methods for Rapid Assessment of Breastfeeding Practices

The first step for assessing breastfeeding status within a country is the review of existing data. Both nationwide surveys (including DHS, World Fertility Survey, contraceptive prevalence surveys, and national nutrition surveys) and small scale studies have been conducted which provide some information on breastfeeding rates. Additionally, ethnographic data are needed to delineate reasons for various practices. A review of current hospital practices is also essential as these flag problems with initiation. The WHO/UNICEF guidelines (1989) has a checklist for desirable hospital practices which would be useful as a tool for evaluating hospital practices. It has been included as Annex I of A.I.D.'s breastfeeding strategy.

If extant data are insufficient, then additional data collection is needed, which may be done by rapid ethnographic assessment of feeding practices, focus groups, site visits to hospitals, and, when necessary, larger surveys. It is also necessary to assess aspects of other child survival programs which facilitate or hinder breastfeeding. The collation of data on legislation related to breastfeeding (maternity leaves, nursing breaks, restriction in sale or import of breastmilk substitutes) and on current marketing practices within the country were also seen as important to collect. The APHA has been collecting such data with A.I.D. funding for the past five years and annually presents a useful summary of their findings. The collection of data on expenditures within hospitals related to use of breastmilk substitutes, bottles, drugs, etc. was also suggested.

The use of periodic surveys to assess the breastfeeding situation was seen as essential. It may be possible to build these periodic surveys into a current nutritional surveillance system, or the data could be collected through sentinel sites, hospital

discharge data, or by employing the "last birth technique" now used in demographic surveys.

The use of proxy indicators was also suggested because of the difficulty in obtaining some data. For example, the percentage of infants being breastfed at hospital discharge could be collected to provide information on initiation of breastfeeding and whether breastfeeding was exclusive. To do this, A.I.D. would have to assist major urban hospitals as well as district hospitals to assure appropriate lactation management practices and record keeping. Although this may not be A.I.D.'s current focus, it is important because negative urban hospital practices are a major contributor to breastfeeding declines in many countries.

The different purposes of a needs assessment for program planning and baseline data collection for evaluation of program effectiveness were discussed. For program planning, a qualitative approach was possible, but for program evaluation, there is a need for quantitative data collected in surveys with adequate sample size.

Research Priorities

In discussing research priorities, the expert group decided to be exhaustive rather than limited in their approach, i.e., the group recognized that no one organization could fund all of the areas listed, but that between the major donors, all areas for research could be addressed. Consensus was reached that a set of criteria be used to establish priorities for research within institutions, such as costs, staffing requirements, impact on policy, etc. The group underscored the need for increased funding for analysis of the wealth of existing data to assess many of the research issues at relatively low cost.

Priority areas for research are listed below in two categories; they include applied and biomedical research. The group agreed that the number one priority in the area of applied research is the development of an evaluation methodology and tools, while in the area of biomedical research, the top priority is the development of growth standards for breastfed infants.

Applied Research Areas:

1. Development of an evaluation methodology and tools using the standard indicators discussed above.
2. Development and deployment of a rapid assessment methodology for diagnosing a country's specific breastfeeding practices and problems.

3. Behavioral research relating to the discarding of colostrum and administration of prelacteal feeds, in order to design appropriate interventions.
4. Development of community-based project strategies to serve women in marginal urban and rural areas.
5. Identification, using behavioral research, of key stages in pregnancy and lactation when mothers make decisions on breastfeeding behavior and the development of interventions and strategies to change these behaviors.
6. Study to understand who in the mother's support network acts as best counselor.
7. Development of realistic strategies for working women, not only in the formal and informal sectors, but at home. What are the obstacles to breastfeeding? (The concern was voiced that we have not yet delineated what we expect working women to do, i.e., mixed feeding, and how does this affect the goals of the program.)
8. Testing of interventions to improve maternal nutritional status through nutrition education, supplementary feeding, reduced work load, etc.
9. Study of promotion of breastfeeding as a method of family planning, specifically looking at child spacing strategies operationally.
10. Study of the risks to child health of prolonged exclusive breastfeeding versus the risk of diarrhea due to contaminated complementary foods, particularly looking at growth faltering.
11. Program evaluations that document changes in infant malnutrition, morbidity, and mortality as a result of changes in breastfeeding practices.
12. Cost-effectiveness studies of changes in institutional practices and policies.
13. Development of a greater number of program performance indicators.

Biomedical Research Areas:

1. Growth standards for breastfed infants.
2. Nutritional requirements during weaning.

3. The biological basis for the insufficient milk syndrome; examine cases of real lactation failure.
4. Storage requirements for breastmilk, the results of which can feed into the applied research issue on working women.
5. The relationship between maternal nutritional status, lactation performance, infant growth and maternal depletion and the relation of maternal pregnancy weight gain to outcome.
6. The relationship of breastfeeding to amenorrhea.
7. Role of enhanced iron absorption through breast milk (lactoferrin) for preventing anemia in infants. When does iron absorption drop occur vis-a-vis type and time of food introduction; does the introduction of juices, for instance, modify that absorption pattern?
8. Effect of colostrum on enhancing cell-mediated immune response to immunizations, e.g., BCG.
9. Appropriate technology for expression of breast milk.
10. Effects of using artificial nipples in combination with breastfeeding on lactational amenorrhea.
11. The role of malting of weaning foods to increase energy density.
12. The relationship between Vitamin K in breast milk and prevention of hemorrhagic disease.
13. The relationship between taurine in breast milk and prevention of retinitis pigmentosa.

Conclusion

The Expert group concluded that it endorsed the strategy put forth by A.I.D. to strengthen breastfeeding. It thought the approach was appropriate, but stressed the need for an individual country focus, with country level assessment of the breastfeeding situation and design of strategies. The group also recommended that the A.I.D. inter-bureau and inter-office group on breastfeeding represented at this meeting continue to meet to enable coordinated implementation of the strategy.

AGENDA

BREASTFEEDING: GLOBAL OPPORTUNITIES
FOR INTERVENTION

American Public Health Association Conference Room
1015 15th Street N.W.
3rd Floor
Washington, D.c. 20005

November 3, 1989

- 9:00-9:30 Welcome, Opening Remarks and Overview
A.I.D., UNICEF, WHO
- 9:30-9:45 Purpose of the Meeting and Expected Outputs
Nina Schlossman
Mary Ann Anderson
- 9:445-11:15 General Review and Comments on Strategy
Chairperson: Derrick B. Jelliffe
Group Discussion
- 11:15-11:30 Break
- 11:30-12:30 Working Groups
- A. Priority breastfeeding promotion activities
with emphasis on expanding beyond formal
health care system, and to rural areas
Chairperson: Audrey Naylor
Rapporteur: Peggy Parlato
- B. Strategy goal, targets and indicators of
program effectiveness
Chairperson: Sandra Huffman
Rapporteur: Gayle Gibbons
- 12:30-1:30 Lunch

AGENDA FOR BREASTFEEDING MEETING (continued)

Page 2

- 1:30-2:30 Plenary Session
- Chairperson: Marcia Griffiths
- Working Group A Report and Discussion
- Working Group B Report and Discussion
- 2:30-3:30 Working Groups
- A. Methods for rapid assessment and operational definitions of breastfeeding practices and their determinants (including initiation, exclusivity, duration, and introduction of weaning foods)
- Chairperson: Miriam Labbok
- Rapporteur: Anne Roberts
- B. Research Priorities
- Chairperson: Beverly Winikoff
- Rapporteur: Mark Belsey
- 3:30-3:45 Break
- 3:45-4:45 Plenary Session
- Chairperson: Marjorie Koblinsky
- Working Group A Report and Discussion
- Working Group B Report and Discussion
- 4:45-5:00 Concluding Remarks and Plans for Follow-up

AGENDA FOR BREASTFEEDING MEETING (continued)
Page 3

WORKING GROUPS

Morning Session

GROUP A

Audrey Naylor (C)
Peggy Parlato (R)
Judy Canahuati
Marcia Griffiths
E.F. Patrice Jelliffe
Marjorie Koblinsky
Margaret Kyenkya-Isabiriye

GROUP B

Sandra Huffman (C)
Gayle Gibbons (R)
Mark Belsey
Derrick B. Jelliffe
Miriam Labbok
Judith McGuire
Anne Roberts
Beverly Winikoff

Afternoon Session

GROUP A

Miriam Labbok (C)
Anne Roberts (R)
Sandra Huffman
Derrick B. Jelliffe
Margaret Kyenkya-Isabiriye
Peggy Parlato

GROUP B

Beverly Winikoff (C)
Mark Belsey (R)
Judy Canahuati
Gayle Gibbons
E.F. Patrice Jelliffe
Marjorie Koblinsky
Audrey Naylor

(C) Chairman

(R) Rapporteur

Attachment 2

BREASTFEEDING: GLOBAL OPPORTUNITIES
FOR INTERVENTION
November 3, 1989

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