BREASTFEEDING ON THE WORLDWIDE AGENDA

Findings from a landscape analysis on political commitment for programmes to protect, promote and support breastfeeding

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EXECUTIVE SUMMARY

INTRODUCTION

Breastfeeding is one of the best values among investments in child survival, recognized for both the magnitude of its effect on mortality and the effectiveness of interventions to promote it[1]. There is compelling scientific evidence[2] that optimal breastfeeding of infants under one year could prevent around a million deaths of children under-five in the developing world. Yet global rates of breastfeeding rates have remained stagnant since 1990 with only 36 per cent of children less than six months exclusively breastfed in 2012[3].

Why has such strong scientific evidence not been translated into political and donor commitment for breastfeeding at the global level and in high burden countries? What can the global breastfeeding policy community do to augment attention and commitment to breastfeeding? Seeking answers to these questions, UNICEF's Nutrition Section conducted a landscape analysis to assess the political commitment and priority for breastfeeding interventions globally and in selected countries, in order to determine the need for, and potential benefits of, a targeted initiative to enhance leadership and advocacy.

Political commitment is defined here as the degree to which leaders of international organizations and national political systems actively pay attention to an issue and provide resources commensurate with the issue's importance[4]. This analysis has focused primarily on the former. It is framed with the acknowledgement that a large variety of determinants influence country and thereby global breastfeeding patterns, and focus the findings and conclusions on the contribution a global community of advocates might make to improving breastfeeding amidst this causal complexity, and particularly in influencing one aspect of the causal picture: global political attention and leadership. The analysis does not address issues and solutions which are outside of this remit, for example those relating to legislation, programmatic strategies, communication for behavior change and so on.

AN ENVIRONMENT THAT IS "POLICY-RICH" AND "IMPLEMENTATION-POOR"

The methodology for the landscape analysis involved a desk review and a stakeholder survey, and the way forward was informed by the outcomes of a stakeholder consultation to review the findings of the landscape scan. The desk review assessed the status of breastfeeding within the publically-available policy/strategy frameworks and statements on the websites of selected, relevant global partnerships, organizations and multi-country reviews or assessments and a stakeholder analysis involving 44 participants identified as key actors in the protection, promotion and support of breastfeeding practices, working at the global, regional and country level for a range of different organizations. It explored their views regarding the current state of political priority for breastfeeding programmes; perceived barriers and opportunities, and suggestions for the way forward. The stakeholder survey results are heavily indebted to a framework developed by Professor Jeremy Shiffman to study issue attention for global health initiatives, drawing on it to examine political priority for breastfeeding. Shiffman's framework defines four main categories influencing issue attention for global health: actor power, issue characteristics, ideas and political contexts. These categories are useful because they reveal underlying factors enabling—or hindering—priority for breastfeeding programmes. In particular, they help us understand the dynamics at play within the breastfeeding policy community and broader development context, and their resulting impact on prioritization of breastfeeding.

Key Findings

Three main issues that need to be addressed have emerged from this landscape analysis:

1. **Polarization and lack of a unified voice**
2. **Leadership gap**
3. **Need to recast the narrative**

Despite the compelling evidence and the presence of ample policy and strategy frameworks, as well as experiences of significant success in some countries to increase breastfeeding rates, breastfeeding advocates have struggled at the global level to define a common policy agenda and to garner attention and commitment. Growing polarization, played out very publically, over private sector engagement and their role in infant and young child feeding, is impacting progress and support. A significant gap in leadership and inadequate guiding institutions over the past two decades has also impacted attention and commitment to breastfeeding. Stakeholders are hopeful a policy window now exists to recast the narrative on infant and young child feeding. They are enthusiastic and optimistic about the potential of bold, innovative and fresh advocacy and communication, deployed both horizontally and vertically, to advance their cause.

The desk review found that all of the nutrition global initiatives/partnerships do reflect breastfeeding quite strongly in their strategies and other documents, but the child survival initiatives appear to provide a more token mention of breastfeeding. A general observation is that for most organizations breastfeeding features more strongly in policy and strategy frameworks than in actual programmes and implementation at scale, with no systems and accountability to report on coverage of interventions. This is also true for many countries, as per several IYCF policy and programme assessments conducted in recent years, pointing to an overall environment that may be characterized as relatively "policy-rich" and generally "implementation-poor".

Exclusive breastfeeding as a goal, programme component or outcome indicator is the breastfeeding practice that tends to be most commonly reflected across the partnerships, different types of agencies and country frameworks, although a significant proportion also refer to early initiation and continued breastfeeding or just "optimal breastfeeding practices". It is important that specific and clear reference is made across all partnership, organization and country frameworks to all recommended breastfeeding practices, as each plays an important role in child survival, growth and development. The sole focus on exclusive breastfeeding may also contribute to the breastmilk substitute industry's current strategies to segment the market and promote "follow-on formula" and "growing-up milks"—in violation of the International Code for Marketing of Breastmilk Substitutes (Code)—capitalizing on and actually encouraging a mistaken belief that breastfeeding exclusively in the first six months is the only priority, and not continued breastfeeding, which is ignored.

A predominance of "promotion" of breastfeeding is referenced in many of the strategy frameworks and statements. The term "promotion" is often intended to imply the full set of actions to

improve breastfeeding, which need to also include professional support by skilled health providers, lactation counselors and community workers and legislative and policy measures to protect breastfeeding, including the Code for subsequent World Health Assembly (WHA) resolutions, maternity protection and workplace policies. Therefore as such the term "promotion" is a misnomer for an all-encompassing approach to improving breastfeeding, as "promotion" is about messaging and information dissemination. This may be due to the dominant notion that improving breastfeeding is primarily behavioural as well as a lack of understanding of the role of professional and lay support and the importance of protecting breastfeeding. On the other hand, a more comprehensive reflection of approaches to improving breastfeeding was observed across a range of organizations.

The key findings of the stakeholder survey, using Shiffman's framework, include the following:

In terms of the ACTORS involved in breastfeeding, the stakeholders highlight that the increase in visibility and action for child undernutrition and stunting has not been accompanied by increased visibility for breastfeeding. Most stakeholders ranked political priority for breastfeeding as average to low, despite it being an essential pillar of infant and young child feeding programmes.

A major finding of the survey was that advocates for breastfeeding lack a common agenda with a shared vision of change, constraining their ability to influence policy makers and raise resources. Several stakeholders characterized breastfeeding as an "orphan issue" not grounded in a cohesive advocacy community. Civil society and NGO stakeholders are polarized in particular over whether and how to engage with the food industry to improve infant and young child feeding practices. These disagreements are played out in the media, in reports questioning the motives of organizations and press releases and at international organizations, and at international meetings. This public divisiveness further harms efforts to advance a coherent breastfeeding/IYCF agenda. Respondents also emphasized siloing of health and nutrition programmes in UN organizations, donor governments and developing countries is a constraint, along with fragmentation in the nutrition community.

Global leadership and champions are critical for advocacy success**.** Stakeholders voiced a common call for leadership, both individual and organizational, calling this the single most important ingredient for successful advocacy. Some respondents commended the current UNICEF Executive Director Anthony Lake's leadership to raise global awareness about stunting. However most interviewees gave WHO and UNICEF barely passing marks for political leadership on breastfeeding in recent years, saying it has "fallen off the map". Respondents testified limited funding was severely restricting their ability to advocate for breastfeeding globally and at the regional and country level.

With respect to the main ISSUES around breastfeeding programming, the stakeholders pointed an urgent need to recast breastfeeding advocacy and communication for a 21st century world, taking into account factors such as globalizing markets, rapid urbanization and increases in working and migrant mothers and new communication technologies. The task at hand is how to deploy the compelling evidence and reframe it in a bold and innovative way that appeals to all the different constituencies for advocacy, particularly political leaders and policymakers who need to be brought on board. A significant scaling up of continuous advocacy, communication and social mobilization is needed to increase attention, commitment and investment in actions to overcome barriers to optimum breastfeeding in the developing world, said respondents to the landscape analysis. A "second breastfeeding revolution" to recast breastfeeding for today's world must be created: more of the same will not produce results. Stakeholders call for effective leadership and guiding institutions to address the scale of the issue.

The need to protect breastfeeding is becoming more urgent as formula companies' influence grows in emerging economies. While stakeholders debate private sector engagement, baby food companies are poised to grow by 37 per cent between 2008 and 2013[i]. Almost two-thirds of this growth will come from Asia–Pacific. To achieve it, companies will need to persuade mothers to give up breastfeeding[5]. Respondents signaled strong concern over the growing success of formula companies in positioning artificial feeding as the desirable, modern choice of families in emerging economies. They reaffirmed the need for a revitalized strategy to protect breastfeeding rights.

[i] Infant formula sales are projected to grow from US$11.5–$42.7 billion between 2008 and 2013, according to Euromonitor International, an industry group.

Stakeholders also conveyed a sense of uncertainty surrounding the best approaches to address sub-optimal breastfeeding practices and barriers women face. They called for more investment in research to better understand the dynamics inhibiting—or enabling—broader adoption of exclusive breastfeeding by families and communities and in improved approaches to protect, promote and support breastfeeding. This is despite the fact that a set of evidence-based interventions does exist; the uncertainty may be related to insufficient dissemination and inadequate monitoring of their status, perhaps contributing to the notion "we don't know how to improve breastfeeding practices".

Regarding the main IDEAS suggested for moving forwards, it is emphasized that the nutrition community has made huge progress of late to align behind a package of cost-effective interventions to reduce child undernutrition. Stakeholders must now reach a technical and policy consensus on scaling up breastfeeding programmes as the foundation of a shared advocacy agenda. While the rationale for investing in breastfeeding as a best buy in global health is no longer in doubt—and there is broad agreement on what needs to be done—stakeholders must work towards consensus on how to do it. The main issues requiring further consultation are agreement on the role of the private sector in improving Infant and Young Child Feeding (IYCF) practices, strengthening the investment case for scaling up programmes, and measurement of interventions. Stakeholders also said more and better evidence is needed to demonstrate that scaling up IYCF programmes will pay significant dividends to increase national productivity and develop human capital. They placed a high priority on strengthening the investment case for the 1,000 days to communicate its economic benefits to government leaders.

The stakeholders recommended a diagonal advocacy approach. This implies neither a solely "horizontal approach" of integrating and mainstreaming advocacy for breastfeeding within existing initiatives, nor a solely "vertical" approach focusing on breastfeeding separately. It implies both integration and influencing within existing partnerships and networks, especially the Scaling Up Nutrition (SUN) movement and the child survival initiative A Promise Renewed (APR), and at the same time some specific "vertical" advocacy on breastfeeding. This will require a strategic, creative, innovative and forward-looking crafting of the advocacy approach to generate attention and "excitement it can be done".

Analysis of the POLITICAL CONTEXT highlights the rise of nutrition on the global development agenda as an encouraging trend. Stakeholders are heartened the "1,000 days window of opportunity" advocacy message[ii] is resonating with political leaders, and acknowledge the potential of the Scaling Up Nutrition Movement (SUN) to spur country action. Stakeholders generally voiced enthusiasm for the potential to advance this via the SUN movement. It provides an opportunity to reverse the trend of low visibility and commitment for breastfeeding.

Furthermore, breastfeeding sits at the nexus of SUN and APR, as well as other child health initiatives. These are unprecedented opportunities to reposition breastfeeding for the 21st century, which have not been yet been capitalized on. The breastfeeding advocacy constituency must broaden and deepen its reach if it is to raise attention and increase political commitment. The timing is right to seize the opportunity and bring an issue long neglected back to center stage with the right combination of leadership, timing, resources and civil society mobilization. However, several civil society representatives cautioned a conflict of interest policy is urgently needed to clarify the role of the private sector in initiatives involving public-private nutrition partnerships such as the SUN and 1000 Days.

The stakeholders called for a social movement for breastfeeding that taps into families' aspirations and uses the potential of new communication technologies. Respondents also recommended the IYCF community make common cause with other advocacy constituencies, given the scale of the nutrition challenge, and its multi-sectoral nature.

Recommendations

These proposals build on key findings of the desk review and stakeholder feedback, and draw upon the outcomes of a small stakeholder consultation in February 2013. They are discussed in more detail in Part 2, The Way Forward.

[ii] 1,000 Days, http://www.thousanddays.org/

1. Recast the narrative: define a shared advocacy and communication vision and agenda for breastfeeding and complementary feeding, with emphasis on "recasting the narrative" for the 21st century; develop associated advocacy materials, strategies and tools. Overcome the "issue fatigue" on breastfeeding and re-energize the debate. This should lead to a transformation of how the issue is perceived and addressed, conveying that it is doable and important to improve IYCF practices. The narrative must strongly reflect a positive voice, rather than the negative attention the issue currently receives. Strengthen the investment case for breastfeeding, building on research highlighting its benefits, cost savings for governments, and costs of delivering a package of effective interventions. Integrate these findings into existing investment cases for nutrition and maternal, newborn and child health.

Best practices in counseling and community mobilization need to be urgently applied and programmes scaled up. Here a community outreach worker teaches a woman proper breastfeeding techniques in Burkina Faso's Plateau-Central Region.

2. Advocate and influence: Integrate this shared IYCF agenda into existing global advocacy initiatives for nutrition and maternal, newborn and child health—notably Scaling Up Nutrition and A Promise Renewed. Develop and execute coordinated communication plans to support high-level advocacy for the 1,000 days window of opportunity and breastfeeding. Build linkages with related advocacy communities. Deploy the advocacy strategies and messages in appropriate global fora, at high level in countries and through relevant channels to the public. Involve global and national champions to promote the message, both celebrities and high-level personalities.

3. Ensure a unified voice: Focus on building consensus goals and strategies and a unified voice which all actors can rally around. Create a space for policy dialogue where outstanding issues of disagreement can be debated. Support civil society organizations and NGOs to nurture a social movement repositioning breastfeeding as the optimum feeding choice for the modern woman and child.

4. Provide strong leadership for cohesive action and results: Provide leadership and backbone support to guide a unified advocacy leadership initiative. Explore the possibilities to shape a global coalition to advance the agenda.

5. Mobilize resources, action and accountability: promote accelerated action and mobilize resources and commitment towards achievement of full coverage of the IYCF indicators and monitor progress of the actions towards these results. Develop and promote a global standard scorecard for performance on the IYCF practice indicators as well as key aspects of policy, programmes and intervention coverage. Increase resourcing for IYCF and breastfeeding. Transform the token attention breastfeeding often receives into a non-negotiable commitment to deliver a comprehensive package of health and nutrition interventions at scale.

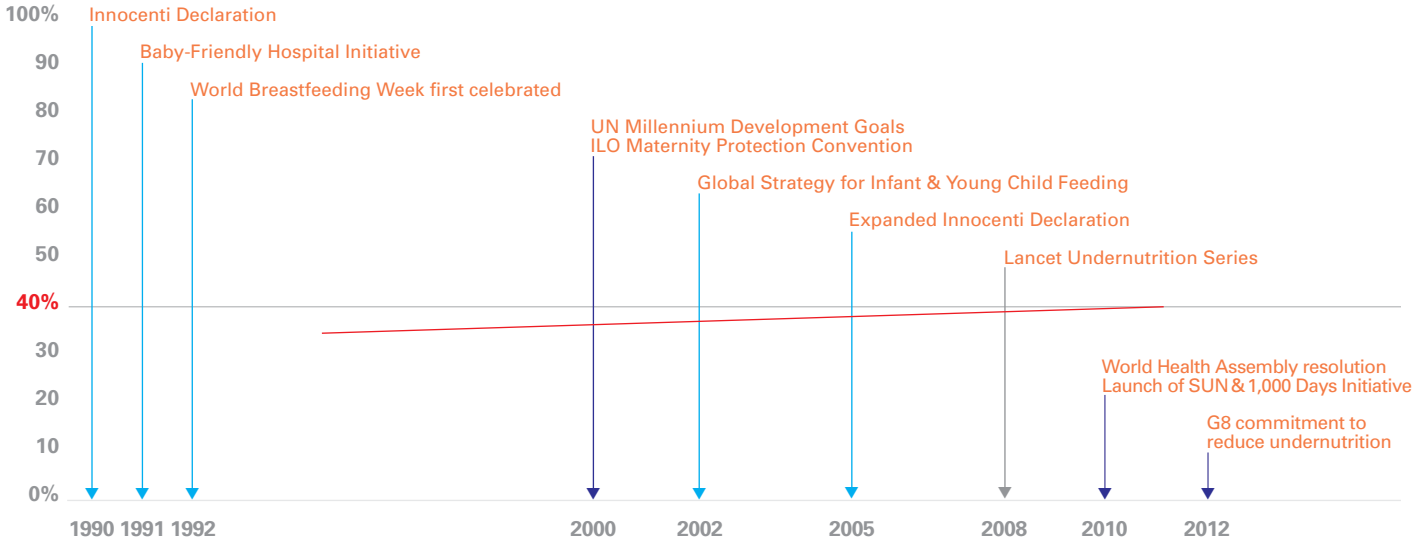
BACKGROUND

In the second decade of the 21st century, undernutrition still causes 45% of all child deaths[iii], and some 165 million children around the world are stunted[iv]. Among the main causes of stunting is chronic deficiency in nutrition during the first 1,000 days of a child's life, from conception to age two[6]—the timeframe when optimal infant and young child feeding is so crucial. Frequent infectious illness during this period also plays a major role—and lack of breastfeeding substantially elevates the risk of illness. The damage stunting causes is irreversible.

Breastfeeding is a key strategy to reduce child undernutrition and reach Millennium Development Goal (MDG) Four: "Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate." It is also indispensable to reaching MDG One: "Halve the proportion of people who suffer from hunger." The evidence for its wide-ranging benefits is compelling, and an evidence-based package of effective interventions to improve breastfeeding practices is available.

FIGURE 1 Since 1990, there has been negligible progress to raise the global rate of exclusive breastfeeding

Exclusive breastfeeding rates among children less than 6 months since 1990 plotted against timeline of key events to promote breastfeeding during the same time period



Note: The red line shows the rate of exclusive breastfeeding, which has increased from 32 to 40 percent between 1995 and 2011, based on available trend data from a subset of 77 countries. Comparable global data is not available for each of the years plotted in the chart, nor for the baseline year of 1990. Source: UNICEF

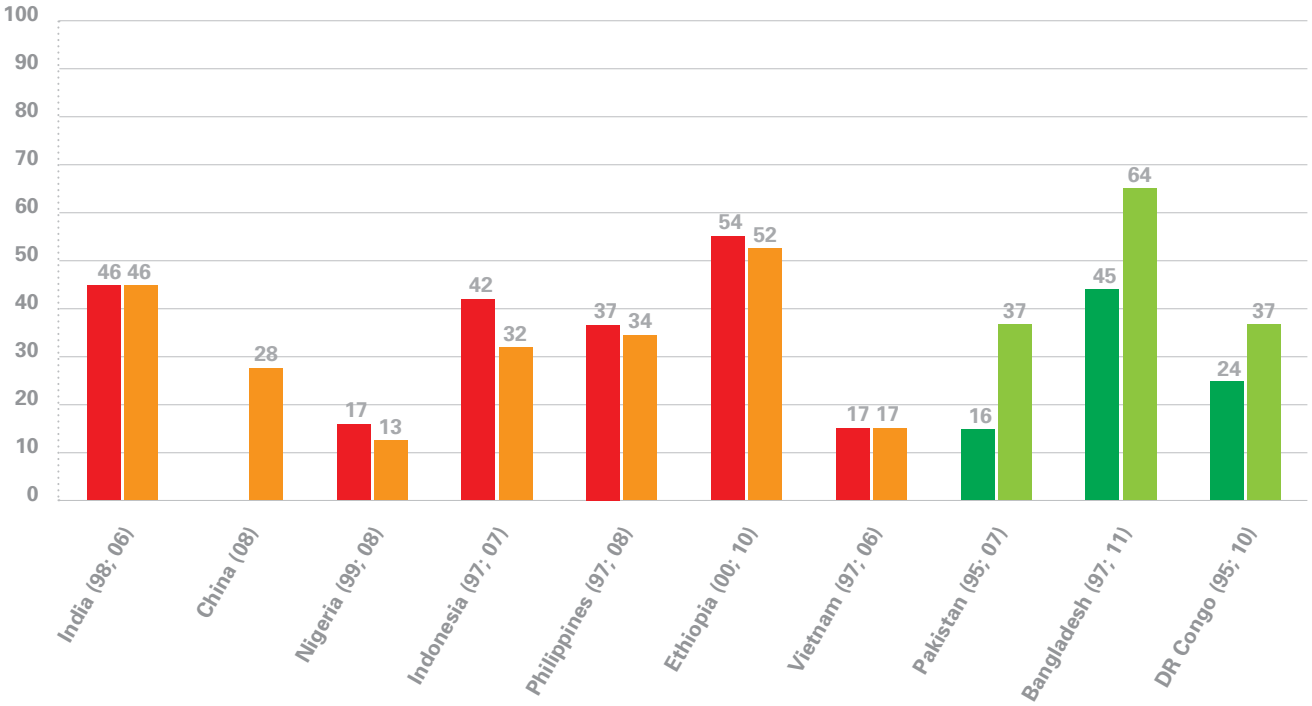
[iii] *The Lancet's* 2013 Series on Maternal and Child Undernutrition—Executive Summary http://www.imagine.in/Sem6-ExeSum.pdf.
[iv] Stunting, or chronic undernutrition, means a child is too short for their age compared to the median WHO growth standards

Global action to promote breastfeeding practices spans more than three decades during which development partners have developed policy, strategy and programme frameworks, compiled the evidence on the wide range of benefits of breastfeeding, worked to raise breastfeeding rates in developing nations through support to implementation of a range of interventions to protect, promote and support breastfeeding, and reflected breastfeeding in global partnerships and movements. The graphic below shows a timeline of some of these key global efforts since the early 1990s alongside the global rate of exclusive breastfeeding:

Despite these efforts, the data confirms a harsh finding: since 1990, there has been negligible progress to raise the global rate of exclusive breastfeeding under six months, which remains under 40 per cent. Some countries have demonstrated it is possible to make dramatic progress[7]. But of the 11 highly populated countries which contain an estimated two-thirds of the non-exclusively breastfed children in the developing world, all but three have either negative trends or no progress between 1995–2011. The lack of progress in most of these countries significantly impacts the global rate of exclusive breastfeeding.

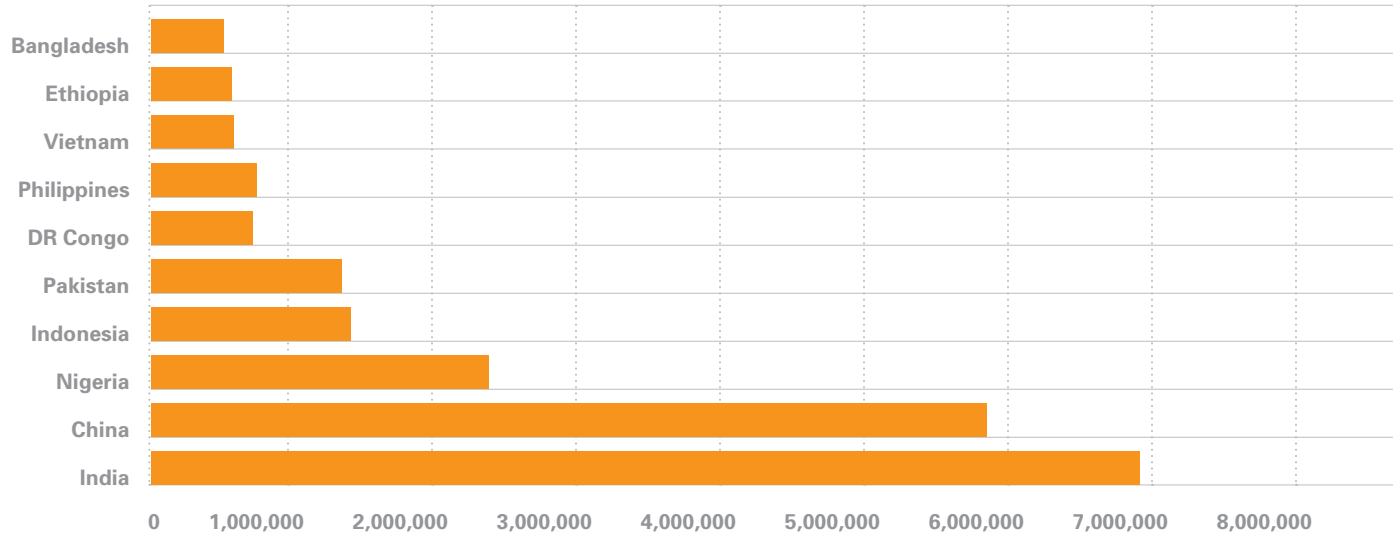
In developing countries, of approximately 56 million infants less than six months of age, approximately 22 million are exclusively breastfed, while over 34 million children are not. Eighty per cent

FIGURE 2 Trends in exclusive breastfeeding rates among children <6mo in the countries representing two thirds of the burden of non-exclusively breastfed children



Excluding China for which no trend data is available
Source: UNICEF database for *The State of the World's Children 2012*

FIGURE 3 **Ten large countries have around two-thirds (or over 21 million) of the 34 million non-exclusively breastfed children in all developing countries**



Data sources: most recent exclusive breastfeeding data point from UNICEF database and population figures in *The State of the World's Children 2012*

of these children who do not benefit from exclusive breastfeeding in developing countries live only in 29 countries. From these 29 countries, the 10 large countries above have two-thirds (over 21 million) of the approximate numbers of non-exclusively breastfed children in developing countries (Figure 3).

"There seems to be a relatively limited focus on breastfeeding", according to a 2011 analysis of political, financial and other commitments to advance the UN Global Strategy on Women and Children's Health[8].

Many country-based stakeholders confirmed the low levels of commitment for breastfeeding in their setting, and the challenges this poses to programming. Others saw advocacy gains: "There's been a huge amount of progress made to align the nutrition community," said one respondent. But she added: "I haven't seen breastfeeding's potential role in that translate into much action."

Why has such strong scientific evidence not translated into political and donor commitment for breastfeeding at the global level and in high burden countries? What can the global breastfeeding policy community do to augment attention and commitment to breastfeeding? Seeking answers to these questions, UNICEF's Nutrition Section conducted a landscape analysis to assess the political commitment and priority for breastfeeding interventions globally and in selected countries, in order to determine the need for, and potential benefits of, a targeted initiative to enhance leadership and advocacy.

METHODOLOGY

This landscape analysis consists of two major components—a desk review summarizing the status of evidence and policy/strategic frameworks; and a stakeholder survey of perceptions and recommendations. The way forward is informed by the outcomes of a small stakeholder consultation conducted in February 2013 in which the findings and recommendations of the landscape analysis were reviewed and articulation of key issues and elements for the future direction was refined.

The desk review involved an online search of the websites of the seven global partnerships, five UN/multilateral agencies, four donors and six non-governmental organizations to identify documents and statements available in the public domain. It assessed how breastfeeding is reflected within the strategies, advocacy publications and other guiding documents and statements of major global movements and partnerships comprising multiple types of agencies and those of selected organizations, as well as policies and strategies in countries. The latter information was obtained from a selection of multi country assessments and review reports. The desk review is not intended to be a comprehensive or detailed assessment of the frameworks of all countries or of every organization and partnership which supports nutrition or child survival, nor the details or status of programmes. The findings are based on information publically available, which may not reflect the full and up to date picture of the policies or programmes of a partnership or organizations, and the conclusions are by nature qualitative.

The survey of stakeholder views is based on responses to a structured questionnaire and related grey literature search. The questionnaire was circulated to stakeholders identified as key actors in the protection, promotion and support of breastfeeding practices, working at the global, regional and country level. It explored their views regarding the current state of political priority for breastfeeding programmes; perceived barriers and opportunities, and suggestions for the way forward.

Forty-four responses were received from UNICEF, WHO & PAHO, the World Bank, donor agencies, academics, NGOs, civil society organizations and consultants. (See Annex 1) Twenty-six hour-long Skype calls were conducted, and 18 written questionnaires were received. Geographic distribution included North America, Europe, Asia, Africa and the Middle East. Responses were evenly matched between external stakeholders and UNICEF staff. To preserve confidentiality, the letter S is used to identify stakeholder quotes, and Q, responses received by questionnaire.

For purposes of analysis, this study uses a framework developed by Jeremy Shiffman, a political scientist and professor at American University. Shiffman has pioneered a new field of inquiry to understand why some global health initiatives have generated political commitment and funding while others are neglected, when severity of disease burden is not the deciding factor[4].

Shiffman's framework defines four main categories influencing issue attention for global health: actor power, issue characteristics, ideas and political contexts. These categories are useful

TABLE 1 A framework for analyzing issue attention in global health and nutrition

Category	Factor	Explanation	Why It Matters
Actors	Policy community cohesion	Brings networks together; connects different types of organizations	Enhances authority
	Leadership	Strong champions for the cause to defend the issue, inspire action and bring policy communities together	Define the issues, inspire action, bring policy communities together
	Guiding institutions	Coordinating mechanisms	Sustainability
	Civil Society Mobilization	Engaged social institutions that press political authorities to act	Source of external pressure
	Donors[v]	Funding organizations providing support for programmes and advocacy	Resources and policy voice
Issues	Importance	Importance of issue relative to other issues; credible indicators the are key	Preferences for causes perceived to be serious; indicators alarm politicians
	Tractability	Extent to which the problem is (perceived to be) surmountable; clear cost effective interventions are key	Policymakers are more likely to act on issues they think they can do something about
	Contentiousness	Extent to which addressing the issue incites opposition	Inhibits progress; inspires action
	Allure	Attractiveness of the issue to those who might want to address it	Reputational effects
Ideas	Internal Frame	Common policy community understanding of problems and solutions	Avert fractiousness, enhance credibility
	External Frame	Public positioning of the issue that inspires external audiences to act	Only some resonate widely; different frames resonate with different audiences
Political Context	Policy Windows	Moment in time when conditions align favorably for an issue	Present windows of opportunity
	Existing Health Priorities	Priority for other health issues	May facilitate or divert policymaker attention

Adapted from Jeremy Shiffman's Framework of Determinants of Global and National Attention for Health Issues in Low-income Countries [vi]

[v] Added to Shiffman's framework for the purpose of this analysis
[vi] See Annex 3 for a summary of Shiffman's original framework

because they reveal underlying factors enabling—or hindering—priority for breastfeeding programmes. In particular, they help us understand the dynamics at play within the breastfeeding policy community and broader development context, and their resulting impact on prioritization of breastfeeding. This framework was also used for case studies on maternal mortality[4] and newborn survival[9], which can provide valuable lessons for breastfeeding stakeholders.

While UNICEF's questionnaire and Shiffman's framework both focus on high-level advocacy, it is acknowledged that there are many other determinants of breastfeeding practices, the analysis of which does not lie within the scope of a landscape analysis on political commitment to breastfeeding.

To provide perspective on stakeholder inputs, a PubMed search was conducted using key words related to the landscape analysis. It yielded very few articles. A grey literature search was more productive. Some of those findings are cited in the section on the stakeholder survey findings.

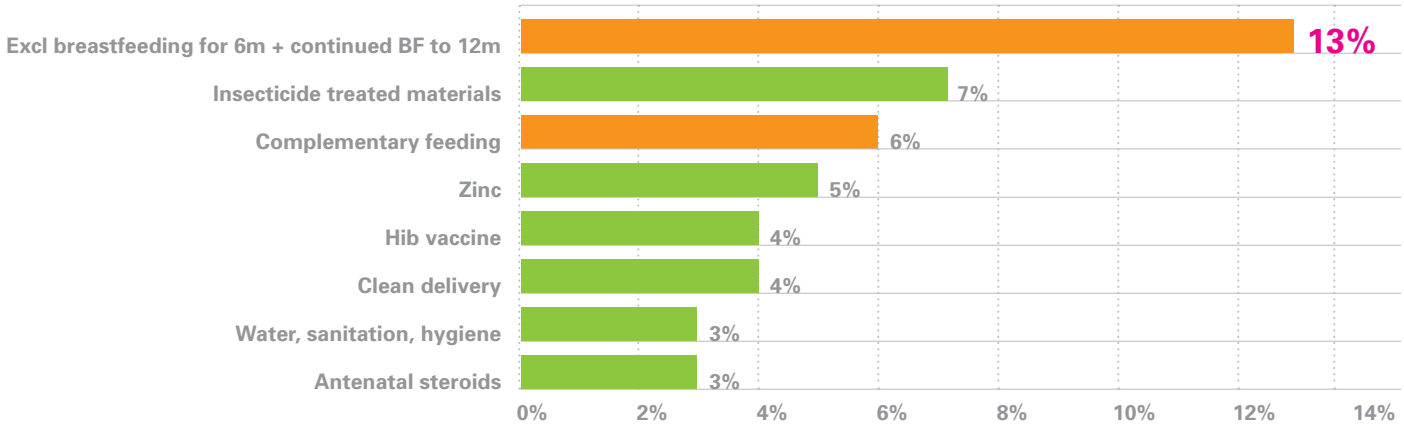
The limitations of the methodology of the stakeholder survey include factors identified by Shiffman and co-author Stephanie Smith in their maternal mortality case study: "the difficulty in controlling for confounding variables of influence, and in assessment of the relative weight of factors"[4]. As they further note, the study of issue ascendance and neglect in global health is in its infancy and requires substantially more research. A survey of perceptions and views is by nature subjective and qualitative.

DESK REVIEW: EVIDENCE, POLICIES AND STRATEGIC FRAMEWORKS FOR BREASTFEEDING

SUMMARY OF GLOBAL EVIDENCE ON BREASTFEEDING

The evidence on the many and remarkable benefits of breastfeeding is well known. High coverage with optimal breastfeeding practices has potentially the single largest impact on child survival of all preventive interventions. The 2003 *Lancet* Child Survival Series[10] ranked breastfeeding (exclusive for the first six months and continued breastfeeding from 6–11 months) as the number one preventive intervention, potentially reducing under-five child deaths by 13%, while complementary feeding contributes a further 6%.

FIGURE 4 Breastfeeding has the single largest potential impact on child mortality of all preventive interventions

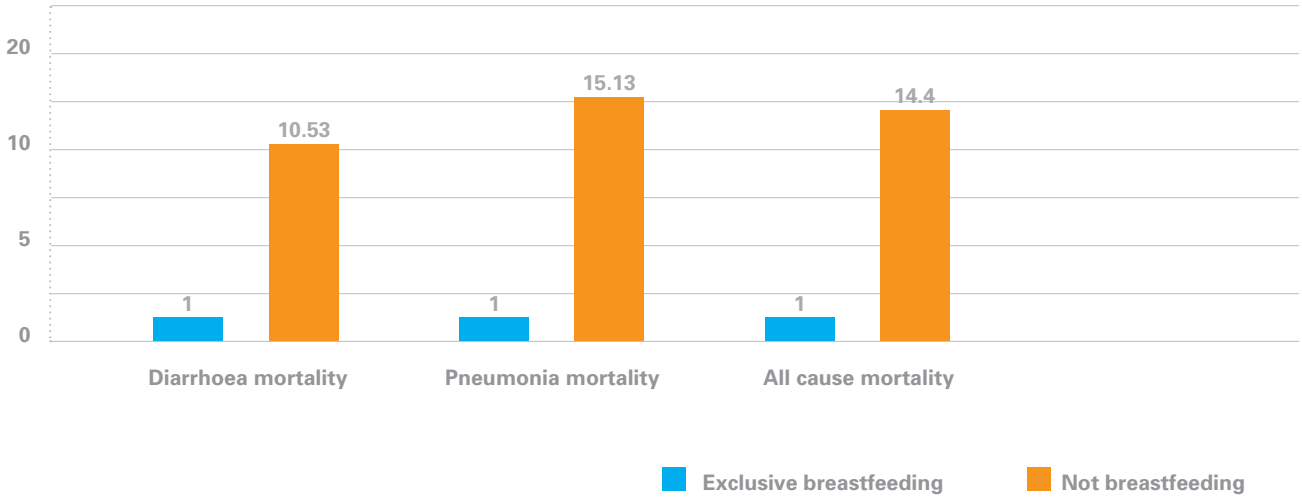


Source: *Lancet* Child Survival Series 2003.

The latest analysis of the evidence, published in the 2013 *Lancet* Series on diarrhea and pneumonia[11], models the large impact of breastfeeding on mortality due to the two major childhood killers, potentially averting over 250,000 deaths. Further, the 2013 *Lancet* Nutrition Series[12] states that sub-optimum breastfeeding among children under two years results in more than 800,000 child deaths annually, or 11.6% of all deaths. There is also growing evidence of the significant impact of early initiation of breastfeeding on reducing overall neonatal mortality: recent studies

STUDIES FROM GHANA AND NEPAL SHOW EARLY INITIATION WITHIN THE FIRST HOUR COULD PREVENT AROUND 20% OF NEONATAL DEATHS

FIGURE 5 **The risk of mortality for non-breastfed children is vastly elevated compared to exclusively breastfed children in the first 6 months of life**



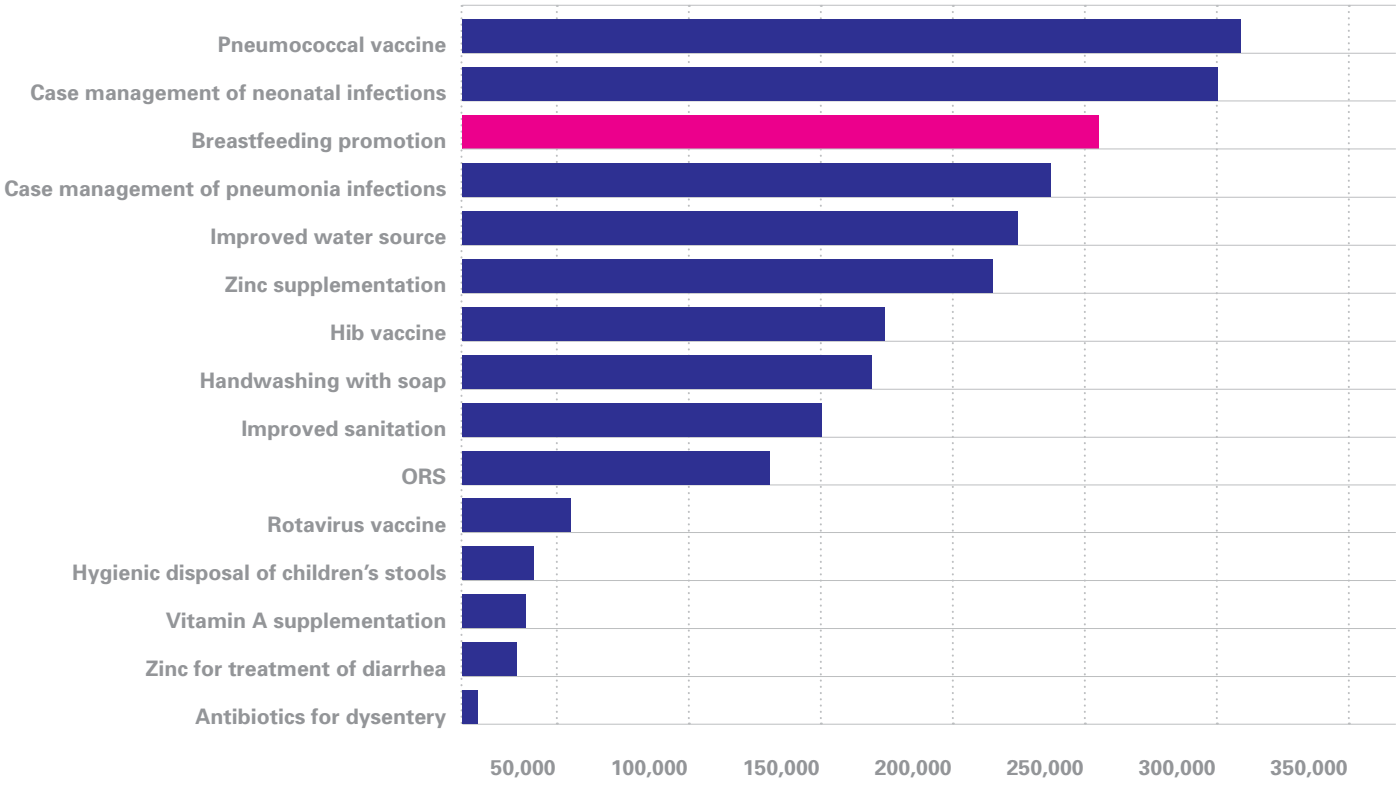
Source: *Lancet* Nutrition Series 2008

from Ghana and Nepal show that early initiation within the first hour could prevent around 20% of neonatal deaths[13,14]. This becomes increasingly important as patterns of the causes of child deaths shift towards a larger proportion of deaths due to neonatal factors.

A large body of evidence is also available on the benefits of breastfeeding for child nutrition status[15,16] its protective effects for later obesity and various chronic, non-communicable diseases[17], its impact on intellectual and motor development and short and long term benefits for maternal health[18]. Economic benefits are also significant in terms of reduced health care costs[19,20], fewer absences of caregivers from work due to child illness[21], and a reduced drain on household resources for breastmilk substitutes and other supplies[22]. Although the economic costs of not breastfeeding generally are considered to be greatest for poor households and poor countries, the evidence suggests that the impact in developed countries is also serious[23].

Scientific evidence has been gathered on the effectiveness of a number of interventions to improve breastfeeding practices. These include maternity care practices, where institutional changes are demonstrated to effectively increase breastfeeding initiation and duration rates[24,25,26]. Professional support by health providers has proven effective in extending the duration of any breastfeeding[27]. Lay counselors have been shown to be most effective in increasing the initiation and duration of exclusive breastfeeding[28]. Further, various types of community-based breastfeeding promotion and support can improve breastfeeding practices in developing countries[29]. In terms of communication, media campaigns improve attitudes towards breastfeeding and increase initiation rates[30] and social marketing has been established as an effective behavioural change model for a wide variety of public health issues, including breastfeeding[31]. Evidence from industrialized countries has shown how workplace support programmes increase the duration of breastfeeding[32], and a study examining the relationship

FIGURE 6 **Breastfeeding promotion could potentially prevent 250,000 child deaths due to pneumonia and diarrhea**



Source: Adapted from *The Lancet* 2013, Childhood Pneumonia and Diarrhea Series, Paper 2.

between advertising in a parenting magazine and breastfeeding found that when frequency of advertisements for artificial feeding increased, the percentage change in breastfeeding rates reported the next year tended to decrease[33]. Analysis reveals a significant correlation between higher exclusive breastfeeding rates and higher levels of Code implementation in 108 countries for which UNICEF has data on both variables.

THE POLICY BASES FOR BREASTFEEDING

The right to nutrition is protected by international human rights law, including the Convention on the Rights of the Child, which commit ratifying countries to promote and protect the nutritional wellbeing of women and children, and report on their progress towards this goal[34]. Global policy frameworks which address breastfeeding include:

- The 1981 International Code of Marketing of Breastmilk Substitutes is one of the first global policy instruments for the protection of breastfeeding, and is further articulated and updated by a series of subsequent relevant WHA resolutions.
- 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding[35]. The 1990 Declaration sets out four targets for national action related to national coordination, the BFHI, the Code and maternity protection.
- 1990 Convention on the Rights of the Child[36] (Article 24) which states that governments must combat disease and malnutrition, through, inter alia, the provision of adequate nutritious foods and ensure that all sectors of society are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, including the advantages of breastfeeding.
- 2002 World Fit for Children[37] which clearly states "*to reduce child undernutrition among children less than five years of age by at least one third, with special attention to children under two years of age*" and "*to protect, promote and support exclusive breastfeeding for six months and continued breastfeeding with safe, appropriate and adequate complementary feeding up to two years of age and beyond*".
- WHO/UNICEF Global Strategy for Infant and Young Child Feeding (2003), endorsed by UNICEF's Executive Board and the World Health Assembly.
- 2005 Innocenti Declaration on Infant and Young Child Feeding[38] which celebrates the 15th Anniversary of the 1990 Declaration[39] commits to urgent actions, and sets concrete targets. The 2005 Declaration adds five more operational tar gets to provide a broader focus, including policy development, protection, promotion and support in the health and other sectors and at multiple levels, complementary feeding promotion, infant feeding in exceptionally difficult circumstances and national legislation to give effect to the Code.
- In 2008, revised IYCF practice indicators were published by WHO.
- In 2012, the World Health Assembly endorsed the six global targets for nutrition, one of which is exclusive breastfeeding, as well as the implementation plan for maternal, infant and child nutrition. A number of other WHA resolutions also refer to breastfeeding.

COMMITMENT TO BREASTFEEDING IN ORGANIZATIONS AND GLOBAL PARTNERSHIPS

As mentioned in the methodology section of the document, the desk review assessed how breastfeeding is reflected within the publically-available strategies, advocacy publications and other guiding documents and statements of major global movements and partnerships comprising multiple types of agencies and those of selected organizations—UN and multilateral agencies, donors, non-governmental organizations, as well as policies and strategies in countries. It is not intended to be a comprehensive or detailed assessment of the frameworks of all countries or of every organization and partnership which supports nutrition or child survival, nor the details or status of programmes, but to provide some examples summarizing the status of breastfeeding within strategic frameworks available in the public domain.

Brief reflections are provided on the relative importance breastfeeding appears to have within these frameworks and point to any major gaps, whether the recommended breastfeeding practices are comprehensively addressed—e.g. early initiation, exclusive breastfeeding and continued breastfeeding, and whether the strategic approach is comprehensive—covering major lines of action recommended for protection, promotion and support as per the Global IYCF Strategy.

Global initiatives, movements and partnerships

The number of health and nutrition related partnerships, alliances, initiatives, campaigns and movements continues to grow, but for the purposes of this review the focus is only on a selection of seven partnerships which directly relate to child nutrition and survival.

The Scaling Up Nutrition (SUN) global movement, launched in 2010, involves over a hundred partner organizations, and Governments from 34 countries have signed up so far. The SUN website[vii] refers to four main "nutrition-specific" interventions which the SUN movement looks to implementing, including:

[vii] http://scalingupnutrition.org/about

- *Support for exclusive breastfeeding up to 6 months of age and continued breastfeeding, together with appropriate and nutritious food, up to two years of age.*

The Scaling Up Nutrition Movement Strategy (2012–2015)[40] refers to four major goals for each country participating in the Movement. The goals address direct and underlying causes of undernutrition and—taken together—aim to meet the global targets established by the 2012 World Health Assembly. One of the four goals is:

- *Increased adoption of practices that contribute to good nutrition (such as exclusive breastfeeding in the first six months of life).*

The strategy's section on measuring impact also references this goal on exclusive breastfeeding as one of the major results.

The SUN Revised Roadmap (2012)[41] references the World Health Assembly targets for nutrition established in 2012. The 2011 first iteration of the Roadmap contained 9 nutrition indicators to measure progress, including *exclusive breastfeeding*. The 2010 document "Scaling Up Nutrition: A Framework for Action" reflects breastfeeding as one of the three main areas of intervention to promote good nutritional practices.

It is noted that breastfeeding features prominently in the various SUN strategic documents. However, in most of the documents reference is only made to exclusive breastfeeding, not to continued breastfeeding, which is important for survival and nutrition status and also longer term impact on later health and for the mother's health.

The 1,000 Days partnership[viii] is an advocacy partnership which *"promotes targeted action and investment to improve nutrition for mothers and children in the 1,000 days between a woman's pregnancy and her child's 2nd birthday when better nutrition can have a life-changing impact on a child's future and help break the cycle of poverty"*. It aims to increase understanding about the crisis of undernutrition in early life and to elevate nutrition on the global agenda. A particular focus is facilitating connections between advocates and the global public to learn and follow the progress of the SUN movement. Its 80+ listed partners are mainly NGOs, but also some donors, UN agencies, governments, foundations and the private sector. Among the three main solutions its website lists, breastfeeding is reflected as follows:

- *Promoting good nutritional practices, including breastfeeding and appropriate, healthy foods for infants.*

The 1000 Days website contains resources on "feeding practices", including technical documents, guidelines, tools, advocacy materials, reports, a newsroom and blogs, etc from different organizations. Its infographic on the conceptual framework for undernutrition emphasizes poor feeding practices under the category of "care" (an important aspect which is rarely reflected in the varying iterations of the conceptual framework of different organizations and publications), and highlights the fact that "nearly a million deaths could be prevented per year if children were exclusively breastfed for the first 6 months".

The large network of partners involved in the 1000 Days initiative and the communication and advocacy approaches could also be opportunities for advocacy for breastfeeding.

REACH[ix] ("Renewed Effort Against Child Hunger and undernutrition", originally called "Ending Child Hunger and Undernutrition Initiative" or ECHUI) is a UN initiative to accelerate the scale up of food and nutrition actions that was established in 2008 and is jointly supported by FAO, IFAD, UNICEF, WFP and WHO. REACH operates at country level as a facilitating mechanism in the coordination of UN and other partners' support to national nutrition scale-up plans through a coordinated, solution-oriented approach under the leadership of national governments. REACH links maternal and child nutrition, food security, health and care through a nutrition-sensitive approach that integrates the support and participation of different government sectors. Its main role is facilitating institutional capacity building, coordination, strengthening policy planning and monitoring skills and prioritizing scarce government resources for national action. To date, REACH operates in 12 countries in Africa and Asia.

REACH promotes 11 interventions, among them breastfeeding and complementary feeding, and provides guides on the interventions, which are technical primers synthesizing why certain interventions are important, how they work, how cost-effective they are, and how to implement them[x]. Breastfeeding features prominently in some of the country plans, for example

[viii] http://www.thousanddays.org/

[ix] http://www.reachpartnership.org/

[x] NB at the time of the desk review, these guides could not be accessed from the website.

in Mauritania, one of the first REACH countries, where rapid progress in exclusive breastfeeding has been observed.

The Infant feeding in Emergencies (IFE) Core Group[xi] is an expert advocacy and resource group focused on the single issue of infant and young child feeding in emergencies. It functions as an interagency collaboration with full and associate members. Its members include UNHCR, UNICEF, WFP, WHO, ACF, Save the Children, Care, IBFAN, Terre des Hommes, and also individuals. The Emergency Nutrition Network (ENN) is the coordinating agency and its website is a 'home' for the resources produced by the IFE Core Group. The IFE Core Group goal is to *"strengthen the protection, promotion and support of safe and appropriate infant and young child feeding in emergencies"*. The IFE Core Group's materials consistently refer to the full set of actions for breastfeeding (protect, promote and support). The IFE Core Group's work to date has centred on development of policy guidance and capacity building tools, capturing and learning from what happens in emergency response with regard to infant and young child feeding and promoting policy and practice change in the context of preparedness and response. The IFE Core Group does not directly implement programmes as a group.

Key resources produced by the IFE Core Group include the 2007 *Operational Guidance on Infant Feeding in Emergencies*[42], an *Orientation Package on IFE*, a training package on integrating IYCF into community management of acute malnutrition (CMAM), a media guide, model joint statement, reviews and various other resources to be found in its online library. The Operational Guide outlines six main steps for ensuring infant feeding is adequately addressed in emergencies, including *protect,promote and support optimal IYCF with integrated multisectoral interventions*.

A Promise Renewed[xii], a global movement launched in 2012, is spearheaded by UNICEF in collaboration with WHO, USAID and various other governments and partners. It focuses on ending preventable child deaths, and "seeks to advance the *Every Woman Every Child* global movement". The goals refer to intensifying efforts to address the five conditions responsible for almost 60 per cent of child deaths—pneumonia, diarrhoea, malaria, pre-term birth complications and intrapartum-related complications. The section in the APR Road Map[43] on "scaling up existing solutions" does not mention breastfeeding. It appears briefly in the annex of the Roadmap where presentations from the launch of APR include *early initiation and exclusive and continued breastfeeding* in the listing of the package of evidence-based interventions across the continuum of care. One other slide notes that "important practices such as exclusive breastfeeding need more attention" and highlights success factors in improving breastfeeding across the domains of protection, promotion and support. It was observed that nutrition did not feature prominently in APR, and while breastfeeding receives relatively little space and attention compared to its potential contribution in preventing and reducing 13% of child deaths. There is likely to be strong potential to elevate breastfeeding within APR and utilize this initiative to contribute to enhancing political commitment for breastfeeding.

Every Woman Every Child[xiii], an initiative of the UN Secretary General launched in 2010, focuses on women's and children's health. The Secretary General's Global Strategy for Women's and Children's Health[44] includes *exclusive breastfeeding* in its description of the package of integrated interventions and services. Similar to A Promise Renewed, this initiative does not feature nutrition or breastfeeding prominently; for example, a high level *Every Woman, Every Child* event in 2011 contained neither speakers nor mention of nutrition or breastfeeding.

The Partnership for Maternal, Newborn and Child Health (PMNCH)[xiv], hosted by WHO, was launched in 2005 and focuses on improving the health of women and children and promoting the continuum of care. It joins the reproductive, maternal, newborn and child health communities into an alliance of more than 450 member organizations from around the world. Its *Strategic Framework 2012–2015*[45] lists exclusive breastfeeding as one of eight tracer indicators of intervention coverage. While its budgets are fairly small, its advocacy and networking reach has good potential for channeling greater attention to breastfeeding.

United Nations and multilateral agencies

UNICEF[xv], as the UN agency mandated to advance the rights of children, addresses breastfeeding primarily through its nutrition work, and also makes reference to it in its health work on newborn care and child survival. UNICEF jointly with WHO adopted the 2002 *Global Strategy on Infant and Young Child Feeding*[46]

[xi] http://www.ennonline.net/ife
[xii] http://www.apromiserenewed.org/
[xiii] http://www.everywomaneverychild.org/
[xiv] http://www.who.int/pmnch/en/
[xv] http://www.unicef.org

endorsed by the World Health Assembly and the UNICEF Executive Board. The Global Strategy, while already more than ten years old, remains highly relevant to improving infant feeding practices today and provides the overarching policy framework and major lines of action needed to protect, promote and support appropriate feeding practices. UNICEF was instrumental in the convening of the 1990 and 2005 global meetings which led to the *Innocenti Declarations* in those years.

UNICEF's 2006–2015 *Joint Health and Nutrition Strategy*[47], while still current until 2015, will soon be superseded by a stand-alone nutrition strategy which is currently under development and will reflect the latest evidence and thinking on nutrition and effective interventions, and will also take into account sociopolitical, economic and climatic changes in a transitioning world going forward. The 2006 *Joint Strategy* reflects *early initiation, exclusive and continued breastfeeding* as priority interventions to achieve MDG4, but does not detail strategic approaches to improving breastfeeding practices. UNICEF's 2006–2013 *Medium Term Strategic Plan (MTSP)* also reflects increasing exclusive breastfeeding as one of the priority actions, targets and indicators for the young child survival and development focus area. A new MTSP is currently under development has exclusive breastfeeding as one of the indicators, although it is not yet final and may undergo more changes.

In situations of crisis, the UNICEF *Core Commitments for Children* (CCCs)[48] in Humanitarian Action provide the strategic framework for response, and includes IYCF as one of 6 commitments for nutrition, emphasizing that "…*the support, promotion and protection of breastfeeding is fundamental to preventing undernutrition and mortality among infants in emergencies*" and laying out some key areas of action on breastfeeding.

In the major advocacy documents on nutrition which UNICEF publishes, such as the 2009 *Tracking Progress on Child and Maternal Nutrition*[49] and the 2013 *Improving Child Nutrition: an Imperative for Global Progress*[50], breastfeeding is well reflected. Breastfeeding-specific advocacy publications have not been issued in recent years. In 2012 UNICEF published an *assessment of IYCF programmes in 65 countries*[51], and has published a number of technical and programmatic guides and tools on how to implement breastfeeding strategies, including the *Programming Guide on Infant and Young Child Feeding (2012)*[52] *and the Community Infant and Young Child Feeding Counseling Package (2012)*[52]. In most UNICEF programme countries with a nutrition programme, UNICEF's main instrument guiding country programmes, the Board-approved Country *Programme Document*, reflects improving breastfeeding as one of the key actions.

The World Health Organization (WHO) as the UN agency mandated for health, addresses breastfeeding primarily through its nutrition department, but also in its work on newborn and child health. WHO and UNICEF are joint "owners" of the 2002 Global Strategy on Infant and Young Child Feeding and WHO co-convened the Innocenti conferences with UNICEF.

In 2012 the World Health Assembly approved a Comprehensive Implementation Plan for Maternal, Infant and Young Child Nutrition developed by WHO, which reflects *"Counselling and support for optimal breastfeeding (early initiation, exclusive breastfeeding for the first six months and continued breastfeeding up to two years of age or beyond)"* as one of the effective direct nutrition interventions. The Plan has as one of six global targets for nutrition the *increase of exclusive breastfeeding to at least 50% by 2025*, from the 2012 baseline of 37%. The six global targets were endorsed by the World Health Assembly in 2012. It is noted that breastfeeding is placed at the same level as nutrition status indicators: the targets include child stunting and wasting, anemia among women, low birthweight and childhood obesity, as well as the exclusive breastfeeding target. This is an important opportunity to focus attention on results for breastfeeding. The World Health Assembly adopted the *International Code of Marketing of Breastmilk Substitutes* in 1981, and has since adopted a number of subsequent resolutions refining and updating the global position on the issue.

WHO has authored several joint technical publications together with UNICEF, such as the *Baby Friendly Hospital Initiative (2009)*[54], the *Integrated Infant and Young Child Feeding Counseling Course* (2007)[55] and the *Planning Guide for National Implementation of the Global Strategy for Infant and Young Child Feeding* (2007)[56] and, together also with other agencies, the *Infant and Young Child Feeding Indicators* (2008)[57], and the *Guidelines on HIV and Infant Feeding* (2010)[58]. WHO has also published various technical documents and tools on breastfeeding, including the *Infant and Young Child Feeding Model Chapter for Medical Textbooks*[59], the *Breastfeeding Counseling*

course (1993; 2013 update in progress) and various summaries of scientific evidence on breastfeeding, for example the scientific basis for the recommendation of six months for exclusive breastfeeding[60],[61].

The World Food Programme (WFP), as the UN agency mandated to address hunger with a focus on the provision of food, has a Nutrition Policy (2012) and Strategic Plan (2008–2013). These do not refer to actions for breastfeeding, although there is reference to *"sensitizing mothers to good care practices"*. The page on the WFP website which refers to nutrition for mothers and young children[xvi] mentions the importance of tackling problems such as *inappropriate feeding and caring practices of children*.

The UN High Commissioner for Refugees (UNHCR), as the UN agency mandated to address the protection, rights and wellbeing of refugees, addresses breastfeeding in its Public Health and HIV Section's *Guiding Principles and Strategic Plans (2008–2012) for HIV and AIDS, Malaria Control, Nutrition and Food Security, Reproductive Health and Water and Sanitation* includes a strategic objective to *establish infant and young child feeding (IYCF) policies and programmes*, with an indicator on exclusive breastfeeding. UNHCR's headquarters is an active supporter of efforts to ensure appropriate infant feeding in emergencies.

The World Bank's January 2013 publication *"Improving Nutrition Through Multisectoral Approaches"* [61] serves as a guidance document for World Bank-supported initiatives in countries. It lists breastfeeding as one of the nutrition-specific priority interventions for scaling up nutrition, under the heading of: *Promoting good nutritional practices, which includes optimal breastfeeding and complementary feeding (after 6 months)*. Breastfeeding features prominently throughout the health sector chapter in particular. The document notes that typical nutrition activities funded by the Bank include the promotion of optimal infant and young child feeding practices (including *breastfeeding* and complementary feeding).

The World Bank's 2010 publication *"Scaling Up Nutrition: What Will It Cost"* [63] provided cost estimates to deliver 13 direct nutrition interventions which fall under 3 broad groups, with the following group including breastfeeding:

- *Behavior change interventions that include promotion of breastfeeding, appropriate complementary feeding practices (but excluding provision of food), and proper hygiene, specifically handwashing. It is assumed that the majority of these services are delivered one-on-one at the community level through platforms such as community nutrition programs*

The World Bank estimated that $2.9 billion would be needed annually for the behaviour change interventions. The costing of $7.50/year per child has been based on "promotional" activities for all the interventions in the community nutrition programmes, but does not separate infant and young child feeding. It does not cover the "promotion" aspect of breastfeeding strategies comprehensively—communication using media and various other channels is not costed—and does not cost actions for "support"—professional support for breastfeeding in health facilities and community based counseling and support services, including pre and in-service training—nor the activities for "protection" of breastfeeding (Code and maternity protection). The costing therefore does not reflect the full set of interventions needed to improve breastfeeding.

The Bank's resource allocation is determined through the country level projects that are submitted, which may or may not include IYCF. The Bank only reports on two nutrition indicators to its Board: Vitamin A supplementation and a new, composite indicator of "the number of women and children reached with nutrition services".

Donors

The UK's Department for International Development (DFID) published *"Scaling Up Nutrition: The UK's position paper on undernutrition"* in September 2011. The foreword of the paper highlights the fact that *"over the past 12 months DFID has dramatically scaled up its work in the area* [of nutrition]*"*, and states that *"in particular, we are putting more money into specific services such as improving vitamin and mineral intake and supporting breastfeeding"*. The strategy emphasizes the focus on scaling up nutrition-specific interventions in the first '1,000 days', featuring support for breastfeeding prominently. It includes breastfeeding in each of the examples of support to large countries such as Nigeria, Bangladesh and India. DFID has become one of the major supporters of nutrition programmes

[xvi] http://www.wfp.org/nutrition/mothers-children

addressing prevention of undernutrition in recent years.

The European Union (EU)'s 2011 *Reference Document: Addressing Undernutrition in External Assistance* features *promotion of breastfeeding* as one of six areas of action under "improving health care" in its *Nutrition Framework for Action* and behavior change communication on infant and young child feeding as one of three areas of action to "improve education". Breastfeeding is strongly reflected in the section on *Improving Nutrition through Health*, which contains a *package of nutrition-specific actions such as breastfeeding promotion, management of severe acute malnutrition and vitamin A supplementation*. Key indicators of nutrition benefits through health include *early initiation of breastfeeding and exclusive breastfeeding*. The section on *Improving Nutrition through Gender* features *gender-sensitive social protection policies (e.g. targeting support to pregnant and lactating women to relieve their economic burden during the later stages of pregnancy and the breastfeeding period)* as well as *legal frameworks which protect women's rights (e.g. …workplace policies supporting breastfeeding)*. The section on *Improving Nutrition through Social Protection* has an indicator *"Breastfeeding is continued through first 12 months of life"* in its key indicators of nutrition benefits through social protection. The chapter providing *Guidance for Addressing Nutrition through Humanitarian Projects* also has *exclusive breastfeeding until 6 months* and *early initiation of breastfeeding* as two of the six key nutrition indicators in emergencies. The EU's strategic document reflects breastfeeding prominently and across various sectors.

The EU has also become a major supporter of preventive nutrition programmes of late, including its initiative on stunting reduction in nine Asian and African countries, in which breastfeeding interventions are included. Its emergency funding for nutrition tends to focus more on treatment of severe acute malnutrition.

The US Government supports country-owned programs to address the root causes of undernutrition mainly through the flagship programmes *Feed the Future* and the *Global Health Initiative* (GHI), in which nutrition programs are integrated. The US Government also reflects breastfeeding in its nutrition assistance in emergencies through the Office of Foreign Disaster Assistance (OFDA). The GHI strategy paper[xvii] refers to breastfeeding and promotion of appropriate feeding of infants and children in the newborn care arm of the strategic component *"Do more of what works: Rapidly scaling up the most relevant high impact interventions..."* and also to *"young child feeding promotion"* in the child health arm. Breastfeeding is also mentioned in the "innovation" component, linked to integrated prevention and treatment of diarrheal disease and pneumonia. A major programme on maternal, newborn and child health in USAID's Bureau for Global Health is MCHIP. Its nutrition component promotes the Essential Nutrition Actions, including early, exclusive and continued breastfeeding. A key strategic document[63] underpinning USAID's maternal and child survival work reflects breastfeeding as one of the high-impact interventions necessary to achieve child survival and nutrition goals, and emphasizes early initiation and exclusive breastfeeding. Feed the Future's nutrition focus area emphasizes improving nutrition during the critical "1,000 day" window of opportunity from pregnancy to two years of age and includes infant and young child feeding practices among the indicators being tracked to measure the impact of investments.

The US Government has invested in a number of projects and initiatives over the years which have featured breastfeeding and complementary feeding prominently in their objectives, strategies and resources, including the *Linkages Project* (1996–2006)[xviii], the *Infant and Young Child Nutrition (IYCN) Project* (2006–2012)[xix] and now the new *Strengthening Partnerships, Results, and Innovations in Nutrition Globally Project (SPRING)* (end 2011–2016)[xx]. SPRING supports the strengthening and scale-up of the country-contextualized strategies for IYCF in its focus countries, and has a strong focus on social behavior change communication. Many useful and practical resources which support breastfeeding programmes were developed under the Linkages and IYCN projects and used in selected areas of various countries for the specific project timeframes; the websites of both projects function as major repositories for resources, tools, reviews and other publications on breastfeeding and infant and young child feeding. The US Government also funds a number of institutions and NGOs which implement breastfeeding programmes within their portfolio of nutrition and child health, such as Save the Children, Helen Keller International, John Snow International (JSI), PATH, World Vision, CARE and others.

[xvii] http://www.ghi.gov/resources/strategies/159150.htm

[xviii] http://www.linkagesproject.org/about/index.php
[xix] http://www.iycn.org/
[xx] http://www.spring-nutrition.org/

The Bill and Melinda Gates Foundation (BMGF) has four main programmes, including Global Policy and Advocacy, Global Health Global Development, the latter including nutrition and maternal, newborn and child health. The Foundation features breastfeeding prominently in its 2011 *Nutrition Strategy*[xxi], which highlights *"Promoting better breastfeeding practices"* as one of the opportunities for nutrition, and states that the Foundation is *"particularly interested in new approaches to improving nutrition for women before and during pregnancy and for children from birth to age 2—when nutrition is most critical to growth and development and lifelong health. This includes new approaches to ensuring immediate and exclusive breastfeeding for the first 6 months of a child's life, followed by a transition to healthy complementary feeding from 6 to 24 months of age"*. "Improving breastfeeding practices" is one of four nutrition focus areas, and the Foundation invests in *"research to test and evaluate ways to encourage more effective breastfeeding practices through mass media, social networks, maternity and marketing policies, and innovative service delivery models and by enhancing the knowledge and skills of frontline health workers"*. To date, the Foundation's funding support for nutrition programmes has been directed more towards product and market based approaches, including large grants to GAIN, the single largest recipient of BMGF funding for nutrition.

The Foundation is also funding a three-country, 6-year learning initiative called Alive and Thrive (A&T)[xxii] implemented by a consortium of seven different partners and aiming to *improve infant and young child nutrition by increasing rates of exclusive breastfeeding and improving complementary feeding practices.* A&T's IYCF strategy[65] outlines in detail the comprehensive approaches taken to protect, promote and support breastfeeding. The strategy includes improving the policy and regulatory environment, using targeted and evidence based advocacy and building capacity for policy dialogue; secondly, household, community, health facility, and mass media interventions are supported to shape IYCF demand and practice. Both supply side interventions (e.g. training, supervision, monitoring, creating structures, etc) and demand-side (interpersonal and mass communication for behaviour and social change) are reflected. A&T has produced various resources and tools on IYCF and is conducting a rigorous evaluation of its programmes to contribute to the global evidence base on IYCF interventions.

The Children's Investment Fund Foundation (CIFF) is a recent donor to join the child nutrition field. One of CIFF's seven priority impact areas is hunger alleviation and nutrition. Its landscape analysis for this priority, conducted in 2009, features infant and young child nutrition as one of five focus areas, with support for *development of models to promote breastfeeding and appropriate complementary feeding at scale and evaluation of breastfeeding promotion in a country with high HIV prevalence*. CIFF is developing a programme for preventing undernutrition of children under two in India, but otherwise its main investment in nutrition thus far has been on the management of severe acute malnutrition, as well as some support for food fortification.

Non-governmental organizations

In this section we focus on some of the main NGOs which strongly focus on nutrition and/or on children, recognizing that there are many others which also include breastfeeding among various nutrition and health portfolios.

The World Alliance for Breastfeeding Action (WABA)[xxiii] is an umbrella body consisting of individuals and organizations concerned with the protection, promotion and support of breastfeeding worldwide. WABA's core partners are IBFAN, La Leche League International, the Academy of Breastfeeding Medicine, Wellstart International and the International Lactation Consultants' Association. WABA is in consultative status with UNICEF.

Its vision is *"a world where breastfeeding is the cultural norm, where mothers and families are enabled to feed and care optimally for their infants and young children thus contributing to a just and healthy society"* and its mission is *"to protect, promote and support breastfeeding worldwide in the framework of the Innocenti Declarations (1990 and 2005) and the Global Strategy for Infant and Young Child Feeding through networking and facilitating collaborative efforts in social mobilisation, advocacy, information dissemination and capacity building"*. Its goal is *"to foster a strong and cohesive breastfeeding movement, which will act on the various international instruments to create an enabling environment for mothers, thus contributing to increasing optimal breastfeeding and infant and young child feeding practices"*.

WABA has hosted and organized *World Breastfeeding Week*[xxiv] globally on an annual basis in August since 1992; this is one of its main activities.

[xxi] http://www.gatesfoundation.org/What-We-Do/Global-Development/Nutrition
[xxii] http://www.aliveandthrive.org/about-us
[xxiii] http://www.waba.org.my/
[xxiv] http://www.worldbreastfeedingweek.org/

The International Baby Food Network (IBFAN)[xxv], formed in 1979, is a coalition of 273 not-for-profit non-governmental organizations, including public interest groups, *working around the world to reduce infant and young child morbidity and mortality… through the protection, promotion and support for breastfeeding and optimal infant feeding practices*. The Code is a strong focus area and was the main issue around which IBFAN was formed, with the principal aim of *"ensuring that the marketing of baby food does not have a negative impact on health"*. IBFAN describes itself as a *"single-issue organization"*. The *International Code Documentation Centre* (ICDC) was established by IBFAN to provide a focus on the implementation of the International Code. ICDC keeps track of Code implementation measures worldwide and supports countries in the drafting of national legislation. IBFAN's main website has a strong focus on the "protection" aspect of actions for breastfeeding—particularly the Code and issue of breastmilk substitutes.

In 2012 IBFAN produced a discussion paper on *"Scaling Up Breastfeeding/Infant and Young Child Feeding Interventions: What Will It Cost?"*[66], aiming to expand the costing beyond estimates for integrated promotional interventions such as the World Bank's, and suggesting that *"the neglect of interventions to enhance breastfeeding has been reflected in the lack of a global budget specifically for implementing them"*. The costing covers selected interventions for protection, promotion and support of breastfeeding, and acknowledges that there is a lack of data about costs for interventions.

IBFAN also hosts the *Global Breastfeeding Initiative for Child Survival* (gBICS), a civil society-driven initiative aiming to accelerate progress in attaining the health-related MDGs, especially Goal 4, by scaling up early, exclusive and continued breastfeeding. A major focus is the assessment of the status of breastfeeding practices and policies and strategies in countries through the *World Breastfeeding Trends Initiative* (WBTI)[xxvi], the results of which are intended to be used to influence policies, for advocacy, for programme initiatives etc. The WBTI uses "combined" data on breastfeeding practices (not verified or endorsed by WHO or UNICEF at global level) together with the data reported by countries on the status of policies and programmes to give countries an overall score.

Save the Children, with its focus on child health, nutrition and hunger, poverty, protection and education, is a strong advocate and supporter of breastfeeding. Its 2012 report *A Life Free from Hunger: Tackling child malnutrition*[67] identifies solutions that are proven to be effective, among them direct interventions, such as exclusive breastfeeding. The chapter on direct nutrition interventions features a dedicated section on IYCF, which reflects the full set of recommended breastfeeding practices. It does not contain much detail on how breastfeeding practices should be improved, but focuses on the term "promotion".

The 2009 plan *"Hungry for Change: an eight-step costed plan to tackle global hunger"*[68] is structured around eight package components to address child hunger, the first of which is *"breastfeeding promotion and support"*. All the recommended breastfeeding practices are presented in the dedicated chapter on this component, and the main lines of action are described, including health facility and community counseling, communication, and support during emergencies. The document also features the Code and maternity protection strongly. The package is costed, with an average of $18 per child per year for the breastfeeding component, comprising *seven breastfeeding contacts, mass media and nutrition education on complementary feeding*. Interestingly, the table on costing is the first time the document has any mention of complementary feeding, although it is also mentioned in several of the examples of programmes supported in the eight focus countries. These examples also feature breastfeeding prominently.

Save the Children UK also published an advocacy document dedicated to breastfeeding *"Superfood for Babies: How overcoming barriers to breastfeeding will save children's lives"*[69], a *"global call to action to rediscover the importance of breastfeeding and to support mothers to breastfeed their babies—especially in the poorest communities in the poorest countries"*.

In emergencies, Save the Children is one of the main implementers of breastfeeding promotion and support among the NGOs supporting humanitarian response on nutrition. It also includes infant and young child feeding in its development focused programmes in countries.

Action Against Hunger (ACF) traditionally focused principally on humanitarian response for nutrition, but recently has begun to address prevention of undernutrition as well, including IYCF.

[xxv] http://www.ibfan.org/all-about-ibfan.html
[xxvi] http://www.worldbreastfeedingtrends.org/

The ACF-International *Policy /Strategy Paper: ACF international technical policy and strategy 2012–2015*[70] reflects breastfeeding as one of the priority areas in the component *"Scaling up of interventions to prevent and treat undernutrition: preventing undernutrition and building resilience*. The ACF International Strategy[71] refers to preventing undernutrition but does not mention infant and young child feeding or breastfeeding. Similarly, the ACF website[xxvii] highlights the window of opportunity for preventing undernutrition, but mentions only treatment of acute malnutrition and micronutrients, not IYCF or breastfeeding. ACF's country programme updates and reports, however, frequently feature actions in support of breastfeeding.

Concern Worldwide's programmes focus on education, livelihoods, HIV/AIDS, emergencies and health, with nutrition one of the components of the latter. In terms of its nutrition programming, Concern is one of the pioneers of community based management of acute malnutrition and this is its major focus. It is one of the major implementers of nutrition response in emergencies, also including infant and young child feeding. Concern has a *Health Policy* (2010) in which nutrition is addressed. The *Health Policy's* only mention of breastfeeding states that *"Concern recognises the importance of breast feeding in child nutrition and will take steps to promote it within the constraints posed by maternal HIV/AIDS infection"*. However, reports of the agency's programmes in countries contain many references to programmes to improve breastfeeding.

Helen Keller International (HKI) focuses on preventing blindness and reducing malnutrition in the world. HKI features breastfeeding within the Essential Nutrition Actions[72] (ENA) framework in which all of the recommended breastfeeding practices are included and main lines of action to improve them are mentioned on the website[xxviii]. The ENA framework, according to the website, features seven areas, the first of which is *early initiation and exclusive breastfeeding in the first six months of life* and the second *optimal complementary feeding from 6 months of age with continued breastfeeding to 24 months and beyond.*

A key strategy of the ENA framework is to *build a broad coalition of advocates to promote messages and services* for the 7 actions. The ENA framework emphasizes reaching children and women through existing programs in multiple sectors such as health, in local communities and through other relevant programs, and has a strong focus on promotion of IYCF behaviours and practices, via dissemination of messages through multiple channels, as well as using the techniques of behavior change communications which move beyond message dissemination to helping individuals and communities in making the transition to healthier practices. Training of health providers and community workers features prominently as an activity. The ENA framework has been applied by HKI and a number of other agencies through projects mainly in Africa and Asia.

The Global Alliance for Improved Nutrition (GAIN), a Swiss foundation which supports public-private partnerships to increase access to the missing nutrients in diets, has an infant and young child nutrition programme[xxix]. The programme's goal is to improve the health and nutrition of ten million children aged 6 to 24 months. Its strategy is to *support public and private partnerships to reach infants in low-income families with multinutrient supplements and high-quality and affordable nutritious foods that complement breast milk from six months of age*. The description of approaches includes a mention of "appropriate marketing in support of breastfeeding" but GAIN's focus is on market-based approaches for food supplements and products for complementary feeding.

A press release in February 2013[xxx] states that *"GAIN promotes early initiation of breastfeeding, exclusive breastfeeding through age 6 months and continued breastfeeding through at least age 24 months with the introduction of appropriate, adequately nutritious complementary foods from 6 months of age"*. A number of similar statements on support for breastfeeding can also be found, but the programmes and initiatives implemented by GAIN do not in practice seem to feature breastfeeding, as per the descriptions of its programmes on its website.

IYCF policies/strategies in countries

This section briefly outlines the main findings from three different multi-country analyses related to the policy environment for IYCF. Each was conducted in the period 2009–2011. WHO assessed some aspects of IYCF policy and programming as part of a broader review of nutrition policies (119 countries), UNICEF assessed IYCF programmes (65 countries) and IBFAN focused in particular on breastfeeding (40 countries). Also highlighted are major findings related to policy environment,

[xxvii] http://www.actionagainsthunger.org.uk/
[xxviii] http://www.hki.org/reducing-malnutrition/essential-nutrition-actions/
[xxix] http://www.gainhealth.org/programs/gain-infant-and-young-child-nutrition-program
[xxx] http://www.gainhealth.org/press-releases/gain%E2%80%99s-response-ibfan-press-release-who-decision

MORE COUNTRIES HAD IYCF POLICIES THAN STRATEGIES AND PLANS OF ACTION

advocacy and leadership from two different reviews of breastfeeding programmes spanning 15 countries, conducted by AED and UNICEF from 2007–2009.

In 2009, WHO[xxxi], conducted a review of nutrition policies in countries, receiving responses from 119 countries, including industrialized countries[73]. The review includes a section reviewing policies on maternal, infant and young child nutrition, comprising responses from 104 countries. Among these, 69% indicated that their country had a policy covering IYCF, with 57% indicating the policy had been officially adopted. Policy content was assessed to some extent, noting reflection of the feeding of low birth weight infants (52% of countries), infant feeding in emergencies (only 31% of countries) and HIV and infant feeding (41% of countries, with 55% of African countries reporting policies on this).

The survey assessed implementation in countries of at least three of four priority actions of the global IYCF strategy (the Code, maternity protection, BFHI and training on IYCF counseling). The results by region showed a range from less than 40% of countries in Eastern Mediterranean (EMR) implementing at least three of the priority areas to over 70% in the European region. The survey also asked about implementation of selected interventions, including *"promotion of breastfeeding"* (98% of countries, with the *"vast majority at national scale"*—which is unlikely and difficult to verify, as few countries have monitoring systems that would enable them to report on scale of actions) and the BFHI, where *"few countries provided detailed information"*. In addition, the WHO survey assessed the presence of various nutrition indicators in national surveys in countries, including exclusive breastfeeding. It was found that only 62% of the 113 countries which responded reporting on the exclusive breastfeeding indicator, ranging from 30% in the European region to 100% in EMR. The report also has a section on the Code, reporting that 71% of the countries had a legal measure, among which 80% had a full measure.

The WHO survey includes a case study entitled *"Breastfeeding in a Globalized World: a Public Health Success Story"*. It includes the statement *"The implementation of a series of policies and programmes to protect, promote and support breastfeeding over the past 30 years has led to remarkable increase in breastfeeding practices measured at global level"*—a statement incongruous with the stagnant trends of exclusive breastfeeding at global level. As evidence supporting this statement, figures are cited on the increase in median duration of breastfeeding in 36 countries with trend data, increases of exclusive breastfeeding in 29 countries in the Americas region and 13 countries with showing gains of more than 25 percentage points. It then goes on to state that *"the proportion of infants breastfed for the six months recommended by WHO is low, indicating an important area for policy and programmatic action"*.

The IYCF policy aspects of UNICEF's 2010–2011 assessment of IYCF programmes in 65 countries[xxxii] found that overall, more countries had IYCF policies than strategies and plans of actions. Approximately 84% of the countries had policies (stand-alone or integrated), 60% had strategies and only 48% had plans of action. The key IYCF practices that are reflected in most country's national IYCF policy were exclusive breastfeeding (85% of countries) and continued breastfeeding from 6–23 months (76% of countries), while early initiation of breastfeeding appeared in only 68% of the countries' policies.

The assessment reported on the whether nine key action areas were reflected in the policies, including the BFHI (in the policies of 73% of countries), the 10 Steps to Successful Breastfeeding in maternities (69%), the Code (66%), maternal nutrition (55%), community actions (87%), mother support groups (47%), behavior change communication (52%), HIV and infant feeding (61%) and IYCF in emergencies (43%). The UNICEF assessment framework also addresses the status of actions in health services, at community level, communication, IYCF in the context of HIV and emergencies, additional complementary feeding interventions in multiple sectors and monitoring and evaluation.

Monitoring of the performance of IYCF interventions, in addition to outcomes in terms of practices, is a crucial aspect in gauging commitment to IYCF. The UNICEF assessment contains questions on geographic coverage (number of districts) of health facility and community based IYCF services, coverage of training for health providers and community workers and population coverage with interventions at health facility and community levels. Just under two-thirds of the surveyed countries reported on the percentage of districts in which health facility IYCF counselling was stated to take place, with a wide range of coverage from 2% to a reported 100%, with an average of 31%. A similar

[xxxi] This report was one of the background documents at the 65th WHA when the nutrition targets and the implementation plan were discussed. A final version does not appear on the website.

[xxxii] The countries assessed were in the 6 regions of Eastern and Southern Africa, West and Central African, South Asia, Middle East and North African, Central and Eastern Europe/Common wealth of Independent States and East Asia and Pacific.

proportion (just under two-thirds) of the countries indicated that health workers had been trained on IYCF counselling since 2006. Of these, just over half of the countries were able to report on the proportion of total applicable health workers who had been trained, with a further 16 countries reporting on the numbers of workers trained but unable to provide a denominator. The proportion trained in the 24 countries was generally very low, with an average of just 6% and a range from 0.1% to 82%. The assessment was unable to obtain responses from the countries on population coverage of IYCF counseling, as they do not collect this information in the health system.

Regarding community based IYCF interventions, around half of the countries were able to indicate the geographic coverage of community-based IYCF activities in terms of the proportion of districts with these services. The range was wide, from 0.5% of districts to a reported 100%, with an average of 60%, which is encouraging. Only a third of the countries were able to report on the proportion of community health workers trained on IYCF counselling since 2006. The average was 30% (ranging from 2% to 100%). A further seven countries reported the number trained but were unable to provide a denominator.

A rapid scan of some examples of country IYCF policies and strategies in Africa and Asia reveals that very few include any process indicators for IYCF interventions, and indicators for geographic and population coverage was not found in any country's strategy. This is a major gap in national systems, which seriously affects countries' ability to make decisions on improving programmes that are data-informed. IYCF practices are generally used as proxies for interventions, but data on practices is collected infrequently and usually only at national level; a programme manager needs much more information than this to design and target interventions effectively and track their progress. A lack of systems to measure the performance of interventions and services also translates to reduced commitment, priority and institutionalization of the actions. The fact that there are no global and national reporting requirements and systems for the status of interventions may also contribute to the lack of awareness of which interventions should be implemented, which was raised by some of the stakeholders in the survey (see the section on "Ideas" in the survey results below).

The IBFAN World Breastfeeding Trends Initiative (WBTI) has been initiated in 82 countries, with 51 reported to have completed their assessments to date. It assesses whether a national IYCF/ breastfeeding policy has been officially adopted/ approved by the Government, whether the policy promotes exclusive breastfeeding in the first six months and continued breastfeeding up to two years and beyond, whether a national plan has been developed with the policy and whether the plan is adequately funded. It also asks whether there is a national coordinating body or mechanism for IYCF that functions.

A summary of the results of the assessment in 40 countries published in 2012[74] revealed that 82% of the 40 countries report having a policy, but only 62% have a national plan and only 28% report that the plan is adequately funded. The WBTi framework also addresses the BFHI, the Code and maternity protection, health and nutrition care systems, mother support and community outreach, information support, infant feeding and HIV, infant feeding during emergencies and monitoring and evaluation. The WBTI did not attempt to assess the scale of programmes other than to ask "do all women have access to IYCF services" and "do IYCF services have national coverage", with response options being yes, to some degree or no. The WBTi, although it states that it tracks infant and young child feeding programmes, does not assess the full set of evidence-based interventions for improving complementary feeding in all settings, covering only actions for the promotion of improved practices.

The Six-Country Review of Breastfeeding Programmes[75] conducted by AED and UNICEF noted that *"when the international community were seen to be giving greater priority in the late 1990s onwards to other health and development priorities as compared to breastfeeding, some countries did so as well"*. It was also noted that the WHO/UNICEF 2002 Global Strategy for IYCF infused new energy and prompted countries to re-examine their strategies. In many of the countries reviewed, respected, trustworthy champions have dedicated decades to the protection, promotion, and support of breastfeeding. Their evidence-based advocacy, passion, persistence, and persuasive skills helped move the agenda nationally. Key lessons learned were captured by the review.

The review's conclusions reaffirmed that is important for all global and country nutrition initiatives emphasize not only

breastfeeding promotion, but also support and protection. Both exclusive breastfeeding up to 6 months and continued breastfeeding after 6 months lead to important health benefits and should be emphasized to measure national progress.

The review of large-scale community based breastfeeding programmes[76] in ten countries reconfirmed the critical role of leadership, partnerships, proof of concept, and resources facilitate programme scale-up. Political leadership and nutrition champions helped to garner commitment and resources. Pilot activities that demonstrated "proof of concept," documented programme strategies, and disseminated innovations, results, and practical tools led to programme expansion as did adequate and sustained funding. In some of the reviewed countries it was demonstrated how breastfeeding practices can change over a relatively short period and need continued reinforcement to be sustained—as negative change can also occur in a short time. We also highlight the finding that multiple programme frameworks offer opportunities for community-based breastfeeding promotion and support, and improved breastfeeding practices add value to all of these programmes. Also important is the finding that effective communication and advocacy are vital to set policy priorities, influence community norms, and improve household practices.

SUMMARY AND ANALYSIS

How prominent is breastfeeding in the strategic frameworks of selected agencies and in the strategic frameworks of countries?

It can be seen that all of the nutrition global initiatives do reflect breastfeeding quite strongly in their strategies and other documents, and there are good advocacy opportunities to raise the attention and commitment to breastfeeding within the initiatives. Despite the compelling evidence on the importance of breastfeeding for survival, the child survival initiatives appear to provide a more token mention of breastfeeding but potentially also afford opportunities for advocacy for breastfeeding.

Among the UN agencies, WHO and UNICEF jointly reflect global leadership in terms of policy, strategy and programme frameworks and resources, which address breastfeeding comprehensively. The World Bank also reflects breastfeeding strongly in its guidance and costing analysis. Breastfeeding features strongly in the majority of the donors' strategic frameworks that were reviewed. Although less prominent in the US Government's flagship health and nutrition frameworks, there have been major USG-funded projects focusing on infant and young child feeding over the years. Among the NGO documents and websites reviewed, a wide range of strategic frameworks and policies are found, from single-issue campaigning and a focus on the protection of breastfeeding in the IBFAN networks, through strong reflection in strategic frameworks, advocacy and programming by Save the Children, inclusion in development and emergency nutrition portfolios and responses (HKI, ACF), to some "political" mention of commitment but no reflection in strategies and programmes (GAIN).

A general observation is that for most organizations breastfeeding features more strongly in policy and strategy frameworks than in actual programmes and implementation at scale, with no systems and accountability to report on coverage of interventions. The three recent assessments of IYCF policies and programmes found that on average more countries (around 78%) had IYCF policies than national plans of actions (55%). At the same time, it was found that only 62% of the 113 countries which responded to the WHO policy survey say they report on the exclusive breastfeeding indicator in national surveys, a result perhaps skewed by the responses of industrialized countries.The assessments showed only moderate performance in terms the presence of recommended programme components in the strategic frameworks, with many gaps still to be addressed. They also found major gaps in terms of the status of actions related to the main programme components, with none of the assessments providing information on intervention coverage and scale of programmes. This points to an environment that may be characterized as relatively "policy-rich" and generally "implementation-poor".

Are all recommended and important breastfeeding practices reflected in strategic frameworks?

Cognizant of the full set of recommended key breastfeeding practices and the eight core indicators that were agreed globally to measure the status of these practices[77], it was noted that exclusive breastfeeding as a goal, programme component or outcome indicator is the breastfeeding practice that tends to be most commonly reflected across the partnerships, different

types of agencies and country frameworks, although a significant proportion also refer to early initiation and continued breastfeeding or just "optimal breastfeeding practices". It is important that specific and clear reference is made across all partnership, organization and country frameworks to all recommended breastfeeding practices, as each plays an important role in child survival, growth and development. The focus on exclusive breastfeeding may contribute to the tendency in the global policy community to separate breastfeeding and complementary feeding ("promoting exclusive breastfeeding for the first six months is about survival; products for complementary feeding from 6–23 months are about reducing stunting"), placing these vital and connected issues at odds with one another. The focus on exclusive breastfeeding may also contribute to the breastmilk substitute industry's current strategies to segment the market and promote "follow-on formula" and "growing-up milks"—in violation of the Code—capitalizing on and actually encouraging a mistaken belief that breastfeeding exclusively in the first six months is the only priority, and not continued breastfeeding, which is ignored[78].

Do strategy frameworks reflect a comprehensive approach to improving breastfeeding practices?

The continuing predominance of "promotion" of breastfeeding in many of the frameworks and statements stood out in the analysis. The term "promotion" is often intended to imply the full set of actions and interventions to improve breastfeeding, but as such it is a misnomer, as "promotion" is about messaging, social marketing and information dissemination. This may be due to the dominant notion that improving breastfeeding is primarily behavioural and a lack of understanding of the role of professional and lay support and the importance of legal frameworks and instruments for protecting breastfeeding. Professional support fulfills a different function than promotion, in that it concerns practical and skilled assistance to mothers to start and sustain breastfeeding after delivery, the solving of breastfeeding problems and ongoing counseling and practical help during lactation. Interventions delivering skilled support and promotional activities complement each other and need to go hand in hand.

The predominant use of the term "promotion" may have the effect of shaping the strategies of organizations and countries, such that they focus more on messaging and do not invest in the health system structures to institutionalize the delivery of professional breastfeeding support and counseling by skilled staff (whether health providers or lactation counselors) and the routine monitoring of intervention coverage and quality. Similarly, investment in systems and structures for community-based counseling and support at scale also lags, as well as effective systems to enforce regulatory instruments for the protection of breastfeeding. The landmark World Bank costing of nutrition interventions, reflecting only "behavior change interventions to promote breastfeeding", mirrors this tendency. On the other hand, we see a more comprehensive reflection of approaches to improving breastfeeding across a range of organizations, including UNICEF, WHO, the World Bank, the EU, A&T, Save the Children and IBFAN, as well as the IFE Core Group.

Is there consensus on measuring the status of IYCF programmes?

The analysis of the two main external assessments of breastfeeding/IYCF programmes in countries (IBFAN's WBTi and UNICEF's IYCF programme assessment) reveals a lack of consensus on measuring the performance of programmes. While there is some common ground, the two external assessment frameworks diverge on which programme components should be assessed and which key process indicators should be measured. A particularly weak link is the assessment of the population coverage of IYCF interventions, including counseling/support and communication: absent in the former and not possible to collect in the latter due to lack of national monitoring systems.

Global consensus on a harmonized and comprehensive set of indicators to measure the performance of IYCF programmes, including geographic and population coverage, is needed. Accountability to report on their status should contribute towards increasing the commitment and priority for breastfeeding and complementary feeding. It will therefore be crucial to advocate for the monitoring frameworks of country strategies and national information systems to be updated to include this set of indicators.

A global policy community is more likely to generate political support for its concern if it is cohesive, well-led, guided by strong institutions, and backed by mobilised civil societies; if it agrees on solutions to the problem and has developed frames for the issue that resonate with political leaders; if it takes advantage of policy windows and is situated in a sector with a strong global governance structure; and if it addresses an issue that is easily measured, is high in severity, and has effective interventions available.

Jeremy Shiffman, 'Generation of political priority for global health initiatives: a framework and case study of maternal mortality', *Lancet*, October 13, 2007

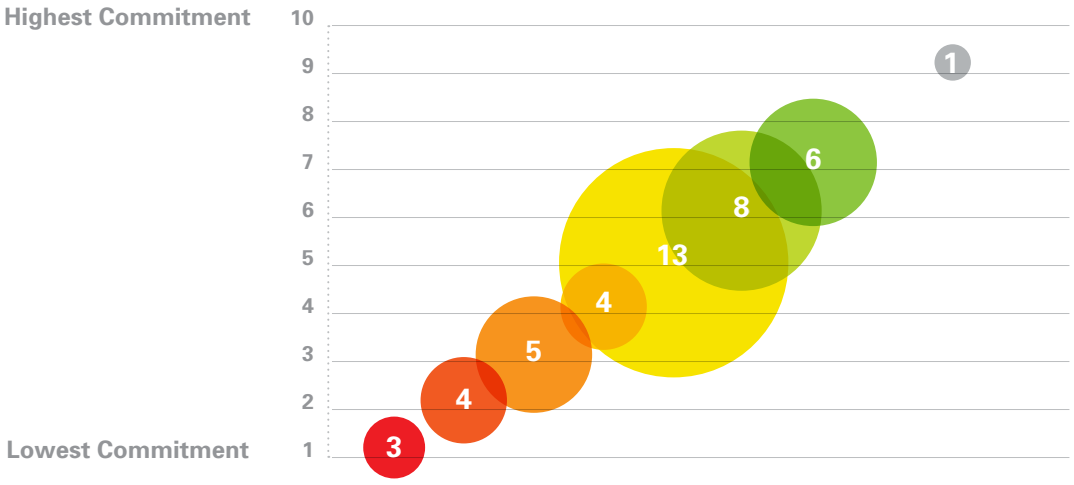
KEY FINDINGS OF STAKEHOLDER SURVEY

ACTORS

How do the actors in the global policy community for breastfeeding—as represented by the wide cross-section of stakeholders consulted during this survey—rank the political commitment to breastfeeding? Stakeholders said the rise of child undernutrition and stunting on the global agenda has not translated into greater visibility for breastfeeding. Most stakeholders ranked political priority for breastfeeding as average to low (see Figure 7 below), despite it being an essential pillar of infant and young child feeding programmes. "Relative to its importance, it's just undervalued" said one respondent. We also see a wide range of views on commitment, which may also reflect the lack of policy community cohesion.

FIGURE 7 Political priority for breastfeeding: "relative to its importance, it's just undervalued"

Stakeholder ranking of political commitment for breastfeeding relative to its potential impact to save lives



The coloured circles represent stakeholders' ranking of political commitment for breastfeeding on a scale of 1 (lowest commitment) to 10 (highest commitment). Forty-four respondents provided ratings.

POLICY COMMUNITY COHESION

Brings networks together, connects different types of organizations

Cohesion and consensus among a policy community are essential in gaining traction around an issue and in advancing an agenda. In its assessment of the degree of cohesion and identification of the major contentious issues, the stakeholder survey throws the spotlight on a situation marked by a serious lack of cohesion and consensus.

All respondents conveyed their commitment to promote infant and young child feeding as a critical child survival and development intervention. But they also identified a set of issues that have fractured the policy community along ideological, professional and gender divides.

One of the big issues which stood out among the findings of the stakeholder survey is the contentiousness and stark disagreement among different constituencies on engagement with the private sector. This disagreement has of late had far-reaching ramifications, such as the public statement from IBFAN that *"in view of the concerns about the role of business in SUN, IBFAN and many of its allies cannot support the SUN initiative"*[79]. This level of disagreement can only hamper the agenda for breastfeeding, creates a distraction from the central issues and contributes to preventing progress by the global policy community.

> *"Stakeholders for breastfeeding are polarized. There's the more militant, anti-corporate community, who perceive themselves as a community because their convictions are so similar. On the other side, you've got middle-of-the-road organizations that absolutely see breastfeeding as a central core component of a good nutrition strategy, but are more willing to work with the private sector. There's no outward fighting, but the community is not aligned and cohesive. There's no good reason for that." (S10)*

The biggest disagreement—*the "elephant in the room"* (S6) – reflects divergent positions on the role of private sector food companies in reducing infant and young child undernutrition. The debate has gained urgency as UN agencies, the World Bank and other global actors increasingly engage in public-private partnerships perceived as crucial to achieving the MDGs. Some respondents such as this NGO representative said it was essential to collaborate with food companies to reduce stunting:

> *"The virulent breastfeeding advocates are now pushing back that no company can be ever be trusted on complementary foods because they'll disturb breastfeeding. They're so ingrained in their promotion of breastfeeding they've lost a sensible view of what it takes to keep a child well-nourished from zero to 24 months. That includes optimal complementary feeding and using fortified products provided in some cases by the local private sector, maybe multinationals. You have this part of our nutrition community that is dead set against any involvement of the private sector. It's really creating problems." (S6)*

Civil society advocates viewed engagement with food companies in a very different light, warning that private gains benefiting shareholders should not be confused with public health goals. They called for conflict of interest policies to be put in place to guard against this. Otherwise, *"you could have formula companies being part of SUN before you know it!"* as one respondent put it. (S11) "States […] have a duty to support exclusive breastfeeding for six months and continued breastfeeding, combined with adequate complementary foods, until the second birthday of the child." according to the UN Special Rapporteur on the Right to Food[80].

Watchdog groups perceive they are shouldering more than their fair share of responsibility to ensure governments fulfill this duty in the absence of a clear breakdown of accountabilities among partners:

> *"One big barrier is clarification of the roles of the actors in protection, promotion, and support of breastfeeding, and holding them accountable for actually fulfilling these roles." (S11)*

Several women stakeholders said professional biases in the nutrition community were also impacting breastfeeding programmes, noting that investment in nutrition has largely been focused on treatment of acute malnutrition with a heavy focus on nutritional products:

NOTHING UNITED RESPONDENTS MORE THAN THE LONGING FOR LEADERSHIP TO ADVANCE POLITICAL PRIORITY FOR BREASTFEEDING PRACTICES

"The nutrition world is looking for a magic bullet through products. You have ready-to-use food, micronutrient powder, fortified complementary food, and very little attention is paid to breastfeeding. With the products and micronutrients, men are more in the lead. Breastfeeding and infant feeding is a woman's world." (S7)

"At the global level, there are a lot of men in senior-level discussions. The fewer women involved, the more breastfeeding gets forgotten." (S6)

Understanding how these dynamics are influencing prioritization of breastfeeding within the nutrition stakeholder organizations and partnerships is essential going forward. There is also an urgent need for a "middle voice", with strong leadership and convening ability, to facilitate greater consensus and common ground to move forwards the agenda for breastfeeding.

LEADERSHIP AND GUIDING INSTITUTIONS

The presence of individuals capable of uniting the policy community and acknowledged as a particularly strong champions for breastfeeding

The effectiveness of organizations, or coordinating mechanisms, with a mandate to reduce maternal and child undernutrition

Global leadership for nutrition in general has undergone a major shift in the last few years, with the emergence of a global movement behind which many stakeholders have rallied and a "leadership group" aims to improve coherence, provide strategic oversight, improve resource mobilization and ensure collective accountability. Cognizant of this context, the stakeholder survey assessed perceptions on the extent to which global leadership for breastfeeding is felt to be present, and found a notable absence of strong leadership over the past two decades.

Nothing united respondents more than the longing for leadership to advance political priority for breastfeeding practices.

"Leadership always trumps everything for me." (S3)

A champion of breastfeeding two decades ago—UNICEF Executive Director James Grant is still the reference point for individual leadership. As one respondent noted:

James Grant, UNICEF Executive Director (1980–1995) was a recognized global champion for breastfeeding.

SILOED PROGRAMMING WAS FLAGGED AS A KEY CHALLENGE

> *"Leadership is the number one factor in building political and donor support. When James Grant took on the Baby Friendly Hospital Initiative, that leadership was transformative." (S1)*

A civil society advocate framed the importance of leadership differently:

> *"It's about brave people committed to human rights who understand political, social, economic determinants and don't think Plumpy'nut is going to save the world." (S11)*

Stakeholders couldn't identify any high profile global breastfeeding champion active today. While recognizing the technical contributions made by WHO and UNICEF as guiding institutions, some respondents questioned the current level of commitment at the highest levels of these organizations:

> *"Globally, both WHO and UNICEF project other priority areas much more than breastfeeding. Budget allocated does not match priority statements." (Q3)*

A US stakeholder commented USAID leadership had also faltered:

> *"USAID has been very focused on private sector engagement and innovations in technology. Those are the two big trendy areas of interest, and breastfeeding fits in neither one of them. It's left on its own as an orphan with no real strong constituency." (S10)*

Donors

Donors play a critical and synergistic role to promote political priority for global nutrition and health initiatives through resources and advocacy. As the financial crisis continues to grip the developed world, donor aid is also constricting after a decade of strong growth. Net overseas development aid fell in 2011—the first drop since 1997—taking inflation into account, according to the OECD[81]. The nutrition slice of this global assistance continues to be tiny. The United States, a key donor, devotes less than 1% of its foreign assistance budget to improve nutritional outcomes[82].

According to the World Bank, despite potentially very high returns on investment, nutrition has been a "forgotten MDG"—often unrecognized, rarely acted upon, and grossly underfunded[83]. This funding shortfall weighs heavily on all the constituencies consulted, including those of the guiding institutions. A UN staff member summarized the situation this way:

> *"There are virtually no resources at the international and national level for breastfeeding support, despite the abundance of evidence of its impact on child survival." (Q1)*

Several women respondents made a connection between ambivalent attitudes towards breastfeeding in donor countries, and levels of funding and political support:

> *"A lot of donors are very Western. They see breastfeeding as a choice for mothers to make. Some donors basically said 'my family formula fed, and are you saying I did the wrong thing by my child?' It's a huge, loaded issue because people become very defensive about what they could and couldn't do." (S8)*

Another added:

> *"We are fighting an uphill battle if we fail to change attitudes and practices in the West/developed countries." (Q4)*

Fragmented programme responses

Fragmentation among the global nutrition community was a persistent theme in the 2008 *Lancet* Nutrition Series[84]. The stakeholder survey identified an ongoing issue of fragmented and siloed programme responses hampering progress for breastfeeding.

Siloed programming was flagged as a key challenge, notably in guiding institutions:

> *"In the global organizations, UNICEF and WHO, nutrition programmes are organizationally separate from MNCH programmes, which is a real barrier to developing an effective strategy and promoting it. That's a problem that needs to be addressed by force. Somebody needs to make such a loud noise that UNICEF and WHO—two key agencies—have no choice but to develop an integrated plan." (S13)*

Fragmented programming can also impact emergency responses, where there can be confusion between health and

nutrition professionals about who is leading and what is technically required. (S8)

Voices calling for cross-cutting approaches to global health[85] and nutrition are growing: the time for silos is past—those working in nutrition, food security, agriculture, water and health must join together to conquer the cause of one third of child deaths worldwide—undernutrition[86].

CIVIL SOCIETY MOBILIZATION

Extent to which grassroots organizations have mobilized to press international and national political authorities to address breastfeeding practices

Non-Governmental Organizations (NGOs) and civil society organizations have played a vital role to protect, promote and support breastfeeding practices. Whether it's running Mother Support Groups, driving advocacy, monitoring the formula industry or supporting breastfeeding in emergencies, they are present on many fronts.

Several respondents noted the contribution IBFAN (International Baby Food Action Network) and other watchdog groups have made (S16, S21) but other felt their message was too negative:

> *"For a long time, breastfeeding has been about anti-formula as opposed to being about breastfeeding. That's perhaps a harsh judgment but sometimes I see a lot of reaction and not much pro-action." (S3)*

World Breastfeeding Week

The World Breastfeeding Alliance (WABA) hosts World Breastfeeding Week[87], held each August since 1992, with support from WHO and UNICEF and other partners. While this study couldn't identify any formal evaluations of the advocacy initiative, stakeholders shared a range of opinions. On the plus side, countries such as the Philippines use World Breastfeeding Week as a major health promotion opportunity. (S8)

Most assessments of World Breastfeeding Week were more critical:

- An Africa-based respondent said they did not *"get value for money"* because one week was too small scale given the problem. (S23) Another noted the difficulty of assessing the impact of an initiative not linked with a clear advocacy strategy. (Q13)
- A stakeholder based in East Asia commented: *"World Breastfeeding Week is nice, but some countries feel 'Okay, if I do that week, I've done my part'*. It's not helping us in a way." (S26)
- A UNICEF Representative in an emerging Asian economy said World Breastfeeding Week couldn't compete with the *"very sophisticated and long-term campaign the formula companies have going here.* (S19)
- Many respondents said advocacy needs to be continuous and expressed a strong need for global, regional and country advocacy plans to guide and unify action. A UNICEF office battling low breastfeeding rates in South Asia said their greatest need was for *evidence-based breastfeeding advocacy*. (Q19)

ISSUES

IMPORTANCE OF THE ISSUE

Size of the potential impact of breastfeeding relative to other interventions, as indicated by objective measures, such as mortality levels, nutrition status, long term effects

Compelling evidence is available on the many benefits of breastfeeding for child survival, nutrition status and development, as outlined above. Breastfeeding does not lack evidence for its importance and its numerous and wide-ranging benefits, and these are quite well-known.

And yet, despite this compelling evidence, global rates of breastfeeding have remained relatively stagnant in the developing world and commitment low. As one stakeholder put it:

> *"With such compelling evidence—shame on us [the global policy community] for not having been able to make the case for breastfeeding."*

The role of advocacy in contributing to the much needed shift in this situation is clear: the compelling evidence needs to be more effectively framed and deployed so that it appeals to

Women must often overcome many barriers to exclusively breastfeed their infants. This baby girl and her mother live in a makeshift shelter following the 2010 earthquake in Haiti, where they receive basic services including breastfeeding counseling for mothers.

political and policy leaders and leads to greater attention, commitment and action for breastfeeding.

> *Evidence correctly placed in an advocacy strategy can change the world. (S13)*

Influence of the HIV epidemic

One of the major factors which has affected the global policy community's ability to clearly and unequivocally advocate for breastfeeding has been the HIV pandemic.

A number of stakeholders referred to the serious impact of the HIV/AIDS pandemic on breastfeeding programmes in the past two decades, especially in Sub-Saharan Africa where the disease struck hardest:

> *"We were doing great work on breastfeeding in the '70s and '80s. The Baby-Friendly Hospital Initiative didn't go far enough into the community, but there were focused set of actions that could be taken. When HIV hit the world stage, all of that stuff stopped. Everything around breastfeeding, all the external dollars, all the fears were about HIV transmission." (S3)*

A research group noted confusing messaging by the UN in relation to HIV and infant feeding had undermined advocacy:

It may take years for national programmes and health services to overcome the confusions created in the wake of the WHO's 2001 infant feeding recommendations. It may take even longer to return breastfeeding to its social position as "the only way to feed an infant", as condition for child survival and as a fundamental commitment of motherhood [88].

NOTHING WORRIED STAKEHOLDERS MORE THAN THE THREAT FORMULA COMPANIES POSE TO BREASTFEEDING

Other stakeholders saw more positive outcomes, facilitated by WHO's 2010 recommendation that all mothers, including those who are HIV positive, breastfeed their babies[89]:

> *"It's a great time [to increase political commitment] because the HIV issue has subsided. There's less controversy around that. If we can get some real innovation around how we advocate and get commitment, it would really make a measurable impact." (S3)*

TRACTABILITY

Extent to which there are effective interventions to protect, promote and support breastfeeding in developing countries

Policy makers are more likely to act on issues for which there are credible, evidence-based interventions[90]. Achieving optimum breastfeeding requires multiple interventions: to promote behaviour and social change, to provide skilled professional support and peer or community based support in many settings, and to afford protection against the marketing of breastmilk substitutes and in favour of maternity leave and workplace policies. Achieving this at the scale of a community, a metropolis or a nation poses challenges.

> *"You rarely hear a woman saying: 'I don't want to breastfeed.' You hear women saying: 'I can't breastfeed.' Our actions need to make the world a more breastfeeding-friendly place." (S21)*

Stakeholders discussed a number of issues related to how programming and communication for breastfeeding needs to be tailored to the lives of women in different contexts in the 21st century: working mothers in emerging economies; mothers and families still exposed to strong traditional beliefs, influences and social norms in some settings, particularly rural Africa and Asia, on the one hand, and influenced by consumer priorities and the private sector on the other, particularly in rapidly urbanizing settings. They also discussed the rapid penetration of cellphone technology and social media and its relatively untapped potential for communication and advocacy on breastfeeding. They emphasized that more of the same was not going to cut it: traditional approaches to programming, communication and advocacy needed to be fundamentally overhauled to make it current, relevant and resonant. This links to the theme of "recasting the narrative" that emerges strongly from the narrative.

CONTENTIOUSNESS

Extent to which addressing the issue incites opposition

Nothing worried stakeholders more than the threat formula companies pose to breastfeeding practices in low and middle-income countries. In 1982, UNICEF Executive Director James Grant made a prescient statement about the growing impact of formula companies on breastfeeding practices in the developing world: "Among the main causes of that decline [in breastfeeding rates] has been the spread of artificial infant milk whose manufacturers looked outward from the stagnating markets of the industrialized countries in the 1960s and 70s and saw the potential of increasing sales among the large and rising infant populations of the developing world".

> *"We need to restart a campaign that reveals what formula companies do. It's simple math: if they sell more formula, less women breastfeed. We have to reveal that fact to the world—come out in front of the curtain and be louder about it." (S19)*

Thirty years later, Grant's statement sounds like a prophet's warning. "Baby food is an attractive industry—a $30 billion market that is growing 10% annually", says *The Economist* magazine[91]. A study in the Philippines found Filipino mothers who had been influenced by advertisements or their doctors to use infant formula were two to four times more likely to feed their babies with those products.[92] Another research group determined one-third of Philippine families living on less than $2 per day purchase formula and had substantially higher medical expenses compared with non-formula-buying families.[93]

The concern expressed was global:

> *"These companies are powerful to such an extent. One day I got an email saying Nestlé and Renault had a better-than-average week, and this had boosted the whole of the EU economy. These things matter to politicians right at the top in countries having crises—how can they make the economy perform, how can they get jobs." (S12)*

FIGURE 8 **These are the words most used by stakeholders to describe the threat that formula companies pose to breastfeeding practices**

"Lobby pressure from infant formula and baby food manufacturing companies is ever strengthening and spreading rapidly in emerging markets. Political commitment is essential to strong, sustainable global and national advocacy for breastfeeding." (Q18)

"There is a huge need to increase political advocacy for breastfeeding in Yemen to mitigate the impact of malicious advocacy efforts of the formula companies here. They are influencing the private health sector, which is providing health services to more than 40% of the population." (Q14)

Among the 68 countries that account for over 95% of maternal and child deaths, only 22 have adopted national legislation covering all provisions of the International Code of Marketing of Breastmilk Substitutes[94]. Many respondents said much more advocacy and political will is needed to strengthen enforcement of the Code, while acknowledging the degree of influence wielded by the baby food industry:

"My feeling is a formula company cannot follow the Code or they won't make any profit. In Zimbabwe—a country I'm working on—they're giving kickbacks to health workers to promote formula. It's happening all over the world." (S4)

The impact of regulation on formula sales in Asia has been noted by the industry itself.

From the China perspective—where only 28 percent of infants under-6 months are exclusively breastfed—India appears to be a model for strong Code implementation, as one stakeholder observed:

"Obviously, battling the formula companies of the world is a huge problem in a country like China. Looking at what India did —tightening up on breastmilk substitutes, putting in tough legislation and taking people to court—that would really make a difference. I can't see that happening in China in the immediate future." (S19)

From the India point of view, the battle isn't won yet:

"The test of legislation in India has not yet taken place at scale because the vast majority of Indians are still living below the poverty line. When that changes, that will prove to what extent legislation—which is good on paper—is enforced so optimal infant feeding practices are protected." (S19)

ALLURE

Attractiveness of the issue to those who might want to address it

Leadership and commitment for an issue does not only stem from champions in the domain of organizations, institutions and Governments, but also champions who capture the public imagination and attention.

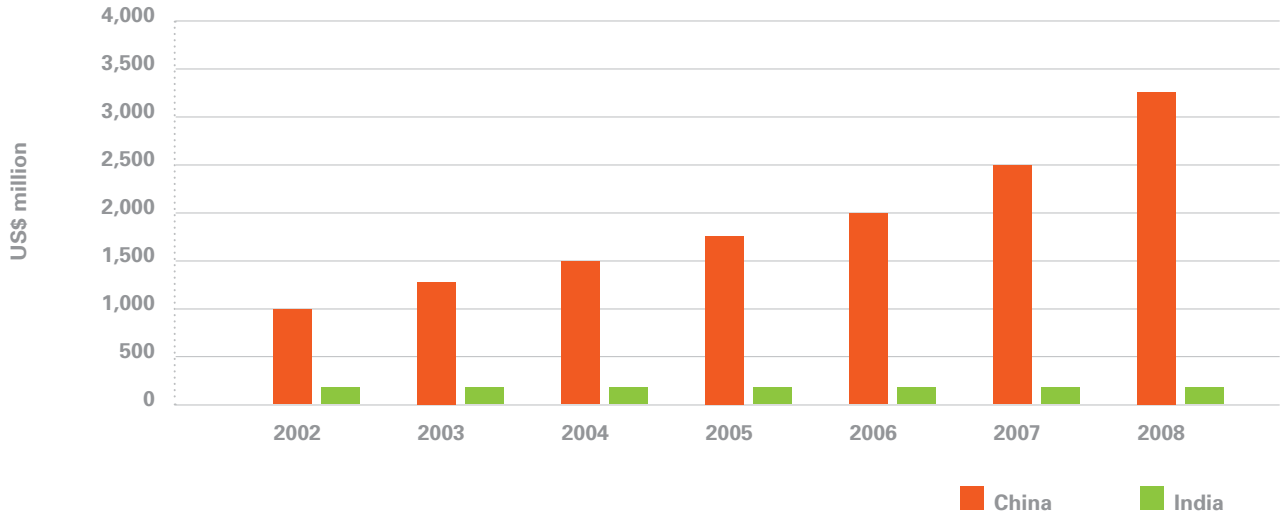
Many stakeholders cited the crucial importance of champions to promote breastfeeding practices, whether the audience is global decision makers or young mothers and their influencers. Respondents said champions who can project charisma (S7) and intimacy (S11) will be particularly effective.

"In the current media environment, people want to see celebrities. If Victoria Beckham breastfeeds her baby, it's much better than Ban Ki-moon telling people to breastfeed." (S16)

Examples of global influencers in top tier circles include Melinda Gates, Michelle Bachelet and Hans Rosling. Women celebrities can also play an important role as role models who advance public debate: "When you have Beyoncé, the recording artist, breastfeeding her baby in public, it caused all kinds of stirs. That's exactly who you want." [95]

FIGURE 9 **Milk formula retail value sales in India and China 2002–2008**

The huge disparity in the retail value of milk formula sales between China and India is mainly due to the significant differences between their official regulatory regimes



Source: Euromonitor International, 2008

Country-based interviewees mentioned national ambassadors such actor Aamir Khan in India and and film artist Ma Yili, UNICEF China Special Advocate for Breastfeeding and Early Childhod Development. They emphasized that First Ladies have been very influential, including First Lady Ani Bambang Yudhoyono, Indonesia's National Breastfeeding Spokeswoman[96].

Women personalities have thrown their weight behind both sides of the controversy, pitting those protecting breastfeeding from corporate marketing influences[97] versus those aligned with the baby food industry[98]. If breastfeeding stakeholders pursue the recommendation to engage more champions and celebrities, it is recommended that an issue paper be developed to define the reputational issues which this may raise, with a view to managing them effectively.

IDEAS

Another area where there is some lack of consensus in the global policy community is evidence for the feasibility and effectiveness of interventions to improve breastfeeding practices.

The evidence base exists and results from a wide range of countries show that breastfeeding practices can change. However, this evidence may not be universally known or used, and this may be the reason why the stakeholder survey revealed a lack of agreement.

While the nutrition community has coalesced around the shared framework of the Scaling Up Nutrition (SUN) movement to scale up action[99], stakeholders raised various concerns on key programme and policy issues.

These are the main topics stakeholders cited as needing more discussion and consensus:

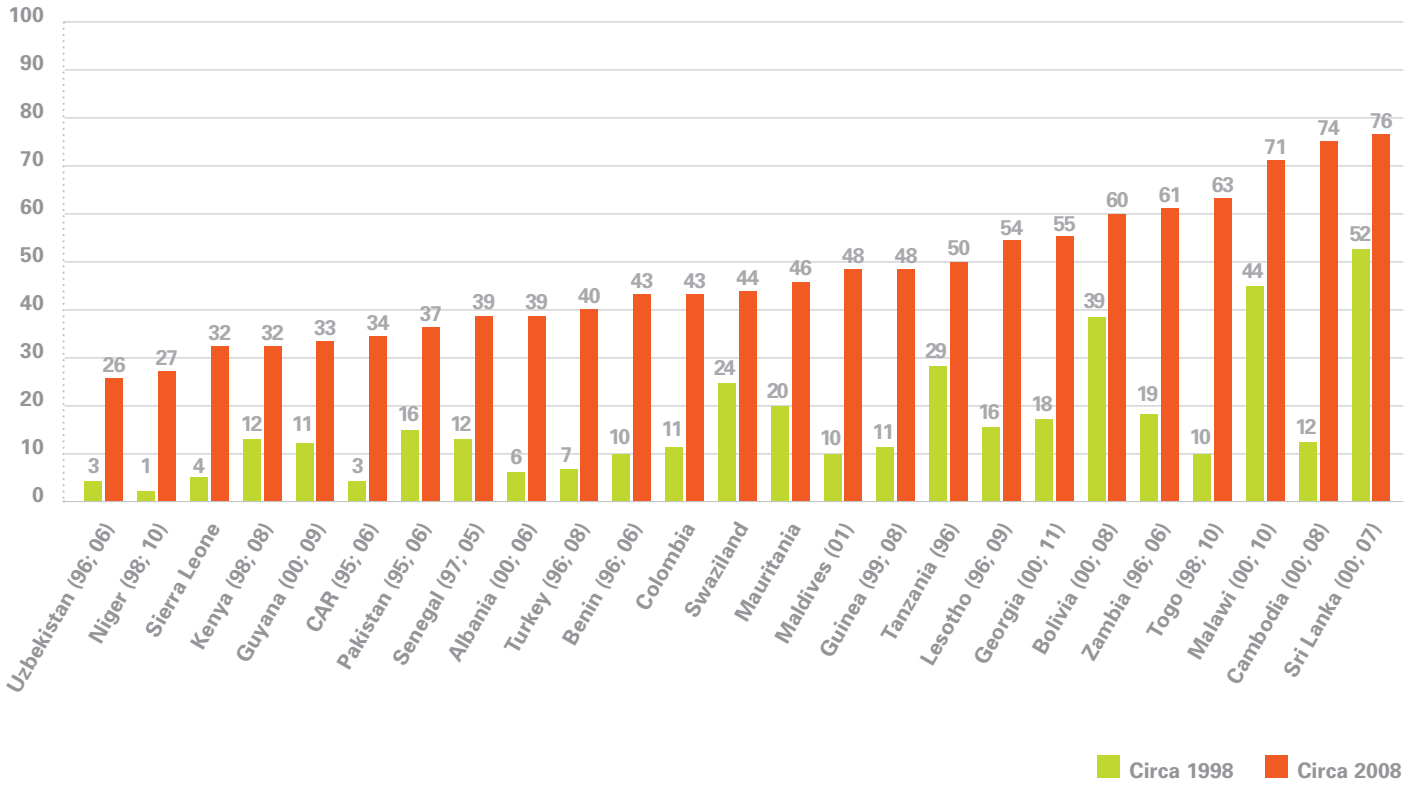
INTERNAL FRAME

Common policy community understanding of problems and solutions related to breastfeeding programmes

Respondents shared differing perceptions regarding the strength of the current evidence base:

FIGURE 10 **Ma Yili with breastfeeding advocates from 15 Chinese cities gather for a workshop on the "10m2 of Love" campaign. The campaign aims to locate, register, certify and publicize breastfeeding rooms, both for employees in private companies as well as for patrons and customers in public buildings and stores.**

FIGURE 11 **25 countries with increases in exclusive breastfeeding in children < 6mo of ~20 percentage points in approx. 10-year period**



Source: UNICEF database for *The State of the World's Children 2012*

"Among stakeholders, there appears to be two camps—those who are convinced breastfeeding is important and practices can be changed, and those who doubt the feasibility and therefore downplay its importance. The later camp will need to be persuaded by evidence 'it can be done' "(Q4).

"There seems to be sufficient knowledge of what needs to be done, based on the Lancet series and Copenhagen Consensus. There is a paucity of evidence on how to do it." (Q11)

While some pointed to the perception breastfeeding practices can't be changed, the data on breastfeeding clearly shows this is not the case: 25 countries have recorded gains of 20 percentage points or more in exclusive breastfeeding rates in the past 5–10 years, according to UNICEF's database.

In fact over 60 per cent of the 93 countries with trend data between 1995 and 2011 show an increasing trend; and some countries have moved from a situation of almost no exclusive breastfeeding to rates over 70 per cent.

Evidence from these countries finds success was linked to comprehensive programmatic approaches at scale, including these elements:

- Policies guided by the WHO-UNICEF Global Strategy for Infant and Young Child Feeding, including adoption and implementation of national legislation on the International Code of Marketing of Breast-milk Substitutes
- Maternity protection for working women
- Ensuring breastfeeding is initiated in maternity facilities (and no infant formula is used)
- Building health-provider and community worker capacity to offer counseling on infant and young child feeding
- Mother-to-mother support groups in the community, accompanied by communication strategies to promote breastfeeding, using multiple channels and messages tailored to the local context.

"We need to generate evidence breastfeeding practices can be improved at large scale within a reasonable time frame, because that creates excitement it can be done. You can only achieve scale if you simplify and focus." (S19)

Some Western countries such as Norway and Sweden have been very successful in promoting the benefits of breast milk over bottle-feeding and shifting the social norm back to breast-feeding and away from formula. One study showed 99 percent of mothers nursed their newborns in the hospital. Six months later, 80 percent were still nursing, compared with 20 percent in Britain and 32 percent in the United States[100].

Many respondents said new research is urgently needed to determine the optimum blend of face-to-face counseling, group communication and remote messaging, designed to raise breastfeeding rates in an economical manner. They are also looking for clear strategies to effectively change social norms. (Q11)

Several said programmes must be embedded within national health systems if they are to be sustained:

"In Madagascar, the rate of exclusive breastfeeding increased quite dramatically at the national level when all agencies were engaged, but after the project nobody followed up. The following survey showed rates fell to what they were earlier. Breastfeeding hasn't been part of any system—it's probably why it's collapsing." (S7)

The stakeholder responses on this issue highlight the need for better sharing of evidence for effective breastfeeding interventions, the wider dissemination of good practices in designing, prioritizing and planning at-scale strategies and also of failed or less successful efforts, and the need for "policies that stick"[101], to quote *The Lancet* 2008 Nutrition Series, meaning commitment to more practical, simple and tailored translation of policies into action.

Tracking breastfeeding interventions: how good is our measurement?

Commitment to the measurement of breastfeeding practices is firmly embedded in the major household surveys which assess health and nutrition, including the Demographic and Health Survey and the Multiple Indicator Cluster Survey. However, efforts to measure the scope, scale and coverage of breastfeeding interventions have not been standardized or universally applied in all developing countries, and even where undertaken, they reveal a far from optimal scope of breastfeeding programmes and fail to capture the scale or coverage[102],[103]. This may be one of the factors contributing to the low traction and resourcing for breastfeeding programmes: no one insists on accountability for coverage of the breastfeeding interventions on the same annual basis as for example immunization coverage or coverage with the treatment of severe acute malnutrition.

A 2011 *Pediatrics* article noted few children in the developing world benefit from optimal breastfeeding and complementary feeding practices. The authors suggest low coverage may be attributable to cultural beliefs, poor quality of counseling and lack of a supportive environment. But they add it may also result from "the gap between the identification of core interventions (what to do) and a set of easy-to-use tools that show how the interventions can be effectively implemented [104]."

As one of the article's authors said:

"We know about vitamin A supplementation. We know about iron supplementation. But do we know whether mothers are counseled, which is necessary for improving feeding practices? Do we know anything about the quality of that counseling? Suddenly we realize there is no data about that." (S1)

STRONG DISAGREEMENTS ON PRIVATE SECTOR ENGAGEMENT STOOD OUT IN THE STAKEHOLDER SURVEY

Academic and WHO respondents flagged the vital need for better data collection on the causes of poor feeding practices and coverage of the nutrition interventions recommended in *The Lancet*. An academic stakeholder added:

> *"We need a unified strategy that has clear interventions, evidence-based interventions that lead to increases in exclusive breastfeeding. Once we have that, those interventions are what we need to track, because that will drive it." (S13)*

This respondent suggested that the Countdown to 2015 data initiative[105] shouldn't only be tracking women's breastfeeding behaviour, but rather the interventions to support it—and holding people accountable for doing that. (S13) Clearly, this requires further discussion regarding data collection at the country level.

> *"What gets monitored gets prioritized", said another interviewee. (S16)*

Cohesion on solutions—can we develop a common agenda on private sector engagement?

The strong disagreements on private sector engagement stood out in the stakeholder survey (see findings 1—Actors, policy community cohesion). The degree to which breastfeeding stakeholders can reach a common understanding on private sector engagement directly impacts their ability to develop a public positioning of their issue that resonates with decision makers.

> *"Ideology is distracting us from coming together to address the problem of breastfeeding with common purpose and an understanding of each other's strengths." (S15)*

Stakeholders were united in recognizing the threat to breastfeeding, though variously engaged in direct action to protect it. They diverged however over whether or not to collaborate with private sector companies to improve complementary feeding. Some civil society respondents warned about conflicts of interest. Another said multinational food corporations are jeopardizing family feeding practices, as well as budgets, in many poor communities:

> *"We work closely with movements on the right to adequate food, health and nutrition. It's not only food security, but also the sovereign nature of people not being always dependent on global markets, their whims and prices. This is about not having to spend money you don't have for Little Gerber jars, but and being able to make complementary food for the baby at home." (S11)*

Respondents working with private sector partners, on the other hand, felt strongly about the need to engage them as stakeholders:

> *"The nutrition community needs to figure out how to work effectively with the private sector on all aspects of integrated nutrition, because they are not going away. They have tremendous potential to address some of the obstacles to improved nutrition. Let's figure out how to do that." (S2)*

Others said there's a need to focus more on the demand side—creating a market for better nutrition. (S10)

> *"It's about understanding people are increasingly using the cash economy. It's that culture of markets that's driving a lot of behavior, and we're not harnessing that well. It's more about engaging with people as consumers and understanding what motivates their behavior at that level. We can learn a lot from business in designing programmes." (S15)*

Some respondents called for a more creative approach:

> *"There are different ways of collaborating [with the private sector]. Can they do hygiene promotion so breastfeeding and infant feeding could be executed in a cleaner environment? How about access to soap? How about creating ways for mothers to reach health facilities on time to receive information? Maybe we're only looking at the food component, and not seeing the whole environment in which breastfeeding becomes optimal." (S16)*

Clearly more dialogue is needed within the IYCF community to arrive at a shared position on private sector engagement. Some respondents, notably UNICEF staff, pleaded for "big picture" thinking on this issue:

> *"Formula and infant feeding companies will grow bigger all over the world. We have a major role to play, engaging with*

THE BREASTFEEDING COMMUNITY MUST DO A BETTER JOB OF REDEFINING ITS MESSAGE AND TELLING ITS STORY

governments so strong policies and laws are enforced. We must also bring the private sector on board, letting them know that not abiding by laws in the country is not an option. This is why those who care about infant and young child feeding need to be together. We cannot afford disjointed messaging or disagreement. We need to focus on the bigger picture." (S18)

EXTERNAL FRAME

Public positioning of breastfeeding programmes that inspires external audiences to act

The survey posed the question whether stakeholders thought an advocacy strategy would be more effective if it were focused solely on mobilizing support and resources for breastfeeding (a vertical approach) versus including breastfeeding-within an integrated package of interventions.

Stakeholders had two messages:

1. Breastfeeding advocacy must be integrated into the nutrition agenda, including messaging on the 1,000 Days window of opportunity[xxxiii], as well as the child survival agenda.
2. There now is a simultaneous need for vertical advocacy to address low levels of breastfeeding in many countries, and promote it as the social norm and preferred feeding option for mother and child.

Several respondents defined this as "the diagonal approach"—a conceptual model for global health governance and service delivery that embeds disease-specific initiatives within broader health systems[106].

"I would recommend a diagonal approach, neither vertical nor horizontal, where breastfeeding is presented as a key building block of feeding in the first two years of life—and supporting mothers who do so. It should be very strong, evidence-based, aspirational advocacy." (S19)

For breastfeeding stakeholders, this means defining the contours of a vertical advocacy drive, and integrating it into the frameworks of the SUN, the 1,000 Days, A Promise Renewed and related initiatives. One respondent described this as 'electrifying' key elements of breastfeeding within an integrated approach, so it isn't forgotten. (S6) A civil society respondent cautioned that integrated plans should not divert resources away from breastfeeding. (Q5) Another stakeholder summarized it this way:

"If we can take advantage of the window of opportunity and a 'driver' to push the process, a vertical approach could help to generate the learning, evidence and excitement needed to sustain funding long enough to demonstrate programmes can regularly be taken to scale." (Q4)

"We need to recast the narrative around breastfeeding. It takes creative people willing to think outside the box and not be dogmatic. It's a nice story that can be told very well, but there needs to be support and people willing to say: 'this is important.'" (S3)

Many stakeholders were enthusiastic about the issue attention which nutrition is now receiving at the global level. They noted that the 1,000 day window of opportunity and stunting reduction messages have already gained political buy in from decision makers at the highest level. They added however that breastfeeding has not benefited from the same attention.

UNICEF media monitoring substantiates stakeholders' perception that nutrition is rising on the global agenda while breastfeeding remains largely invisible. A review of UNICEF media coverage reveals that 13 percent of media stories focused on undernutrition, while breastfeeding's share remained at 2 percent.

Issue ascendancy for breastfeeding is tied to increased media visibility

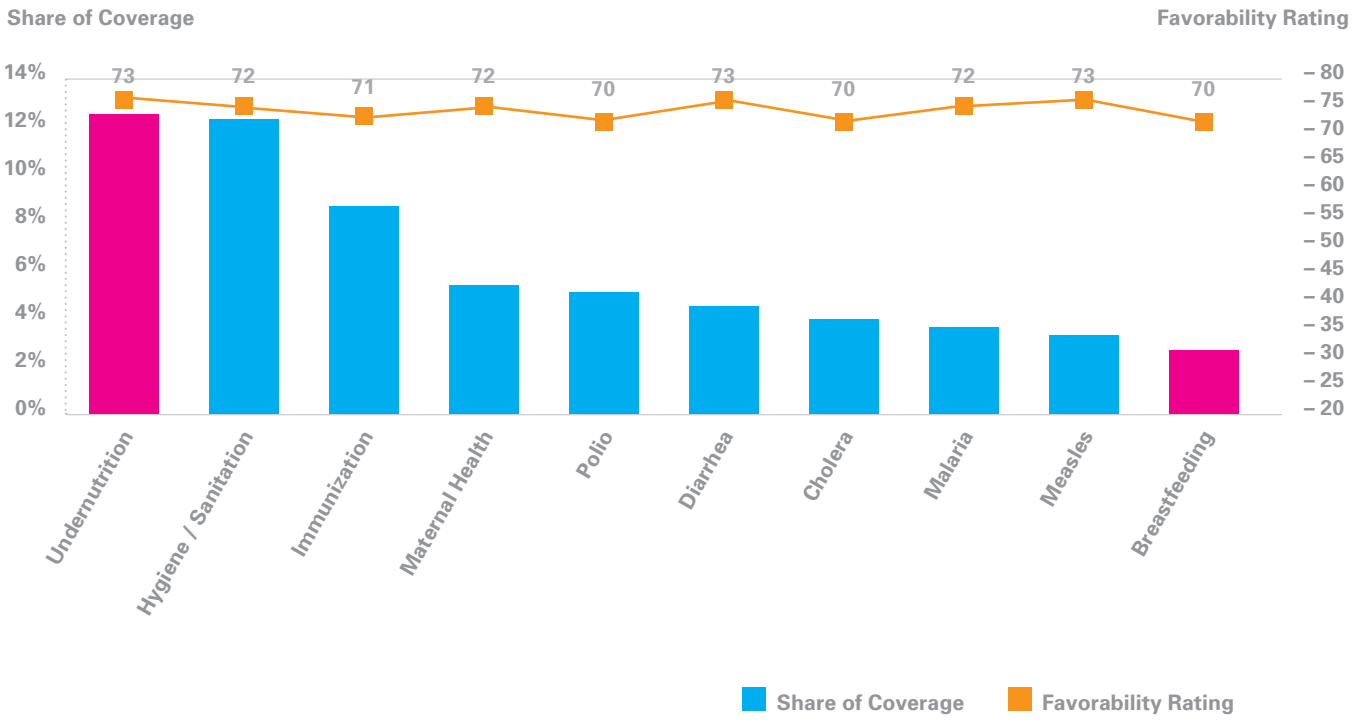
Media coverage is a useful proxy indicator for issue visibility, since policy decisions aren't made in a vacuum. The media plays an important role in informing and influencing decision-making and public debate[107]. Researchers who studied the topic of media visibility for global health priorities proposed a cyclical relationship between global attention, increased funding, new initiatives and media coverage.

Respondents acknowledged the breastfeeding community must do a better job of redefining its message and telling its story. Building on the 1,000 days message platform, it must develop a resonating frame for breastfeeding that can generate

[xxxiii] 1,000 Days Initiative, http://www.thousanddays.org/

FIGURE 12 UNICEF media coverage confirms undernutrition is rising on the global agenda, but breastfeeding is much less visible

Leading child survival topics: share of traditional media coverage January 2010–May 2012



Source: CARMA International, Global Media Analysts

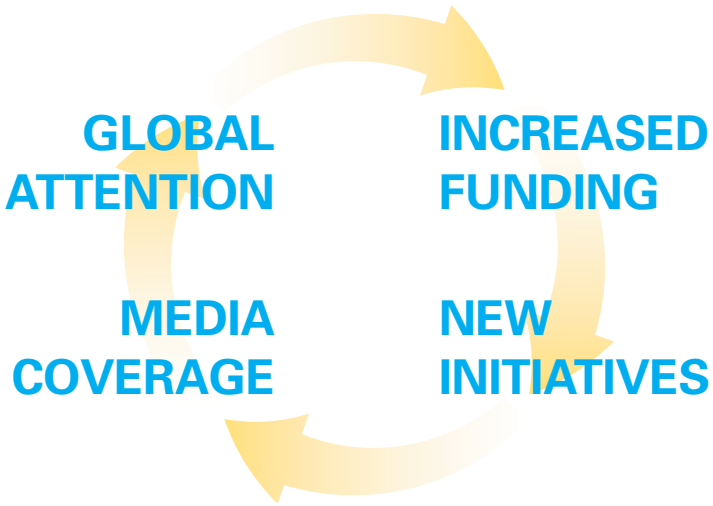
buy in from government leaders and other influentials.

To do so, the community can learn from media research. Too often, the story on breastfeeding is narrowly framed around the mother and child. Framing literature tells us that unless we explicitly change the picture, it will be hard for audiences to see why policy matters. Advocates should look beyond the portrait of the individual mother and describe the social and cultural factors that make it difficult or undesirable to breastfeed[108].

Advocates will have to agree on their priority issues, as well as on the language they use:

> *"Organizations need to stop just considering breastfeeding. It's not that women don't breastfeed and do nothing. They'll do something else, and we need to address what the something else is. There's definitely a reluctance to talk about formula feeding. I think that's a huge problem." (S9)*

FIGURE 13 **A compelling communication strategy can contribute to a virtuous circle of media visibility, public attention, further funding and new initiatives**



Source: Hudacek D et al. Analyzing Media Coverage of the Global Fund Diseases Compared with Lower Funded Diseases. PLOS One.

Policy makers' perceptions must be addressed

Women respondents in particular said it was sometimes difficult to get decision makers to understand "what the problem is" in relation to improving breastfeeding practices:

> *"Global leaders don't tend to think about it because they tend to be men. The visual image of women in poor countries breastfeeding lead people to think it's being done. They don't realize we're talking about specific optimal breastfeeding behaviors, which are not being done. So they think: 'I'm not going to worry about a bunch of women breastfeeding.'" (S6)*

Another interviewee added:

> *"Probably 'optimal practices' are not very clear in the minds of policy makers. Even with donors, there is a lack of understanding of what it is." (S7)*

An updated advocacy case for breastfeeding needs to address these perceptions, and explore metaphors and non-technical language which resonates with decision makers:

> *"Nothing was more powerful for Bill Gates than to be told by a woman in India that breastmilk was her baby's first immunization. He said, 'Okay, I'm a vaccine guy, and that's your first immunization'. That captivated him." (S3)*

THE CURRENT LEVEL OF STATED POLITICAL PRIORITY TO REDUCE CHILD STUNTING IS UNPRECEDENTED

POLITICAL CONTEXTS

Moments in time when conditions align favorably for an issue

The current political contexts at global, national and local levels influence which issues gain attention and represent opportunities for advocacy. Nutrition has risen exponentially on the global agenda and on national agendas in many countries in the last few years. This opportunity must be capitalized on with urgency for the proposed "diagonal approach" to advocacy for breastfeeding.

> *"Country agendas are heavily influenced by global action, or lack of it. If there is global attention, there is a push for accountability and the issue gets more attention. This hasn't been the case for breastfeeding in recent years." (S16)*

Policy windows and advocacy opportunities

Issues long neglected can return to center stage with the right combination of leadership, timing, resources and civil society mobilization. The current level of stated political priority to reduce child stunting is unprecedented at the global level, including a 2012 G-8 commitment to a New Alliance for Food Security and Nutrition[109].

Leaders of high burden countries such as India are also signaling a new resolve to address the problem with a high level, inter-sectoral response[110].

Stakeholders acknowledged the current window of political attention must not be missed, and recommended follow up action via the SUN public-private partnership in particular. They suggested the SUN platform be used to reposition breastfeeding as the *"cornerstone"* for improving maternal and child nutrition during the 1,000 days (Q16) and *"central intervention that anchors everything else"*. (S6)

Civil society respondents generally concurred, while flagging the risk of conflict of interest for private sector actors. They called on the SUN to put a strong policy in place to guard against this, saying: *"You could have formula companies being*

FIGURE 14 Stakeholders agreed the rise of nutrition on the global development agenda is an encouraging trend, including increased awareness by government leaders of countries with large numbers of non-exclusively breastfed children such as India

MAIL TODAY BUREAU | MAIL TODAY | NEW DELHI, JANUARY 11, 2012 | UPDATED 14:30 IST

Malnutrition is a national shame, says Prime Minister Manmohan Singh

TAGS: Malnutrition | Prime Minister Manmohan Singh | Amartya Sen | Integrated Child Development Scheme

Prime Minister Manmohan Singh has called malnourishment among children a "national shame".

Source: Screen grab, INDIATODAY.in

part of SUN before you know it!" (S11). Since the survey was conducted, one of the civil society stakeholders has taken the position that *"in view of the concerns about the role of business in SUN, IBFAN and many of its allies cannot support the SUN initiative"* [111].

The SUN consultation process should be conducted in close liaison with its Coordinator, and be inclusive of civil society advocates. In developing the updated advocacy case, stakeholders should build wherever possible from the wealth of existing resources.

Several UNICEF country representatives said the SUN agenda must be integrated into existing country programmes to have sustainable impact. A couple of case studies are presented to illustrate country efforts and approaches in this regard.

The Tanzania country office credited high-level political attention via the SUN as a major catalyst for government commitment to tackle undernutrition through integrated approaches (see box)

Country data can provide a powerful advocacy opportunity. Stunting reduction is both an indicator and frame that resonates with Ministers of Finance, since it communicates the loss of individual and national potential. Country nutrition data can provide a powerful advocacy opportunity (see Advocacy Case

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ADVOCACY CASE STUDY: A high-level Tanzania visit shines SUN light on infant and young child feeding

Tanzania has made striking progress in many health indicators over the past decade, but not nutritional status. Stunting currently affects 42 percent of under-five children, with Tanzania's stunting burden the third highest in Sub- Saharan Africa, after Ethiopia and the Democratic Republic of Congo.

Half of Tanzanian infants aged less than 6 months are exclusively breastfed. Young infants are often given water, juices, porridge and other foods, which family members and peers often encourage, not realizing they endanger the nutritional status and health of infants.

The biggest problem was breaking through a lack of acceptance at the top level about the importance of nutrition, said UNICEF Tanzania respondents. Government and development partners had drafted a national nutrition strategy, but it took a high-level visit in June 2011 by US Secretary of State Hillary Clinton and Ireland's Deputy Prime Minister to catalyze a political breakthrough.

It was during their stay that Tanzania signed up to the global SUN movement as one of the "early riser" countries, with President Kikwete later accepting an invitation to join the SUN Lead Group. "The government was ready to move forward, but that provided the push to make it happen", said UNICEF respondents. Tanzania's Prime Minister announced six major commitments for nutrition at the time, all of which have now been met or seen significant progress.

UNICEF Tanzania praised the government's integrated approach: "It's not just a matter of promoting breastfeeding. The issue must be looked at in a comprehensive manner, including actions to address the challenges women face to feed and care for their young children, such as their high workload."

UNICEF is working with local government authorities to enhance their leadership and management skills for improved nutrition, and supporting parliamentarians and a civil society-led partnership including indigenous NGOs and faith-based organizations covering most of the country.

Source: UNICEF Tanzania

NEW CHAMPIONS ARE NEEDED TO ENSURE POLITICAL PROMISES ARE TRANSFORMED INTO GENUINE ACTION

Supporting women to breastfeed must be a prioritized across the African continent. A woman breastfeeds her baby under a mosquito net, in the village of Garin Badjini, in Niger. Her village has benefited from sessions raising awareness of essential family practices, including exclusive breastfeeding.

Study on Vietnam). Stunting reduction is both an indicator and frame that resonates with Ministers of Finance, since it communicates the loss of individual and national potential.

The SUN movement is not the only major opportunity for breastfeeding advocacy—a number of global health initiatives also afford important opportunities to integrate efforts to enhance political commitment to breastfeeding. Accountability for breastfeeding should be shared by health and nutrition, requiring an integrated advocacy approach and strategy.

To be successful, advocacy at all levels must be integrated across both sectors. Many respondents highlighted the need for this integration, including this plea from an Africa-based respondent:

> *"The one thing I hope would not happen is a special new initiative on breastfeeding because we can't keep up! We get a new initiative every week. Rather, it's placing breastfeeding within the framework of the thousand initiatives already underway!" (S23)*

Stakeholders said the first priority is to engage the reproductive, maternal, newborn and child health communities who have coalesced around the UN Secretary General's *Every Women, Every Child* global effort [xxxiv], A Promise Renewed[xxxv], Saving Newborn Lives[112], the Partnership for Maternal, Newborn and Child Health[113] and the Countdown to 2015 tracking initiative[114].

New champions are needed to ensure political promises are transformed into genuine action said many interviewees, and breastfeeding advocates need to be more strategic in identifying

[xxxiv] Every Woman, Every Child, http://www.everywomaneverychild.org/
[xxxv] A Promise Renewed, http://www.apromiserenewed.org//

A NEW SOCIAL MOVEMENT IS NEEDED TO RE-ESTABLISH A "CULTURE OF BREASTFEEDING"

ADVOCACY CASE STUDY: Drawing influence maps to protect women's right to breastfeed in Viet Nam

"Viet Nam takes negative data about its development very seriously", said UNICEF Representative Lotta Sylwander. "They don't like the fact that 30–35% of the country's children are still stunted, so they want to do something about it."

It was findings from a national Nutrition Survey that provided UNICEF and the Alive and Thrive initiative with the ammunition they needed for a major advocacy drive on breastfeeding. "When the survey was published, it was a big blow—being a lower middle-income country and still having one third of your child population being stunted." Breastfeeding rates had plummeted in Viet Nam as in other East Asian countries where infant formula is aggressively marketed. An Alive and Thrive survey also revealed pressure to return to work was forcing Vietnamese women to abandon exclusive breastfeeding.

Armed with these findings, the two organizations went to the National Assembly and worked with its Center for Legislative Studies to craft strong laws addressing both issues. Alive and Thrive and UNICEF supported preparation of high quality policy briefs making the case to parliamentarians. They also worked with the Assembly to take the debate about young child feeding and breastfeeding to the regional and local levels, supported by Alive and Thrive's provincial staff.

Both partners focused significant energy on identifying those key individuals who could make the case to high-level decision makers in government and the legislature. "We are constantly drawing an influence map," said Sylwander.

Their efforts paid off: in June 2012, Viet Nam's National Assembly passed the Law on Advertisement which includes a ban on the marketing of breastmilk substitutes for children under 24 months. Parliamentarians also passed a Labour Code revision by a wide margin, allowing the extension of maternity leave from four to six months.

Now the focus is on ensuring the new legislation is put into practice—and promoting behaviour change via one-on-one, telephone and group counseling, supported by a sophisticated media campaign positioning breastfeeding as the clear choice for the modern Vietnamese women.

"the right players in the game"—not always the most obvious. (S19) Suggestions include a UN Special Envoy for Infant and Young Child Feeding (S16) and an IYCF *"czar"* in country, who has the direct support of the Health Minister. (S8)

Nurturing a social movement for breastfeeding

Social movements can be important for fostering broad, popular involvement, ownership and commitment to a cause or issue, with participation from a wide range of stakeholders. Such a movement could help to bring about the social changes and shifts in values among all constituencies, from families and grassroots organizations to governments, donors and companies, that are needed for breastfeeding's star to rise. Some of the survey participants said a new social movement is needed to re-establish a "culture of breastfeeding", to be developed in partnership with related constituencies. To grow a social movement, learn from other advocates.

The WASH programme has gained valuable experience, for example, on WASH in schools, handwashing with soap and shifting social norms on open defecation.

Among their lessons learned: [115]

- focus on want, need, desire
- for behaviour to change, experiences have to be 'radical, real, immediate and dramatic'

- when frames of mind change, behaviour change is easy
- for behaviour change, social norms must change.

A breastfeeding stakeholder in West Africa gave this example:

> *"In the north of Ivory Coast, which has very low exclusive breastfeeding, we had one village where almost all mothers are breastfeeding exclusively. Then the other villages are interested and they want to be part of the movement. So, there's kind of a buzz. It takes time though. It's not going to be a magic bullet. That is what we need to understand." (S23)*

Others spoke about the need to reach out to groups working for consumer education and sustainable development:

> *"What we don't have right now is a focus on the importance of creating a movement among consumers to have better literacy around nutrition, so they demand better products and services from governments. Markets are driving a lot of behavior, and we're not harnessing that well." (S15)*

From India—home to the largest number of stunted children[116]—came this perspective:

> *"What's emerging in India is that the largest inequities are related to complementary feeding practices, whereas breastfeeding indicators are less inequitable. That is telling us exclusive breastfeeding will be seen as something for the poor. If our advocacy is not able to present exclusive breastfeeding as something the elite aspire to, we will see declining rates, because India is changing. It's a new time, and our advocacy needs to be new." (S17)*

Another pondered:

> *"How do we make breastfeeding and nutrition aspirational to mothers, families, communities, policy makers and public opinion at large? How do we link optimal breastfeeding practices to brain development, school performance and success in life? If we hit that one, all the rest—legislation, monitoring the private sector and so forth—will come into line." (S18)*

DISCUSSION

It is acknowledged that breastfeeding practices and patterns are determined by a large array of context-specific factors, only some of which are amenable to influence and change by a global policy community.

Some of these factors, referenced by the stakeholders, include economic development patterns that put more and more women into the workforce (but without supporting mechanisms for optimal infant feeding), social changes such as urbanization that also alter women's lives (which this community cannot influence), the diffusion of norms surrounding breastfeeding (which this community may have some influence on but there are many other determinants of this, and has more to do with context-specific programmatic interventions for social and behavior change), and food industry efforts to penetrate infant feeding markets (which this community can shape to some extent but also are determined by many other factors).

The analysis focuses on the contribution a global community of advocates might make to improving breastfeeding patterns amidst this causal complexity, and particularly in influencing one aspect of the causal picture: global political attention and leadership.

Thus the analysis and recommendations do not aim to address technical and programmatic issues, including communication to the public on social and behavior change. On some aspects of the survey, the stakeholder responses sometimes veered into issues not related to global political commitment and advocacy, perhaps reflecting their programmatic and country focus or perhaps their partial understanding of the meaning or boundaries of the domain of political commitment and advocacy. We have therefore omitted from the findings some of these points that do not directly reflect the goals and focus of the analysis.

The desk review found that all of the nutrition global initiatives/partnerships do reflect breastfeeding quite strongly in their strategies and other documents, but the child survival initiatives appear to provide a more token mention of breastfeeding. A general observation is that for most organizations breastfeeding features more strongly in policy and strategy frameworks than in actual programmes and implementation at scale, with no systems and accountability to report on coverage of interventions. This is also true for countries, pointing to an overall environment that may be characterized as relatively "policy-rich" and generally "implementation-poor".

Exclusive breastfeeding as a goal, programme component or outcome indicator is the breastfeeding practice that tends to be most commonly reflected across the partnerships, different types of agencies and country frameworks, although a significant proportion also refer to early initiation and continued breastfeeding or just "optimal breastfeeding practices". It is important that specific and clear reference is made across all partnership, organization and country frameworks to all recommended breastfeeding practices, as each plays an important role in child survival, growth and development.

A predominance of "promotion" of breastfeeding is referenced in many of the strategy frameworks and statements. The term "promotion" is often intended to imply the full set of actions to improve breastfeeding, which need to also include professional support by skilled health providers, lactation counselors and community workers and legislative and policy measures to protect breastfeeding, including the Code for marketing of breastmilk substitutes, maternity protection and workplace policies. Therefore as such the term "promotion" is a misnomer for an all-encompassing approach to improving breastfeeding, as "promotion" is about messaging and information dissemination. This may be due to the dominant notion that improving breastfeeding is primarily behavioural as well as a lack of understanding of the role of professional and lay support and the importance of protecting breastfeeding. On the other hand, a more comprehensive reflection of approaches to improving breastfeeding was observed across a range of organizations.

While most countries collect data on many of the standard IYCF practice indicators through national household surveys, a major gap that was identified is the lack of standard frameworks and systems to monitor the performance and coverage of IYCF interventions. Global consensus on a harmonized and comprehensive set of indicators to measure the performance of IYCF programmes and interventions, including geographic and population coverage, is needed. Accountability to report on their status should contribute towards increasing the commitment and priority for breastfeeding and complementary feeding. It will therefore be crucial to advocate for the monitoring frameworks of country strategies and national information systems to be updated to include this set of indicators.

The landscape scan highlighted and reaffirmed a number of issues and factors that have been hampering progress:

- insufficient global leadership and guiding institutions
- low prioritization and financial commitment by donors and policy makers
- lack of policy community consensus and unity, with negative attention and fraught discussions, rather than pro-active prioritization and engagement
- uncertainties on private sector collaboration in the area of IYCF and growing polarization over support to breastfeeding vs complementary feeding instead of a comprehensive approach to improve both
- lack of advocacy and communication with compelling, up-to-date information and effective approaches.

Shiffman's analysis of the maternal health community[117] identified four challenges advocates needed to overcome to advance their cause: solidify policy cohesion, so the community speaks with authority and a unified voice; create enduring guiding institutions to sustain the initiative; find external frames that resonate with political leaders, and build strong links with civil society organizations and initiatives at the country level. Those challenges and questions are the same ones raised by breastfeeding stakeholders:

> We have guiding institutions. Will they lead?
>
> We know breastfeeding stakeholders are polarized over key issues. Are they willing and able to find common ground?
>
> We have national civil society and NGO advocacy initiatives. Can we strengthen their roles and unify their voices?
>
> We've created a resonating frame for the 1,000 days. Can we do the same to recast the narrative on breastfeeding for the 21st century and make an aspirational case that resonates with all the constituencies who need to come on board to achieve the vision of improving breastfeeding practices?
>
> And last but not least: can we find the resources we need to advance this process?

The answers to these questions will determine the future success of breastfeeding advocates to realize their exceptional potential to save lives and promote healthy development. Advocates now have the best political opportunity in a generation to advance their cause—if they are ready to capitalize on it.

To do so, breastfeeding stakeholders must be willing to make a big leap forward: come together as a cohesive advocacy community grounded in a common agenda, with shared measurement and mutually reinforcing activities.

In the past few years, nutrition advocates have made remarkable strides to secure commitments at the highest levels of government for global and national investment in the 1,000 days window of opportunity. Stakeholders consulted for this study called for a 'diagonal approach' to breastfeeding advocacy to reaffirm its multi-faceted contribution. They proposed a vertical advocacy initiative for breastfeeding within the 1,000 days and SUN context.

Realizing a new vision for breastfeeding advocacy will take courage, creativity, perseverance—and flexibility. It will require each individual and stakeholder organization to come together with fresh purpose to transcend policy disagreements that have constrained common action in the past. Those who have gained the most from the community's dissonance are shareholders of baby food companies. Those affected most detrimentally are women and families struggling to give their infants the best start in life.

A SIGNIFICANT SCALING UP OF CONTINUOUS ADVOCACY IS NEEDED TO INCREASE ATTENTION AND COMMITMENT

THE WAY FORWARD

A significant scaling up of continuous advocacy, communication and social mobilization is needed to increase attention, commitment and investment in actions to overcome barriers to optimum breastfeeding in the developing world, said respondents to the landscape analysis. A "second breastfeeding revolution" to recast breastfeeding for today's world must be created: more of the same will not produce results. Stakeholders call for effective leadership and guiding institutions to address the scale of the issue.

A global initiative to address these issues is urgently needed, with a clear focus on global advocacy, leadership, mobilization of commitment, rather than technical or programmatic issues. The proposed initiative should aim to help ensure that in a rapidly changing world, all children everywhere benefit from optimal infant and young child feeding practices both for their survival, growth and development in childhood and for long term outcomes in adulthood. The following proposals build on stakeholder feedback from the survey, as well as the outcomes of the small stakeholder consultation held in February 2013 to review the findings of the landscape analysis and contribute to articulating concrete proposals for the way forward. The ultimate goal of the five recommended actions is:

To galvanize action for the protection, promotion and support of optimal breastfeeding and complementary feeding in the 21st century, in pursuit of accelerated improvement of the infant and young child feeding indicators for all children everywhere.

1. **Recast the narrative:** Define a shared advocacy and communication vision and agenda for breastfeeding and complementary feeding, reframing the narrative for the 21st century. This is the opportunity for a 'coalition of the willing' to join forces to craft a common vision, strategy and tools to support global, regional and country evidence-based advocacy for breast-feeding and the 1,000 days. Recasting or reframing the narrative on optimal infant and young child feeding implies creating and effectively deploying the *right narrative for the right people at the right time.*

   A common global advocacy and communication agenda should define key audiences, measurable goals, indicators for measuring progress and mutually reinforcing activities. The agenda should confirm how each partner will contribute, based on their expertise and potential to add value. New messages, tailored to audience, context and to what resonates and motivates different stakeholders, are needed for country leadership and opinion shapers, donors, agencies and the public. More of the same will not produce results. The case for optimal IYCF has to be aspirational for all the different stakeholders. In developing the advocacy agenda, it will be important to consider the stakeholder inputs regarding the barriers women face to breastfeed in a 21st century world and policy action to create a more supportive environment. Asia-based stakeholders called for new resources making the advocacy case for breastfeeding in emerging economies where child mortality has declined, and government leaders are focused on developing human capital and competitiveness.

"Issue fatigue" on breastfeeding needs to be overcome and the debate needs to be re-energized. This should lead to a transformation of how the issue is perceived and addressed, conveying that it is doable and important to improve IYCF practices. The narrative must strongly reflect a positive voice, rather than the negative attention the issue currently receives. The aim is to bring about a shift from the current token reflection that breastfeeding often receives in movements, organizations and countries, towards non-negotiable commitment to at-scale and comprehensive delivery of the interventions to improve practices at the heart of policies and programmes for child survival and nutrition.

This essential area of action requires multiple agencies working in a coordinated manner. It requires professional support from experts on communication, marketing and advocacy. This is crucial to the "recasting" process, which must entail a shift from previous paradigms and approaches which have not yielded the intended results in terms of political priority and commitment. The recasting process also involves a skill set related to review of the scientific literature on all aspects of the benefits of optimal feeding the effectiveness of interventions to provide correct and succinct information to the advocacy and marketing specialists.

The advocacy initiative will require a strategy, materials, messages and tools addressing the various stakeholders and events. These may include the development of a detailed advocacy strategy and toolkit for countries and stakeholders. This will involve both a summary of scientific evidence on all impacts of IYCF (survival, nutrition, learning, economic arguments, development, NCDs/obesity) and a communication/advocacy piece on how to frame and recast the message, which must be fresh and different from previous messaging. Different messages/hooks will be needed for different audiences.

FIGURE 15 **These are some of the words stakeholders used to describe the focus and tone for future breastfeeding advocacy initiatives**

2. **Advocate and influence:** The stakeholders recommended a diagonal advocacy approach. This implies neither a solely "horizontal approach" of integrating and mainstreaming advocacy for breastfeeding within existing initiatives, nor a solely "vertical" approach focusing on breastfeeding separately. It implies both integration and influencing within existing partnerships and networks, especially SUN and APR, and at the same time some specific "vertical" advocacy on breastfeeding. This will requires a strategic, creative, innovative and forward-looking crafting of the advocacy approach.

   A shared IYCF agenda needs to be integrated into existing global advocacy initiatives for nutrition and maternal, newborn and child health. While advocacy for IYCF and breastfeeding have a natural home under the SUN umbrella, they must also be fully integrated within major advocacy initiatives for health, notably A Promise Renewed, and in other related sectors, and also within the frameworks for emergency responses. Links with the increasingly prominent nutrition-sensitive agriculture and social protection initiatives also need to be explored.

   Different groups to be addressed include leadership of countries, donor and agency leadership, partnerships, potential champions, the media and public opinion. Events and opportunities for advocacy and influencing need to be identified. Coordinated advocacy plans need to be developed and executed, deployed in appropriate global fora, at high level in countries and through relevant channels to the public. A particular aim is to motivate politicians, policy makers, donors and others that results for IYCF are desirable and possible in relatively short time. They need to be provided with tools and support so they, and others, can become "ambassadors" for this cause.

   An important aspect is strengthening the investment case for breastfeeding, building on research conducted by the World Bank, UNICEF, Save the Children and IBFAN highlighting its benefits, cost savings for governments, and costs of delivering a package of effective interventions. The investment casing needs to blend the data-based case with an aspirational message promoting the 1,000 days as a smart investment with big returns. These findings need to be integrated into existing investment cases for nutrition and maternal, newborn and child health. Take this case to government leaders and decision-makers at all levels, including policy dialogues and practical guidance regarding indicators to monitor the effectiveness of programmes and the outcomes of the investment.

   Media—both new and traditional—can play a powerful role to raise awareness among the public in donor and programme countries and policy makers alike, regarding the benefits of breastfeeding and often-invisible costs of formula and mixed feeding. It will be important to scan the development and social media landscape to identify opportunities for integrating breastfeeding messages and lessons learned from early adopters. A social media strategy to integrate breastfeeding protection, promotion and support into partner communication outreach needs to be developed.

   Global and national champions could be enlisted to promote the message, both celebrities and high-level personalities. Prominent personalities and celebrities at global and national levels could be enlisted, especially but not only women, to convey the message as part of an aspirational advocacy and communication campaign to position breastfeeding as the feeding choice of the modern mother in the North and South.

   Also critical is nurturing a social movement repositioning breastfeeding as the optimum feeding choice for the modern woman and child, which civil society organizations and NGOs should be supported to do in a positive and proactive way, applying best practices from social change campaigns, consumer education and private marketing, notably via community building online. To increase impact, dialogue and integrated advocacy with related constituencies should be developed, such as those advocating for maternal, newborn and child health, early childhood, WASH, HIV prevention and treatment, gender equality, girls' education and youth engagement.

3. **Ensure a unified voice:** The lack of cohesion and unity among the global policy community stood out in the stakeholder analysis. The nutrition and child survival advocacy communities will have most impact when they speak with one voice. NGO and civil society partners in particular should work towards a unified position on the role of the private sector in advancing IYCF goals.

This area of the agenda involves global coordination to ensure a unified voice and consensus on goals and strategies, recognizing that cohesion and consensus are vital on the main priorities and issues and also recognizing that not everyone will always agree with everything. It should center on creating a safe space for policy dialogue where outstanding issues of disagreement can be debated constructively and the best interests of the child placed at the center—so all actors can rally together. Establishing a global coalition may play an important role to play in addressing misinformation and ensuring that the diverging views are better managed to shift the narrative to a more positive space and reduce the current high level of negativity that threatens to derail the agenda.

4. **Provide strong leadership for cohesive action and results:** Stakeholders called for strong leadership and guiding institutions to advance the agenda. This area of action involves assuming a leadership function and backbone support to pursue the global, unified advocacy and leadership initiative on IYCF. This will include amongst other things the development and execution of a strategy and plan related to this agenda, coordinating the development of advocacy messages and materials, pursuing opportunities for advocacy, and spearheading the process of reaching areas of consensus in the global community of stakeholders. Actions for the leadership body may also include convening events, consultations and meetings.

   Possibilities to shape a global coalition to advance the agenda should be explored. A coalition, which does not necessarily need to be a "Partnership" or a separate entity, should be characterized by its impartiality, professionalism, trust and respect, and could bring more impetus, strength and unity. It should serve as a bridge to multiple agendas, nurturing partnership and links with SUN, APR and other fora, aiming to serve the goals of these partnerships and fill gaps. The coalition needs to be bold, up front and innovative in making the case for IYCF: it will need to "think big". It should also have clear tangible goals, deliverables and plans that contain the key elements underpinning its purpose.

5. **Mobilize resources, action and accountability:** Stakeholders consistently noted a lack of resources was inhibiting their ability to advocate and scale up action for breastfeeding. A dearth of funding has contributed to the pattern of low investment—low effectiveness—low visibility respondents described. A lack of human resources capacitated for IYCF advocacy, policy and programming was also noted.

   This fifth area will involve promoting accelerated action and mobilizing resources and commitment for accelerated action towards achievement of full coverage of the IYCF indicators[118]. This promotion should focus not just on the indicator of exclusive breastfeeding, but also early initiation of breastfeeding and continued breastfeeding, as well as the complementary feeding indicator of minimum acceptable diet and its two component parts (diversity and frequency).

   It also involves identifying and promoting ways to hold countries accountable for the World Health Assembly (WHA) target on exclusive breastfeeding that they signed off on[119]. In addition, the important role of improved breastfeeding and complementary feeding practices in addressing a number of the other WHA targets, such as stunting and wasting, also needs to be accompanied by a process of greater accountability towards progress. It was noted that an implementation plan related to these targets exists, but that the accountability mechanism is not clear. Industrialized countries should also be accountable to report. In terms of measuring progress towards the achievement of the IYCF indicators, it was noted that for most countries data is available, for example as reported in the Countdown Report, by UNICEF, WHO etc. However, there is need to generate more attention to progress and lack of progress. There is also a need for more frequent, better reporting both on interventions and practices—annually if possible. To this end, standard IYCF scorecards need to be developed, agreed and their use promoted to improve the comprehensiveness and frequency reporting on both the performance of IYCF interventions and the results in terms of IYCF practices.

   Prioritization of breastfeeding and IYCF interventions in terms of resources needs to substantially increase if the targets are to be met and the goals of the nutrition and child survival movements met. This may imply shifting to greater prioritization for IYCF prioritization within existing resource

envelopes as well as seeking new resources, maximizing synergies and opportunities, directing policies and programme design towards greater institutionalization and sustainability, and ensuring more focus on capacity building of human resources for quality IYCF programming and technical skills. The increased financial prioritization can be reflected in national budgets, donor support and public-private partnerships consistent with the Code. The potential for private sector support needs to be carefully explored, ensuring company goals are do not conflict with and are aligned with those of IYCF stakeholders, and proposals have been fully vetted to conform to the Code and avoid conflicts of interest. Nutrition donors play an essential role to advance IYCF as strategic partners, advocates and funders. Today they can make all the difference by seeding new initiatives that spark a positive cycle of investment and attention. Partners are motivated to work with them to define shared indicators of progress.

In terms of other opportunities to ensure IYCF is strongly reflected as a target, stakeholders mentioned that in the post-2015 agenda, IYCF indicators should be reflected.

New research, advocacy and communication including prize money for innovative approaches could be funded. Resources can be allocated to a range of constituencies, including guiding institutions, academics, NGO and civil society actors such as faith-based organizations and women's groups. Governments need to be motivated to position infant and young child feeding centrally in budgets for nutrition and child survival, whether national resources or external funding, and whether development programmes or emergency response.

ACKNOWLEDGEMENTS

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Ruth Landy, principal consultant for Strategic Communication for Social Impact, conducted the stakeholder survey, prepared the report and draft presentation, as well as the Executive Summary.

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Among newborns, only 43 per cent started breastfeeding within the first hour after birth. Breastfed infants are much less likely to die from diarrhoea, acute respiratory infections and other diseases. A newborn nurses at his mother's breast at a hospital in Kabul, capital of Afghanistan.

ANNEX 1 | STAKEHOLDERS CONSULTED

	Stakeholders	Organization
WHO & World Bank		
1	Bernadette Daelmans Coordinator, Policy, Planning & Programmes	World Health Organization Geneva, Switzerland
2	Chessa Lutter Regional Advisor	Pan American Health Organization Washington D.C., USA
3	Leslie Elder Senior Nutrition Specialist	World Bank Washington D.C. USA
Donors		
4	Anna Taylor Senior Nutrition Adviser Ruth Lawson Senior Health Adviser for MNCH	UK Department for International Development (DfID) London, United Kingdom
5	Ellen Piwoz Senior Program Officer, Nutrition	Bill & Melinda Gates Foundation Seattle, USA
NGOs & Civil Society		
6	Rae Galloway Senior Nutrition Officer	PATH Washington D.C., USA
7	Luann Martin Communications Specialist	Alive and Thrive Washington D.C., USA
8	Victoria Quinn Senior Vice President of Programs	Helen Keller International New York, USA
9	Agnes Guyon Senior Advisor	John Snow Inc. Washington D.C., USA
10	Ali Maclaine Senior Humanitarian Nutrition Advisor	Save the Children UK London, United Kingdom
11	Dominic Schofield Director, Multi-Nutrient Supplements	Global Alliance for Improved Nutrition Washington, D.C., USA
12	Lida Lhotska	Geneva Infant Feeding Association (GIFA) Geneva, Switzerland
13	Jennifer Mourin Artist & Activist	World Alliance for Breastfeeding Action (WABA) Penang, Malaysia
14	Miriam Labbok Professor of the Practice of Public Health	University of North Carolina Chapel Hill, USA (representing WABA)

	Stakeholders	Organization
15	Patti Rundall Policy Director	Baby Milk Action Cambridge, UK
16	Dr Arun Gupta, Regional Coordinator	IBFAN Asia, New Delhi, INDIA
	Independent Consultants	
17	Rukhsana Haider Chairperson	Training and Assistance for Health and Nutrition Foundation, Dhaka, Bangladesh
18	Mary Lung'aho Director	Nutrition Policy and Practice USA
	Academics	
19	Jennifer Bryce Senior Scientist	Johns Hopkins Bloomberg School of Public Health Baltimore, USA
20	Karleen Gribble Researcher	University of Western Sydney Sydney, Australia
21	Nita Bhandari Coordinator	Centre for Health Research and Development New Delhi, India
	Global Health and Nutrition Partnerships	
22	Lucy Sullivan Director	1000 Days Initiative Washington D.C., USA
23	Carol Presern Director	Partnership for Maternal, Newborn & Child Health Geneva, Switzerland
	UNICEF	
24	Olivia Yambi Consultant, Previous UNICEF Representative	Dar es Salaam, Tanzania
25	Joyce Greene Consultant, Nutrition Section	UNICEF, New York
26	Victor Aguayo Chief Nutrition	UNICEF India New Delhi, India
27	Lotta Sylwander UNICEF Representative	UNICEF Vietnam Hanoi, Vietnam
28	Gillian Mellsop UNICEF Representative	UNICEF China Beijing, China

ANNEX 1 | STAKEHOLDERS CONSULTED

	Stakeholders	Organization
29	Noreen Prendiville Chief Nutrition	UNICEF Bangladesh Dhaka, Bangladesh
30	Koen Vanorgmelingen UNICEF Representative	UNICEF Angola Luanda, Angola
31	Dorothy Rozga UNICEF Representative Harriet Torlesse Nutrition Manager	UNICEF Tanzania, Dar es Salaam, Tanzania
32	Felicite Tchibindat Senior Regional Advisor Nutrition	UNICEF West & Central Africa Regional Office Dakar, Senegal
33	Angela Kearney UNICEF Representative	UNICEF Indonesia Djakarta, Indonesia
34	France Begin Senior Regional Advisor Nutrition	UNICEF East Asia & Pacific Regional Office Bangkok, Thailand
35	Peter Salama UNICEF Representative	UNICEF Ethiopia Addis Ababa, Ethiopia
36	UNICEF Nigeria—collective reply	UNICEF Nigeria Abuja, Nigeria
37	UNICEF Egypt—collective reply	UNICEF Egypt Cairo, Egypt
38	UNICEF Uganda—collective reply	UNICEF Uganda Kampala, Uganda
39	UNICEF Yemen—collective reply	UNICEF Yemen, Sana'a, Yemen
40	UNICEF Mozambique—collective reply	UNICEF Mozambique Maputo, Mozambique
41	UNICEF South Africa—collective reply	UNICEF South Africa Pretoria, South Africa
42	UNICEF Iran—collective reply	UNICEF Iran Tehran, Iran
43	UNICEF Philippines—collective reply	UNICEF Philippines Manila, Philippines
44	UNICEF Pakistan—collective reply	UNICEF Pakistan Islamabad, Pakistan

ANNEX 2 | QUESTIONNAIRE

STAKEHOLDER QUESTIONNAIRE: POLITICAL COMMITMENT TO PROTECT, PROMOTE AND SUPPORT BREASTFEEDING PRACTICES

Introductory Note

Exclusive breastfeeding in the first six months and continued breastfeeding up to 1 year is the single most effective intervention for preventing child deaths, yet less than 40 percent of infants under 6 months old are exclusively breastfed in developing countries and there has been negligible improvement globally since 1990.

For the purposes of this questionnaire, we define political commitment as the degree to which leaders of international organizations and national political systems actively pay attention to an issue, and provide resources commensurate with the problem's severity.

Political commitment can be measured by:

- **Leadership**—Global and national leaders publicly and privately express sustained concern about an issue
- **Policies & Programmes**—Global organizations and governments formally enact policies and programmes that offer widely embraced strategies to address the problem
- **Resourcing**—International organizations, donors, governments, civil society and other stakeholders allocate and release funding commensurate with the problem's severity

Questionnaire

The Situation Today

1. How would you rank the current state of global political commitment to programmes to protect, promote and support improved breastfeeding practices, in relation to their potential impact on child survival?

   (If you work at the country level, what is current state of government commitment?)

   Rank on a scale of 1–10, with 10 being the highest level of commitment. Please explain your ranking.

2. How would you evaluate the impact of existing advocacy initiatives to increase political and donor commitment for programmes to improve breastfeeding practices? Please share any evidence you are aware of on this subject.

3. Is there a need to increase the level of political advocacy and commitment for breastfeeding at the global level and in countries? If yes, why?

4. How do you think programmes to improve breastfeeding practices are currently prioritized by your organization relative to other nutrition and family health priorities?

   What are the underlying reasons for this?

5. Any other key points and issues you would like to share regarding the current situation with regard to advocacy, commitment and prioritization for breastfeeding?

Barriers

6. Please rank the significance of the following factors which may be preventing organizations and governments from making breastfeeding programmes a higher priority. Rank from most to least important:

   Lack of evidence that programmes can be implemented at scale

   Perception that breastfeeding is not an important priority

   Perception that stakeholders lack a unified strategy to address the problem

   Perception that breastfeeding is a less reliable health and nutrition investment since it's based on a behavioural intervention rather than a product

   Other factors?

7. Any other key points and issues you would like to share regarding the barriers to prioritization of programmes to improve breastfeeding?

Opportunities

8. What opportunities currently exist to raise awareness and build commitment for breastfeeding as a key child survival and nutrition intervention?

   How would you recommend advocacy strategies related to breastfeeding take best advantage of these opportunities?

9. Please rank the importance of the following factors in building political and donor commitment for breastfeeding programmes:

   evidence that programmes work at scale

   leadership

   powerful ideas (the way advocacy approaches tell the story)

   guiding institutions

other factors?

Provide an explanation for your ranking and add other factors you prioritize.

10. Any other key points and issues you would like to share regarding opportunities?

The Way Forward

11. What are the greatest needs today, in terms of advancing breastfeeding advocacy at the global level?

12. At the country level, what type of breastfeeding advocacy is likely to have the most impact on national programmes?

13. What key factors would motivate political leaders and donors to prioritize breastfeeding?

14. How effective do you think an advocacy strategy would be if it were focused solely on mobilizing support and resources for breastfeeding (a vertical approach) versus including breastfeeding within an integrated package of interventions?

    If you favour an integrated approach, what actions do you recommend to ensure this priority is not lost within broader agendas?

15. What next steps do you recommend to advance this process?

16. Any other key points and issues you would like to share regarding the way forward?

A final request: Data on funding for breastfeeding protection, promotion and support

Does your organization have disaggregated data showing current programme or donor expenditures to improve breastfeeding practices?

If so, would you be willing to research and provide us with this information?

Our goal in making this request is to put together a more comprehensive picture of overall support for breastfeeding programmes, and share this with you.

ANNEX 3 | STAKEHOLDER PROPOSALS FOR STRENGTHENING THE BREASTFEEDING INVESTMENT CASE

Breastfeeding helps develop economies and human capital

- Focus on the impact on productivity and economic development and decreasing chronic diseases, so there is less drain on health services. (Q3)
- Build on the work done by PROFILES , to estimate the economic loss due to malnutrition (including low BF rates) and presents costing needs to ensure >95 per cent children are ensured the right to BF. (Q13)
- 'Unpack the package of IYCF interventions'. "We keep talking about this important package of direct nutrition interventions in the SUN and 2008 *Lancet* series, but we need to prioritize. The Minister of Finance is going to want to know what are the top 3 things he should focus on, not the top 13 or 15." (S2)
- Take a middle approach—strong new emphasis on IYCF within a stunting context that combines need for behavioural and commodity-based approaches and includes a strong operational research component. Ensure linkages to broader child survival agenda and multi-sectoral nutrition agenda of SUN are very clear. (Q10)
- For countries with low exclusive breastfeeding rates, budget the cost of scaling up peer counseling and other interventions and the potential return in terms of lives saved. (Q2)

Breastfeeding brings health and lifestyle benefits to mother and child

- Communicate that breastfeeding is the single most important intervention to prevent infant mortality, has a large protective effect on neonatal mortality, prevents short and long-term child morbidity and increases IQ. Women who breastfeed also have reduced risk of ovarian and premenopausal breast cancer and cardiovascular disease. (Q1)
- Promote the health benefits of breastfeeding in relation to preventing non-communicable diseases, including obesity. Highlight the risks of formula feeding including sugar content in infant formula, which many people don't realize is there. (S12)
- Link breastfeeding to the consumer movement for healthier lifestyles, where citizens demand better products and better services from their governments. (S10, S15)

Breastfeeding saves newborn lives and promotes early childhood development

- Capitalize on donor interest in newborn health, and the potential of early initiation of breastfeeding to reduce neonatal mortality. (S1)

- Embed breastfeeding in the context of early child development, and link back to development of human capital. (S2)

Breastfeeding improves child learning and future success in life

- Make breastfeeding aspirational by strengthening the evidence base on the impact it has on a child's intellectual, health, and emotional development. That will really make an impact in emerging economies. (S20)
- Link breastfeeding and nutrition to families' priorities—going to school, learning, succeeding and breaking the 'inter-generational karma of deprivation'. (S18)

Formula feeding has invisible costs for families, nations and the environment

- Track how many babies die every year from sub-optimal breastfeeding and cost financial burdens on government budgets due to formula-related child morbidity and mortality. (S6)
- Calculate the environmental cost of formula feeding with breastfeeding—from production costs through the carbon footprint to ship formula around the world, the cost of heating water and discarded tins. (S11)
- Document and quantify Code violations in specific countries, such as numbers of health workers given formula samples and asked to promote it. (S1)

In discussing the public positioning of breastfeeding, stakeholders also had the following recommendations:

- Reach out to the women's health and gender communities to dialogue about the barriers women face to breastfeed and advocate jointly for better maternity protection. (S2)
- Engage with civil society constituencies with shared values and goals, including parliamentarians, faith-based organizations and youth.
- Define and propose indicators to measure government and donor accountability for meeting their commitments to support breastfeeding, so these become more than mere declarations of principle. (S8)
- Increase policy makers' knowledge regarding the indicators they need to use for monitoring the effectiveness of programmes. Currently, there is little demand for this information, limiting political leaders' ability to track progress. (S1)
- Invest in high quality marketing and advertising, including services of private sector companies, since this is essential to change social norms and promote behavior change in today's marketplace. (S8)
- Scale up the use of cell phone technology and social media to reach young women and their families for breastfeeding promotion and support. (S2, S16, S24, Q16)

ANNEX 4 | ORIGINAL FRAMEWORK—PROFESSOR JEREMY SHIFFMAN

Category	Factor	Explanation	Why It Matters	Examples
Actor Power	1 Policy community cohesion	Coalesce among networks; multiple types of organizations	Enhance authority	Positive shift in maternal community
	2 Leadership	Strong champions for the cause; they defend the issue, inspire action, bring together the policy communities	Defining the issue, inspire action, bring together the policy communities	Jim Grant for child survival
	3 Guiding institutions	Coordinating mechanisms	Sustainability	National AIDS commissions
	4 Civil society mobilization	Engaged social institutions that press political authorities to act	Source of external pressure	
Ideas	5 Internal frame	Common policy community understanding of problems and solutions	Avert fractiousness, enhance credibility	TB community coalesce around DOTS
	6 External frame	Public positioning of the issue that inspires external audience to act	Only some resonate widely; different frames resonate with different audiences	Case of HIV/AIDS; Finance ministers v. health ministers
Political Context	7 Policy windows	Moment in time when conditions align favourably for an issue; often follow disasters, discoveries, forums; At national level may follow regime changes	Present windows of opportunity	MDG's
	8 Existing health priorities	Priority for other health issues	May facilitate of divert policy-maker attention	Newborn survival in Nepal and Bangladesh; Donor prioritization of AIDS
Issue Characteristics	9 Severity	Size of burden relative to other problems; Credible INDICATORS are the key	Preferences for causes perceived to be serious; indicators alarm politicians	DHS indicators for maternal health
	10 Tractability	Extent to which problem is (perceived to be) surmountable; CLEAR, COST-EFFECTIVE INTERVENTIONS are key	Policy-makers are more likely to act on issues they think they can do something about	Immunize children
	11 Danger	Degree to which problem is perceived to pose a threat; especially to rich people	Pressure for immediate action to contain threat	SARS v. pneumonia
	12 Contentiousness	Extent to which addressing the issue incites opposition	Inhibits progress; inspires action	Reproductive health and church in Latin America
	13 Culpability	Degree to which those with the condition perceived to be responsible	Reluctant to act if perceived individual responsibility alone; need to shift locus of responsibility to society	Obesity v. malnutrition
	14 Allure	Attractiveness of the issue to those who might want to address it	Reputational effects	AIDS vs. diarrheal diseases

ACRONYMS

A&T	Alive and Thrive
ACF	Action Contre la Faim (Action Against Hunger)
AED	Academy for Educational Development
AIDS	acquired immune deficiency syndrome
APR	A Promise Renewed
BF	breastfeeding
BFHI	Baby Friendly Hospital Initiative
CCCs	Core Commitments for Children in Humanitarian Action
CIFF	Children's Investment Fund Foundation
DFID	Department for International Development (United Kingdom)
DOTS	directly observed therapy, short-course
EMR	Eastern Mediterranean
ENA	essential nutrition actions
ENN	Emergency Nutrition Network
EU	European Union
FAO	Food and Agriculture Organization
GAIN	Global Alliance for Improved Nutrition
gBICS	global Breastfeeding Initiative for Child Survival
HIV	human immunodeficiency virus
HKI	Helen Keller International
IBFAN	International Baby Food Action Network
ICDC	International Code Documentation Centre
IFAD	International Fund for Agriculture Development
IFE	infant feeding in emergencies
IYCF	infant and young child feeding
IYCN	infant and young child nutrition
JSI	John Snow Incorporated
MDGs	Millennium Development Goals
MNCH	maternal, newborn and child health
MTSP	medium term strategic plan
NGO	non-governmental organization
OFDA	Office of Foreign Disaster Assistance (United States government)
PAHO	Pan American Health Organization
PMNCH	Partnership for Maternal, Newborn and Child Health
REACH	Renewed Effort Against Child Hunger and undernutrition
SPRING	Strengthening Partnerships, Results and Innovations in Nutrition Globally
SUN	Scaling Up Nutrition
TB	tuberculosis
UK	United Kingdom
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
USG	United States Government
WABA	World Alliance for Breastfeeding Action
WASH	water, sanitation and hygiene
WBTi	World Breastfeeding Trends Initiative
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization

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