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**EXECUTIVE SUMMARY**

Appropriate breastfeeding is one of the most cost-effective means of ensuring child survival, and yet such practices are not uniformly common in many developing countries. But where breastfeeding has been actively promoted and supported, declines have been stabilized or reversed.

Breastfeeding promotion and support have not to date been a major focus of A.I.D.'s child survival, health, population, and nutrition activities. Recognizing the need therefore to enhance the breastfeeding component of A.I.D.'s programs, this Breastfeeding for Child Survival Strategy has been developed. It makes explicit the following benefits of breastfeeding and the critical relationship between breastfeeding and child survival:

- Breast milk is ideal food for infants
- Breastfeeding saves lives
- Breastfeeding saves money
- Breastfeeding prevents diarrhea
- Breastfeeding confers immunity
- Breastfeeding protects mothers' health
- Breastfeeding is effective family planning

This strategy seeks to protect and promote breastfeeding by creating an environment of awareness and support so that those women who choose to breastfeed are able to do so. More specifically the goal is to increase the percentage of infants who are: 1) breastfed within one hour of delivery; 2) exclusively breastfed from birth through four to six months of age; 3) fed appropriate complementary foods in addition to breast milk by the end of six months of age; and 4) breastfed for one year or longer.

The Agency will strengthen and focus breastfeeding promotion within its child survival, health, population and nutrition programs. Activities are needed along the entire continuum from pregnancy through weaning. The breastfeeding action agenda for A.I.D. is to:

- Assess breastfeeding situation in assisted countries
- Develop country specific substrategies
- Implement appropriate activities, especially within ongoing related programs
- Continue and expand centrally funded field support
- Disseminate information on the problem and solutions
- Support research on breastfeeding
There is great potential for promoting and supporting breastfeeding within ongoing efforts aimed at diarrheal disease control, immunization, nutritional improvement, child spacing, prenatal care, health care financing, and food aid. Existing programs should not present inherent obstacles to optimal breastfeeding. Successful approaches to breastfeeding promotion and support include: training of hospital-based and other health workers in lactation management, communication and social marketing, and mother-to-mother support groups. Effective methods to facilitate breastfeeding by working women and to reach women outside the formal health sector need to be developed.
I. BACKGROUND

A. Rationale

Research has conclusively documented the significant impact of breastfeeding on child survival, with the risk of death from all causes for non-breastfed infants approximately double that of those exclusively breastfed.

Given the enormous direct impact that breastfeeding has on child survival, in addition to the critical role breastfeeding plays as an enhancer of each of the key child survival interventions--diarrheal disease control, immunization, nutrition, and child spacing--A.I.D. has developed this Breastfeeding for Child Survival Strategy. The Strategy provides guidance for strengthening and focusing A.I.D. breastfeeding promotion and support projects and activities. Considering the success the Agency has had in promoting oral rehydration therapy and immunization and the relative neglect of breastfeeding promotion in most programs, the Strategy is a call to action to assure optimal breastfeeding practices within child survival programs, and also in the broader health, population and nutrition sectors.

B. Benefits of Breastfeeding

Exclusive breastfeeding through the first 4-6 months of life is probably the single most cost-effective child survival intervention available. The benefits of breastfeeding are numerous and include:

1) Nutritional Value

Breast milk is a unique and invaluable food. No breast milk substitute is the nutritional or immunological equivalent of human milk. It has not been possible to invent an infant formula to replicate the highly complex and unique nature of human milk, with its over 100 known constituents and singular ability to adapt over time to match the infant's changing nutritional and immunological needs and demands. Research continues to reveal previously unknown, essential constituents in breast milk.

Cow's milk and cow's-milk-based infant formulas contain a lower proportion of fat and a higher proportion of protein than breast milk, which contribute to different growth patterns between breastfed and artificially fed infants. Research is needed to develop more appropriate growth standards for breastfed infants since existing reference curves are based on U.S. infants who were primarily fed with breast milk substitutes.
During the weaning phase, the ideal balance of amino acids provided by breast milk adds to the quality of protein in the total diet, which is frequently deficient in other sources of animal protein. Since breast milk is a rich source of Vitamin A, breastfeeding may reduce the risk of Vitamin A deficiency and xerophthalmia in later infancy. Furthermore, the absorption of zinc and iron from breast milk is unsurpassed by any other source in early infancy, thus protecting against early iron deficiency anemia and zinc deficiency.

2) Reduced Mortality

That the risk of death from all diseases for non-breastfed infants is nearly twice that of breastfed infants has been documented in many countries, including the Philippines, India, Malaysia, Egypt, Brazil and Chile. The younger the infant and the longer the breastfeeding, the greater the mortality reduction.

In an A.I.D.-funded 1977 study in Malaysia, after correcting during analysis for biases in the data, it was concluded that twice as many babies would have died after the first week of life had there been no breastfeeding. Infants fully breastfed during the first week of life had 16 fewer deaths per 1000 at 8-28 days of age than infants not breastfed. Partial breastfeeding also contributed to survival but saved only one third as many infant lives as full breastfeeding. The protective effect of breastfeeding continued through 7-12 months of age.

A 1969-70 study in rural Chile found that postneonatal death rates were three times higher among infants who started bottle feeding in the first three months than among those who received only breast milk. In Egypt, children who were breastfed for 15 to 20 months had a 93% probability of surviving until the birth of the next child, whereas children never breastfed or breastfed for less than three months had only a 64% survival probability. Other studies have looked specifically at the effects of breastfeeding on diarrheal mortality. A review of nine studies from five countries found the median relative risk of mortality from diarrhea to be 25 times higher during the first six months of life for non-breastfed infants; and the median relative risk of mortality from diarrhea to be over 8 times higher for partially breastfed infants versus exclusively breastfed infants.
3) Diarrhea Prevention

Nearly all studies to date have found breastfeeding to be associated with either lower incidence of diarrhea or less severe diarrheal morbidity. Non-breastfed infants generally experience at least twice the risk of diarrheal morbidity of exclusively breastfed infants. More research is needed on the ages up to which the benefits of breastfeeding on diarrheal prevention are the greatest, but some studies suggest that the protective effect peaks between the age of three to nine months and declines thereafter. Studies in the Philippines and Peru demonstrate a large beneficial effect throughout the first six months of life. In the Philippines, non-breastfed infants were 5 to 17 times as likely to have diarrhea as exclusively breastfed infants. This particular study provides compelling evidence that until the infant requires additional nutrients to promote normal growth, usually around 5-6 months, the feeding of other foods and liquids contributes considerably to diarrheal morbidity by displacing breast milk and its inherent anti-infective factors, and introducing the infant to food- and water-borne pathogens.

4) Immunological Protection Against Other Infectious Diseases

Breastfeeding is a passive form of immunization which assists, along with trans-placentally acquired maternal antibodies, in protecting the infant from common bacterial and viral pathogens prior to and during the time of acquiring active immunity through vaccination. Colostrum, transitional breast milk and mature breast milk contain substances that guard the infant against diarrheal disease, acute respiratory infection, otitis media, and measles. Recent research has also shown that colostrum enhances the infant's immune response to BCG vaccine given at birth.

A few case reports have suggested the possible transmission of human immunodeficiency virus (HIV-AIDS) through the breast milk of HIV positive mothers. However, the evidence to date is not conclusive and there is general consensus that children of HIV-infected mothers in developing countries who are not breastfed are at far greater risk of dying from diarrhea, malnutrition, and other diseases than are breastfed children who face the small risk of acquiring HIV through breast milk. Breast milk is also important in preventing intercurrent infections which could accelerate the progression of HIV-related disease in already infected infants. Therefore, breastfeeding by the biological mother should continue to be the feeding method of choice for all infants, irrespective of the mother's HIV-infection status (Annex IV).
5) **Child Spacing Benefits**

From a demographic standpoint, breastfeeding can have a significant impact on fertility rates. One A.I.D.-funded study suggested that breastfeeding reduces total possible fertility by an average of 34% for five countries in Africa, by 30% for twelve countries in Asia, and by 16% for another twelve countries in the Americas. This analysis projects that if the current median durations of breastfeeding were to be halved, fertility would increase by 27% in Ghana and Senegal, 17% in Haiti, 37% in Indonesia, and 33% in Nepal.

Breastfeeding and appropriate family planning methods can prevent between 10 to 20% of infant deaths and reduce maternal deaths by 25 to 50%. Exclusive (or almost exclusive) breastfeeding delays ovulation and provides a high degree of protection from pregnancy, thus lengthening the birth interval. The following consensus statement on lactational infertility was adopted at a conference of international scientists held in 1988 in Bellagio (Italy): "The maximum birth-spacing effect of breast-feeding is achieved when a mother 'fully' or nearly fully breastfeeds and remains amenorrheic (bleeding before the 56th postpartum day being ignored). When these two conditions are fulfilled, breastfeeding provides more than 98% protection from pregnancy in the first six months." What is new about this concept is the clarification of the type of breastfeeding practices (i.e. full or exclusive) required for maximum protection and the fact that a breastfeeding woman can determine how long she is protected based on the timing of return of her menstrual period and age of the baby. Without breastfeeding, ovulation resumes, on average, at about two months postpartum. Introduction of complementary weaning foods with a cup or spoon rather than bottle, at 5-7 months, along with frequent, continued breastfeeding, can contribute to, but not guarantee, further delay in the return of fertility.

To ensure adequate child spacing, appropriate, complementary family planning methods (preferably those that do not interfere with lactation) should be introduced when any one of the following questions can be answered with a "yes" by breastfeeding women: 1) Have menses returned?; 2) Is the mother more than six months postpartum?; 3) Has the breastfeeding pattern changed from exclusive or almost exclusive to partial or token?; and 4) Is the baby sleeping through the night (Annex V)?

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6) **Other Child Health and Psychological Benefits**

Other benefits of breastfeeding include:

a) facilitating a close emotional bond between the mother and child;
b) preventing hypothermia in the newborn;
c) ensuring that infants receive adequate visual and tactile stimulation, essential for normal cognitive and social development (one outcome of increased bottle feeding is the widespread practice of leaving the infant alone with a propped bottle, where there is no mother/infant contact);
d) avoiding dental caries caused by children sleeping with bottles in their mouths;
e) promoting normal facial development and alignment of the teeth;
f) minimizing the risk of allergies to proteins in cow's milk and other foods;
g) reducing the risk of developing neonatal sepsis and meningitis.

Breastfeeding may also play a partial protective role in preventing acute necrotizing enterocolitis, sudden infant death syndrome, diabetes, and lymphoma.

7) **Maternal Health Benefits**

Breastfeeding benefits the mother in several ways. Frequent suckling at the breast, commencing within the first hour after delivery, probably reduces the risk of postpartum hemorrhage and retained placenta by stimulating the pituitary gland's release of oxytocin, which hastens contractions and involution of the uterus. Early postpartum uterine contractions decrease the likelihood of prolonged bleeding which can be fatal for the mother and which exacerbates iron deficiency anemia.

Exclusive breastfeeding continues to offer the mother protection from iron deficiency anemia because iron loss in menstrual fluid is prevented during prolonged lactational amenorrhea. In addition, epidemiological studies indicate that breastfeeding may be one factor in reducing a woman's lifetime risk of developing breast or ovarian cancer. The longer a woman breastfeeds seems to be correlated with the degree of protection offered. Finally, there are numerous suggestions in the literature that for many women
breastfeeding is accompanied by a sense of calm and satisfaction, which may be related to hormonal changes.

8) Cost Savings

Breastfeeding offers important economic as well as ecological benefits. These benefits can be summarized at the family, formal health sector, and national levels as follows:

a) Family Level

Breast milk substitutes can cost families several hundred dollars per year or an amount equal to or greater than the average per capita income in many countries. The costs of breast milk substitutes, related equipment, fuel for sterilization of the equipment, refrigeration, as well as the value of time required for obtaining water, preparation, and feeding, are in total appreciably higher than the cost of the mother's added nutritional intake to produce breast milk and the value of her time spent on breastfeeding. The high cost of breast milk substitutes leads families to attempt to extend their limited resources by improperly over-diluting them during preparation.

When comparing the indirect costs of bottle feeding—increased infant malnutrition, morbidity, and mortality and shorter birth intervals—with the indirect costs of breastfeeding—possible maternal nutritional depletion among very underweight women, breastfeeding represents a further savings. In addition, breastfeeding provides economic benefits in terms of lower health care expenditures and reduced time burden to parents caring for sick children.

b) Formal Health Sector Level

The economic benefits of breastfeeding at this level, including public and private health care facilities, are of at least two types: 1) reduced expenditures on curative care for diarrhea, malnutrition and other diseases due to breastfeeding's beneficial, preventive effects; and 2) reduced expenditures on inpatient maternity and pediatric care where breastfeeding is actively encouraged.

Policies that favor breastfeeding, especially rooming-in policies, where mothers and infants are kept in the same room, save maternity care facilities money on infant formula, bottles, nipples, water and power for sterilization, glucose water, intravenous fluids, drugs such as oxytocin, and staff costs. Nursery personnel, no longer needed due to rooming-in, can be employed elsewhere in the hospital and the space occupied by the nursery used for
other purposes. For example, the A.I.D.-funded Wellstart lactation management education program for health professionals from the Philippines effectively catalyzed a rooming-in program at the Dr. Jose Fabella Memorial Hospital, resulting in a $310,034 savings in one year (or approximately 8% of the budget).

Breastfeeding also represents a potential savings to family planning programs. If breastfeeding rates decline, significant increases in contraceptive use become necessary simply to maintain birth rates at the current level.

c) National-Level Economy

The billions of liters of breast milk produced annually by mothers around the world should be viewed as a natural resource and a valued food commodity. At the national level, by assuring that breast milk is used as a vital indigenous food resource, financial outlays are saved (including foreign exchange). In the Philippines, for example, it was recently estimated that the equivalent of U.S. $33 million was spent in one year on breast milk substitutes, many of them imported. Even in Pakistan, where breastfeeding is the norm, expenditures on imports of breast milk substitutes were nearly U.S. $8 million in 1985-86.

Breast milk is not the only valuable natural resource wasted by bottle feeding. Firewood, which is necessary for boiling utensils and water to assure sterile bottle feeds, is disappearing at an alarming rate in many parts of the world.

Policies that are supportive of breastfeeding are also environmentally sound. For every 3 million bottle fed babies, 450 million tins of infant formula are consumed, resulting in 70,000 tons of discarded metal that may not be recycled. Non-biodegradable plastics and other packaging materials used for breast milk substitutes also are not accumulated as waste if mothers breastfeed instead.

C. Statement of the Problem

Despite the overwhelming evidence to date in support of the benefits of breastfeeding, the preponderance of literature suggests an overall decline in both incidence and duration of breastfeeding as countries modernize, similar to that experienced by the developed countries in the 1940's through the early 1970's. Dramatic declines in breastfeeding have been most noted in urban areas, but declines are also occurring in rural areas. Moreover, studies that have gone beyond general descriptions of incidence and duration to collect detailed information on
breastfeeding practices reveal that these practices are far from optimal.

A number of factors have contributed to significant negative changes in breastfeeding practices. Urbanization and economic transition have taken women out of traditional social support systems. These changes have altered women's perceptions of breastfeeding; men's attitudes toward breastfeeding have also been affected. An increasing percentage of women deliver in hospitals where they are exposed to Western medical beliefs and practices that interfere with and discourage breastfeeding (Annex I). There is a pervasive availability and marketing of breast milk substitutes, often misrepresented as a desirable alternative to breastfeeding. Women's work outside the home often results in early separation of the mother and infant for lengthy periods which makes breastfeeding difficult.

The following are common breastfeeding practices that are considered sub-optimal (Annex II):

1) **Breastfeeding is initiated too late or not at all**

Delayed initiation of breastfeeding is a common practice in both urban and rural areas worldwide. In urban hospitals, breastfeeding initiation is often delayed several hours after delivery, during which time glucose water or infant formula may be given. In rural settings, the first milk, colostrum, is discarded and replaced with a wide range of prelacteal feeds, including herbal mixtures, water, teas, and ritual tastes of food. Whereas delayed initiation in hospitals derives from Westernized medical beliefs and practices, in rural areas, the practice is a result of traditional beliefs that portray colostrum as dirty, spoiled, poisonous and harmful to the infant.

In either setting, late initiation has serious consequences. It delays mother-infant bonding, increases the risk of hypothermia in the newborn, exposes the infant to diarrheal pathogens in the prelacteal feeds, and deprives the infant of the nutrients and anti-infective properties unique to colostrum. Furthermore, delayed initiation leads to engorgement of the breasts and potential breast infection, causing maternal discomfort and contributing to the "insufficient milk" syndrome, due to reduced suckling stimulus provided by the infant, and to rejection of the breast. The benefits of early initiation for reducing postpartum hemorrhage and aiding uterine involution are also important to women's health.

Another growing concern is the small but important proportion of women (especially in urban areas) who do not initiate breastfeeding at all. This problem is more
pronounced in the Latin America and Caribbean region and in some of the more economically advanced countries of Asia. The practice of not breastfeeding at all is spreading to the economically disadvantaged in the periurban and rural areas, having a serious impact on fertility, and on infant malnutrition, morbidity and mortality.

2) **Exclusive and frequent breastfeeding is rarely practiced**

Exclusive breastfeeding, where no other liquids or solids are given, is recommended for infants through 4-6 months of age due to the advantages of breast milk and the many dangers of non-breast milk foods and liquids. Yet, early supplementation within the first four months with breast milk substitutes or other foods and liquids ("partial breastfeeding"—see breastfeeding definitions in Annex III) is a problem worldwide.

A vast number of studies document this trend toward partial breastfeeding. One A.I.D.-funded study showed the use of breast milk substitutes or other foods within the first three months of life to be high among breastfeeding mothers in all four of the countries studied. In Colombia, rates of exclusive breastfeeding fell precipitously from only 46% of infants in the first month of life to 10% by the end of the second month and 2% by the end of the third month. Indonesia and Kenya reported similar patterns where, by the third month of life, exclusively breastfed infants were only 13% and 11% of all infants, respectively. In Thailand, over 66% of infants were receiving other foods and 45% bottled milk within the first month of life. The same study revealed that over 86% of Kenyan mothers believed that supplementation with infant formula in the first three months of life would make their children healthier. Infant formula was actually misperceived as a special tonic or nutrient booster.

Partial breastfeeding reduces milk production. The physiology of natural suckling is vastly different from that of feeding from a bottle with a nipple. This partial breastfeeding (breast plus bottle) causes "nipple confusion," resulting in decreased suckling and consequent lower breast milk output. Partial breastfeeding also leads to earlier return of menses and fertility.

Infants have immature digestive and immune systems. Unhygienically prepared breast milk substitutes, other liquids, and weaning foods expose the infant to diarrheal pathogens. Furthermore, these feeds may be over diluted due to the family's inability to pay for adequate amounts, resulting in the infant's nutrient requirements not being
Infants who consume breast milk substitutes also suffer from other infections, such as those of the respiratory system, more often than exclusively breastfed infants, because of their lower intake of the protective, anti-infective substances in breast milk. The diarrhea, other infections, and inadequate nutrient intake, due to partial breastfeeding during the first 4-6 months of life, lead to the infant's failure to gain adequate weight or actual weight loss, and sometimes death. Yet even in the best of circumstances, when breast milk substitutes are prepared in a sterile manner and in the proper proportions, they are still not the equivalent of breast milk, and reduce the infant's ingestion of the immunity enhancing factors found only in breast milk, leaving the infant more vulnerable to diarrhea, respiratory, and other infections.

Infrequent breastfeeding, where mothers feed on a fixed schedule with long intervals in-between (greater than 4 hours), instead of the preferred pattern of feeding whenever the infant demands, also contributes to lower breast milk output and an earlier return of fertility.

3) Duration of breastfeeding is shorter than desirable

Given the many nutritional, immunological, and child spacing benefits of breastfeeding, it should be continued well into the second year of life. Abrupt weaning from the breast, or infrequent or token breastfeeding after six months of age are common problems. The mean duration for which infants continue to receive some breast milk for the Asia/Near East and Africa regions is reportedly high, at around 20 months or more, but the range reveals actual duration in some countries of only 6 months. In the Latin America/Caribbean region, where average duration is reportedly between 5 and 9 months, actual duration is only 2 months in some countries.

4) Weaning with complementary foods begins at inappropriate ages.

The danger of introducing weaning foods to infants too early has been discussed. However, introducing weaning foods too late to complement breast milk can lead to growth retardation due to the inability of breast milk alone to fulfill the infant's total nutrient requirements after about 5-6 months of age. In some areas of the world exclusive breastfeeding is practiced up to 12 and even 18 months, despite clear growth faltering beginning around 6 months of age.

Research clearly documents that adequately nourished mothers who exclusively breastfeed can successfully meet all of their infant's nutritional needs, so that normal growth
can be achieved throughout the first six months of life. Studies have shown breast milk quality to remain fairly constant among well-nourished and malnourished women, while output has been found to vary with maternal nutritional status. Even among very undernourished mothers, exclusive breastfeeding usually fosters normal infant growth through 4 months of age.

Maternal nutrition is not the only factor which affects breast milk production. Breast milk output is determined by maternal hormonal and neurological pathways, and many conditions and practices inhibit these pathways, especially inappropriate management of breastfeeding.

Measures to assure that mothers are healthy, well nourished, and have sufficient knowledge and support concerning the proper management of breastfeeding, can combine to sustain normal infant growth on breast milk alone throughout the first six months of life. Where maternal malnutrition is severe, both maternal and infant nutritional status can be improved by increasing maternal food intake (especially prenatally). Supplementation of the mother's diet is preferable to early supplementation of infants which exposes infants to greater risk of infection in most settings, especially settings which are so impoverished that maternal malnutrition is a problem.

D. Reversing the Trend

The trend toward sub-optimal breastfeeding practices is not irreversible. Where breastfeeding has been consciously promoted in recent years (the United States, the Dominican Republic, Costa Rica, Brazil, Honduras, Guatemala, Jamaica, Sri Lanka, Indonesia, the Philippines, Singapore, and Jordan), there has been stabilization and in some cases increases in the incidence and duration of breastfeeding.

II. STRATEGY

A. Goal

A.I.D.'s Breastfeeding for Child Survival Strategy seeks to protect and promote breastfeeding by creating an environment of awareness and support so that those women who choose to breastfeed are able to do so. More specifically the goal is to increase the percentage of infants who are:

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

Countries should set their own targets for improving breastfeeding by the year 2000 and measure progress toward achieving the above goal. Such targets should be based on local assessment of the nature and magnitude of sub-optimal breastfeeding practices and the feasibility of improving them. Improved reporting on breastfeeding will be incorporated into the ongoing child survival reporting system.

B. Specific Objectives

Successful breastfeeding requires information and support at many points along a continuum, especially during the pregnancy, peri-delivery, early postpartum, and weaning stages. A range of activities can address problems encountered at different stages of the continuum. The Agency's specific objectives for achievement of the breastfeeding goal are to:

1. Significantly enhance and focus breastfeeding promotion and support within child survival, health, population and nutrition programs. Each of the four major Child Survival Program interventions—immunization, diarrheal disease control, nutrition, and child spacing—offer great potential for promoting and supporting breastfeeding. Prenatal care is also an obvious entry point for breastfeeding promotion. Existing programs will be reviewed to identify the best opportunities for breastfeeding promotion and to assure that they present no inherent obstacles to optimal breastfeeding (See Appendix VII);

2. Increase countries' capacity to:
   • identify sub-optimal breastfeeding practices, determine key constraints to successful breastfeeding, assess feasibility of alleviating specific constraints, and take advantage of opportunities for removing these constraints.
   • improve health professionals' lactation management skills;
   • inform leadership at all levels about the benefits of breastfeeding;
   • develop a written breastfeeding policy that is routinely communicated to all health care staff;
mobilize public and private sector support for breastfeeding activities, including working with U.S.-based and indigenous private voluntary organizations (PVOs) and professional associations;

- cultivate a positive image for breastfeeding throughout society;

- incorporate breastfeeding information into health education curricula in schools;

- improve practices in MCH and maternity services, and in hospitals, where these interfere with breastfeeding;

- provide women with the necessary knowledge, skills, logistical, and psychological support to ensure successful initiation and continuation of breastfeeding, including the design and implementation of policies that make it possible for working women to continue breastfeeding;

- improve maternal health and nutrition, particularly in areas where these factors contribute to low birth weight and high maternal mortality;

- encourage exclusive breastfeeding to maximize lactational amenorrhea, and improve access to appropriate and complementary family planning methods which do not interfere with the quantity and quality of breast milk.

C. Implementation

The Agency for International Development's comparative advantage in breastfeeding promotion and support lies in its extensive experience and ongoing involvement in the application of proven child survival technologies on a large scale through well-developed institutional networks. Programs that have trained hospital-based personnel in the clinical management of breastfeeding, and used social marketing techniques to promote breastfeeding are examples of successful approaches that have been well developed over the last decade. The experience of A.I.D. in qualitative research, formative evaluation, and other techniques for analyzing consumer demand and behavior can help countries to elucidate the determinants of the decline in breastfeeding and sub-optimal breastfeeding practices, identify new areas for intervention, and develop new, improved, or adapted approaches.

Such approaches may include community-based outreach to women who do not have access to the formal health care system,
mother-to-mother support networks and work site services for female employees. The Agency's commitment to economic development and to increasing women's participation in that development give it a comparative advantage in helping countries to develop breastfeeding promotion and support activities which are relevant to changing social and economic conditions.

At the country level, the selection of approaches will depend on the nature and determinants of sub-optimal breastfeeding practices and the barriers to optimal practices. The following approaches to breastfeeding promotion and support address each stage of the pregnancy and lactation continuum (See Annex VI).

- Training of hospital-based personnel in lactation management toward the goal of hospital policy reform and country breastfeeding programs
- Training of other health care providers outside of hospitals
- Curriculum development and information dissemination
- Communication and social marketing
- Outreach to women:
  - Prenatal care and nutrition support
  - Mother-to-mother support groups
  - Strategies for working women
- Improving weaning practices
- Research
- Policy dialogue

D. Key Considerations

1. Assess the breastfeeding situation and design activities to address real constraints.

A priority for any A.I.D. program should be to assess the breastfeeding situation in terms of initiation, exclusivity/frequency, duration, weaning, and maternal nutritional and health status (including birth spacing), and to identify the barriers to optimal breastfeeding practices. This may include reviewing existing data, such as Demographic and Health, World Fertility, and Contraceptive Prevalence surveys, national nutrition surveys, and small scale and ethnographic studies. In some cases, specific surveys or research may also be required. Qualitative
methods such as rapid ethnographic assessment of feeding practices, focus group discussions, and systems analysis of hospital practices should be part of the design of interventions and messages. In addition, it will be necessary to examine what other Child Survival Programs are doing that may or may not be supportive of breastfeeding. Such data should guide the design and formative evaluation of appropriate interventions for the local situation and provide A.I.D. with the necessary information to measure program impact.

2. **Emphasize coordination at the policy and programmatic levels.**

At the policy level, A.I.D. should coordinate its breastfeeding efforts with the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and other donors. At a central level such coordination has been achieved to date through the informal Interagency Group for Action on Breastfeeding which the Agency will continue to support.

Like A.I.D., UNICEF and WHO are reassessing the breastfeeding component of their programs and formulating official strategies for the 1990's to strengthen and enhance breastfeeding programming. An intent to place programmatic emphasis on the perinatal stage of the pregnancy and lactation continuum, focusing on physician training, has been indicated by UNICEF. In addition, WHO and UNICEF are undertaking activities that are complementary to those proposed in A.I.D.'s Breastfeeding Strategy, including, periodic reporting on: 1) infant and young child nutrition; and 2) distribution and marketing of breast milk substitutes; and 3) monitoring the extent to which the 1989 WHO/UNICEF guidelines on Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services are being implemented. In addition, both WHO and UNICEF have recognized that good, reliable breastfeeding data are scarce and that there is an urgent need to expand the collection and analysis of such data.

At the programmatic level, it is mandatory that breastfeeding's existing linkages with A.I.D.'s major Child Survival Program interventions be strengthened, that is, with diarrheal disease control and adjunct oral rehydration therapy, immunization, nutrition including food supplementation (PL480 Title II Project Food Aid), and child spacing programs. It is also important that breastfeeding promotion and support activities be linked to private sector initiatives and health care financing, where possible, and with women-in-development programs (See Annex VII).
Also at the programmatic level, linkages should be explored with U.S.-based and indigenous private voluntary organizations (PVOs) who play a special role in the provision of services to otherwise inaccessible portions of the target population, and in initiation of pilot, innovative, or experimental activities for possible replication. Establishing links with organizations whose primary purpose is the promotion and support of breastfeeding, such as La Leche League International (LLLI), will be beneficial. Involvement of private physicians, pharmacists, other health care providers, traditional birth attendants (TBAs), local healers, religious leaders, and influential others in the mother's support network, who provide much of the information and care to pregnant and nursing women in rural areas, should also be sought.

3. **Ensure Sustainability**

Programs should address the question of sustainability directly at the design stage and implementation plans should include mechanisms for gradually increasing the self-sufficiency of assisted programs. Outside donor assistance, from any available source, may be critical to starting-up certain programs. Yet experience has shown that donor assistance will not in and of itself produce the conditions needed for a continuation of such programs. If donor assistance is available for a limited period of time, which may be difficult to ascertain in the beginning, then the continuation of efforts must rely on other self-sustaining resources. Some of the factors which can affect sustainability follow:

a. **Financial**

Improved breastfeeding promotion and support can reduce recurrent costs of health programs; rooming-in is one example. To ensure commitment of policy makers, programs should collect data which demonstrate the cost-effectiveness of proposed or ongoing breastfeeding promotion and support activities. Financial sustainability of breastfeeding programs cannot be divorced from that of the health sector. Health care financing activities which stimulate cost-effectiveness in the sector are likely to enhance preventive activities such as breastfeeding. In the U.S., for example, Health Maintenance Organizations such as Kaiser Permanente have some of the best breastfeeding support programs and policies.
b. Institutional

These factors are the policies and organizational resources of public agencies involved in health and social services as well as the organization and viability of local agencies which have a popular following. Local organizations can encourage networking and follow-up after donor-funded projects. Indigenous breastfeeding promotion and support organizations, where they exist, can be assisted to strengthen their infrastructure and linkages with the national health system. These organizations can also be assisted to improve their capabilities of supporting mothers so that self-sustaining systems may be developed in-country. In addition, there is a need to develop a knowledge base in communities concerning networks of volunteers who can participate in maintaining mother-to-mother support.

c. Managerial and Other Human Resources

This includes continued training and technical assistance, encouraging donors to play a role as advocates, educators, catalysts, and facilitators of effective management.

III. Action Agenda for A.I.D.

In order for A.I.D. to enhance and focus breastfeeding promotion and support activities, the following steps are planned:

A. Field Actions

1. Sponsor rapid assessments and surveys in as many countries as possible to understand the nature, magnitude, and determinants of breastfeeding practices and to establish a solid data base. This may include modifying existing child survival, health, population and nutrition survey instruments to add questions on breastfeeding.

2. Develop appropriate, country specific substrategies for each mission which has a Child Survival Strategy. Other missions that have health, population and nutrition programs are also encouraged to develop substrategies. Each country substrategy should include a problem statement, objectives and targets, planned activities, costs, and a monitoring and evaluation plan. Formative evaluation should be incorporated into design of interventions and messages.
B. **A.I.D. Washington Actions**

1. Continue and expand ongoing centrally funded S&T/N, S&T/POP, and S&T/H sector projects that provide both long- and short-term technical assistance and training for breastfeeding promotion and support to A.I.D.-assisted countries.

2. Disseminate information widely on the magnitude of the problem of sub-optimal breastfeeding practices and workable solutions.

3. Support applied and biomedical research on breastfeeding.

C. **Joint Actions**

1. Design and implement appropriate activities within ongoing child survival, health, population and nutrition projects to assist host countries to carry out breastfeeding promotion and support with a special emphasis on countries with sub-optimal breastfeeding practices.

2. Foster linkages between breastfeeding and other programs, including health care financing and private sector activities and initiatives, PL 480 Title II supplementary feeding, and women-in-development.
CHECK-LIST FOR EVALUATING THE ADEQUACY OF SUPPORT FOR BREAST-FEEDING IN MATERNITY HOSPITALS, WARDS AND CLINICS

The following check-list has been prepared for use by the competent authorities in countries - health and nutrition policy-makers; managers of maternal and child health and family planning services; clinicians, midwives, nursing personnel and other support staff in maternity services and facilities for the care of newborn infants; health workers' organizations; and mothers' support groups. It is intended to be a suggestive rather than exhaustive inventory of the kinds of practical steps that can be taken within and through maternity services to protect, promote and support breast-feeding, and should be used in conjunction with the main text of the joint WHO/UNICEF statement. Under ideal circumstances, the answer to all of the questions in the check-list will be "Yes". A negative reply may indicate an inappropriate practice or routine that should be modified in accordance with the statement.

POLICY

1. Does the health care facility have an explicit policy for protecting, promoting and supporting breast-feeding?

2. Is this policy communicated to those responsible for managing and providing maternity services (for example in oral briefings when new staff are employed; in manuals, guidelines and other written materials; or by supervisory personnel)

3. Is there a mechanism for evaluating the effectiveness of the breast-feeding policy? For example:
   - Are data collected on the prevalence of breast-feeding initiation and breast-feeding at the time of discharge of mothers and their infants from the health care facility?
   - Is there a system for assessing related health care practices and training and promotional

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materials, including those commonly used by antenatal and postnatal services?

4. Are the cooperation and support of all interested parties, particularly health care providers, breast-feeding counsellors and mothers' support groups, but also the general public, sought in developing and implementing the health care facility's breast-feeding policy?

STAFF TRAINING

5. Are all health care staff well aware of the importance and advantages of breast-feeding and acquainted with the health care facility's policy and services to protect, promote and support breast-feeding?

6. Has the health care facility provided specialized training in lactation management to specific staff members?

STRUCTURE AND FUNCTIONING OF SERVICES

7. Do antenatal records indicate whether breast-feeding has been discussed with a pregnant woman? Is it noted:
   
   • Whether a woman has indicated her intention to breast-feed?
   
   • Whether her breasts have been examined?
   
   • Whether her breast-feeding history has been taken?
   
   • How long and how often she has already breast-fed?
   
   • Whether she previously encountered any problems and, if so, what kind?
   
   • What type of help she received, if any, and from whom?

8. Is a mother's antenatal record available at the time of delivery?
   
   • If not, is the information in point
7 nevertheless communicated to the staff of the health care facility?

- Does a woman who has never breast-fed, or who has previously encountered problems with breast-feeding, receive special attention and support from the staff of the health care facility?

9. Does the health care facility take into account a woman's intention to breast-feed when deciding on the use of a sedative, an analgesic or an anaesthetic, if any, during labor and delivery?

- Are staff familiar with the effects of such medicaments on breast-feeding?

10. In general, are newborn infants:

- Shown to their mothers within 5 minutes after completion of the second stage of labor?

- Shown/given to their mothers before silver nitrate or antibiotic drops are administered prophylactically to the infants eyes.

- Given to their mothers to hold and put to the breast within a half-hour of completion of the second stage of labor, and allowed to remain with them for at least one hour?

11. Does the health care facility have a rooming-in policy? That is, do infants remain with their mothers throughout their stay?

- Are mothers allowed to have their infants with them in their beds?

- If the infants stay in cots, are these placed close to the mothers' beds?

- If rooming-in applies only during daytime hours, are infants at least brought frequently (every 3-4 hours) to their mothers at night?
12. Is it the health care facility's policy to restrict the giving of prelacteal feeds, that is any food or drink other than breast milk, before breast-feeding has been established?

HEALTH EDUCATION

13. Are all expectant mothers advised on nutritional requirements during pregnancy and lactation, and on the dangers associated with the use of drugs?

14. Are information and education on breast-feeding routinely provided to pregnant women during antenatal care?

15. Are staff members or counsellors who have specialized training in lactation management available full time to advise breast-feeding mothers during their stay in the health care facility and in preparation for their discharge? Are mothers informed:

- About the physiology of lactation and how to maintain it?
- How to prevent and manage common problems like breast engorgement and sore or cracked nipples?
- Where to turn, for example to breast-feeding support groups, to deal with these or related problems? (Do breast-feeding support groups have access to the health care facility?)

16. Are support and counselling on how to initiate and maintain breast-feeding routinely provided for women who:

- Have undergone caesarean section?
- Have delivered low-birth-weight infants?
- Have infants who are in special care for any reason?

17. Are breast-feeding mothers provided with printed materials that give relevant guidance and information?
18. If "discharge packs" containing baby-and personal-care products are provided to mothers when they leave the hospital or clinic, is it the policy of the health care facility to ensure that they contain nothing that might interfere with the successful initiation and establishment of breast-feeding, for example feeding bottles and teats, pacifiers and infant formula?

19. Are mothers or other family members, as appropriate, of infants who are not fed on breast milk given adequate instructions for the correct preparation and feeding of breast-milk substitutes, and a warning against the health hazards of incorrect preparation?
   - Is it the policy of the health care facility not to give such instructions in the presence of breast-feeding mothers?

20. Is every mother given an appointment for her first follow-up visit for postnatal and infant care?
   - Is she informed how to deal with any problems that may arise meanwhile in relation to breast-feeding?
ANNEX II

BREASTFEEDING MANAGEMENT GUIDELINES FOR OPTIMAL CHILD SURVIVAL AND CHILD SPACING

- Begin breastfeeding as soon as possible, preferably within the first hour after the child is born. The first milk, colostrum, present in the breast during the first few days following birth, is of particular nutritional and health value to the infant given its high content of proteins and vitamins and its anti-infective properties. It is the infant's first immunization. Close mother-child contact immediately following birth and frequent suckling at the breast stimulates milk secretion and aids uterine contractions. This assures an adequate milk supply and may prevent postpartum hemorrhage. Initiation of breastfeeding within an hour after delivery also promotes mother-infant bonding and prevents hypothermia in the newborn.

- Breastfeed frequently, whenever the infant is hungry, both day and night. This pattern is sometimes referred to as "on-demand" feeding and may be as often as every hour or more, especially in the early weeks. A rigid feeding schedule dictating lengths of time at the breast, or specific intervals, should not be followed, and long intervals (more than 4 hours) should be avoided.

- Breastfeed exclusively through 4-6 months. Do not give the infant other foods or liquids or water before the age of 5 to 7 months. Occasional tastes of ritual foods, water or non-breast feeds are common practices, but these expose the infant to diarrhea and reduce suckling and breast milk secretion. Exclusive breastfeeding is the pattern that yields optimal health and child spacing benefits through age 4-6 months.

- Begin appropriate complementary, semi-solid foods after 4-6 months of age, but continue to offer the breast first. It becomes necessary to introduce complementary foods when the infant ceases to gain weight adequately despite being breastfed frequently and exclusively. A rule of thumb is that normal average weight gain of healthy breastfed infants from 4-6 months is approximately 500 grams per month. A gain of less than 400 grams per month in an exclusively

1 Adapted from: Guidelines for Breastfeeding in Family Planning and Child Survival Programs, Georgetown University, Los Angeles Regional Family Planning Council and University of Pittsburgh Graduate School of Public Health, October 1989.
breastfed infant is cause for alarm. It is essential to first assure that the mother's breastfeeding practices are optimal. Then inadequate weight gain indicates that complementary foods are needed in addition to breast milk. In cases where weighing the infant regularly is not possible, solids should be introduced no later than 7 months of age and no earlier than 5 months of age.

- **Breastfeed well into the second year of life.** Even after the introduction of complementary foods, breast milk remains an excellent source of nutrients and complements those found in local weaning foods. Breast milk also continues to offer immunological protection. Therefore, breastfeeding should be continued during the weaning period. Frequent breastfeeding will assure an adequate milk supply and, depending on the pattern, may continue to have a child spacing effect.

- **Continue to breastfeed, even if mother or baby becomes ill.** It is extremely important to continue breastfeeding even if the mother or baby has a fever, cold, flu or some other illness, to ensure adequate milk supply, prevent breast engorgement and mastitis, and provide the infant with immunological protection. During diarrhea, breastfeeding plus ORT should be continued because this reduces the risk of dehydration, the severity and duration of the diarrheal episode and the negative nutritional consequences.

- **Position the infant so that its mouth covers both nipple and areola and latches on properly.** Correct positioning of the infant is important to facilitate feeding, ensure milk supply and help prevent sore or cracked nipples and breast engorgement.

- **Avoid using bottles, pacifiers (dummies), or other nipples.** Use of artificial nipples may decrease an infant's ability and desire to suckle at the breast. When a baby is given weaning foods or liquids, a spoon or open cup should be used to reduce the introduction of contaminants due to improper hygiene or handling, and to avoid nipple confusion.

- **Eat and drink enough to satisfy mother's hunger.** Breastfeeding mothers need to eat more food and drink to thirst to produce adequate breast milk without depleting their own nutrient stores. Special attention should be given to eating available foods rich in nutrients which are deficient in the local diet. However, no one special food or diet is required and the breastfeeding mother's needs can usually be met by just eating more of her usual diet and drinking lots of water. When food or vitamin-mineral supplements are available, however, they should be taken. No food is forbidden.
ANNEX III

SCHEMA AND FRAMEWORK FOR BREASTFEEDING DEFINITIONS

A meeting on Definitions Related to Breastfeeding was held on April 28, 1988, under the auspices of the Interagency Group for Action on Breastfeeding (IGAB). The meeting was attended by representatives from A.I.D., UNICEF, WHO, International Lactation Consultants Association (ILCA), Population Council, Wellstart, and Family Health International and was moderated by a representative from the Institute for International Studies in Natural Family Planning/Georgetown University, Secretariat for IGAB.

The original definitional schema was subsequently refined and a framework to more completely describe breastfeeding behavior was added. This schema was generally endorsed at a meeting of the Office of Population, A.I.D., and selected Cooperating Agencies on Breastfeeding, July, 1988, and the Interagency Workshop on Health Care Practices Related to Breastfeeding, December 1988. Minor revisions suggested at the Interagency Group for Action on Breastfeeding on June, 28, 1988, and the Bellagio Consensus Meeting on Breastfeeding, August, 1988, were incorporated into the final schema.

The definitional schema presented here is an attempt to: 1) highlight the fact that the term "breastfeeding" alone is insufficient to describe the numerous types of breastfeeding behavior, and 2) gain consensus on a standard nomenclature so that researchers and agencies involved in the breastfeeding field can begin to use consistent terminology. It also serves as a basis upon which to build a more comprehensive definition of specific behaviors. It is hoped that this schema will be useful both for the collection of valid and reliable information on breastfeeding and for proper interpretation in the formulation of policy.

The basic schema for defining breastfeeding is shown in Figure 1. The schema is to be use to provide a description of infant consumption of breast milk at a single point in time. The schema divides breastfeeding into two major categories, "full" breastfeeding and "partial" breastfeeding, and the additional category of "token" breastfeeding.

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Many studies of breastfeeding consequences have included non-nutritive supplements in their definition of exclusive breastfeeding. Since research has shown that even minimal supplements have an effect on morbidity and mortality in infants, the definition "almost exclusive" is an important adjunct to "exclusive" in the "full" breastfeeding category. It should be emphasized that exclusive breastfeeding is defined here in the strictest sense, i.e., no other liquid or solid enters the infant's mouth.

"Partial" breastfeeding includes three levels of substantial feeding: "high" (>80% of feeds are breastfeeds), "medium," and "low" (<20% of feeds are breastfeeds). It seems appropriate to have a few logical divisions among the partial breastfeeders to account for the possible differences in health and fertility impacts of these different patterns.

"Token" breastfeeding, when the breast is used primarily for infant or child comfort and consoling and not for major nutritive purposes, is an important distinction. In the past, this group has been counted along with all others as "breastfeeding." This has contributed significantly to misunderstanding and misinterpretation by policy makers of national and international level breastfeeding data which have included all these differing patterns as breastfeeding.

The major contributions of this schema are: 1) a distinction between full and partial breastfeeding, 2) the subdivision of full breastfeeding into categories which describe both exclusive and almost exclusive breastfeeding, 3) the differentiation between levels of partial breastfeeding and, 4) the recognition that there can be token feeding with little to no nutritional impact. If every researcher or program manager precisely defines breastfeeding according to the schema, comparisons of patterns of breastfeeding would be improved and research conclusions strengthened.
While the schema may present some difficulty to those actually tasked with measuring breastfeeding practices, it does serve a useful purpose by providing a broad categorization of the major types of infant feeding. The distinction between full and partial breastfeeding, in its broadest sense, will be key to ensuring that breastfeeding data are appropriately disaggregated in the future, since much of the data collected to date does not make this important distinction.
BREAST-FEEDING/BREAST MILK AND HUMAN IMMUNODEFICIENCY VIRUS (HIV)

In view of the importance of breast milk and breast-feeding for the health of infants and young children, and of the increasing prevalence of human immunodeficiency virus (HIV) infection in many parts of the world, a Consultation on Breast-feeding/breast milk and HIV infection was organized by the Special Programme on AIDS and the Division of Family Health from 23-25 June 1987. Its purpose was to review currently available information on the possible relationship between breast-feeding/breast milk and HIV transmission, and to identify further research needs in this area. Twenty participants from 15 countries attended the consultation. The participants represented epidemiology, immunology, virology, pediatrics and nutrition. The conclusions of the consultation are summarized below.

Evidence concerning the transmission of HIV from infected mothers to their infants suggests that between 25% and 50% of all offspring will be infected. The risk of transmission may depend on a number of factors, including: the timing of the mother's HIV infection; the mother's immunologic and overall health status; her parity and intercurrent infections; and other possible factors.

Transmission of HIV from infected mothers to their infants may occur before, during or shortly after birth. The possibility that HIV could be transmitted through breast-feeding/breast milk is supported by a report that HIV can be cultured from breast milk of mothers who are themselves infected. At present, the risk of HIV transmission from mothers to infants through breast-feeding has not been defined, but available information suggests that if such transmission occurs, the relative contribution of this route is probably small, as compared with in utero and intrapartum transmission. For example, a substantial number of infants born to infected mothers have been breast fed without their having any evidence of acquiring HIV infection. On the other hand, there are a few reported cases where mothers became infected postpartum through blood transfusions, and where their...
infants, in turn, became infected, possibly through breast-feeding. This does not necessarily imply, however, that such transmission occurs among mothers who are infected with HIV before or during pregnancy.

The immunologic, nutritional, psychosocial and child-spacing benefits of breast milk/breast-feeding are well-recognized. They have been reflected increasingly in national and international policies on child and maternal health.

Breast milk is also important in preventing intercurrent infections which could accelerate progression of HIV-related disease in already infected infants. The importance of breast milk and breast-feeding for the survival and development of infants and young children, as well as for child spacing and hence maternal health, should continue to be emphasized in all health and nutrition policies.

Additional epidemiologic and laboratory research is needed on the risks of HIV transmission through breast milk and on the potential benefits of breast milk in situations where infants have been exposed to HIV or are already infected.

In the interim:

A. Breast-feeding should continue to be promoted, supported and protected in both developing and developed countries. The overall immunologic, nutritional, psychosocial and child-spacing benefits of breast-feeding to infants and their mothers continue to be important factors in determining the overall health of mother and child.

B. If, for whatever reason, the biological mother cannot breast-feed or her milk is not available, and the use of pooled human milk is considered, the report of isolation of HIV in breast milk should be taken into account. Pasteurization at 56 degrees C for 30 minutes has been reported to inactivate the virus. Further research on the effectiveness of different methods of pasteurization, however, is needed. As an additional precaution, the possibility of screening donors (in accordance with WHO criteria on HIV screening) should be considered, especially in areas where the prevalence of HIV infection is known to be high. Similarly, if, for whatever reason, the biological mother cannot breast-feed, or her milk is not available, and where wet-nursing is the next obvious choice, care may need to be taken in selecting the wet-nurse, bearing in mind her possible HIV-infection status and that of the infant who is to be fed.

C. In individual situations where the mother is considered to be HIV-infected, and recognizing the difficulties inherent
in assessing the infection status of the new-born, the known
and potential benefits of breast-feeding should be compared
to the theoretical, but apparently small, incremental risk
to the infant of becoming infected through breast-feeding.
Consideration should be given to the socio-economic
environment of the mother-child pair and the extent to which
alternatives can safely and effectively be used. In many
circumstances and, particularly where the safe and effective
use of alternatives is not possible, breast-feeding by the
biological mother should continue to be the feeding method
of choice, irrespective of her HIV-infection status.
FAMILY PLANNING OPTIONS FOR BREASTFEEDING WOMEN

Breastfeeding women using lactational amenorrhea as a family planning method, as well as breastfeeding women at risk of unplanned pregnancy (i.e., more than six months postpartum, menstruating or not following the breastfeeding practices that maximize the fertility impact of breastfeeding) should be counseled about complementary family planning options as well as about which methods are most appropriate during breastfeeding. The chart below lists the various contraceptive methods, especially as they relate to the specific concerns of breastfeeding clients.

ADVANTAGES AND DISADVANTAGES OF FAMILY PLANNING OPTIONS FOR BREASTFEEDING WOMEN:

<table>
<thead>
<tr>
<th>METHOD</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrauterine devices (Non-hormonal IUDs)</td>
<td>• No effect of IUD itself, or of the copper in some IUDs, on breastfeeding</td>
<td>• Possible increased risk of expulsion and uterine perforation if not properly placed</td>
<td>• Insertion may need to be delayed to reduce the possibility of expulsion and/or perforation of the uterus</td>
</tr>
<tr>
<td>Condoms</td>
<td>• No effect on breastfeeding</td>
<td>• Dryness of vagina may require additional lubrication</td>
<td>• Offers some protection against sexually transmitted diseases</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>• No effect on breastfeeding</td>
<td>• Diaphragm must be refitted postpartum and after the uterus has returned to the pre-pregnancy size</td>
<td>• May not be widely available</td>
</tr>
<tr>
<td></td>
<td>• Can be very effective if used correctly</td>
<td></td>
<td>• Effectiveness depends on use with a spermicide</td>
</tr>
<tr>
<td>METHOD</td>
<td>ADVANTAGES</td>
<td>DISADVANTAGES</td>
<td>COMMENTS</td>
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</tbody>
</table>
| Spermicides                                | * No effect on breastfeeding  
* Can be effective if used correctly                                            | * May be irritating to the genital area                                                                 | * Small amounts may be absorbed into maternal blood and there may be some passage into milk. There is no known effect on the infant. |
| Natural Family Planning (Periodic Abstinence) | * No effect on breastfeeding  
* Can be effective if used correctly                                            | * May require extended periods of abstinence  
* May be difficult to interpret fertility signs during breastfeeding                                     | * Additional training of method users may be necessary to accurately interpret signs and symptoms of fertility during breastfeeding  
* Calendar rhythm method cannot be used during amenorrhea. |
| Vasectomy (Male voluntary sterilization)    | * No effect on breastfeeding  
* Nearly 100% effective                                                      | * Minor surgery with chance of side effects for the father  
* Irreversible                                                                                   | * A recommended method if no more children are desired  
* Counselling necessary for couples                                                                |
| Tubal ligation (Female voluntary sterilization) | * No direct effect on breastfeeding  
* Nearly 100% effective                                                      | * May involve mother/infant separation, but this can be minimized  
* Anesthesia can pass into breast milk and sedate infant  
* Surgery, with chance of side effects for the mother  
* Irreversible                                                                                   | * A recommended method if no more children are desired  
* General anesthesia is not recommended  
* Counselling necessary for couples                                                                |
Second Choice: Progestin-only Methods

<table>
<thead>
<tr>
<th>METHOD</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Progestin-only methods (Mini-pill, injections, implants)</td>
<td>• Extremely effective</td>
<td>• Some hormones may pass into breast milk</td>
<td>• There is no evidence of adverse effects on the infant from the very small amount of hormone which passes into the milk.</td>
</tr>
<tr>
<td></td>
<td>• May increase milk volume</td>
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<td></td>
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<tr>
<td></td>
<td>• Effectiveness during breastfeeding approaches that of the combined pill</td>
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Third Choice: Methods Containing Estrogen
(Only when other methods are inappropriate, or unavailable)
If Possible, these methods should be avoided until the child is at least six months of age and beginning to consume supplemental food.

<table>
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<tr>
<th>METHOD</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined Oral Contraceptives (Estrogen and Progestin)</td>
<td>• Most effective non-clinical method</td>
<td>• May reduce milk supply</td>
<td>• There is no evidence of a direct negative effect on infants: however, in some women, suppression of milk supply appears to lead to earlier cessation of breastfeeding</td>
</tr>
</tbody>
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ANNEX VI

APPROACHES FOR STRATEGY IMPLEMENTATION

I. TRAINING OF HOSPITAL-BASED PERSONNEL IN LACTATION MANAGEMENT TOWARD THE GOAL OF HOSPITAL REFORM AND COUNTRY BREASTFEEDING PROGRAMS

Westernized health delivery systems tend to institutionalize procedures that work against breastfeeding, including anesthesia during labor; separation of the mother and baby in the maternity ward; delayed initiation of breastfeeding and the use of prelacteal feeds like glucose water or infant formula; inadequate or improper breastfeeding instruction; rigid feeding schedules; distribution of free samples of infant formula; and feeding of low birth weight babies with infant formula instead of mothers' own breast milk. To reverse the effects of these negative practices, A.I.D. has, since 1983, supported the training of hospital-based personnel from developing countries. Through the Wellstart/San Diego Lactation Management Education program, physicians, nurses, and nutritionists involved in the perinatal care of women and their newborns are educated as multidisciplinary lactation specialists. They then return to their respective countries and institute policies and changes in medical and nursing school curricula, set up programs of secondary and tertiary training, and work with their governments towards national breastfeeding policies and programs.

Wellstart's education components include a mix of classroom theory and discussion on scientific and clinical aspects of lactation, clinical management, assessment of mother and baby, and program development and evaluation. To date, more than 220 health professionals from 50 teaching hospitals in 21 countries have received in-depth training. These professionals in turn, have educated over 16,000 ancillary health providers in their own countries through 350 secondary workshops, seminars, and lectures. By 1993, it is estimated that Wellstart graduates will be responsible for over 15 million mother-infant pairs receiving scientifically sound lactation management and breastfeeding information and care.

Although the Wellstart program has yet to be independently evaluated, there is mounting evidence that the program has been successful in promoting and achieving impressive hospital reforms through its graduates. These reforms have led to increased initiation and duration of breastfeeding, and reduced infant morbidity and mortality. To multiply the effects of this approach A.I.D. will soon provide support for regional lactation manage
ment training centers in developing countries, run by graduates of Wellstart.

II. TRAINING OF OTHER HEALTH CARE PROVIDERS OUTSIDE OF HOSPITALS

In a large number of developing countries, many women still deliver their babies at home rather than in hospitals. In developing countries whose populations are predominantly rural, many women are unlikely to be reached through the formal health care system. In these settings, training in lactation management should also be targeted to community-based health care providers who can play an effective supportive role in outreach to these women, such as auxiliary health workers, traditional birth attendants, volunteers, private physicians, and other providers.

Well trained health, nutrition, and family planning personnel in the community can fill the gap posed by inaccessible health care facilities. However, without specific skills-development training, these workers are not likely to possess adequate and appropriate knowledge to teach mothers and their families about breastfeeding, since breastfeeding is a learned rather than an intuitive art. There is no assured success of breastfeeding in the absence of the appropriate skills and a supportive environment. This type of training lends itself to linkages with the private sector, particularly with private voluntary organizations, known for their small-scale, innovative, community-based activities.

III. CURRICULUM DEVELOPMENT AND INFORMATION DISSEMINATION

Good educational materials are an essential complement to training and communications and social marketing activities. Yet, materials that incorporate breastfeeding information in an appropriate, accurate and sensitive way in widely used local languages are scarce. There is a particular dearth of useful breastfeeding training materials, even in French.

Existing educational materials, including medical and nursing school curricula and textbooks, and paraprofessional training materials will often need revision to incorporate appropriate and supportive breastfeeding information. For example, a recent A.I.D.-funded curriculum development workshop brought nursing school professionals from the Latin America/Caribbean region together to develop a breastfeeding promotion and support module for incorporation into existing undergraduate nursing school curricula. Furthermore, Wellstart graduates, since they come from major teaching hospitals, have been effective in revising textbooks and curricula for their countries. These kinds of activities should continue to be supported and encouraged.
It is also important to ensure that any information related to breastfeeding, including research, and promotion strategies, be tracked, collected, and disseminated to interested professional and lay people. Newsletters and clearinghouse activities are among the information dissemination programs that A.I.D. has provided support for, especially the Clearinghouse on Infant Feeding and Maternal Nutrition at the American Public Health Association. Other vehicles for information dissemination, such as professional medical associations, should also be used to promote breastfeeding. Knowledge of lactation management should be a part of certification testing for physicians, nurses and other health professionals. In addition, breastfeeding information should be incorporated into health education curricula in schools. This could be particularly effective at the secondary level in countries where adolescent pregnancy is common.

IV. COMMUNICATION AND SOCIAL MARKETING

Communication and social marketing are powerful tools for changing behavior, as has been well documented in a number of A.I.D. and other donor funded child survival, health and nutrition projects. This is an area where A.I.D. has a significant comparative advantage given its decade of experience with state-of-the-art communication and social marketing programs.

Communications and social marketing programs have positively affected breastfeeding practices by providing information, support and advice to nursing mothers and women of all ages; by reaching audiences other than mothers such as policy makers, government officials, administrators, employers, and other influentials; and by creating a favorable social environment for breastfeeding mothers by portraying breastfeeding as a normative behavior. Countries in which successful breastfeeding promotion and support programs have been carried out over the past decade include Honduras, Brazil, the Dominican Republic, and Jordan.

Future activities in this area should be designed to incorporate the following: a) systematic diagnosis of the incidence and underlying causes of specific breastfeeding behaviors, and use of social marketing techniques to develop strategies and materials; b) in addition to the benefits of breastfeeding, identification of other issues which are important to women, such as policies in the workplace or in hospitals; c) evaluation of behavioral change, in order to gauge impact; and d) focused promotion of breastfeeding not just integrated messages, e.g., recommending continued breastfeeding during diarrheal episodes as part of good diarrheal disease control case management. While integrated messages can be useful, it is important to have focused programs that address the entire
spectrum of breastfeeding behaviors, since integrated messages typically include only one aspect. The need for this focused approach has been documented in a recent review for A.I.D. of breastfeeding media promotion activities by the Academy for Education Development.

V. OUTREACH TO WOMEN

1) PRENATAL CARE AND NUTRITION SUPPORT

Education and counseling during prenatal care offers the pregnant woman accurate, essential and timely information and advice on how to meet the increased nutrient requirements of pregnancy and lactation and other basic "how-to's" of breastfeeding.

Individual counseling of pregnant women, tailored to their specific situation, has proven to be the most effective way to provide education to women prenatally. However, such counseling can be reinforced and usefully complemented by group sessions. In order to tailor prenatal advice to the needs of individual women, an essential element of prenatal care is taking a comprehensive health history during the first visit. The history should include questions about the woman's knowledge, attitudes and beliefs about breastfeeding and prior infant feeding experiences, as well as questions that capture information on socioeconomic status and dietary habits and intake. A health worker should not underestimate the difficulties associated with guiding and encouraging even those women who express a desire to breastfeed. Women who have several children and bring a past history of bottle feeding present the greatest challenge to health workers because their behavior may be very difficult to change.

Prenatal physical examinations of women, which include assessment of nutritional status and checking of the nipples for anatomical malformations which can impair breastfeeding, are critical. Such conditions as inverted nipples are rare, but can usually be corrected by simple pulling exercises performed by the woman during the last trimester of pregnancy. In the context of such examinations, women can be reassured that breast size bears no relation to successful lactation. Information from the woman's health history and physical examination can be used along with results of laboratory tests to assess whether the woman, the fetus, or the family are at increased risk of failing to achieve the objectives of prenatal care and should provide the basis for intervention. This is particularly important with reference to preventing low birth weight which is associated with breastfeeding difficulties in the infant.
If a woman's prepregnancy weight or weight gain are found to be inadequate, interventions to improve maternal nutritional status should be stressed as part of prenatal care. When targeted to underweight women, maternal dietary supplementation from the second trimester of pregnancy through the first six months of lactation has proven effective for increasing birth weight and assuring adequate growth of exclusively breastfed infants through 4-6 months of age. Therefore, high priority should be given to using PL480 Title II project food aid for maternal supplementation. In addition, nutrition education, to increase maternal dietary intake from the available household food supply, and methods for reducing women's workload to conserve her energy, should also be emphasized. Specific nutrient deficiencies which are widespread during pregnancy and which pose added risks to mothers and infants should be corrected, e.g., nutritional anemia due to iron and folate deficiency.

2) MOTHER-TO-MOTHER SUPPORT GROUPS

In recent decades, traditional family support systems which facilitate breastfeeding have deteriorated, due to rapid urbanization, and the separation of the extended family. New support systems need to be established to assist mothers in their management of both household tasks and breastfeeding. Support systems are needed particularly in urban areas, where mothers lack the encouragement and practical advice needed for successful breastfeeding. This kind of "grassroots" support has been provided to mothers in the U.S. and elsewhere by groups such as La Leche League, through group meetings, telephone help, referrals, materials, or individual one-on-one support.

The mother-to-mother support group approach, as it has evolved in developed countries, depends on voluntarism and has attracted mainly middle-income women. Recently, however, this approach was adapted in Guatemala and Honduras, with A.I.D. support, to reach disadvantaged mothers in less well-organized communities. Future activities using a mother-to-mother approach should build on the lessons learned from these two programs and investigate using La Leche League or other local breastfeeding support group memberships and networks in countries where they are present.

Existing support networks, such as hospital and community outreach workers, traditional community groups, and women's clubs, may be able to help provide guidance and encouragement to mothers where mother-to-mother support groups are not feasible.
3) STRATEGIES FOR WORKING WOMEN

As women are more frequently employed in the formal and informal sectors, provisions to facilitate breastfeeding by working women become necessary. Breastfeeding and the workplace do not have to be incompatible, as proved by many working mothers around the world, who have successfully dealt with the problems associated with breastfeeding and working. Although legislation supportive of working women and breastfeeding exists in some countries, such as maternity leave, creches, breastfeeding breaks, flexible schedules, and facilities for expressing and storing breast milk, such laws are rarely implemented. Some studies have reported that women's concerns for the enforcement of maternity protection laws are generally outweighed by their concern to obtain and retain secure employment. In addition, formal employment status has been found to correlate with shorter breastfeeding duration because the period of breastfeeding coincides with the length of legally entitled postpartum maternity leave received, usually four to six weeks.

While it is inappropriate for A.I.D. to monitor employer compliance with maternity legislation or to undertake policy dialogue to enforce legislation through punitive measures, the Agency can play an effective advocacy role in demonstrating to employers the benefits of a work environment conducive to breastfeeding. Studies have revealed that employers who have provided on-site day care facilities, places for expressing and storing milk, and flexible work schedules, have resulted in increased employee productivity, morale, and reduced absenteeism.

Another role that A.I.D. could play in this area is to conduct research to determine how working women have managed to breastfeed successfully, so as to share this information with women who assume that work and lactation are not compatible. Basic "how-to" manuals on maintaining breastfeeding while working could be important outcomes of this research.

VI. IMPROVING WEANING PRACTICES

Programs which blend social marketing and growth monitoring to promote appropriate weaning practices have been very effective where the necessary infrastructure exists. Examples of successful projects supported by A.I.D. can be found in India, the Dominican Republic, Ecuador and Indonesia.

The first step in this approach is understanding what the existing weaning practices are and knowing what foods are locally available which can be made at home and promoted as more nutritionally balanced than traditional foods. Exclusive and frequent breastfeeding is promoted through the first 4-6 months of life. Once optimal breastfeeding practices have been assured,
growth monitoring is used to determine the age at which breast milk alone is no longer sufficient for the infant's normal weight gain. The infant's weight gain chart is used to counsel the mother on the amount of weaning foods to be given along with continued frequent breastfeeding to assure normal growth. This approach frequently includes face-to-face counseling and nutrition education materials along with mass media for reinforcement. Whether or not the infrastructure is adequate to sustain growth monitoring, complementary foods should be introduced no later than at the end of six months of age and nutrition education programs should be used to promote this.

VII. RESEARCH

A.I.D. is involved in a number of research activities in breastfeeding, particularly as it relates to fertility and diarrheal disease. A recent examination of A.I.D.'s and other donor programs, and a polling of experts in the field of breastfeeding promotion and support, identified the following research priorities:

**Applied Research**

1) Development of an evaluation methodology and standard program performance indicators.

2) Development and deployment of a rapid assessment methodology for diagnosing a country's specific breastfeeding practices and problems.

3) Behavioral research relating to the discarding of colostrum and administration of prelacteal feeds, in order to design appropriate interventions.

4) Development of community-based project strategies to serve women in marginal urban and rural areas.

5) Identification, using behavioral research, of key stage(s) in pregnancy and lactation when mothers make decisions on breastfeeding behavior and the development of interventions and strategies to change these behaviors.

6) Study to understand who in the mother's support network acts as best counselor.
7) Development of realistic strategies for working women, not only in the formal and informal sectors, but at home. What are the obstacles to breastfeeding?

8) Testing of interventions to improve maternal nutritional status through nutrition education, supplementary feeding, reduced work load, etc.

9) Study of promotion of breastfeeding as a method of family planning, specifically looking at child spacing strategies operationally.

10) Study of the risks to child health of prolonged exclusive breastfeeding versus the risk of diarrhea due to contaminated complementary foods, particularly looking at growth faltering.

11) Cost-effectiveness studies of changes in institutional practices and policies.

Biomedical Research

1) Growth standards for breastfed infants.

2) Nutritional requirements during weaning.

3) The biological basis for the insufficient milk syndrome; examine cases of real lactation failure.

4) Storage requirements for breast milk, the results of which can feed into the applied research issue on working women.

5) The relationship between maternal nutritional status, lactation performance, infant growth and maternal depletion and the relation of maternal pregnancy weight gain to outcome.

6) The relationship of breastfeeding practices to amenorrhea.

7) Role of enhanced iron absorption through breast milk (lactoferrin) for preventing anemia in infants. When does iron absorption drop occur vis-à-vis type and time of food introduction; does introduction of juices, for instance, modify that absorption pattern?

8) Effect of colostrum on enhancing cell-mediated immune response to immunizations, e.g., BCG.
9) Appropriate technology for expression of breast milk.

10) Effects of using artificial nipples in combination with breastfeeding on lactational amenorrhea.

11) The role of malting of weaning foods to increase energy density.

12) The relationship between Vitamin K in breast milk and prevention of hemorrhagic disease.

VIII. POLICY DIALOGUE

Policy makers and planners at both the national and community levels have a primary role to play in determining the most appropriate actions to take in the promotion and support of breastfeeding. Information should be targeted toward key decision makers regarding the health and economic benefits of breastfeeding as well as appropriate measures they can take to support women's efforts to breastfeed. For example, the A.I.D.-supported Panama National Breastfeeding promotion and support Program included advocacy among policy makers at the national level. This program recognized that in order to gain support for hospital reform, the policy makers were a critical first target group. Other successful approaches developed with A.I.D. support that have targeted national leaders to raise awareness about population growth and its impact, and are adaptable to breastfeeding promotion and support, include the Resources for the Awareness of Population Impact on Development (RAPID presentation) and the Innovative Materials for Population Action (IMPACT) projects.
GUIDELINES FOR LINKING BREASTFEEDING WITH OTHER PROGRAMS

There are some activities within existing child survival programs that may have a negative impact on breastfeeding. These obstacles to breastfeeding must be removed in order to optimally promote and support breastfeeding within the context of other child survival interventions.

DIARRHEAL DISEASE CONTROL PROGRAMS

Breastfeeding promotion and support has obvious natural linkages with control of diarrheal disease and adjunct oral rehydration therapy programs (CDD/ORT). Promoting exclusive breastfeeding is the most effective measure for diarrhea prevention in infancy. Continuing breastfeeding during episodes of diarrhea is an essential part of oral rehydration therapy. Yet some CDD/ORT programs have inherent obstacles to breastfeeding, many of which derive from poor training or misinformation. Some of these obstacles include: 1) failing to promote exclusive breastfeeding from birth through 4-6 months to prevent early diarrhea; 2) advising the mother to stop breastfeeding during her infant's bout with diarrhea; 3) emphasizing ORS administration and forgetting to mention the importance of continued breastfeeding; 4) separating the breastfeeding pair in inpatient or outpatient wards while the infant is receiving treatment; 5) using bottles and nipples to provide ORS to infants; and 6) administering ORS for mild cases of diarrhea without dehydration, disrupting breastfeeding and exposing the child to harmful pathogens if the ORS is not sterile.

To effectively link breastfeeding promotion and support activities with CDD/ORT programs, the following should be emphasized:

1) medical education and training in CDD should include sessions on the role of exclusive breastfeeding in preventing diarrhea and its importance to ORT;

2) training of CDD workers should include the benefits of breastfeeding as well as appropriate skills for managing breastfeeding problems;

3) routines in hospital ORT or IV units should be supportive of breastfeeding;

4) packets of ORS should include instructions to continue breastfeeding a child with diarrhea;
5) dietary management of diarrhea instructions should include information about lactation management;

6) communication and social marketing programs to promote ORT should convey the essentials of lactation management as well as the benefits of breastfeeding.

EXPANDED PROGRAM ON IMMUNIZATION (EPI)

While immunization programs have a unique opportunity to promote breastfeeding because of their continuing contact with the mother both prior to and after delivery, these opportunities have not, with very few exceptions, been seized. Linkages with prenatal tetanus toxoid immunization programs are especially promising as they provide the opportunity to counsel the pregnant women about breastfeeding and adequate food intake. Post-delivery, while the child progresses through the immunization series, health workers can not only give support to the lactating mother to continue breastfeeding and help resolve any problems, but can ensure that breastfeeding/weaning practices remain appropriate for the age of the child. Immunization and breastfeeding promotion and support programs should use every contact with the mother to reinforce the educational messages of both programs.

Immunization programs should recognize and promote breastfeeding as the first immunization in the immunization series. Universal coverage of all infants with colostrum from their mother's first milk should be emphasized as equally important to achievement of any of the other immunization targets and therefore included in a child's immunization record. This is critical since breastfeeding can buy time for immunization programs to reach children that are difficult to access, by providing passive immunological protection prior to the infant acquiring active immunity through vaccination. Furthermore, colostrum has recently been shown to be especially beneficial for enhancing cell-mediated immune response to BCG given at birth.

NUTRITION PROGRAMS--GROWTH MONITORING

Growth monitoring and promotion should be used where possible to measure the normalcy of the infant's weight gain and to provide critical information for determining the age at which complementary weaning foods need to be introduced into the infant's diet, in addition to breast milk. Caution should be taken in diagnosing growth faltering from 4-6 months of age because existing growth charts are based on U.S. reference standards from primarily bottle fed infants who gain more weight than healthy breastfed infants. Until more appropriate standards for breastfed infants are developed, a rule of thumb is that normal average weight gain for healthy breastfed infants from 4-6
months of age should be approximately 500 grams per month. Therefore, in the absence of a recent, acute illness, a gain of less than 400 grams is an indication that complementary foods may be necessary. To ensure an accurate diagnosis, all efforts should be made to first see that the mother's breastfeeding practices are optimal. If so, then inadequate weight gain indicates a need to introduce complementary foods in addition to breast milk.

Throughout the period of exclusive breastfeeding during the first 4-6 months and during the entire weaning period, the practice of regular weighing and monitoring of growth, and counseling on appropriate infant feeding practices, can provide women with frequent opportunities to discuss and resolve problems with breastfeeding and weaning practices amongst themselves and with visiting health workers. Thus, promotion of breastfeeding, appropriate weaning practices and, ultimately, normal infant growth, are essentially inter-linked components of any intervention to improve infant nutrition and survival.

CHILD SPACING

Breastfeeding contributes significantly to child spacing programs because it extends the period of postpartum infertility, when practiced exclusively or almost exclusively. Child spacing/family planning programs can contribute significantly to breastfeeding programs because they can promote breastfeeding and adequate spacing between births for the health of children. Family planning clinic and home outreach workers can, with supportive and accurate information, be effective breastfeeding advocates. Education of key personnel in the complementarity between breastfeeding and family planning and the development of programmatic objectives that support this complementarity, are a critical first step in successful integration of the two programs. Optimally, family planning workers must take local breastfeeding patterns into account and offer contraceptive methods that do not interfere with breast milk quantity and quality. (Annex V). Family planning is essential after six months post-partum in order to prevent pregnancy and thereby to ensure continued lactation. Programs that take these considerations into account assure that fertility, nutrition and health objectives are met synergistically.

FOOD SUPPLEMENTATION (PL 480 TITLE II PROJECT FOOD AID)

Food supplementation programs have considerable potential as a vehicle for breastfeeding promotion and support because they are so widespread, because they are almost always intended to nutritionally support and encourage breastfeeding, and because they act as an incentive for potential beneficiaries to avail
themselves of health and nutrition services. However, while food aid may lure women to MCH sites, food distributed for pregnant or lactating women in take-home programs is not necessarily consumed by them due to sharing with other household members or substitution for the usual diet. Food distribution can interfere with the delivery of health services and nutrition education at primary health care sites. More needs to be done to ensure that supplementary foods are actually consumed by pregnant and lactating women and that health services and nutrition education are not disturbed.

In addition, direct supplementation of underweight pregnant and lactating women in the intended quantities should be emphasized so that maternal nutritional status may be improved as a result of MCH project food aid. Furthermore, breastfeeding promotion and support activities should be an integral component of all supplementary feeding programs which have pregnant and lactating women as beneficiaries. Precautions should be taken that non-fat dried milk distributed in these programs is not used as a breast milk substitute. In Food for Work projects that employ women, provisions should be made to facilitate continued breastfeeding by working women.

HEALTH CARE FINANCING

Health sector financing programs typically focus on a goal of ensuring public, tax-based funding for services that are public goods. (Public goods would include those public health programs which provide benefits to the community as a whole, such as communicable disease control, certain preventive medicine services, and regulation of the quality of food and drugs.) Financing Programs may also attempt to strengthen financial support for personal health services, which are private goods.

The following are examples of elements that could be considered in a Financing Program to encourage breastfeeding.

1) **Resource generation through cost-recovery:** Remove the public and/or private subsidies from free distribution of breast milk substitutes and charge market level fees for breast milk substitutes distributed in medical care institutions.

2) **Social financing of demand for health services:** Use health insurance, employers' insurance, and social security mechanisms as a vehicle to encourage breastfeeding and discourage use and financing of breast milk substitutes. Breastfeeding education could be included in the disease prevention/health promotion education program that a prepaid health program would offer to its members. Such education
reduces subsequent morbidity in the child and consequent
costs for health care services due to such morbidity.

3) **Public-private sector collaboration:** Provide incentives to
employers to endorse and encourage breastfeeding; develop
educational programs for breastfeeding through employer-
based health plans. (See also Private Sector Linkages
below.)

4) **Resource allocation, use and management:** Examine the
present health sector financial burden and priority-setting
mechanism for ways to encourage breastfeeding.

5) **Health service production efficiency and cost containment:**
Conduct cost studies of hospital and primary care services
which focus on the full costs of service programs with and
without policies of encouraging breastfeeding. Conduct
surveys of family expenditure patterns which focus on infant
feeding costs and disseminate results to policy makers and
planners.

**PRIVATE SECTOR ACTIVITIES**

Breastfeeding relates to the private sector in numerous
ways. Many initiatives through private voluntary organizations,
private professional organizations, and private medical care
facilities have been discussed elsewhere in this Strategy. In
this section, private activities outside of the health sector are
discussed. There are many opportunities to involve private
sector organizations in breastfeeding initiatives. The following
program elements should be considered:

1) employers' roles can include encouragement of breastfeeding
by making facilities available in the work place that assure
continued breastfeeding;

2) roles for cooperative and business trade organizations can
include creating a greater awareness of potential benefits
of breastfeeding promotion and support in their trade or
industry; and

3) opportunities exist for other private sector organizations
in education and support for breastfeeding, such as
philanthropic activities.
WOMEN-IN-DEVELOPMENT ACTIVITIES

Women in development programs offer access to women who may be influential in the business community, who may be opinion leaders, and who may work in areas or function in networks where health systems penetrate very little. These networks can be used to develop policies and messages about breastfeeding and child care which interface appropriately with women's economic activities, and to generate awareness of breastfeeding as an element of women's reproductive and economic well-being.
This resource annex is intended to show what types of centrally-managed projects are available to provide field support to Missions for breastfeeding promotion activities. Since none of the projects described in this list are dedicated exclusively to breastfeeding promotion, funds available for field support are limited. Because of these budgetary limitations, cost sharing by Missions, via buy-ins, will often be necessary for technical assistance, training, and other activities. A detailed description of these projects follows.

I. Training of hospital-based personnel

1. Women's and Infants' Nutrition (WIN): Lactation Management Education (Subproject).

II. Training of other health care providers and community-based approaches

1. Maternal and Neonatal Health and Nutrition (MotherCare).
2. Peace Corps - Child Survival PASA.
3. Women's and Infants' Nutrition (WIN): Lactation Management Education (Subproject).
4. NurseCare.
5. Natural Family Planning.


III. Curriculum Development

1. NurseCare.
2. Natural Family Planning.

IV. Information Dissemination and Coordination

1. Women's and Infants' Nutrition (WIN): Clearinghouse on Women's and Children's Nutrition (Subproject).
2. Natural Family Planning.
V. Communication and Social Marketing

1. Nutrition Education and Social Marketing Field Support.
4. Natural Family Planning.

VI. Prenatal Care and Maternal Nutrition

1. Maternal and Neonatal Health and Nutrition (MotherCare).
2. Food Aid (PL 480 Title II) Voluntary Agency Program Sponsors

VII. Mother to Mother Support Groups

No resources currently available.

VIII. Strategies for Working Mothers

No resources currently available.

PLANNED: Women's and Infants' Nutrition (WIN): Service, Technical Assistance and Field Support (Subproject)

IX. Improving Weaning Practices

1. Nutrition Education and Social Marketing Field Support.


X. Applied or Operations Research (including contraceptive research)

1. Natural Family Planning.
3. Family Health International.
5. Maternal and Neonatal Health and Nutrition (MotherCare).

XI. Policy Dialogue

1. Natural Family Planning.
2. Technology for Primary Health Care II (PRITECH).
XII. **Rapid Assessment of Breastfeeding Practices.**

1. Maternal and Neonatal Health and Nutrition (MotherCare)
2. Nutrition Education and Social Marketing Field Support

**PLANNED:** Women's and Infants' Nutrition (WIN): Service, Technical Assistance, and Field Support (Subproject)

XIII. **Surveys to Assess Trends**

1. Demographic and Health Surveys (DHS).
2. Contraceptive Prevalence Surveys (CDC).

XIV. **Technical Assistance for Strategy Formulation and Project Design.**

1. Maternal and Neonatal Health and Nutrition (MotherCare)

**PLANNED:** Women's and Infants' Nutrition (WIN): Service, Technical Assistance, and Field Support (Subproject).

XV. **Grants to Private Voluntary Agencies**

1. PVO Child Survival Competitive Grant Program
   (For activities in any of the functional areas listed above.)
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Women's and Infants' Nutrition (WIN)
PROJECT NUMBER: 936-5117
SUBPROJECT: Lactation Management Education
FUNCTIONAL AREA(S): Education and training of hospital-based personnel, training of other health care providers and community-based approaches.

This new project will continue to support the Wellstart San Diego Lactation Program begun under Project 931-1010. Wellstart currently provides education in lactation management to health professionals involved in the perinatal care of women and their newborns and to appropriate Health Ministry personnel in the developing world. The course consists of a 4-week program that blends classroom teaching and clinical experience, and is intended for multidisciplinary teams of doctors, nurses, and nutritionists from developing countries to implement changes in their own hospitals to promote and facilitate the initiation of breastfeeding and set up country lactation education (including curriculum changes) programs for training of district- and community-level personnel (e.g., midwives and traditional birth attendants). Each team receives teaching materials, including a library of articles, books, and slides, and follow-up mailings of 6-8 articles each month on current aspects of lactation to help keep them up-to-date. Under Project 936-5117, the project will also support the development of new regional Wellstart centers in developing countries to train community-based health workers and traditional birth attendants.

AID/W Project Manager: Nina Schlossman
S&T/N
Telephone: (703) 875-4003
FAX: (703) 875-4394
Implementing Agency: Wellstart
4062 First Avenue
San Diego, CA
Telephone: (619) 295-5192
FAX: (619) 454-1799 or 454-1786
Contact: Audrey Naylor or Ruth Wester
Buy-ins Accepted: Yes
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Women's and Infants' Nutrition (WIN\textsuperscript{1})

PROJECT NUMBER: 936-5117


FUNCTIONAL AREA(S): Training of other health care providers and community-based approaches, improving weaning practices.

The purpose of this project is to increase breastfeeding initiation where it has declined, and improve feeding during the weaning and post-weaning periods. This integrated infant feeding activity will provide a package of services and technical assistance in all aspects of the infant and young child feeding continuum in health and during diarrhea and illness. The contractor will assist missions and ministries in the assessment of infant feeding practices including breastfeeding initiation, duration, introduction of complementary foods, weaning, dietary management of diarrhea, and the design, coordination, and implementation of interventions to improve these practices.

AID/W Project Manager: Nina Schlossman
S&T/N

Telephone: (703) 875-4003
FAX: (703) 875-4394

Implementing Agency: To be determined through competitive process in early FY 1990.

Buy-ins Accepted: Yes

\textsuperscript{1} The contract is expected to be awarded competitively in FY90.
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Women's and Infants' Nutrition (WIN)

PROJECT NUMBER: 936-5117

SUBPROJECT: A Global Clearinghouse on Women's and Children's Nutrition

FUNCTIONAL AREA(S): Information dissemination

Collects and disseminates literature on all aspects of infant nutrition and health, including breastfeeding. The Clearinghouse also publishes the newsletter Mothers and Children three times a year in French, Spanish, and English, and performs literature searches on any topic related to maternal and child nutrition free of charge for professionals from less-developed countries.

AID/W Project Manager: Nina Schlossman
S&T/N

Telephone: (703) 875-4003
FAX: (703) 875-4394

Implementing Agency: American Public Health Association
1015 Fifteenth St., N.W.
Washington, D.C.

Telephone: (202) 789-5600
FAX: (202) 789-5661

Contact: Gayle Gibbons, or Virginia Yee

Buy-ins Accepted: No under current Cooperative Agreement. Yes beginning in August 1990.
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Nutrition Education and Social Marketing (NCP)

PROJECT NUMBER: 936-5113

FUNCTIONAL AREA(S): Communication and Social Marketing

The purpose of this project is to reduce the incidence and severity of malnutrition among young children and their mothers in developing countries and foster positive changes in nutrition-related endeavors. The project provides field support for nutrition education activities, especially growth monitoring, breastfeeding, and weaning practices. The project also supports training and other activities that strengthen the role of nutrition in child survival.

AID/W Project Manager: Nick Luykx

Telephone: (703) 875-4176

Implementing Agency: Academy for Educational Development
1255 23rd St., N.W.
Washington, D.C. 20037

Telephone: (202) 862-1900
FAX: (202) 862-1947

Contact: Margaret Parlato, or Claudia Fishman

Buy-ins Accepted: Yes
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Maternal and Neonatal Health and Nutrition (MotherCare)

PROJECT NUMBER: 936-5966

FUNCTIONAL AREA(S): Communication and social marketing, prenatal care and maternal nutrition, training of health care providers and community-based approaches, applied research, rapid assessment strategy formulation and project design.

The purpose of the project is to improve pregnancy outcomes for the woman and neonate by strengthening and increasing utilization of services and influencing behaviors that affect health and nutritional status. An important focus is the promotion of early, continuous, and exclusive breastfeeding through prenatal counselling and dietary supplementation of mothers and support for breastfeeding at the time of delivery and during the first month of life. Technical assistance and research grants are available on a limited basis for training trainers of health care providers at all levels, and the development or enhancement of community-based prenatal and delivery care, breastfeeding promotion and support programs. The project also supports rapid assessments of breastfeeding practices including behaviors that encourage or discourage breastfeeding and strategy formulation.

AID/W Project Manager: Mary Ann Anderson
S&T/H/HSD

Telephone: (703) 875-4663
FAX: (703) 875-5490

Implementing Agency: John Snow, Inc.
1100 Wilson Boulevard, 17th Floor
Arlington, VA 22209


Telephone: (703) 528-7474
FAX: (703) 528-7480

Contact: Marjorie Koblinsky

Buy-ins Accepted: Yes
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Communication for Child Survival (HEALTHCOM I and II)

PROJECT NUMBER: 931-1018.1

FUNCTIONAL AREA(S): Communication and social marketing.

The HEALTHCOM project is designed to apply the health communication/social marketing methodology in support of specific child survival interventions, including breastfeeding. Technical assistance is available on a limited basis for qualitative research on breastfeeding practices and their determinants, and for designing communication and social marketing strategies.

Geographic Area: Worldwide

AID/W Project Manager: Robert Clay
S&T/H/HSD

Telephone: (703) 875-4761

Implementing Agency: Academy for Educational Development
1255 23rd St, N.W.
Washington, D.C. 20037

Contact: Mark Rasmuson

Telephone: (202) 862-1900

Buy-ins Accepted: Yes
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Technology for Primary Health Care (PRITECH II)

PROJECT NUMBER: 936-5969

FUNCTIONAL AREA(S): Policy dialogue, communications.

The purpose of PRITECH II is to promote and assist the development of oral rehydration/diarrheal disease control programs in developing countries through planning and management assistance to governmental and nongovernmental organizations, and through communications interventions. In addition to providing technical assistance to breastfeeding promotion programs on a limited basis, PRITECH II advocates breastfeeding promotion among governmental and non-governmental organizations, facilitates linkages between people and resources for breastfeeding promotion, and stimulates policy dialogue about the need to support breastfeeding activities, since breastfeeding is the most effective way to prevent diarrhea.

Geographic Area: Worldwide

AID/W Project Manager: Lloyd Feinberg
S&T/H/HSD

Telephone: (703) 875-4479
FAX: (703) 875-5490

Implementing Agency: PRITECH/Management Sciences for Health
1925 N. Lynn St. Suite 400
Arlington, VA 22209

Telephone: (703) 516-2555
Contact: Robert Simpson

Buy-ins Accepted: Yes
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Oral Rehydration Therapy - Health Education and Long Term Planning (ORT-HELP)

PROJECT NUMBER: 936-5939.22

SUBPROJECT: Peace Corps - Child Survival PASA

FUNCTIONAL AREA(S): Training of other (non-hospital) personnel.

This project provides pre-service, and in-service training for Peace Corps Volunteers in child survival interventions, including some breastfeeding.

Geographic Area: Worldwide

AID/W Project Manager: Lloyd Feinberg
S&T/H/HSD

Telephone: (703) 875-4479
FAX: (703) 875-5490

Implementing Agency: Peace Corps
806 Connecticut Ave. N.W., Rm. 701
Washington, D.C. 20526

Contact: Phyllis Gestrin

Telephone: (202) 254-8400

Buy-ins Accepted: Yes
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: NurseCare (formerly MEDEX Support)
PROJECT NUMBER: 936-5932
FUNCTIONAL AREA(S): Curriculum development.

NurseCare provides pre-service and in-service training for nurses, and supports curriculum development activities. Both of these activities include some breastfeeding content.

Geographic Area: Worldwide
AID/W Project Manager: Holly Fluty
S&T/H/HSD
Telephone: (703) 875-5508
FAX: (703) 875-5490
Implementing Agency: MEDEX Group, University of Hawaii
1833 Kalakaua Ave., Suite 700
Honolulu, HI 96815-1561
Contact: Richard Smith
Telephone: (808) 948-8643
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Demographic and Health Surveys (DHS)

PROJECT NUMBER: 936-3023

FUNCTIONAL AREA(S): Surveys to assess trends

DHS is a joint S&T/POP and S&T/H project that provides technical assistance and financial support for surveys on health- and population-related topics, including contraceptive use, antenatal and maternity care, and breastfeeding. The breastfeeding and maternal care components have been considerably strengthened and expanded in the newly-revised questionnaire. The primary objective of the project is to conduct demographic and health surveys. Other objectives include strengthening institutional capability to conduct demographic and health surveys; disseminating survey results to policy makers; promoting further analysis of DHS data by host country researchers, program managers, and international health and financial communities; and improving survey methodologies. Data from over 20 countries surveyed during Phase I are currently available. Approximately 25 new surveys will be carried out during Phase II, which began in FY 1989.

AID/W Project Managers: Richard Cornelius S&T/POP
Petra Reyes S&T/H/AR

Telephone: (703) 875-4734 (Cornelius)
(703) 875-4705 (Reyes)

FAX: (703) 875-5490

Implementing Agency: Institute for Resource Development
8850 Stanford Blvd.
Suite 4000
Columbia, MD 21045

Telephone: (301) 290-2800
FAX: (301) 290-2999

Contact: Martin Assen

Buy-ins Accepted: Yes (for both data collection and analysis).
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Natural Family Planning

PROJECT NUMBER: 936-3040

FUNCTIONAL AREA(S): Information dissemination, operations research, policy dialogue.

The purpose of this project is to make information and technical resources on Natural Family Planning and breastfeeding available to family planning service providers, consumers, and developing country policy makers. Activities include support for biomedical, social science, and operations research on how to support nursing women, as well as technical assistance and training activities on a limited basis. The project is aimed primarily at the level of policy makers, program managers, and service providers. The Institute for International Studies in Natural Family Planning (IISNFP) also serves as the Secretariat for the Interagency Group for Action on Breastfeeding and thus plays a pivotal role in coordination of A.I.D.'s activities with those of other major donors such as UNICEF and WHO.

Geographic Area: Worldwide

AID/W Project Manager: Carol Dabbs
S&T/POP/R

Telephone: (703) 875-4665

Implementing Agency: Institute for International Studies in Natural Family Planning (IISNFP)
Department of Obstetrics and Gynecology
Georgetown University
3800 Reservoir Road, N.W.
Washington, D.C. 20007

Contact: Miriam Labbok

Telephone: (202) 687-1392

Buy-ins Accepted: Yes
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Population Council Project
PROJECT NUMBER: 936-3050
FUNCTIONAL AREA(S): Applied research

The purpose of this project is to develop new contraceptive technologies. One of its areas of emphasis is the development of more appropriate contraceptive methods for breastfeeding women. The project also supports operations research to investigate the effect of breastfeeding promotion on breastfeeding rates and diarrheal disease on a limited basis.

Geographic Area: Worldwide
AID/W Project Manager: Laneta Dorflinger
S&T/POP/R
Telephone: (703) 875-4676
Implementing Agency: The Population Council
Center for Biomedical Research
1230 York Avenue
New York, NY 10021
Telephone: (212) 570-8717
Contact: Beverly Winikoff
Buy-ins Accepted: Yes
PROJECT TITLE: Family Health International
PROJECT NUMBER: 936-3041
FUNCTIONAL AREA(S): Applied research, operations research

The purpose of this project is to assess and improve contraceptive technologies and to disseminate information on their safety, effectiveness, and acceptability. Specific activities related to breastfeeding include clinical trials of the effectiveness of lactational amenorrhea as a family planning method, and operations research on breastfeeding promotion, and the effects of increased breastfeeding on the duration of lactational amenorrhea.

Geographic Area: Worldwide

AID/W Project Manager: Laneta Dorflinger
James Shelton
Victoria L. Ellis
S&T/POP/R

Telephone: (703) 875-4676 (Dorflinger)
(703) 875-4702 (Shelton)
(703) 875-4510 (Ellis)

Implementing Agency: Family Health International
P.O. Box 13950
Research Triangle Park Branch
Durham, NC 27709

Contact: Nancy Williamson or
Kathy Kennedy

Telephone: (919) 544-7040
FAX: (919) 544-7261

Buy-ins Accepted: Yes
PROJECT TITLE: Strategies for Improving Service Delivery

PROJECT NUMBER: 936-3030

FUNCTIONAL AREA(S): Operations research

This is primarily an operations research project aimed at improving the quality, accessibility, and cost-effectiveness of family planning and maternal-child health delivery systems, including breastfeeding; and strengthening institutional capability to use operations research as a management tool. It also provides short-term and long-term technical assistance and funding for the design, implementation, and evaluation of projects that look at service delivery systems, including the interaction with breastfeeding on a limited basis.

Geographic Area: Worldwide

AID/W Project Managers:

ANE: Sidney Schuler (703) 875-4678 (Univ. Res. Corp)
LAC: Carol Dabbs (703) 875-4460 (Population Council)
AFR: Laneta Dorflinger (703) 875-4676 (Population Council)

Implementing Agencies: The Population Council, New York
Margaret McEvoy (212) 644-1710

University Research Corporation
Jack Reynolds (Dhaka: 880-2-311225) (301) 654-8338

Buy-ins Accepted: Yes
FIELD SUPPORT PROJECTS FOR BREASTFEEDING PROMOTION

PROJECT TITLE: Child Survival Competitive Grant Program

FUNCTIONAL AREA(S): Grants to Private Voluntary Organizations

The Office of Private and Voluntary Cooperation (FVA/PVC) sponsors an annual child survival competitive grant program that provides funding to U.S. private voluntary organizations (PVOs) to carry out child survival interventions in the 22 Child Survival emphasis countries, and other eligible countries (i.e., Uganda, Burkina Faso, Cameroon, Mozambique, South Pacific, Belize, and the Dominican Republic). ORT and immunizations have been the primary focus of the program in the past. However, this year's Request for Applications includes a new emphasis on breastfeeding, infant weaning practices, maternal nutrition, and malaria control activities. Additionally, PVOs are encouraged to develop urban child survival activities.

AID/W Project Manager: John McEnaney
FVA/PVC

Telephone: (703) 875-4718
FAX: (703) 875-5693

Address for proposal submissions: PVO Child Survival Grants Program
Office of Private and Voluntary Cooperation
Bureau of Food for Peace and Voluntary Assistance
1400 Wilson Blvd.
Room 323 (SA-8)
Rosslyn, VA 22209