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**Women and Infant Nutrition Field Support Project (WINS)**

**WINS' Participation in the  
International Forum for Francophone  
Africa on Infant Feeding  
and Child Survival**

Lomé, Togo  
September 9 - 13, 1991

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## **Abbreviations**

<b>A.I.D.</b>	<b>United States Agency for International Development</b>
<b>APAIB</b>	<b>Association pour la Promotion de l'Alimentation Infantile au Burkina</b>
<b>ATGN</b>	<b>Association Togolaise-Groupe Nutrition</b>
<b>CRS</b>	<b>Catholic Relief Services</b>
<b>GM&amp;P</b>	<b>Growth monitoring and promotion</b>
<b>GOT</b>	<b>Government of Togo</b>
<b>HIID</b>	<b>Harvard Institute for International Development</b>
<b>IBFAN</b>	<b>International Breastfeeding Action Network</b>
<b>IEC</b>	<b>Information, Education and Communications</b>
<b>MESRES</b>	<b>Ministère de l'Enseignement Supérieur et de la Recherche Scientifique et Technique (Ministry of Higher Education and Scientific Research)</b>
<b>NCP</b>	<b>Nutrition Communication Project (A.I.D. funded project implemented by the Academy for Educational Development)</b>
<b>ORT</b>	<b>Oral Rehydration Therapy</b>
<b>PRITECH</b>	<b>Primary Health Care Technologies Project (A.I.D. funded project implemented by Management Sciences for Health)</b>
<b>SCF-USA</b>	<b>Save the Children Federation/USA</b>
<b>UNICEF</b>	<b>United Nations Children's Fund</b>
<b>U.S.A.I.D.</b>	<b>United States Agency for International Development</b>
<b>WHO</b>	<b>World Health Organization</b>
<b>WINS</b>	<b>Women and Infant Nutrition Field Support Project (A.I.D. funded project implemented by Education Development Center, Inc.)</b>

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## I. EXECUTIVE SUMMARY

Bibi Essama, Director of the Women and Infant Nutrition Field Support (WINS) project and Dr. Joanne Leslie, technical consultant to the WINS project, were invited to participate in the International Forum for Francophone Africa on Infant Feeding and Child Survival held in Lomé, Togo from September 9 through 13, 1991.

The conference was sponsored by the United States Agency for International Development (A.I.D.) and was jointly organized by the Nutrition Communication project (NCP) and the Primary Health Care Technologies project (PRITECH). The local host was the recently founded Association Togolaise/Groupe Nutrition (ATGN).

The objectives of the conference were to (a) facilitate an exchange of ideas among professionals and decision-makers concerned with maternal and child health and nutrition issues on recent research findings related to diarrheal disease control, infant and young child feeding and maternal nutrition; (b) review research and program activities implemented by the participating countries in these areas; and (c) develop tentative plans of action which could be supported by U.S.A.I.D. and/or donors to address current or future program needs.

Invited participants included individual researchers and technical experts, as well as teams representing eight francophone African countries (Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Niger, Senegal and Togo). Several individual participants came from other countries (e.g., the Gambia and Zaire). Last minute difficulties prevented the Zaire team from participating.

This report summarizes what the WINS team learned and was able to accomplish on behalf of the WINS project during the team's participation in this international forum. The report discusses the rationale for WINS' participation in the conference, highlights some of the most interesting, substantive issues that arose during the conference, summarizes our discussions with country teams concerning possible future collaboration with WINS on nutrition related activities, and outlines specific steps that could be taken by WINS as a follow-up to the conference.

There appeared to be three major substantive agenda items for this conference. The first was an attempt to breathe new life into nutrition as a field for social action in francophone African countries, both at the U.S.A.I.D. mission level, and at the governmental level. The second was to present and discuss the scientific basis for recent recommendations concerning exclusive breastfeeding during the first six months of an infant's life. The third was to promote greater awareness of and collaboration among donors and providers of technical assistance (both across agencies and among U.S.A.I.D. contractors) who are or could be active in nutrition research and projects in francophone Africa.

The recommendation concerning exclusive breastfeeding for six months was subjected to considerable scrutiny and debate throughout the week. A general consensus emerged that the scientific evidence supporting the claim that, even in hot dry climates, infants do not need

supplemental water if they are being breastfed on demand was clear and compelling. However, since this runs contrary to what most medical and public health practitioners have been previously taught, as well as to well established cultural practices and beliefs, it will not be easy to change.

Less consensus emerged about the nutritional appropriateness of exclusive breastfeeding in the four to six month period, or the practicability of asking families to refuse supplemental food to infants who might begin to indicate a desire to share family food after four months. There was a general sense that more research was needed on nutritional implications of exclusive breastfeeding for the first six months within the context of sub-Saharan African countries, and that a more prudent approach must be used in IEC efforts aimed at improving infant and young child feeding in the region. Consistent with this prudent approach to changing established practice, the recommendations formulated at the end of the conference advocate exclusive breastfeeding for the first 4 to 6 months and introduction of weaning foods between the age of 4 and 6 months.

Other breastfeeding related issues that received considerable attention were the recently published research from Kigali, Rwanda concerning transmission of HIV through breastmilk, and the time and work burdens of women and the problems that this could pose in terms of exclusive breastfeeding. Concerning the latter issue, a consensus emerged that more research was needed on the characteristics and circumstances of women who currently practice breastfeeding for as long as six months (a relatively small percentage, even in most African countries), and on women's perceptions of the constraints that they might experience if they were to try to exclusively breastfeed for this long.

There seemed, overall, to be a high interest among the country teams in the WINS project and what it has to offer in the way of technical assistance and research collaboration. The flexibility of WINS to offer assistance across a broad range of intervention and research related needs appeared to be particularly attractive.

The genuine interest expressed by country teams from Togo, Cameroon, Niger, Senegal and Burkina Faso in the flexibility and broad range of services offered by the WINS project provides a strong rationale for pursuing discussions with the U.S.A.I.D. Missions and respective governments for broad based collaboration to address critical maternal and early childhood nutrition issues.

## II. INTRODUCTION

Bibi Essama, Director of the Women and Infant Nutrition Field Support (WINS) project and Dr. Joanne Leslie, technical consultant to the WINS project, participated in the International Forum for Francophone Africa on Infant Feeding and Child Survival held in Lomé, Togo from September 9 through 13, 1991.

The conference was sponsored by the United States Agency for International Development (A.I.D.) and was jointly organized by the Nutrition Communication project (NCP) and the Primary Health Care Technologies (PRITECH) project. The local host was the recently founded Association Togolaise/Groupe Nutrition (ATGN).

The objectives of the conference were to:

- a) facilitate an exchange of ideas among professionals and decision-makers concerned with maternal and child health and nutrition issues on recent research findings related to diarrheal disease control, infant and young child feeding and nutrition and maternal nutrition;
- b) review research and program activities implemented by participating countries in these areas; and
- c) develop tentative plans of action which could be supported by U.S.A.I.D. and/or donors to address current or future program needs.

Invited participants included individual researchers and technical experts, as well as teams representing eight francophone African countries. Countries which were represented at the conference included Burkina Faso, Cameroon, Cote d'Ivoire, Guinea, Mali, Niger, Senegal and Togo. Several individual participants came from other countries (e.g., the Gambia and Zaire). Unfortunately, last minute difficulties prevented the Zaire team from participating.

This report summarizes what we learned and were able to accomplish on behalf of the WINS project during our participation in this international forum.

The remainder of this report is organized into four sections. The first section presents the rationale for WINS' participation in the conference. The second section highlights some of the most interesting, substantive issues that arose during the conference. The third section summarizes our discussions with country teams concerning possible future collaboration with WINS on nutrition related activities. The last section proposes a number of specific steps that could be taken by WINS as a follow-up to the conference.

### **III. RATIONALE FOR WINS PARTICIPATION IN THE CONFERENCE**

It was felt desirable to have participation by representatives of the WINS project in this conference for several reasons:

First, the conference was an important regional forum for discussion of the 1990 Innocenti Declaration on Breastfeeding, and particularly debate concerning the more recent recommendation to promote exclusive breastfeeding for the first six (rather than the first four) months. Second, it provided an occasion for WINS to learn more about ongoing and planned

research and projects in nutrition in the participating countries. Third, it was an appropriate and efficient opportunity to disseminate information about the services available through WINS and to explore specific possibilities for collaboration with countries that expressed an interest. Finally, the organizers of the conference felt that both of the WINS representatives could make valuable technical contributions to the conference.

#### IV. CONFERENCE HIGHLIGHTS

Discussions throughout the week were lively and substantively useful, not only during plenary sessions and in the working groups, but also outside the organized conference sessions. It is certainly beyond the scope, and not the purpose of this report to do justice to the range and depth of the views exchanged. (There will be a proceedings to the conference published in due course.) Therefore, the issues highlighted here should simply be viewed as a reflection of discussions in which we participated, and points which struck us as particularly interesting.

There appeared to be three major substantive agenda items for this conference. The first was an attempt to breathe new life into nutrition as a field for social action in francophone African countries, both at the U.S.A.I.D. mission level and at the governmental level. The second was to present and discuss the scientific basis for recent recommendations concerning exclusive breastfeeding during the first six months of an infant's life. The third was to promote greater awareness of and collaboration among donors and providers of technical assistance (both across agencies and among U.S.A.I.D. contractors) who are or could be active in nutrition research and projects in francophone Africa. (A copy of the program for the conference is attached as Annex B.)

The recommendation concerning exclusive breastfeeding for six months was subjected to considerable scrutiny and debate throughout the week. A general consensus emerged that the scientific evidence supporting the claim that, even in hot dry climates, infants do not need supplemental water if they are being breastfed on demand was clear and compelling. However, since this runs contrary to what most medical and public health practitioners have been previously taught, as well as to well established cultural practices and beliefs, it will not be easy to change. The majority of participants felt that it was important to continue to promote ORT during episodes of diarrhea, and emphasized that if this was the only time when a child was given supplemental fluid, such a child should still be considered as being exclusively breastfed.

Less consensus emerged about the nutritional appropriateness of exclusive breastfeeding in the four to six month period, or the practicability of asking families to refuse supplemental food to infants who might begin to indicate a desire to share family food after four months. Several participants emphasized the serious problem of delayed introduction of supplemental foods in sub-Saharan Africa; for example, it was reported that, in Mali, 50 percent of the children 6-11 months, and 20 percent of children 12 months or older receive only breastmilk and water. In addition, Dr. Doh presented the results of a study he had done in Togo showing a significant gap between the protein needs of infants 3-6 months and the protein concentration in maternal

milk. There was a general sense that more research was needed on nutritional implications of exclusive breastfeeding for the first six months within the context of sub-Saharan African countries, and that a more prudent approach must be used in IEC efforts aimed at improving infant and young child feeding in the region. Consistent with this prudent approach to changing established practice, the recommendations formulated at the end of the conference advocate exclusive breastfeeding for the first 4 to 6 months and introduction of weaning foods between the age of 4 and 6 months. (A copy of the draft conference recommendations is attached as Annex C).

Another breastfeeding related issue that received considerable attention was the recently published research from Kigali, Rwanda concerning transmission of HIV through breastmilk. This study (published in the August 29, 1991, New England Journal of Medicine) indicates higher rates of postnatal transmission of HIV from mothers to infants than had previously been documented. Nonetheless, WHO and A.I.D. continue to recommend breastfeeding even among mothers at risk of acquiring HIV infection, given the greater risks associated with bottle feeding. The participants at this conference seemed, on the whole, willing to endorse this recommendation.

The time and work burdens of women and the problems that this could pose in terms of exclusive breastfeeding also received considerable attention. Although a number of participants stressed that the majority of African women are self-employed as food producers or engaged in informal sector jobs, the discussion tended to focus on the situation of women in formal sector jobs, resulting in a lively debate about the feasibility of different ways of extending maternity leave to allow exclusive breastfeeding for at least four months. A consensus emerged that more research was needed on the characteristics and circumstances of women who currently practice breastfeeding for as long as six months (a relatively small percentage, even in most African countries), and on women's perceptions of the constraints that they might experience if they were to try to exclusively breastfeed for this long.

## V. POTENTIAL WINS ACTIVITIES

There seemed, overall, to be a high level of interest among the country teams in the WINS project and what it has to offer in the way of technical assistance and research collaboration. Our supply of WINS brochures and catalogues of services ran out quickly. The flexibility of WINS to offer assistance across a broad range of intervention and research related needs appeared to be particularly attractive. In addition, two specific intervention ideas that were presented by Bibi during a plenary session attracted a lot of interest. One of these was the Agescale for growth monitoring, which is currently being tested in a pilot project in Nigeria by Dr. Marian Zeitlin. The second was Children's Services of Colorado's approach to the provision of child care through the establishment of home-based child care centers run by lactating mothers. (A copy of the presentation is attached as Annex D.)

Initial discussions were held with host country teams, or at least with some members of each team, about current and anticipated nutrition related programs and research in their respective countries. In several cases, this led to follow-up meetings to examine ways in which the WINS project could support these activities. The main conclusions reached are summarized below on a country by country basis, starting with those with whom future collaboration seems most likely.

#### A. TOGO

A number of factors converge to make it potentially attractive for WINS to work in Togo. These factors include constraints (both technical and program) as well as opportunities for effective collaboration which were identified during our discussions with Togolese team members.

The major constraints that were discussed with the WINS team include:

1. the current vertical approach to the delivery of health/nutrition services. Donor assistance has also reinforced this vertical approach by targeting specific programs (e.g., immunization, diarrheal disease control, malaria, etc). This has made coordination and integration of the various technical interventions difficult.
2. the low coverage and limited outreach capacity of the formal health care delivery system, and the need to find innovative ways of integrating growth monitoring activities into other community based programs for the prevention and early detection of malnutrition in rural areas.
3. a strong emphasis on clinic based rehabilitation in government programs that are administered through infant feeding centers and school feeding centers. The situation is further complicated by the food supplements which are provided by CRS as part of its growth monitoring and promotional efforts. This food distribution component of the CRS program seems to have created a disincentive for participation of the populations in government-sponsored growth monitoring and promotion (GM&P) activities, which provide no food supplements.
4. supplementation and weaning pose serious problems and need to be carefully addressed. The definition of exclusive breastfeeding is problematic as a large proportion of infants are commonly given traditional herbal concoctions in addition to breastmilk. To what extent do we consider these concoctions supplementation?

On the positive side, the following factors converge to make Togo a suitable site for a comprehensive WINS program:

1. There seems to be a reasonable amount of information already available about the prevalence of nutritional deficiencies. The existing data suggest a recent increase in the duration of breastfeeding among women with secondary education, compared with women with primary education.
2. There is increased political awareness of the seriousness of the malnutrition problem and willingness to make programs more responsive to community needs and problems.
3. Both the Ministry of Public Health (Maternal and Child Health Division) and Catholic Relief Services (CRS) are interested in reorganizing their GM&P activities in order to strengthen integration of two programs. They are also interested in working with other sectors (social services, agriculture, education...) to identify opportunities that will facilitate the access of households to food and non-food resources for improved infant and young child nutrition.
4. The new six year, U.S.A.I.D. funded Togo Child Survival and Population project (1992-1998) provides an effective operational framework for addressing some of the constraints and issues which were raised by the Togolese team. The goal of the project is to improve the health status of Togolese women and children by enhancing program integration, expanding service delivery in rural areas through public and private sector channels and improving MOPH institutional capacities to plan and deliver basic health services. The project includes strengthening and expanding child growth monitoring and reducing anemia among pregnant women as two of its specific objectives. It provides for long-term and short-term technical assistance, long-term and short-term participant training, in-country training workshops and operational and special studies to address specific health and nutrition related issues. A demographic and health survey is also planned under the project; this survey will provide comprehensive baseline data on the health and nutritional status of Togolese women and children.
5. The newly created ATGN (Association Togolaise-Groupe Nutrition) by the pluridisciplinary nature of its membership, has the potential for serving as a national or even regional source of technical expertise in nutrition. ATGN membership includes nutritionists, food and nutrition program planners and policy makers, health and agriculture specialists, university researchers and representatives of private institutions concerned with or working in the food and nutrition sector.
6. The potential also exists for expanded private sector participation in the production and marketing of low cost, nutritious weaning foods. A packaged weaning food has been developed with World Bank financing and is currently being marketed through local drugstores and supermarkets by a local private firm (AJDC Project Nutri 2,000). In discussions with the WINS team, the head of the

firm expressed a need for WINS' technical assistance to improve product quality and/or formulation, contain costs and expand its distribution to rural areas through local market channels.

7. The genuine interest expressed by Ministry of Health officials as well as by the U.S.A.I.D. Mission Director (unfortunately, it was not possible to talk with the Mission Health Officer, Paul Ehmer, who was in Abidjan during the week of the conference), the ATGN, the University, and CRS, in the broad range of services offered by the WINS project, provides a strong rationale for pursuing discussions with the U.S.A.I.D. Mission, the Government of Togo (GOT) and interested institutions on broad based cooperation in the nutrition sector.

The Togolese country team expressed interest in collaborating with the WINS project in the following activities:

1. develop a decentralized nutrition surveillance system which would result in greater involvement of community members and community-based health and social structures in nutrition monitoring and education efforts, and facilitate early identification of malnourished children in rural areas. The MOH would be the in-country lead institution for this activity.
2. develop a coordinated strategy that effectively integrates GOT/MOPH and CRS GM&P efforts with preventive health programs and community development activities implemented by other ministries, in order to enhance the nutritional impact of these programs.
3. assist the newly established ATGN to identify research priorities and to design and conduct collaborative inquiries to meet program development needs. Potential research issues which were cited by the Togolese team included constraints to proper weaning and young child feeding, growth monitoring techniques and food toxins and inhibitive substances as they relate to traditional food preparation and conservation methods.
4. assist the GOT and the private sector with the evaluation of the nutritional quality of traditional and locally manufactured weaning foods and in the development of appropriate marketing and other strategies to facilitate access to and consumption of nutritious weaning foods by children of low-income families.

## B. CAMEROON

Most of the members of the Cameroon country team were already known to one or both of us,

in part through our previous involvement in the Cameroon Weaning Practices Improvement Project. This not only facilitated discussions during the conference, but also provided a strong basis for working together on any future WINS activities in Cameroon.

Cameroon has had a long historical collaboration with A.I.D. in the area of infant and young child feeding and nutrition, through centrally funded and bilateral projects. As a result, there already exists many foci of nutrition knowledge and programmatic experience acquired through various studies and program interventions implemented by researchers from the Ministry of Higher Education and Scientific Research (MESRES), the University of Yaoundé, and government personnel working in Save the Children and CARE health projects in the East and Extreme North and the PRITECH assisted national program for diarrheal disease control.

Despite official government support for the primary health care strategy (PHC), the approach to the delivery of basic health care services remains for the most part curative and vertical. However, integrated community based approaches to the provision of health care services have been successfully implemented in selected areas, and are increasingly gaining acceptance in other regions. Some interesting research has been carried out by the Center of Nutrition of MESRES on the development of a nutritious weaning food using a low-cost, drought resistant, high yield local variety of yam. There is a vibrant informal private sector in Cameroon, which offers opportunities for microenterprise development for weaning food production and marketing.

Cameroon has the potential of becoming a site for WINS comprehensive activities. All members of the Cameroon country team expressed strong interest in building on existing expertise and collaborating with WINS on future research or interventions in the areas of young child feeding and weaning, weaning food development, development of community based growth monitoring and child care support systems (to improve young child nutrition and growth) and the development of guidelines for nutritional assessments. The following potential areas of collaboration were identified:

1. support the work of the Center of Nutrition on the development of a nutritious weaning food and explore marketing possibilities through market women vendors and traditional makers of "kourou-kourou" or "pap" (the traditional weaning food), to increase consumption of low-cost, nutritious weaning foods by children from low income families.
2. assistance to the MOH and MESRES in the development of protocols for the conduct of nutritional assessments.
3. Given the strong emphasis of the U.S.A.I.D. Mission assistance strategy on policy reform for the development of market-oriented, broad based development economic system, the WINS team indicated the potential usefulness of assessing the impact of the Mission's supported policy reform initiatives in the agriculture and private sectors (e.g., the development of improved varieties of crops, the free zone initiative) on the nutritional status of women and young children (0-3 years).

Given the fact that a substantial number of A.I.D. contractors and grantees are already working in Cameroon in health and nutrition related areas (e.g., Management Services for Health, the Academy for Educational Development, CARE, HIID, Drew Medical Center, SCF-USA, FHI, etc.) and given the already established relationships with these institutions, the Cameroon team members stressed the need to coordinate all A.I.D inputs to ensure that the support provided by each contractor complements the efforts undertaken under other projects. Accordingly, a meeting was convened by the team on the last day of the conference to outline a coordinated strategy for a joint WINS, NCP and WELLSTART assessment visit to Cameroon. Participants to the meeting included the Cameroonian team members, PRITECH's resident advisor to Cameroon (Hugh Waters), WINS' Project Director (Bibi Essama), WELLSTART's representative (Ann Brownlee) and NCP's project coordinator (Claudia Fishman). The proposed joint visit was tentatively scheduled for mid-November 1991, and the PRITECH in-country representative offered to assist the Cameroonian team with in-country coordination for the visit and to secure U.S.A.I.D. Mission concurrence. The purpose of the visit would be to follow-up on the discussions held with the Cameroon team members regarding specific requests for assistance and seek U.S.A.I.D. Mission's support for these requests. To date, no formal feedback has been received from either PRITECH or the U.S.A.I.D. Mission regarding the proposed joint WINS/NCP/WELLSTART visit. In light of the numerous opportunities that exist in Cameroon for broad based collaboration under the WINS project, and the genuine interest of Cameroonians in collaborating with the WINS project, WINS plans to discuss with the U.S.A.I.D. Mission the possibility of an exploratory visit by a WINS team in January 1992.

### C. NIGER

A seven member team from Niger attended the conference. Given the fact that WINS Project Director Bibi Essama had completed a reconnaissance visit to Niger one month before the conference, and that a number of potential areas of collaboration had been discussed during that visit, the WINS team did not meet extensively with the Niger country team. However, discussions were held with individual team members including the U.S.A.I.D. TAACS. During these discussions, the MOH representatives reaffirmed the MOH's interest in a long-term collaborative relationship with the WINS project in a broad range of areas including nutrition related assessments, program planning and evaluation, nutrition sector strategy and policy development, nutribusiness and food technology (including weaning food development). For more detailed information on potential WINS' activities in Niger, please refer to the report on WINS' visit to Niger.

The Nutrition Division of the MOH reaffirmed its need for WINS technical assistance to conduct an assessment of current nutrition programs and projects, as had been tentatively agreed upon during the WINS Project Director's visit to Niger in July 1991. The U.S.A.I.D. TAACS advisor indicated that there had been some delay at the U.S.A.I.D. Mission level in preparing the necessary documentation to authorize the proposed assessment, however the expectation is that this activity will go forward, probably in November 1991. The Head of the Nutrition Division expressed strong preference for Bibi Essama returning to Niger, to work with an in-country team on the assessment, to build on the momentum and enthusiasm generated by her

first visit and to continue the work she had already begun. Bibi reassured the team of WINS continued interest and availability to work in Niger to support efforts designed to enhance the nutritional status of women and young children. Bibi further indicated that she plans to return to Niger to assist with the assessment, subject to U.S.A.I.D.'s approval and support. She added that the composition and source of technical assistance to be provided through the WINS project will depend on the scope of the proposed assessment, the mix of skills that will be required to complete the scope of work, and the expertise available locally.

In light of the communications difficulties between Niger and the USA, the two teams (WINS and MOH) agreed to meet during the week of the conference to prepare an initial draft (in french) of the terms of reference for the proposed assessment, draft which would be circulated within the Ministry of Health and U.S.A.I.D./Niger for comments/revisions. Unfortunately, due to repeated last minute revisions of the conference program, the scheduled meeting(s) had to be postponed and then canceled, to allow the Niger team to participate fully in conference activities.

The WINS Director and the MOH team subsequently agreed to work on the scope of work for the assessment upon their return to their respective posts.

#### D. SENEGAL

Following Bibi's presentation at the conference and the review of WINS project materials by the Senegalese team, the head of the delegation (Dr. Mbaye) and his colleagues requested a meeting with Bibi to explore possibilities of collaboration with the WINS project, to strengthen their growth monitoring and nutritional surveillance activities in Senegal.

Dr. Mbaye is the head of SANAS (Service d'Alimentation du Nourrisson au Sénégal), a MOH institution responsible for planning, coordinating and monitoring activities designed to improve infant and young child nutrition in Senegal. SANAS' specific mandate includes the design of a national nutrition strategy to address early childhood malnutrition, the development of guidelines for the conduct of assessments, the design of related training programs and activities and the design and conduct of evaluations and operational research to support implementation of the national nutrition strategy. Currently, there is no national nutrition program in Senegal, and there is very limited technical coordination and guidance from the central level for nutrition activities.

The current U.S.A.I.D. Mission assistance program to Senegal concentrates on agriculture and child survival and its support to nutrition has been done essentially within the context of its child survival program, through a buy-in to the PRITECH project.

SANAS cooperation with PRITECH began about three years ago. The bulk of PRITECH's technical work in Senegal has been in the area of diarrheal disease management and control primarily through ORT promotion, health workers' training and operational research. However,

PRITECH has also provided technical assistance to SANAS for the development of a national nutrition plan. The plan was completed in August 1990, but has not been operationalized to date.

Dr. Mbaye became head of the SANAS in September 1990 and began reviewing and revising the plan. He is currently trying to identify ways and means to implement it, using A.I.D.'s central and bilateral resources, and possibly other donors.

In discussions with Bibi, Dr. Mbaye stressed the seriousness of the malnutrition problem in Senegal (about 1/5 of the children less than five years of age suffer each year from protein energy malnutrition; about half of pregnant women who are screened have iron deficiency anemia, and goiter is endemic in certain regions). He indicated that although the MOPH has, since 1973, implemented a national program of health and nutrition care targeted at young children (less than five years of age) and pregnant and lactating women (Programme National de Protection Nutritionnelle et Sanitaire - PPNS), growth monitoring and nutrition surveillance are not systematically carried out or sufficiently integrated into preventive health and social programs. He noted that a strong clinical and rehabilitation orientation continues to permeate many nutrition related programs, particularly the activities of the CRENs (Centre de Récupération et d'Education Nutritionnelle). He added, however, that interesting community based pilot projects have been carried out by the SANAS and/or PVOs (e.g., World Vision International) in some regions and positive results have been obtained by integrating nutrition and child survival interventions, using community based structures and groups.

Dr. Mbaye expressed his interest to learn more about the Agescale technique and in collaborating with the WINS project to develop community based approaches to growth monitoring and young child nutrition programming. He wants to go beyond the formal health care system (which has demonstrated its limitations in terms of coverage and outreach to rural areas) and explore the feasibility of integrating growth monitoring and young child feeding activities into child care and other community based service delivery structures and programs to achieve improved infant and young child nutrition. He wants to shift the focus of nutrition activities from rehabilitation to the prevention of malnutrition through GM&P and nutrition education. Accordingly, he is interested in collaborating with WINS to undertake operational research studies to address community level constraints to optimal infant and young child feeding and growth.

## E. BURKINA FASO

Neen Alrutz, the current Child Survival advisor at the U.S.A.I.D. Mission in Ougadougou was at the conference along with a reasonably large Burkina team. Ms. Alrutz communicated to us that the absorptive capacity of government programs for technical assistance in the nutrition area was probably temporarily saturated. However, she expressed strong support for and interest in the flexible, practical approach being taken by the WINS program. She encouraged us initially

to explore possibilities for collaboration on breastfeeding research with Mrs. Binta Barry, and perhaps in the future (i.e., in two years) to see if there might be a larger role for WINS in more broad based nutrition activities in Burkina Faso. Mrs. Binta is a government midwife, who also heads the recently established Association pour la Promotion de l'Alimentation Infantile au Burkina (APAIB), which is the local affiliate of IBFAN (the International Breast Feeding Action Network).

APAIB promotes breastfeeding, children's rights, optimal infant feeding practices and good dietary practices of pregnant and nursing mothers. It provides technical support and coordination to the Ministry of Health and Social Action on maternal and young child nutrition issues. Its activities include research, short-term training of field health personnel and IEC. Under APAIB/IBFAN sponsorship, a small scale survey of breastfeeding practices among health care personnel was recently carried out in Bobo Dioulassou, and is underway in Ougadougou. This operational research activity was funded by UNICEF. Mrs. Barry is very interested in expanding this research activity in 1992 both to get a representative sample from rural parts of the country, and to learn more about women's own attitudes and constraints to breastfeeding (the current study, like most that were reported on in the conference, included only health personnel in its sample, not mothers). Both Ms. Alrutz and Mrs. Barry expressed strong interest in exploring possibilities for WINS to provide some technical assistance in the next phase of breastfeeding research in Burkina, perhaps after the APAIB/IBFAN semi-annual planning meeting in November (1991), during which their 1992 plan of action will be developed.

## F. GUINEA

For the moment, the possibilities for any U.S.A.I.D. assisted nutrition activities in Guinea seem to be extremely limited; even many health sector activities such as the CCD program have been recently curtailed. However, the in-country interest in addressing nutritional problems appears to be quite high. For example, information on nutrition has been introduced into the secondary school curriculum, as well as into the professional level training. The Guinea team emphasized, in particular, the urgent need to address the severe iodine deficiency disorder problem in their country. They reported almost unbelievable prevalence figures of 70 percent of the population with goiters and 2 percent cretins.

## VI. NEXT STEPS/FOLLOW-UP ACTIVITIES

### a) Country Teams

Country teams from Togo, Cameroon and Senegal recommended that the WINS project plan a visit to their respective countries in November 1991 or January 1992, to continue discussions with their governments and U.S.A.I.D. Missions on potential areas of collaboration and outline a tentative program of collaboration. Bibi encouraged them to share their needs with their respective U.S.A.I.D. Missions, (in order to obtain the Missions' concurrence with the proposed

visits) and to advise the WINS Project Director of their plans. Bibi promised to discuss their needs with the A.I.D. Technical Officer for the WINS project and with her approval, outline a strategy and tentative schedule for reconnaissance visits to these countries. Bibi added that coordination with other A.I.D. contractors and grantees who are already working in each of these countries (e.g., PRITECH, NCP, CARE...) will be essential in planning these trips, in order to ensure coordination of A.I.D. inputs and enhance program coherence.

Mrs. Barry invited the WINS Project Director to attend the APAIB semi-annual planning meeting in November, and promised to keep the WINS project informed of APAIB's activities and plans. Bibi indicated that she planned to do so if that could be coordinated with her proposed trip to Niger during the same month, but failing that, that she was looking forward to receiving a copy of the Action Plan.

The Niger's team promised to send a cable to A.I.D.'s Office of Nutrition, requesting WINS' assistance to conduct an assessment of approaches to nutrition service delivery in Niger.

b) ICRW

There seemed to be a lot of interest among the participants in looking at women's work, and trying to understand constraints that women might experience in attempting to exclusively breastfeed for six months. It might be extremely desirable to talk with staff at ICRW about jointly developing a study design to look at this issue in a number of settings. If WINS had a design study, or even just a series of questions, it seems likely that there would be a number of opportunities to include them in future collaborative research activities.

Another potential joint activity with ICRW might be the development of a model nutrition project focusing on making credit available to women. Given the economic climate in most sub-Saharan African countries, interventions that expand credit (in this case, credit to be used for income generating activities and/or to finance bulk purchases of food under a cooperative scheme or for community kitchens) might offer more possibility for sustainability and be more attractive to governments than interventions that impose a high recurrent cost burden.

c) WHO

WHO has declared the 1990's as the Decade of Food and Nutrition" ("Decennie de l'Alimentation et de la Nutrition"). There appears to be potential for mutually beneficial collaboration between WINS and the research division of the diarrheal disease control program of WHO/Geneva. We learned from discussions with Isabel de la Zoysa that simple, fast, low-cost situation analyses of infant feeding practices are being carried out in a number of countries. They are developing a standard study design with four elements: 1) a survey of current infant feeding practices, particularly prevalence of exclusive breastfeeding; 2) a study, perhaps on a sub-sample, of determinants of infant feeding practices; 3) a survey of attitudes of health personnel and hospital practices concerning infant feeding practices; and 4) a survey of

marketing of breastmilk substitutes. WHO would welcome collaboration on these situation analyses, and Isabel de la Zoysa encouraged WINS to consider what role it might play.

d) Other Countries

Neen Alrutz (U.S.A.I.D./Burkina) drew our attention to the fact that a large U.S.A.I.D. Child Survival Project is currently being developed for Mozambique, and that, in part because of their enormous refugee problem, Mozambique is currently receiving a high level of U.S.A.I.D. assistance. In light of WINS' special interest in nutribusiness opportunities for women, as well as in the linkages between nutrition and food aid and nutrition and other resource enhancing opportunities (e.g. cooperatives, credit unions, microenterprise development), Ms. Alrutz encouraged WINS to explore how we might be able to play a useful role in upcoming nutrition sector activities in Mozambique, and perhaps in Angola, Namibia, and Malawi, which are also likely sites of new or expanding bilateral U.S.A.I.D. programs.

## VII. CONCLUSION

WINS' participation to this forum was a worthwhile effort. Although all country teams (with the exception of the participants from Niger, which had had contacts with the WINS Project Director prior to the conference) had not heard about the WINS project before the conference, by the end of the conference, all participants had a clear sense of the WINS project's objectives, mandate and technical resources, and five of the participating countries expressed strong interest in collaborating with WINS on specific research activities or interventions.

Additionally, the WINS' team left the conference with a greater appreciation of constraints to infant and young child feeding and nutrition in the West African region and with increased knowledge of on-going and planned nutrition related research and program activities in the participating countries.

The challenge now lies in demonstrating to the U.S.A.I.D. Missions, in concrete terms, and within the context of their respective program strategies, how the WINS project can support their efforts to strengthen the capacity of local institutions to address nutrition problems of infants, young children and women.

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## **APPENDIX B**

## II. PROGRAMME

### LUNDI le 9 septembre

- 08h30 à 9h30      Séance d'ouverture
- Formalités et allocutions
- Intervention de USAID
  - Messages des organisations collaboratrices
  - Allocution de son Excellence M. le Ministre de la Santé Publique
- 09h30 à 10h00      Pause café
- 10h00 à 10h10      Présentation des objectifs de la Conférence. *Dr. Ananivi Doh, Chef de l'Antenne de l'OCCGE, Ministère de la Santé Publique*
- 10h10 à 10h20      Détails de l'organisation et du matériel. *Mme. Jeanine Daniels, Coordinatrice du Forum*
- 10h20 à 11h00      Présentation des participants
- 11h00 à 12h00      Exposé I sur le thème: Progrès dans le domaine de la survie de l'enfant et perspectives pour les années 1990.
1. La survie de l'enfant en Afrique: Bilan des dix dernières années et perspectives en matière de nutrition. *Dr. Baba Traoré, Chef de la Division Planification Familiale, CERPOD, Mali*
  2. Bref aperçu sur les interventions relatives aux programmes d'allaitement au sein et de lutte contre les maladies diarrhéiques: (a) SSP (Initiative de Bamako), (b) LCMD, (c) Alimentation et Nutrition. *Dr. Kader Kondé, Directeur général, Ministère de la Santé, Guinée*
  3. *Déclaration d'Innocenti: Recommandations internationales pour l'alimentation du nourrisson. Dr. Joseph Andoh, Chef de Pédiatrie, CHU, Treichville, Côte d'Ivoire*
- 12h00 à 12h30      Débat. *Dr. Doh*
- Déjeuner              (Ensemble)
- 15h00 à 17h45      Présentation des expériences et Discussion, I
- Brèves présentations (15 minutes) de chaque délégation sur la situation dans leur pays en matière de la nutrition et la santé maternelles et infantiles.

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

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

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MARDI le 10 septembre

08h30 à 09h45 Présentation des expériences et discussion, II

08h30 à 08h45	Sénégal
08h55 à 09h10	Togo
09h20 à 09h35	Zaïre

09h45 à 10h00 Pause café

10h00 à 11h00 Exposé II: Soutien de la femme pendant la grossesse, optimisation de la santé de la mère et l'enfant pendant la période post-partum

*Dr. Muderwha Runesha, CEPLANUT, Zaïre*

1. Apport nutritionnel et dépense d'énergie pendant la grossesse: prise de poids recommandée et répercussions d'un déséquilibre énergétique provenant, par exemple, de carences en fer et en iode.
2. Préparatifs pour l'allaitement avant, pendant et après l'accouchement. Rôle des services de santé. *Dr. Bongo Lyamba, Zaïre et M. Abdou Fall, Sénégal*
3. Soutien nutritionnel et social pour les femmes post-partum.
4. Les enfants de faible poids à la naissance et les risques encourus.
5. Implications éventuelles.

11h00 à 11h15 Discussion

- Groupe 3: La croissance des nourrissons exclusivement allaités au sein. *Facilitatrice: Dr. Tayé Georgette*
- Groupe 4: La femme qui travail à l'extérieur et l'allaitement exclusif. *Facilitatrice: Dr. Barry Binta*
- Groupe 5: Les besoins de suppléments d'eau pour maintenir l'homéostasie hydrique chez les nourrissons pendant les 4 à 6 premiers mois. *Facilitateur: Dr. Tetanve*
- Groupe 6: Prévention et traitement de la diarrhée. *Facilitateur: Dr. Gamatie*

18h30 à 20h00 "Cocktail"

*Exposition du matériel éducatif de chaque pays. Dr. Etsri Akolly, EPS, Ministère de la Santé, Togo.*

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MERCREDI le 11 septembre

8h30 à 09h30 Présentation du rapport des travaux du 2ème jour. *Dr. Doh et rapporteurs de chaque groupe de travail*

09h30 à 10h30 Exposé V: Diversification alimentaire. *Dr. Muderhwa*

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

10h30 Pause café

10h45 à 12h00 Discussion guidée par un groupe d'experts: Recherches et programmes visant à encourager une bonne croissance et de bonnes pratiques de sevrage: expérience des pays. *Dr. Eléanore Seumo Fosso, Facilitatrice. Dr. Colette Geslin, Dr. Kaynada Samba et Mme. Kanté Dandara Touré.*

Déjeuner (Libre)

15h00 à 15h15 Définition de programmes d'action: Préambule. *Mme. Cooney.*

15h00 à 16h00 Vidéo: *Préserver une ressource naturelle.* Discussion.

- 11h15 à 12h15 Exposé III: Optimisation de la santé de la mère et du nourrisson.  
*Dr. Amsagana Boukar, Niger*
1. Lait maternel (qualité nutritionnelle, biochimie et immunologie) et la conduite de la lactation.
  2. L'allaitement au sein et l'espacement des naissances. *Mme. Kristin Cooney, Institut de la Santé Reproductive (anciennement l'Institut d'Etudes internationales de planification familiale naturelle) de l'Université de Georgetown*
  3. Réduction de l'épuisement maternel.
  4. Implications.
- 12h15 à 12h45 Discussion
- 12h45 à 12h55 Définition des groupes de travail pour l'après-midi
- Déjeuner (Libre)
- 15h00 à 16h00 Exposé IV: Prévention et traitement de la diarrhée. *Dr. Ekoe Tetanye, Professeur de Pédiatrie, Hôpital de Yaoundé, Cameroun*
1. L'eau et autres liquides supplémentaires données à l'enfant pendant les six premiers mois -- Présentation des recherches et des implications.
  2. Etude de réplique: Cameroun.
  3. Traitement et gestion nutritionnels des enfants diarrhéiques. *Dr. Gamatie Youssouf, Chef de Pédiatrie, Hôpital National, Niger*
- 16h00 à 18h00 Travaux de groupes 2/: Les participants se répartiront en groupes de travail pour discuter des obstacles à l'application des nouvelles données scientifiques et identifier des moyens pour surmonter ces obstacles. *Introduction: Dr. Doh*
- Groupe 1: Apport nutritionnel et dépense d'énergie pendant la grossesse. *Facilitateur: Dr. Muderhwa*
- Groupe 2: Soutien nutritionnel et social pour les femmes post-partum. *Facilitateur: Dr. Amsagana*

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

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- 16h00 à 17h00 Exposé VI: Obstacles et opportunités relatifs à l'intégration des activités pour l'alimentation optimale du nourrisson (AON) dans les programmes de SSP. *Dr. Kader Kondé et Mme. Bibi Essama, Directrice, Projet WINS, Etats-Unis*
1. Les efforts globaux relatifs à la promotion de l'allaitement au sein et l'alimentation optimale du nourrisson.
  2. Gestion des programmes intégrés.
- 17h00 à 17h30 Discussion
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JEUDI le 12 septembre

- 08h30 à 08h45 Présentation du rapport des travaux du 3ème jour.
- 08h45 à 11h00 Travaux de groupe: Les participants se répartiront en groupes de travail pour formuler des avant-projets de recommandations pour le renforcement des programmes complémentaires à l'alimentation optimale du nourrisson, notamment les soins prénatals et périnatals, la nutrition, les services de PF et la prévention et le traitement des maladies les plus courantes chez les mères et les enfants.
- Groupe 1: Intégration des activités pour l'alimentation optimale du nourrisson dans les programmes de SSP: MCH/PF, LCMD, IRA, PEV.
- Groupe 2: Intégration des activités pour l'alimentation optimale du nourrisson dans les programmes de nutrition communautaire.
- Groupe 3: Assurance des prestations de maternité respectant les *Dix conditions pour le succès de l'allaitement maternel* (OMS/UNICEF).
- Groupe 4: Révision des programmes de formation destinés à tout le personnel de santé, y compris médecins, infirmières, sage-femmes et agents de santé primaire.
- Groupe 5: Intégration des objectifs opérationnels pour la promotion de l'allaitement maternel dans les politiques nationales de la santé et du développement.

Groupe 6: Promulgation de lois protégeant le droit de la femme qui travaille d'allaiter son enfant et élaboration de mesures pour assurer leur application. Mise en vigueur du code de marketing.

11h00 à 12h30 Discussion en séance plénière

Déjeuner (Libre)

14h30 à 16h00 Présentation des bailleurs de fonds: intérêts, politiques et priorités. Exemples de programmes financés récemment.

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

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

Formation de spécialistes de la lactation: Wellstart, San Diego

Projet de Soutien de la nutrition maternelle et infantile (WINS)

Projet de Communication pour la Nutrition

PRITECH

16h00 à 16h15 Approche pratique pour planifier la mise en oeuvre des activités. Revue du Protocole de planification pour développer des projets relatifs aux thèmes du Forum. Dr. Ann Brownlee, Wellstart.

16h15 à 18h00 Travaux en commission (par pays) sur les projets relatifs aux thèmes de la conférence. (Moment où les équipes nationales discutent des plans de travail avec les bailleurs de fonds et les animateurs techniques.)

20h00 Dîner (en groupe)

VENDREDI le 13 septembre

09h00 à 12h00      Travaux en commission (suite)

Bailleurs de fonds et animateurs disponibles pour des discussions individuelles avec les équipes nationales, sur la planification des futures étapes et les possibilités de proposition/financement/assistance technique.

Déjeuner            (Libre)

14h30 à 15h30      Présentation du rapport des travaux du 4ème jour

15h30 à 16h00      Conclusions et recommandations du Forum (en réponse à la *Déclaration d'Innocenti*)

16h00 à 16h30      Les Actions proposées: Président

16h30 à 17h00      Séance de clôture

19h00 à 20h30      Réception

## APPENDIX C

**RECOMMENDATIONS  
FORUM ON OPTIMAL INFANT FEEDING  
LOME, TOGO**

We, the delegates from BURKINA FASO, CAMEROON, COTE D'IVOIRE, GAMBLA, GUINEA, MALI, NIGER, SENEGAL, TOGO, and ZAIRE, participants in the

**INTERNATIONAL FORUM ON INFANT FEEDING AND CHILD SURVIVAL**

have established that the deficiencies in infant feeding and the disturbing decline in breastfeeding pose a serious risk in general for the survival of African children, resulting in high morbidity and mortality due to malnutrition and diarrheal diseases.

Although this situation can in part be explained by the general economic crisis of the countries of the continent, the fact remains that the African states bear an unequivocal responsibility, particularly because of:

- 1 - the absence of a clearly defined health policy that places importance on nutrition as part of overall health problems of the population and the health problems of women and children in particular;
- 2 - the inadequacies of existing laws protecting pregnant and nursing women;
- 3 - the inadequate application of the International Code on the Marketing of Breast Milk Substitutes;
- 4 - the shortage of health personnel involved in nutrition and the promotion of breast feeding.

Endorsing the INNOCENTI DECLARATION on protection, encouragement, and support of Breastfeeding, and in order to change the above-mentioned deplorable situation and ensure the health of Women and Children,

We Recommend:

To African Governments:

1. Define and establish, in the shortest time possible, a pertinent and integrated policy on Food and Nutrition, focusing particularly on the promotion of breastfeeding and the survival of children;
2. Adapt the different laws in governing maternity leave with the goal of truly promoting exclusive breastfeeding;
3. Take adequate measures to ensure optimal nutrition for women in general, and pregnant and nursing women in particular;
4. Take adequate measures to improve the skills of health personnel in our various countries in the area of nutrition and promotion of breastfeeding;

5. Ensure that the Structural Adjustment Plans to which our developing countries must adhere, take into consideration these recommendations in order to protect conditions for Infant Nutrition and Child Survival.

**To Health Authorities:**

6. Promote exclusive breastfeeding from birth until age 4 to 6 months, taking into account that breastfeeding, on the one hand, completely meets the nutritional and fluid needs of infants and, on the other hand, serves as an effective means of spacing births;
7. See that weaning foods are introduced gradually and in sufficient quantities, using local foods that are nutritionally adequate and culturally acceptable; these foods should be offered between 4 and 6 months while continuing to promote breastfeeding until 2 years of age and beyond;
8. See that breastfeeding is maintained and associated with oral rehydration in the event of diarrhea in a nursing infant and that this treatment is also associated with continuing to feed a child who is already weaned;
9. See that breastfeeding continues to be encouraged, even among populations with a high incidence of HIV infection, taking into account the increased risks of mortality linked to a decline in the practice of breastfeeding;
10. Ensure that these recommendations are applied.

**To International and Non-Governmental Organizations and Bilateral Aid Agencies:**

11. Place more emphasis on national food and nutrition programs, particularly in the area of applied research, in order to strengthen the conditions needed for the Survival of Mothers and Children.

## **APPENDIX D**

**OBSTACLES AND OPPORTUNITIES FOR INTEGRATING  
OPTIMAL INFANT FEEDING ACTIVITIES INTO  
PRIMARY HEALTH CARE PROGRAMS**

Review paper prepared by  
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Education Development Center, Inc.  
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For discussion  
at the International Forum for Francophone Africa on  
Infant Feeding and Child Survival  
Togo, 9-13 September 1991

## OUTLINE

- I. Introduction
- II. Rationale for Integrating Infant Feeding Activities into PHC
- III. Constraints
  - A. Organizational and management constraints
  - B. Community participation issues
  - C. Institutional policies and practices
- IV. Opportunities for Optimizing Infant and Young Child Nutrition Outcomes through PHC
  - A. Integration of breastfeeding promotion into diarrheal disease control efforts
  - B. Integration of growth monitoring and promotion activities into infant feeding and PHC programs
  - C. Integration of nutrition education into primary schools
  - D. Integration of nutrition education into community based MCH programs
  - E. Maximizing community participation and program sustainability
- V. Examples of Effective Approaches to Community-Based, Integrated Infant and Young Child Nutrition
  - A. Use of growth monitoring to improve young child nutrition in the Dominican Republic: INCS/CRS/CARITAS project
  - B. Use of the Agescale to improve young child nutrition in Nigeria: Tufts/UNICEF/LUTH project
  - C. Integration of nutrition education into primary schools: INCS' experience in Jamaica
  - D. Support to breastfeeding and working women through the promotion of in-home child care centers: CSI's Model
- VI. Concluding Remarks

## **I. Introduction**

Developing and industrialized nations are increasingly recognizing the important role of nutrition in socio-economic development and the interrelationships between nutrition, health and other sectors of development. As a result of this awareness, development agencies have supported a number of initiatives aimed at improving the nutritional status of vulnerable groups. Some of these initiatives have been implemented within the framework of primary health care (PHC) programs and others as vertical programs.

Unfortunately, many of these initiatives have had a relatively limited impact, and as we enter the 1990's, high levels of infant and young child malnutrition and morbidity continue to prevail in many parts of the world, and particularly in Africa. This situation has led some decision-makers to dismiss PHC as a workable strategy and to recommend "new" or alternative approaches to the delivery of health care.<sup>1</sup> However, numerous case studies have also documented innovative and effective approaches to the delivery of basic health and nutrition services in Africa and underscored the need to further test these approaches in various settings within the context of community-based, integrated programs in health, nutrition and related sectors.

This paper is an attempt to review what we have learned from various health/nutrition programs and to identify practical ways of improving infant and young child feeding and nutrition, within the context of an integrated, participatory primary health care strategy.

First, the author discusses the rationale for integrating infant and young child feeding activities into PHC. Secondly, she examines the major constraints to effective integration of these activities into PHC efforts and finally she describes specific approaches or interventions for achieving effective integration of nutritional considerations in PHC programs and optimizing infant and young child nutrition.

## **II. Rationale for Integrating Infant and Young Child Feeding Activities into PHC**

PHC is generally considered to encompass the following elements:

- provision of an adequate supply of food and proper nutrition;
- health education and training;
- immunization;
- maternal and child health and family planning;
- provision of essential drugs;
- treatment and prevention of common diseases and injuries;
- provision of safe drinking water and sanitation, and
- control of communicable diseases.<sup>2</sup>

In addition to these aspects, PHC programs are increasingly focusing on issues related to the special needs of women, given the potential impact of these issues on women's health and development and on the health and welfare of their families.

Given the multisectoral nature of PHC programs, it can be inferred that the PHC strategy embodies the concept of integration, which may be defined as "an intentional fusion or coordination of goods and/or services to a common target".<sup>3</sup>

Numerous studies have documented the complex interaction between infection and nutrition and environmental and social conditions. These interrelationships provide the organizational rationale for an integrated service delivery approach. Thus, James E. Austin et al. write:

*The same low-income family has a poor water supply, inadequate sanitary facilities, large number of closely spaced children who become sick and malnourished and die. Transportation may make it impossible for them to visit several different-service facilities... Thus, the same disadvantaged women and children are most likely to require several of the integrated services simultaneously and to have low mobility for obtaining these services from several sources. Moreover, the presence of each service helps reduce the perceived and real risks of adopting innovative behavior required by others. For these reasons, integrated service delivery can be expected to be more effective.*<sup>4</sup>

Case studies and project evaluations suggest that PHC programs or interventions that combine breast feeding promotion and/or young child feeding with other child survival (CS) interventions such as oral rehydration therapy (ORT), the management of acute respiratory infections (ARI) or immunization are more effective in reducing infant/young child mortality and morbidity and improving child growth than single interventions.<sup>5</sup> Programs in Tanzania, Togo, and Nigeria (to name a few) have clearly demonstrated these synergistic effects of infant and young child feeding education activities with other CS interventions in lowering levels of malnutrition, the incidence of diarrhea and mortality among infants and young children.

Based on the conclusive evidence that breastfeeding "provides significant protection against illness and death associated with diarrhea while enhancing the child's nutritional status", the World Health organization (WHO), UNICEF and USAID are recommending a new strategy for the control of diarrheal diseases. In addition to rehydration, this strategy includes the promotion of breastfeeding, improved weaning practices and measles immunization".<sup>6</sup>

Table I below, suggests that integrated population, health and nutrition programs contribute to increased program acceptance and impact. Table I shows that the four integrated MCH programs were successful in lowering mortality rates of infants and young children 1-to-4 year old by 30 percent to 75 percent. The table suggests that integrated population, health and nutrition programs contribute to increased program acceptance and impact. The key factor of effectiveness seems to be the combination of "preventive" and "curative" services.

**Table I: Mortality Rates in Four Integrated MCH - Nutrition Programs<sup>7</sup>**

	<u>Population Receiving Services</u>		<u>Population in Same Area Without Services</u>	
	<u>Infant Mortality Rate</u>	<u>Age 1-4 Mortality Rate</u>	<u>Infant Mortality Rate</u>	<u>Age 1-4 Mortality Rate</u>
Imesi (Nigeria)	57.3	18.0	91.4	51.2
Guatemala	55.4	5.9	84.7	22.0a
Narangwal (India)	95.5	10.1b	126.5	16.3b
Jamkhed (India)	39.0	2.0	90.0	2.0
Hanover (Jamaica)	10.6	5.6	47.0	14.5
Kauar (India)	64.3	n.a.	127.7	n.a.

Source: McCord 1977; Gwatkin et al. 1980

a- From official statistics, which are probably low estimates.

b- Mortality rate for one-to-three-year olds.

### III. Constraints to Effective Integration of Optimal Infant and Young Child Feeding Activities into PHC Programs

While some PHC programs have contributed to lowering infant and young child mortality, implementation of the PHC strategy has proven to be more difficult than expected by the sponsors of the Alma Mata Declaration. Policy, program implementation and institutional constraints have limited the impact of many community-based, integrated health/nutrition programs. These constraints will be analyzed here within the context of integrated infant and young child nutrition programs. These constraints can be grouped into the following categories:

#### A. Organizational and management constraints

1. Given the multifaceted nature of infant and young child malnutrition, its resolution in the medium and long term requires a multisectoral approach to program planning, implementation and evaluation which far exceed the institutional and resource capacities of most health ministries. While the health ministries have been given the mandate to plan, implement and coordinate nutrition activities, proper mechanisms do not exist for monitoring and evaluating nutrition related activities of other ministries and agencies. "Intersectoral" or "interministerial" committees for food and nutrition or primary health care which have been established at various levels in many countries do not have the necessary authority nor an adequate infrastructure for effective coordination, monitoring and evaluation of interventions affecting many sectors.

2. Existing vertical structures and programs do not lend themselves easily to the integrated approach. Indeed, following the Alma Mata Declaration in 1978, international development assistance agencies including U.S.A.I.D., UNICEF, and WHO launched a number of initiatives in the 1980's e.g. GOBI-FFF, Child Survival, Universal Immunization, Control of Diarrheal Diseases, Eradication of Poliomyelitis, the Acute Respiratory Infection Program, in an effort to achieve rapid and significant reductions in infant and young child mortality and morbidity in developing countries. While those initiatives have been successful in lowering infant and young child mortality and morbidity, the focus of many of these efforts on single health issues has fostered the development of "vertical" programs which have not lent themselves well to integration and intersectoral collaboration.<sup>8</sup> Integration of these vertical programs into PHC efforts has been difficult to achieve mainly because their implementation has required a lot of financial and technical resources which exceed the absorptive capacities of most PHC structures. As a result, most of these programs have been heavily subsidized by donor agencies, implemented at an accelerated pace (as "3-5 year projects") and in contrast to the slower, participatory process characteristic of the PHC strategy. It is therefore not surprising that in many African countries, CDD and Nutrition Rehabilitation and Education Programs function in a parallel and semi-autonomous fashion within the same health Ministry, despite the fact that they essentially serve the same population group.
  
3. Most training activities designed and conducted within the context of PHC or community-based integrated nutrition programs have not adequately prepared service providers at all levels to manage integrated programs. Most of the training programs have tended to focus on the specific technical and administrative needs of a single vertical program or project. There is a need to strengthen the management skills of service providers in integrated service planning and delivery and in the practical use of data for decision-making at different levels of the health system in order to enhance the effectiveness of integrated nutrition programs.<sup>9</sup>

#### B. Community participation issues

Failure to adequately involve community members in the assessment and active resolution of their nutritional problems has limited the impact of many nutritional interventions. Frequently, what the community perceives as important needs does not coincide with the priorities identified by external agents. Also frequently, participation for many service providers means community's compliance with or acceptance of prescribed norms or behaviors which may not necessarily rank high on the community's scale of priorities.

Successful community-based programs have been those programs where community participation has been viewed not only as a means for mobilizing community's resources and support for specific interventions, but also as an institutional building objective which is pursued by using and building upon local expertise and know-how to increase communities and individuals' confidence in their ability to address their nutrition and related development problems. This is a slow and time-consuming process which must be built in during the program design phase, and consolidated in the course of program implementation and evaluation. Unfortunately, most nutrition/health program planners do not adequately address this latter objective and tend to view community participation as a tool for achieving the technical objectives of their programs. Effective community participation requires that program personnel at all levels be trained to serve as facilitators of the needs assessment, program design, implementation and evaluation processes, and not as the sole providers of knowledge and know-how.<sup>10</sup> Training programs must therefore emphasize communication, motivational and community development skills as much as technical skills.

P. Kashyap and R.H. Young stress the importance of community participation in needs assessment. The authors challenge the excessive reliance on conventional quantitative methods of nutritional assessments and demonstrate the usefulness of rapid qualitative appraisal techniques for generating a better understanding of coping strategies used by families to address constraints to nutrition and food security at the household and community levels. They highlight the importance of personal interviews and group discussions in eliciting the opinions of community members on particular issues, and stress the use of anthropological methodologies to determine the principal causes of malnutrition at the community level.<sup>11</sup> It should be noted however, that the methodology used by Kashyap and R.H. Young is cited here not as the approach to be used in all settings, but as one example of the many innovative approaches for optimizing community involvement in the diagnosis of community nutrition problems. Similar innovative approaches have been used or developed by others and merit consideration in our search for workable strategies.<sup>12</sup>

### C. Infant feeding policies and practices

Inadequate knowledge among health workers of basic aspects of breastfeeding, lactation management and weaning has prevented effective integration of optimal infant feeding practices into national PHC programs. A review of health institution policies and practices and their effects on breastfeeding and infant/young child nutrition has been the subject of numerous studies and is beyond the scope of this paper. Some of the detrimental practices which have been cited and prevail in many parts of Africa include:

- use of glucose water as a prelactal or first feed;
- routine use of drugs during childbirth;
- routine separation of the mother and baby immediately after the baby's birth;
- use of nurseries for normal infants rather than "rooming-in" arrangements;
- lack of arrangements for providing breast milk to premature newborns and sick infants.<sup>13</sup>

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These practices point to the need for developing a coherent service policy in order to prevent conflicting messages conveyed by different programs and to ensure coherent guidelines for the training, supervision and performance evaluation of health and related service personnel. For example, on the one hand, we are encouraging mothers to breastfeed exclusively and not to give water or teas from the first day to six months and on the other hand, we are promoting ORT as a cost effective measure for combatting dehydration in infants and young children suffering from diarrhea. Although the two messages are scientifically valid, it is important for health service providers to consider carefully how these messages are being perceived by the target audience and the potential conflicts that may result in their application.

#### **IV. Opportunities for Optimizing Infant and Young Child Nutrition Outcomes through PHC.**

The analysis of constraints in the preceding section clearly demonstrates that different approaches need to be designed and tested to meet the various needs of nutritionally vulnerable groups, in a manner that is affordable and culturally appropriate. This section discusses some approaches which have proven to be effective in optimizing infant and young child nutrition outcomes through PHC and describes a few examples of successful integrated nutrition interventions, drawn from secondary sources. Given the objectives of this conference, the author will mainly focus on nutrition interventions designed to improve infant and young child feeding practices.

##### **A. Integration of Breastfeeding Promotion into CDD Efforts**

Diarrheal disease control (CDD) programs present an excellent opportunity for promoting breastfeeding and improving young child feeding practices. Health workers who are involved in CDD efforts frequently have to deal with numerous cases of diarrhea that can be linked to suboptimal breastfeeding and young child feeding practices. Health care providers must take advantage of the interaction they have with the mothers to promote breastfeeding (BF) and proper weaning practices as part of an integrated strategy of diarrheal disease management and prevention.

CDD training units provide an opportunity to solve BF problems through individual counseling and demonstration. To the extent possible, the service focus of ORT corners should be expanded to include BF promotion and counseling activities, in order to limit the number of referrals of malnourished children to special rehabilitative units to very serious cases only.

Inpatient and outpatient sections of CDD units must coordinate their efforts to ensure that BF mothers are not separated from their children and are allowed to breastfeed during the treatment. Furthermore, many CDD programs have significant training resources which can be mobilized to support BF promotion and related IEC efforts.<sup>14</sup>



B. Integration of Growth Monitoring and Promotion into Infant Feeding and PHC Activities.

Growth monitoring has been shown to be most effective when it is combined with IEC activities tailored to the specific conditions of each child.

C. Integration of Nutrition into Primary Schools.

In light of steady increases in primary school enrollments in many African countries, primary schools provide an opportunity for influencing children's knowledge and practice related to health and nutrition by introducing practical and simple nutrition concepts at a very early stage when children are very eager to learn.<sup>15</sup>

D. Integration of Nutrition into the Traditional Health Care System

Traditional health care providers (e.g. traditional healers and traditional birth attendants) constitute an effective channel for reaching women of reproductive age and children. Their scope of work can be broadened through practical training in women's and children's health and nutrition. For instance, marasmus and/or kwashiorkor in certain traditional African cultures are considered acts of punishment of the mother for her sexual misconduct.

E. Integration of Nutrition into formal MCH Programs

Modern MCH services can also be expanded to include basic nutrition education services. To the extent feasible, dietary assessments should be introduced as a complementary method for monitoring the nutritional status of pregnant women and for identifying at risk groups, as weight alone cannot adequately reflect changes in food availability at the household level.<sup>16</sup> This approach has its limitations in the African context where there is shortage of health/nutrition personnel and significant regional and tribal differences in dietary practices.

F. Local capacity building for nutrition development

Various participatory approaches and community financing schemes have been used to optimize health outcomes through PHC. These approaches can be used to optimize infant and young child nutrition by building the technical, managerial and financial capacities of community based organizations to address community nutrition problems. Some of the approaches which have been used effectively include:

1. the creation of local NGOs (e.g. local breastfeeding and nutrition support organizations such as IBFAN) to increase awareness among policy makers and influential members of the community of the importance of breastfeeding and nutrition and to support the development of policies for optimal infant and young child feeding practices.

2. the formation of women's groups, credit unions and cooperatives at the community level. Many of these structures are currently active in Africa and could be used to provide or facilitate access to a variety of education, training, and credit services to nutritionally at-risk families. These groups have the potential of improving the nutrition of women, infants and young children if their mission could be broadened to include health and nutrition education, as well as child care services (including supplementary feeding).

Related to this issue is the issue of long term sustainability of community based integrated nutrition programs. A major challenge of primary health care or community-based nutrition programs in developing countries is how to assure they are self-sustaining in the long run.

With the economic crisis affecting most African countries, resources allocated to social sector programs are expected to continue to decline in real terms over the next ten years. The recent review of 66 "successful" nutrition projects in Africa by the World Bank suggest that the following elements seem to enhance programs' sustainability:<sup>17</sup>

1. Community participation has been sustained by working with pre-existing community institutions which enjoy local support and have the local experience and know-how.
2. Sustainable nutrition programs have been those that have been implemented by NGOs with strong local government support. Many of the projects reviewed have established strong linkages with the government through secondment-type of arrangements or by involving government and NGO personnel jointly in project activities.
3. Sustainable programs have also been those that have demonstrated a flexible approach and developed effective mechanisms for responding to the felt needs of the targeted group. For instance, the Togo Infant Feeding program was completely restructured to respond to the needs of the mothers. Prior to the evaluation, the project had very little impact on the nutritional status of participating children. The approach to growth monitoring was top-down and clinic based, with very little feedback given to or obtained from the mothers. As a result, participation by mothers in project activities was poor. In an effort to address the deficiencies noted by the evaluation team, mothers were interviewed to obtain their views on the problems and the changes required. Their suggestions were incorporated into a revised strategy which now includes training the mothers as home visitors. Similarly, the Ghana Applied Nutrition program was revised to include a credit component to address the need for income (in addition to nutrition education) expressed by the mothers to improve infant feeding practices.

4. Finally, projects that are more likely to be self-sustaining in the long run are those where some kind of cost sharing arrangement is established from the beginning, and where funds from the community, the local government and external donors are combined. A good example cited is the Kinshasa Urban Nutrition program, in which recurrent costs of the program are covered by funds generated through the commercial sale of a weaning food.

#### F. Mass Media

The potential of the mass media to communicate health messages and modify attitudes has been demonstrated through various IEC projects. Radios and TVs are becoming increasingly available in rural areas in Africa and should be increasingly used to increase community awareness of the extent and scope of malnutrition problems among infants, children and women. Because of the interaction of nutrition and other factors, these media should also be used to increase awareness of related development issues (e.g. women's issues) and opportunities (e.g. how to obtain a loan, how to join a local credit union, a cooperative, etc...).<sup>18</sup>

#### V. **Examples of Effective Approaches to Community-Based, Integrated Infant and Young Child Nutrition**

##### A. Use of growth monitoring to improve young child nutrition in the Dominican Republic: INCS/CRS/CARITAS project

The experience of the International Nutrition Communication Service (INCS) project in the Dominican Republic represents a good example of effective use of growth monitoring to improve young child nutrition. In the Dominican Republic, INCS provided technical assistance to Catholic Relief Services (CRS) and CARITAS in the use of growth monitoring to address infant and young child malnutrition problems within the context of a community-based health program. The first step consisted of increasing awareness among community members and particularly the mothers, that nutrition is a very important determinant of children's health. The second step was to interest the communities in a weighing program as an effective tool for monitoring growth. As community members began to take interest in the program, they began to participate actively in the design of educational messages which were targeted at children who failed to gain weight. The population also became actively involved in testing these messages within their communities and in evaluating them for their clarity, coherence and appropriateness to the local culture. These messages were developed in such a way that they could be used by field workers with low literacy skills. They were printed on counselling cards and each card specified the target group of children for which it was designed. Project data indicates that children who participated in the program maintained or improved their nutritional status (despite the economic difficulties the country was experiencing) while the nutritional status of the children who did not participate in the program declined significantly.<sup>19</sup>

B. Use of the Agescale to improve young child nutrition in Nigeria: Tufts/UNICEF/LUTH project

Tufts University's experience with the Age Scale in Nigeria is an interesting approach to community-based growth monitoring and nutrition education. The project is an operational research funded by UNICEF and implemented by Tufts University's School of Nutrition. It was designed to test an innovative, community-based approach to the delivery of nutrition education to improve breastfeeding and young child feeding practices. Specific objectives of the project were to a) identify obstacles and constraints to breastfeeding and young child feeding at the household and community level in order to define a realistic framework for effecting changes in infant and young child feeding practices and b) test the effectiveness and appropriateness of the Agescale as a simplified and participatory tool for community-based growth monitoring.

The Age Scale is a new method designed to help parents and community workers to monitor children's growth closer to their home and community. It assesses the child's weight for age by indicating if the child weighs at least the minimum expected for her/his age. It can be used with children (0-4 years of age). In the Nigeria study, three contracting forms - one for each of the three age groups (0-4 months, 5-9 months, and 10-24 months) were designed to support the counselling. Specific messages were developed and discussed with the mothers to address specific problems related to their child's growth (see Annex I).

Preliminary findings from this study seem to indicate that positive changes in breastfeeding and young child feeding practices can be achieved if the desired changes are negotiated with the mothers in terms of what they can and are willing to make. The contracting process appears to be an effective tool for effecting behavior change. By emphasizing individualized problem diagnosis and problem-solving based on the contracting messages, it allows the field worker and the family to define a realistic framework for optimizing infant and young child feeding and nutrition. The Agescale has also proven to be an effective tool for community-based growth monitoring. By eliminating some of the problems associated with the use of growth charts, (it does not require plotting a graph and can therefore be used in communities with low literacy skills), it has encouraged parents to play a more active role in monitoring their own children's growth.<sup>20</sup>

C. Integration of nutrition education into primary schools: INCS' experience in Jamaica

An interesting approach to primary school nutrition education was used a few years ago by the INCS project, in collaboration with the Ministries of Health and Education in Jamaica. The approach consisted of integrating practical nutrition education concepts and messages into primary school primers, thus enabling children to learn about nutrition as they learned to read. Social marketing techniques were used to develop the messages. The materials which were developed were introduced on a pilot basis in 20 primary schools in Jamaica, representing a target population of 2,500 children. Evaluation results revealed that the approach was effective in teaching the children practical steps to addressing specific nutritional problems.<sup>21</sup>

D. Support to breastfeeding and working women through the promotion of in-home child care centers: CSI's Model

An innovative approach to the provision of child care was recently proposed to the Women and Infant Nutrition Support project by Children Services International of Colorado (CSI). The model provides support to breastfeeding and working women through the promotion of in-home child care centers. It consists of the establishment of in-home child care centers (in communities where there is a need and interest for such services) operated by nursing mothers and used by working women with toddlers. Participating mothers are trained in infant and young child care and nutrition, business management and related skills. Each center is operated by one or two women who are either pregnant or breastfeeding, and utilized by 10 to 12 working women with preschool children. Women utilizing the centers pay those operating the centers a fee for their services. These in-home centers are designed to operate on a rotating basis so that as one breastfeeding mother/center operator weans her child from the breast, she can transfer her child and the other children in her care to another breastfeeding woman in the cluster. However, mothers are given the option to continue operating their in-home center as a business venture if they so desire.<sup>22</sup> This approach has been used effectively in the United States by Children Services of Colorado (CSC) to provide low-cost, community-based infant/child care services to low income working women as well as an alternative source of income to breastfeeding mothers who choose to stay home and care for their infants. The approach needs to be considered as we explore community-based, cost effective options for child care in Africa.

## VI. Conclusions

This paper analyzes the major constraints and effective approaches for optimizing infant and young child nutrition within the context of the PHC strategy. It is noted that in many cases, community-based integrated nutrition programs are hindered by inadequate funding. Health and other service providers as well as community members are not appropriately trained to manage and implement community-based, integrated health and nutrition activities.

Despite the failures of many community-based integrated health programs, the experience of 66 integrated nutrition programs/projects in Africa over the past few years seems to indicate that the community-based integrated approach to the delivery of health and nutrition services can be effective in addressing constraints to optimal infant and young child feeding.

Integrated nutrition interventions which seem to have worked in Africa over the past five years are those that a) have strong government and community support, b) are implemented by private voluntary organizations with strong program linkages with a government institution, c) use low cost and simplified technologies which can be easily acquired by the communities with minimal training and resources, d) are financed through a combination of external, local government and community funds, and e) are linked to income-generating and related health development activities.

Given the relatively low coverage of the rural population in Africa by the formal health care system and declining national budgets, clinic based health/nutrition interventions seem to offer a limited return on the investment. Innovative, community-based, participatory approaches and simplified technologies which have been effective in delivering nutrition and other development services in other settings need to be tested and evaluated in the African context for their effectiveness, efficiency and relevance to the local culture.

There is also the need to adapt qualitative research techniques for use at critical stages in the program design and implementation phases in order to gain a better understanding of the communities' perceptions of their nutrition problems, their development agenda and the coping strategies devised by families to deal with malnutrition and poverty.

Opportunities do exist to achieve significant improvements in infant and young child nutrition through integration of optimal infant and young child feeding, growth monitoring and promotion and income generating activities into child survival and related development activities.

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## ANNEX

AGESCALE GROWTH CHART - MOTHER'S CONTRACTING FORM 3

10 to 24 months. Giving family food.

The child is ready for family foods. The child needs three meals a day and at least two snacks.

The child should eat with the mother or father, but using his or her own dish. If children eat together, they should each have their own bowl.

Give any food which the family eats. Make it soft. Help the child to eat by feeding him or her, and by encouragement.

Each of the child's meals should have some growth food with it. Growth food include: ewa, soya, moin-moin, eja, eyin, egusi, ede, and eran. Good snacks for children are milk, biscuit, akara, puff-puff, and fruits.

A child who wants to eat food or snacks five or six times a day is not spoiled. Growing children need to eat often. Both food and breast milk help to make the child grow strong and clever.

Breastmilk is still very important. Continue to breastfeed in the daytime and at night. But do not give breastfeeds instead of the child's five or six meals and snacks.

When you are ready to stop breastfeeding, the child is losing something good. In place of that, give other good things, especially extra food to eat, with plenty of growth food.

Also give extra attention and stimulation to the child. Talk with him or her, teach the child, play and sing together, provide things to play with, and keep the child near you whenever you are at home.

Do not send the child away in order to wean from the breast.

Contracting form	Days of contract week						
	M	Tu	W	Th	F	Sa	Su
1. Mother will feed three meals every day.							
2. Mother will give two snacks or fruits every day.							
3. Mother will feed the child when she is eating.							
4. The child will have his or her own dish of food.							
5. Mother will not reduce breastfeeds until she is ready to stop breastfeeding.							
6. _____							
7. _____							

Source: Dr. Marian Zeitlin, Tufts University School of Nutrition

# AGESCALE GROWTH CHART BIRTH TO TWO YEARS

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Age in months | Date | Agescale



Give only breastmilk every time baby is hungry or thirsty.  
Give both breasts and take your time.  
Let baby decide when to stop each feed.

0		
1		
2		
3		
4		



Continue to breastfeed as much as before.  
Add thick ogi enriched with growth foods.

ogi with  
bean flour or beans  
palm oil

ogi with  
milk or egg  
sugar  
margarine

ogi with  
fish  
okra or ewedu  
palm oil



Give enriched ogi 1 time a day.

Give enriched ogi 2 times a day.

Give enriched ogi 2 times a day.

Give enriched ogi 3 times a day.

Give enriched ogi 3 times a day.

5		
6		
7		
8		
9		

Give any food which your family eats,  
but make sure that it is soft:  
rice, amala, eba, lafun, lyan

Always give some growth food with baby's food:  
ewa, soya, moin-moin, eja, eyin, agusi, eds, cran

Give snacks and milk:  
biscuit, akara, puff-puff, milk

Give fruit:  
orange, banana, pawpaw

Give food 3 times each day.

Give snacks 1 or 2 times a day.

Give fruit 1 or 2 times a day.

10		
11		
12		
13		
14		
15		



16		
17		
18		
19		



Breastmilk is very good up to two years.  
Be sure your child is eating  
plenty of other foods, too.  
Don't reduce breastfeeding  
before you are ready to stop.  
When you stop breastfeeding, give your  
child extra stimulation and good food.



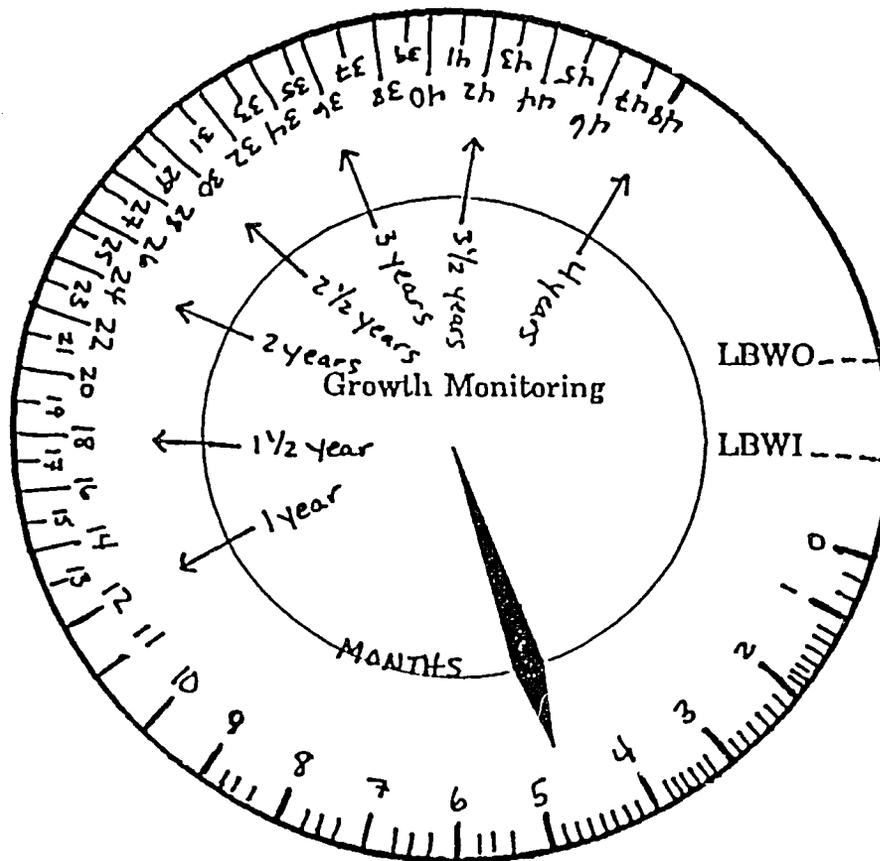
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DRAFT for concept testing

**GOOD FOOD IS A FOUNDATION  
FOR LIFETIME SUCCESS**

Fold under on  
double line  
before using  
as wall poster.

## USING THE AGE SCALE



- o The Age scale gives a number which shows immediately if the child weighs enough for his age.
- o The dashed lines marked LBWO and LBW1 indicate the danger levels for referral at birth and at one month, for babies who are born small or early, i.e. the Low Birth Weight babies (LBW).
- o If the Age scale number is HIGHER than the age, CONGRATULATE the family.
- o If the Age scale number is LESS than the age, LEARN MORE from the family and then ADVISE and FOLLOW-UP.
- o If the Age scale number is HALF of the age, REFER the family to Lagos Univ. Teaching Hospital (LUTH).

SOURCE: DR. MARIAN ZEITLIN, TUFTS UNIVERSITY.