UNICEF and the Global Strategy on Infant and Young Child Feeding (GSIYCF)

Understanding the Past – Planning the Future

UNICEF Working Paper

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GLOSSARY OF TERMS AND ABBREVIATIONS

ARI	Acute Respiratory Infection
BFHC	Baby-friendly Health Care
BFHI	Baby-friendly Hospital Initiative
BFPP	Breastfeeding Practice and Policy course
CICH	Centre for International Child Health
C-IMCI	Community - Integrated Management of Childhood Illness
CODE	International Code of Marketing of Breastmilk Substitutes
DHS	Demographic and Health Surveys
Global Criteria	Standards to be met in order to obtain BFHI designation.
GSIYCF	Global Strategy for Infant and Young Child Feeding
HIV+	Sero-positive for the Human Immunological Virus
HIV/AIDS	Human Immunological Virus/Aquired Immune Deficiency Syndrome
IBFAN	International Breastfeeding Advocacy Network?
IECD	Integrated Early Childhood Development
IGBM	
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IYCF(C)	Infant and Young Child Feeding (and Care)
LAM	Lactational Amenorrhea Method
LME	Lactation Management Education
MICS	
MOH	Ministry of Health
MTSP	Medium Term Strategic Plan
NGO	Non-governmental Organizations
NIDS	National Immunization Days Strategy
NYHQ	UNICEF New York Headquarters
ORS	Oral Rehydration Solution
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
SCN	
Step 10	The final step in the Ten Steps Programme. Step 10 says "Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic."
Ten Steps	Ten Steps to Successful Breastfeeding Programme
Tool	National Tool for Assessing IYCF Practices, Policies and Programmes
TOT	Training of Trainers
UN	United Nations
USAID	United States Agency for International Development
WABA	World Alliance for Breastfeeding Action
WHA	World Health Assembly
WHO	World Health Organisation

I. INTRODUCTION

The WHO/UNICEF *Global Strategy* on IYCF (GSIYCF), approved in 2002, sets the standards for global action in support of optimal breastfeeding, complementary feeding, and related maternal nutrition and health. In moving forward on this strategy, it is important to consider the knowledge and experience gained from 22 years of work on the Code of Marketing of Breast-milk Substitutes, and 11 years on work on the Baby-friendly Hospital Initiative. Both initiatives were moved forward following the Innocenti Conference and Declaration of 1990. UNICEF played a major role in the implementation of the Innocenti Goals, however, many partner organizations and new UNICEF staff are no longer aware of these four goals. The new *Global Strategy* reconfirms these goals, and adds new attention to the community and the family.

In 2003, we remain focussed on the Millennium Development Goals and the goals of the World Fit for Children, as well as recognizing the apparently increasing number of unstable situations and reality of the HIV/AIDS pandemic. In order to learn from the efforts of the 1990s to inform planning and country office programming in the next decade and beyond, a workshop, "Working Session on UNICEF and the *Global Strategy* on Infant and Young Child Feeding: Understanding the Past – Planning the Future" was held in April 2003. Its purpose was to explore key lessons from the past efforts, including programme experience, re-analyses of survey data, and field-based learning, and to reformulate plans for action in today's context. Participants were invited from major government, multilateral, and NGO and other civil society partners. Participants were asked to share assessments and current innovations, and to engage in informal problem solving in order to develop specific suggestions to support the implementation of the *Global Strategy* with its emphases on policy, health system, and community action to support optimal infant and young child feeding.

Optimal infant and young child feeding practices include the following:

- Six months of exclusive breastfeeding
- Continued breastfeeding for two years or beyond
- Timely, adequate, safe and appropriate complementary foods and feeding starting after six months, and
- Related support for maternal health, nutrition and birth spacing

Optimal breastfeeding:

- Save another 1-2 million lives each year (in addition to the millions it saves today)
- Reduce ARI and diarrhea deaths by 50-95%
- Significantly increase the effectiveness of immunizations
- Reduce the need for ORS by more than 50%
- Significantly increase intelligence and readiness to learn
- Automatically reduce mother to child transmission of HIV an estimated 10-20%
- Reduce child desertion in hospitals and strengthens mother-child protective bond
- Increase growth, and provide the majority of an infant's nutritional nee

Governments and organizations world over have recognized the centrality of optimal infant and young child feeding and have shown commitment through a number of goals and strategies to achieving these goals:

The Code of Marketing of Breastmilk Substitutes was approved by the World Health Assembly in 1981 and the *Innocenti Declaration* of 1990 that called on governments to take measures to establish

1. A national breastfeeding coordinator of appropriate authority, and multisectoral national breastfeeding committee
2. Maternity services fully practicing the Ten Steps to Successful Breastfeeding [the Baby-friendly Hospital Initiative]
3. Implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions
4. Legislation for the breastfeeding rights of working women and its enforcement

The *Millennium Development Goals*, pledged by 189 United Nations members, states

- Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
- Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
- Reduce hunger and poverty

The *World Fit for Children* goals, the consensus outcome document of the General Assembly, calls for

- Reduction in the infant and under-five mortality rate by at least one third
- Reduction of child malnutrition among children under five years of age by at least one third, with special attention to children under two years of age, and reduction in the rate of low birth weight by at least one third of the current rate
- "To achieve these goals and targets, we will carry out the following strategies and actions: ...Protect, promote and support exclusive breastfeeding of infants for six months and continued breastfeeding with safe, appropriate and adequate complementary feeding up to two years of age or beyond. Provide infant-feeding counseling for mother living with HIV/AIDS to that they can make free and informed choices"

In May 2002, a *Global Strategy on Infant and Young Child Feeding* was developed through a two-year participatory process and was adopted by the World Health Assembly and later endorsed by the UNICEF Executive Board.

UNICEF through its Medium Term Strategic Plan (MTSP) and rights based programming works to sustain these commitments and realize the rights of every child. Children have rights – they have the rights to adequate nutrition, good health and proper development. One of the five MTSP priority areas - Integrated Early Childhood

Development (IECD) – strives to realize these rights so children can get the best start in life.

By the end of the 1990s, more than 15,000 hospitals and maternities had been certified as Baby-friendly. Baby-friendly, the Code or some aspects of it had been adopted in about 60 countries, and Maternity Protection was re-established by the ILO. As a result, there was nearly a 17% increase in exclusive breastfeeding globally. This increase meant:

- more than a billion woman-months of behaviour change
- more than a million infant lives saved
- significant reduction in morbidity and mortality from diarrhea and pneumonia and other infectious diseases, and
- increased time between births, resulting in --

⇨ Improved survival, growth and development of children everywhere.

Despite these significant milestones in policy and programming, proper infant and young child feeding remains a problem in much of the developing world. Malnutrition plays a significant role in more than half of the nearly 11 million deaths each year of children under five. One hundred fifty million children are still malnourished. Fifty percent of infants are not exclusively breastfeed during the first six months of life, while only a small minority is breastfed through the second year and beyond. Infants not breastfed are more likely to suffer from diarrheal disease and acute respiratory infections, with mortality rates at 14-times and 4-times greater respectively in comparison to non-breastfed infants.

The additional circumstances of complex emergencies and the HIVpandemic continue to challenge societies to provide proper care and feeding for their infants and young children. Nearly 5.5 million refugees and internally displaced persons of the 40 million total are children under five years of age. An estimated 1.6 million children are born to HIV-infected women each year. 90% of HIV-infected children under age 15 contract HIV from mother-to-child transmission. Without intervention, 10-20% of these children may be infected through breastfeeding.

The Workshop in April 2003 was designed to address the continued gaps and complexities in the field of infant and young child feeding and move forward on the *Global Strategy* on Infant and Young Child Feeding. Participants explored lessons learned from IYCF programme experience, including identification of successes, challenges and gaps and consideration of cross-cutting issues such as emergencies and HIV/AIDS. Recommendations were proposed for UNICEF and partners in the areas of 1) advocacy, 2) comprehensive policies, regulation and legislation, 3) health systems, 4) and community action/social mobilization. The workshop concentrated mainly on the issue of breastfeeding, since this was the aim of previous UNICEF programming, and since WHO had recently held a meeting on complementary feeding. The outcomes obtained from the Workshop were used to finalize UNICEF's Programme Guidance Note on Action Programming for IYCF.

The purpose of this report and annexes is to provide technical experts and advocates in the field of infant and young child feeding with a consensus document that assesses past experience, reiterates the call for urgent action, and proposes concrete recommendations to move forward. Recommendations put forward include the following:

Advocacy

- Identify resources to support decision-makers to invest in IYCF
- Develop a strategy for internal and external advocacy
- Build upon HIV programmes and policies, and ensure they support optimal infant feeding globally
- Convene future meetings to support partners' collaboration

Comprehensive Policy, Regulation and Legislation

- Develop guidance for Comprehensive IYCF policy
- Increase awareness of IYCF as Emergency Preparedness
- Implement all Executive Directives and programme guidance on IYCF issues
- Ask the Executive Director to include her enthusiasm for this issues in statements, speeches and directives

Health Systems

- Implement the broader concept of Baby-friendly health care (BFHC) that would include revitalizing BFHI
- Clarify that we now support health-system-wide BFHC
- Change emphasis to pre-service training and job tools for all levels
- Maintain at least one center of international expertise while establishing regional training centers
- Increase the capacity of UNICEF staff

Community Mobilization/Social Action

- Identify existing guidance on community breastfeeding support and repackage appropriately for different audiences
- Develop programmes that build on NIDS and on 'Baby-friendly communities'
- Advocate for IYCF in the community as emergency mitigation

The actions brought forth in this report were identified and discussed by workshop participants. Section II describes the relevance of their findings and recommendations to current UNICEF and global development needs.

II. HOW SUPPORT FOR INFANT AND YOUNG CHILD FEEDING ADDRESSES CURRENT UNICEF AND GLOBAL DEVELOPMENT NEEDS

This successful meeting of partners reconfirmed that support for infant and young child feeding remains vital for achievement of development goals today, as it did in the 1980s and 1990s, when WHO/UNICEF initiatives began to highlight its important. Born out of the Nestle Boycott, GOBI, and Innocenti, the WHO/UNICEF *Global Strategy* meets today's needs as well.

- UNICEF's Medium Term Strategic Plan for Early Childhood:
  The integrated approach to early childhood gives the child the best start in life. IYCFC contributes to this larger framework and is integral to early child development, specifically responsive feeding, while providing all the nutrients, enzymes and hormones needed for optimal growth and development.

- The Millennium Development Goals:
  IYCF addresses directly addresses seven of the eight goals. Optimal IYCF and Care:
  1. reduces poverty and hunger,
  2. increases education by increasing brain capacity,
  3. increases gender equality by providing the best start for all,
  4. prevents child mortality by at least 20%-50%,
  5. improves maternal health by impacting on postpartum blood loss and contributing to birth intervals,
  6. combats the spread of HIV from mother to child when breastfeeding is practiced exclusively, and,
  7. helps ensure environmental sustainability by reducing many forms of waste.

- Addressing HIV/AIDS:
  The *Global Strategy* and the Framework for Action will increase understanding in the HIV/AIDS community of the need to support optimal infant feeding for all children.

- Addressing unstable situations and emergencies
  More than 50 UNICEF country offices report expectation of some form of instability, whether by man or by nature, each year. The work of the Infant Feeding in Emergencies group is key, as well as concentration on the role of IYCF in ameliorating displacement for the child, and contributing to survival.

- Supporting Capacity development
  The Strategy calls on multilaterals, governments and civil society to contribute to capacity development to meet the advocacy and educational needs to ensure that optimal IYCF is supported everywhere.

- Addressing Donors Needs

Donors wish to address activities with known, positive impact. This meeting brought together the most up-to-date knowledge and experience on protecting, promoting and supporting breastfeeding, and, with other ongoing research, illustrates that we know what works, and how to create a positive change in IYCF patterns.

- Addressing the Rights of Women and Children everywhere: Advancing Humanity

  The Convention on the Rights of the Child, in Article 24 on the right to the enjoyment of health, records that "States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures to diminish child mortality…(and) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding…and encourage international cooperation with a view to achieving the full realization of (this) right."

III. IMPACT OF THE INNOCENTI PROGRAMMES: CARRYING BFHI AND THE INTERNATIONAL CODE OF MARKETING FORWARD UNDER THE *GLOBAL STRATEGY* ON INFANT AND YOUNG CHILD FEEDING

Two major areas of activity in support of breastfeeding were initiated within the past twenty years:

1. The International Code of Marketing of Breastmilk Substitutes in the 1980s, and
2. The Baby-friendly Hospital Initiative, including Step 10 in the community, in the 1990s.

After the Code had been in existence for nearly a decade, it was reconfirmed and set as a goal by the Innocenti Declaration. Two other areas called for in the Innocenti Declaration were establishment of national authorities to provide oversight and standards, and maternity protection legislation.

UNICEF dedicated significant resources to these "twin engines", and these activities, the challenges and evaluation findings are presented below.

III A. NATIONAL IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES: 1995-2002 (Clark presentation.)

III A 1. The International Code of Marketing of Breastmilk Substitutes

The World Health Assembly in 1981 passed the International Code of Marketing of Breastmilk Substitutes.

- The Code is a global recommendation that
  - ✓ Recalls that breastfeeding must be actively protected and promoted in all countries.
  - ✓ Stresses that adoption and adherence to the Code is a minimum requirement.
  - ✓ Urges all Member States to translate the Code into national measures.

  For the purposes of Article 24(e), Code is an appropriate measure that governments must take to ensure everyone has knowledge of the advantages of breastfeeding and is supported in the use of this knowledge.

- In drafting national measures, governments are advised to turn to WHO and UNICEF for assistance. Manufacturers and distributors of breastmilk substitutes should not influence the drafting process.

  Effective measures are expected to incorporate all provisions of the Code and subsequent resolutions. To be effective, measures must include implementation and enforcement provisions that identify the (a) independent body responsible for monitoring; (b) person to whom violations should be reported; (c) forum for adjudication; and (d) effective actions that will act as deterrents.

- Once adopted, regulation and other enforcement and monitoring measures should be publicly stated.

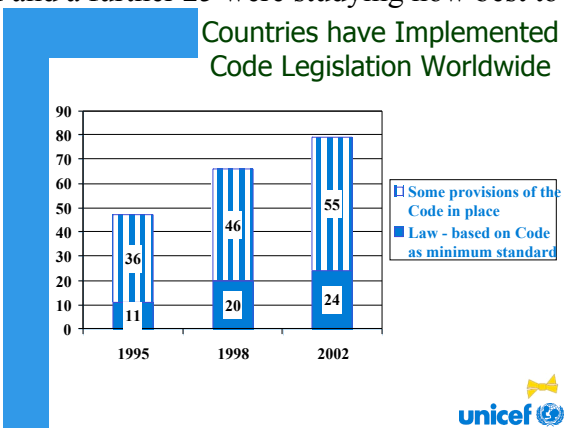
Even if governments are slow in implementing the Code, under Article 11.3, there is an obligation placed on companies to take steps to ensure that their conduct at every level conforms to the Code "independently of any other measures taken for implementation of the Code. That is, Code becomes part of internal customary law (or "corporate culture"). There is support for the proposition that the obligation is a legal one and not just an ethical one.

- UNICEF contributes to implementation of the Code via advocacy, training, and technical support. The Code is part of a comprehensive IYCF Policy in that it protects breastfeeding from being undermined. Under its advocacy role, country offices encourage counterparts to move ahead on Code implementation. UNICEF advocates for Code implementation as a human rights issue. Communications and publications form part of advocacy efforts, as well as international meetings. UNICEF offers technical advocacy support as well as legislative drafting support to national governments. UNICEF also supports international, regional and national training for Code. The purpose of the training is to build a critical mass of Code advocates, and to develop capacity for Code implementation and enforcement.

III A 2. Progress and Contributions to Date

In 2002, the Nutrition Section, UNICEF NYHQ, carried out an assessment of experience with the Code and the other three Innocenti goals.[1] (See Labbok presentation.) While less than half of country offices replied, the information obtained from responding countries gives a good picture of the progress in Code implementation since 1995.

First, the number of countries with Code legislation has continued to rise. By 2002, 55 countries had some provision of the Code in place, and another 24 had adopted a law, based on Code as a minimum standard. In addition, 16 countries had measures drafted awaiting final approval and a further 25 were studying how best to implement the Code.



[1] Clark D, 2002, Assessment of Code and Other Innocenti Goals. UNICEF Nutrition Section NYHQ, unpublished document.

UNICEF's support has been instrumental to this progress. UNICEF contributed to the preparation of 25 national measures, 9 of which have been adopted into law. In addition, since 1995, UNICEF has advocated for the Code, and carried out or participated in 5 international, 4 regional and 10 national Code training workshops, often in collaboration with IBFAN. More recently, workshops are being replicated at the local level.

Strength of the Code courses has been the collaborative development of curricula and the use of the Code handbook. The activities of specialized NGOs in the development and monitoring of national Codes of Marketing and Codex Alimentarius standards has been of great value, too. IBFAN, IGBM, and NGO Networks have all contributed to monitoring efforts in collaboration with UNICEF.

III B. BABY-FRIENDLY HOSPITAL INITIATIVE (See Kroeger presentation)

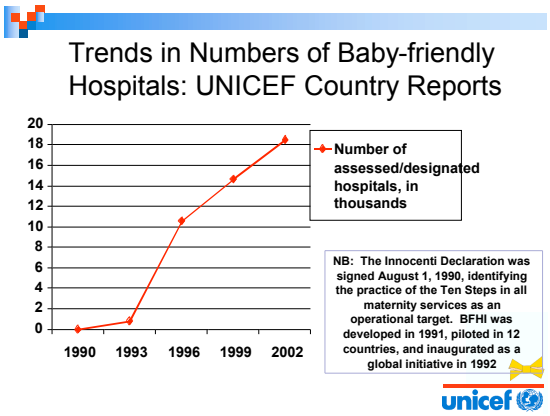
The Innocenti Declaration was a major milestone in the commitment of UNICEF and WHO to the protection, promotion and support of breastfeeding. It brought about national authority, Code reinforcement, the Baby-friendly Hospital Initiative (BFHI) and maternity entitlement.

BFHI is based on the Ten Steps to Successful Breastfeeding, a programme that was initiated in 1990. Ten Steps summarizes the practices that maternity wards need to adopt to support breastfeeding. By 2003, the Ten Steps and Global Criteria have had over a decade's use.

This section describes the achievements of BFHI and identifies shortfalls. It presents lessons learned from BFHI that could apply to IYCF *Global Strategy*. It identifies the challenges currently facing extending and sustaining BFHI, and suggests approaches and tools for expansion of BFHI in the next decade.

III B 1. Progress and Contributions to Date

There are now more than 16,000 Baby-friendly Hospitals in 135 countries. The 2002 survey of UNICEF country offices established that the number of hospitals designated has continued to rise.



The 2002 assessment of the experience with the Innocenti goals found that BFHI has successfully introduced breastfeeding issues into the population. BFHI has put breastfeeding on national and international agendas. For example, the World Alliance for Breastfeeding Action (WABA) coordinates the annual World Breastfeeding Week. Celebrated in 120 countries every 1-7 August, it is aimed to pull together efforts to generate public awareness ad support for breastfeeding.

In UNICEF, BFHI secured top level advocacy. UNICEF International, UNICEF Regional and UNICEF Country offices all support BFHI.

Information on the impact of BFHI on the duration of breastfeeding and extent of breastfeeding, especially exclusive breastfeeding in the first six months of life, is limited but suggests that BFHI will need strengthening to obtain greater levels of sustained breastfeeding practices. Recent studies have shown a significant increase in breastfeeding, and exclusive breastfeeding rates after implementation of BFHI or similar principles.[2] [3] However, as impressive as those results are, more needs to be done. Interventions based solely in hospitals or maternity wards may increase breastfeeding rates in the short-term, but have limited effect over the infant's first six months of life, and up to two years. Additional complementary strategies are needed to support the breastfeeding mother in the community.

III B 2. Quality Assurance

Despite BFHI's many successes and wide spread application, more needs to be done in accelerating the process of BFHI, looking at both quantity and quality. The quantity and quality of the BFHI today is less than desired.

Staff turnover and time have resulted in declining BFHI practices. Assessments have also shown that some BFHI hospitals have poor compliance with free formula. They allow promotion of formula to health workers, and have informational materials that violate Code. Hospitals may need to verify that the Global Criteria continue to be filled in existing Baby-friendly maternity services. Building in monitoring and a periodic renewal process, with re-assessment and re-education, could help sustain BFHI practice standards. Quality assurance should accompany plans to expand BFHI to new facilities and/or extend BFHI to new programming areas (e.g. PMTCT). However, virtually all countries report insufficient funds to reassess Baby-friendly Hospital facilities.

UNICEF's goal is to have national authorities, supported by the governments, assume BFHI assessments. Assessment and quality assurance could be implemented by:

- MOH
- Community
- Health Facility, or
- Some combination of these interests.

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[2] Kramer MS, Chalmers B, Hodnett ED, et. al. Promotion of Breastfeeding Intervention Trial. A (PROBIT), a randomized trial in the Republic of Belarus. JAMA. AJPH 2003; 93/8:1277-1279

[3] Braun MLG, Giugliani ERJ, Soares MEM, et al Evaluation of Impact of the Baby-friendly Hospital Initiative on Rates of Breastfeeding.

The IYCFC Unit of Nutrition at UNICEF HQ is assembling a consultants' list for use by country offices to assist ministries with external evaluators for the re-evaluation of hospitals already awarded BF status, or assessment of hospitals in the process of recognition.

Over the past decade, UNICEF asked countries to use the original assessment tool for quality control. UNICEF currently wants to maintain quality, but is open to new tools and approaches. WHO and Wellstart have developed and field-tested new monitoring and reassessment tools. (See Brownlee presentation.) The key changes are:

- 1/3rd as many questions and fewer types of interviews.
- Key new measurements of free and low-cost breast milk substitutes
- Follow-up measures after discharge for tracking breastfeeding, exclusive breastfeeding at 2 month, 4 month intervals, etc.
- Graphs each component of each step
- Computerized reporting system
- Can be done with local assessors or internal monitors
- Much less costly and time consuming
- Action planning by hospital itself is a key part of process.

Training is another important mechanism for upgrading quality of BFHI activities. Training activities of less than 18 hours in classroom and clinical time have not been shown to transform attitudes and practices of health care workers effectively. It does motivate change, give information and bring interested people together, but for lasting change in maternity practices more training time and depth are needed.[4] Monitoring that targets the key aspects of Ten Steps needing improvement can help hospitals in design of cost-effective refresher training.

III B 3. Lessons Learned

The experience with BFHI offers some possible lessons that could be applied to IYCF *Global Strategy*. The assessment of the Code and other Innocenti goals concluded that Ten Steps is a "package", easy to understand and appealing. The Ten Steps and Global Criteria define exactly what to do to go to scale. They are well worded to apply equally to all countries and are feasible to apply in both simple and high technological health facilities.

Different Steps were found problematic in different countries. Step 10 Community outreach is least developed of all the Steps and very few countries have active implementation of this life-saving intervention. Experience has shown that Step10 must build on established social support networks if the support groups are to flourish. The number one problem cited by the countries reporting is a decline in resources for support groups. Importantly, all recognized that there is a need for strengthening of support for breastfeeding-related activities.

[4] Clark D, 2002, Assessment of the Code and Other Innocenti Goals, UNICEF Nutrition Section NYHQ, unpublished document.

Another lesson learned is that the National Breastfeeding Coordinator was strategic to BFHI programmes. A national mandate and budget were necessary to achieve an active Coordinator.

The Global Criteria have been important for quality control. Achievable standards were set for all countries, and a scoring system allowed for at least 20% of imperfection in practice. International questionnaires, summary sheets and scoring sheets yielded objective results across national boundaries. The BFHI award recognized national progress.

External assessment caused discomfort at first to hospitals new to the experience. Advance discussion, informational videotape, and later feedback smoothed the process. Assessors needed time to become familiar with the assessment instruments.

In-service training was successful in training of health care workers, and the "training cascade" was strategic to expanding the quantity of health care professional prepared to support breastfeeding in maternity services.

For the *Global Strategy* a more integrated strategic plan on training is needed. Not only should leaders and health professionals receive training, but also advocates, including UNICEF staff, journalists, fathers and other child caretakers, and lay community workers. A consistent and sustainable training strategy should be brought into the MTSP.

III B 4. Challenges to Extending and Sustaining BFHI

BFHI is directed towards improving breastfeeding practices within maternity wards in the health system. Little is known about changes in breastfeeding practices after discharge from the hospital. The fact is that approximately 80% of births occur outside of hospitals, and the highest level of maternal and infant mortality occurs in communities. Greater attention needs to be given to identifying the adoption, implementation and sustainability of BFHI principles in communities.

There is a need to address Home-based maternity care with BFHI principles. Breastfeeding is part of a continuum of what Chalmers calls "humane perinatal care". We need to find a way that such programming reaches communities.

Bilateral donors and philanthropic institutions increasingly have a "results-orientation". They are also more open to approaches that collaborate with communities in acting on locally perceived problems. This suggests that BFHI should be tied to better outcomes for the child. That will require improved monitoring and evaluation; including community participatory evaluation techniques.

High levels of HIV have raised concerns about BFHI. Yet, BFHI does not coerce any woman to breastfeed. The BFHI does not tell women what they must do; it focuses on making changes in institutional patterns of maternity/newborn care instead. The Ten Steps improve care for women who will feed artificially, and purchased formula may be used in any Baby-friendly Hospital. For those women who choose to breastfeed, the

establishment of exclusive breastfeeding may be vital to protecting the newborns against mother to child transmission of HIV.[5] This message will need to be clearly disseminated at national, regional and local levels.

Health systems incorporate a number of interventions directed toward improving the survival and health of the mother, infant and child. The principles of BFHI, the Ten Steps, could be integrated into IMCI, Safe Motherhood, Family Planning, HIV, Well Child, etc. It will be a challenge to do so, intervention by intervention, as each intervention has its own technical and professional staff, training, and assessment standards. If BFHI were integrated into pre-service clinical education and continuing education, BFHI principles would become more mainstream clinical practice in the various interventions.

More needs to be done in assuring quality of the BFHI today. However, international and national assessments are costly. Containing costs in health systems is a major issue for governments and the public alike. Various approaches to lowering costs of assessment include internal monitoring, cross-monitoring by staff from other services; use of district level monitors to train and supervise hospital monitors; and hospital competitions.

In addition, an economical way to ensure good quality at the community level is not currently known. One suggestion is to bring the community mothers themselves into the quality process. (For example, asking mothers what they see as key aspects of mother-Baby-friendly care in the community.) Mothers can also be brought into the hospital monitoring process, by reporting on what changes they want in hospital care. The one-page WABA Action Folder mother questionnaire is an example of a tool for bringing mothers into the quality assurance process.

III C. COUNTRY AND GLOBAL ASSESSMENT OF THE IMPACT OF INNOCENTI-RELATED ACTIVITIES: Case studies, questionnaires, and surveys.

III C 1. Country Programmes and Impact: Case Studies

The Innocenti Declaration led to a rapid increase in countries reporting activities in BFHI and Code implementation. A comprehensive assessment of BFHI was carried out and case studies developed for 6 country programmes in the 1999 [LINK]. It was clear that while countries followed the same broad outline of activities, the actual implementation varied appropriately with the context.

The case studies were from Bolivia, Chile, Mongolia, Nicaragua, Poland and Zambia and are examples of the kinds of dramatic changes that are taking place in all 125 countries that embraced the BFHI in that decade. They demonstrated great commitment on the part of government, health workers and communities in these countries and highlighted areas of continuing need. It was clear that the BFHI encountered obstacles from the powerful breastmilk substitute lobby, for despite the fact that over 100 countries established a ban

[5] Clark D, from "Lessons Learned", Assessment of Code and BFHI Experience, UNICEF Nutrition Section, NYHQ, unpublished document, 2002.

on the distribution of free or low-cost breastmilk supplies through their health care systems, the practice was, and remains, widespread. Baby-friendly hospitals were found to be aware and beginning to address the sensitive issue of the difficult choices for mothers with HIV/AIDS.

In Bolivia, the BFHI took advantage of the commitment and expertise of a breastfeeding support committee of physicians and nurses called COTALMA to spearhead its campaign. Dramatic changes in practices were seen: close to 100 per cent of the16 BFHI hospitals in the country had developed breastfeeding policies (2% in 1991), rooming-in (80% in 1991), exclusive breastfeeding (57% in 1991) and early attachment (0% in 1991). The BFHI model and strategies have been so successful that the Bolivian Ministry of Health asked COTALMA to develop a programme to change attitudes and behaviours in the health care system at all levels.

In Chile in 1992, 21 hospitals and five clinics were certified Baby-friendly. The rates of full breastfeeding at six months increased from 4 per cent in 1985 to 45 per cent in 1996. Chile effectively moved the Baby-friendly designation to community clinics, educating pregnant women, addressing breastfeeding problems and teaching mothers who work outside the home to express and conserve their milk.

In Mongolia, a country going through great political and economic change, all 27 major health facilities country achieved BFHI status. In 1992, when the BFHI was launched, the percentage of mothers breastfeeding at four months was only 48 per cent. In 1998, the percentage had jumped to 93 per cent. More than 90 per cent of babies now breastfeed within 30 minutes of birth. These achievements may in part reflect the fact that a poor country with a small population does not attract the baby food and feeding bottle companies, but it also demonstrates the effectiveness of government commitment to the programme .

In Nicaragua, the Mother-Baby-friendly Hospital Initiative, MBFHI, launched in 1993, led to 10 of the country's 19 hospitals certified, and all 19 showed improved their breastfeeding practices. While in 1993, 53 per cent of infants in hospitals were bottle-fed, now none are - and all hospitals practice rooming-in. Ten of the country's health centres and 19 health posts have also been designated Mother-Baby-friendly. NGOs and universities have also been active in promoting breastfeeding in Nicaragua.

Poland's transition to a market economy and the resulting aggressive promotion of breastmilk substitutes in the 1990s presented a huge challenge to its efforts to re-establish breastfeeding. A series of breastfeeding promotion activities that began on a small scale in Poland in 1986 were given funding to go nationwide in 1992, with the worldwide launching of the BFHI. By 1995, rooming-in had increased from 19 per cent in 1998 to 60 per cent and the practice of giving infants water or other drinks had decreased from 54 per cent in 1988 to 22 per cent. By 1997, 22 hospitals had been designated Baby-friendly.

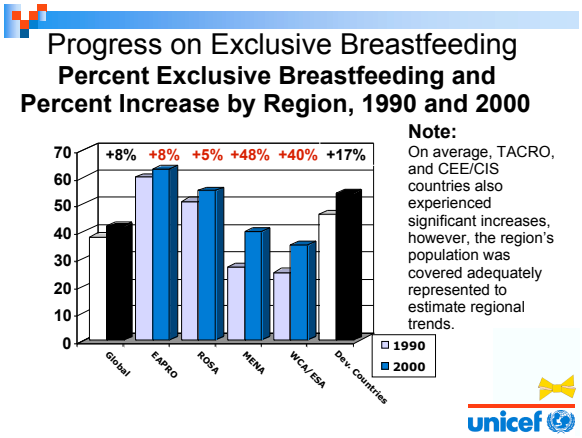
BFHI was launched in Zambia in 1992. By December 1997, 46 health facilities had been declared Baby-friendly and the exclusive breastfeeding rate for less than two months of

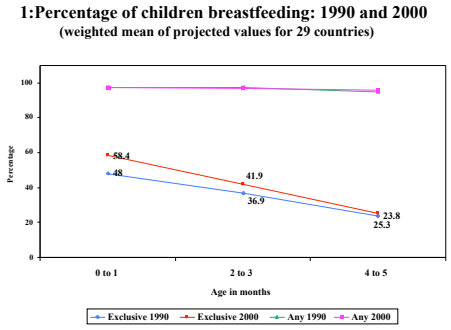
age had increased from 16 per cent in 1992 to 35 percent. As well, the National Code of Marketing Breastmilk Substitutes was revised and a National Breastfeeding Policy and an HIV/AIDS and Infant Feeding Policy framework had been developed.

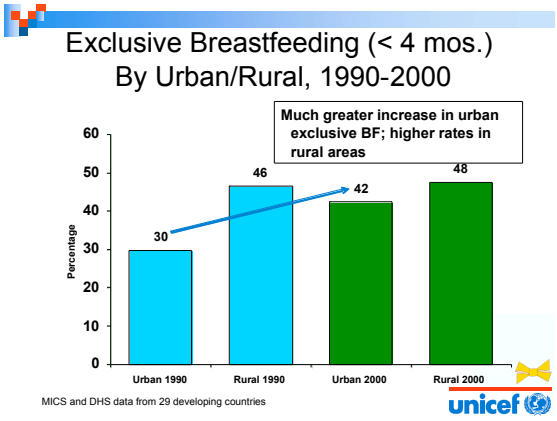
III C 2. Country Programmes and Impact: National Survey Findings

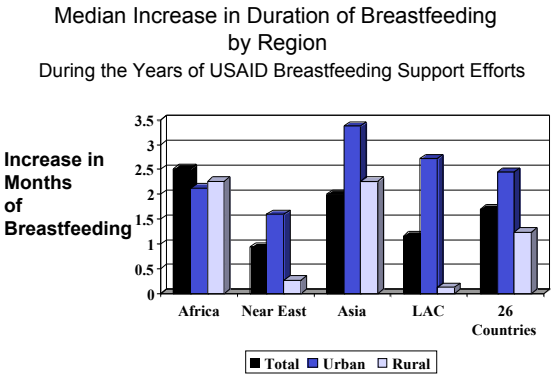
Perhaps most interesting are the results from the analyses of the several national surveys that were carried out in nearly all158 countries where UNICEF has offices. The UNICEF database relies on national surveys carried out by the Demographic and Health Surveys of MACRO, International (funded by USAID), other national survey findings, and the MICS Surveys carried out by UNICEF.

Fndings from MICS includes a real increase in exclusive breastfeeding, which only reflects a small part of the shift from bottle to breast. Findings also indicate that the greatest increases have been in the urban areas, where the marketing of breastmilk substitutes tends to be most intensive, and in Latin America, where commercial marketing is well established. (See Wardlaw presentation.) Perhaps as a result of the improvements in early and exclusive breastfeeding, the duration of breastfeeding have increased in the DHS countries, but not significantly among the larger grouping of countries. (See Mukuria presentation.)









Country-specific analyses were sufficiently informative to encourage programme assessment, with some countries showing shifts away from excessive water use, and others showing little change.

III C 3. Impact of the Code on Promotion of Breastmilk Substitutes

Has Code implementation reduced or eliminated promotional activities on the part of companies that market and/or distribute breastmilk substitutes? Experience suggests that while the law is necessary, it is not sufficient to obtain compliance. In 1997 the IGBM report "Cracking the Code" reported less promotional violations in Bangladesh which has a Code in place, than in Poland, which has no Code in place. However, research by Aguayo et al revealed similar violations in a country with Code (Burkina Faso) and one without (Togo) such legislation. (See Aguayo presentation.)

Aguayo and colleagues monitored compliance with the International Code in Burkina Faso and Togo. They found that manufacturers of breastmilk substitutes are using national health care systems to promote their products. Such promotion includes distributing free samples and "educational materials" to mothers, and distributing free samples and promotional material to health providers. Caretakers can perceive such promotion as the health profession's endorsement of commercial breastmilk substitutes, and affect caregivers' breastfeeding decisions. Violations were not limited to the health care system; labeling of breastmilk substitutes is of particular concern.

III C 4. International Training Programmes and Outcomes: 1983-2002

David Clark has noted that the BFHI and Code activities rest upon training – training of health and other professionals, training of policy makers, and training of community workers. [6] This section describes two international training programmes that have played a major role in providing substantive training for key personnel at national levels, and follow-up technical support. For the past decade, Wellstart International and the Institute for Child Health have been important partners of UNICEF in building country capacity in breastfeeding programming.

Wellstart International's Lactation Management Education Programme **(See** Naylor presentation**.)**

In 1983, Wellstart International began, at the University of California San Diego, an education programme to change hospital policies and medical staff practices regarding infant feeding. The objectives of the LME programme were to:

- Increase knowledge and skills of perinatal health care providers.
- Provide technical assistance and materials, and field support
- Facilitate expertise at local, national and regional levels
- Integrate breastfeeding promotion into related health programmes (e.g. child survival)

The LME followed a training-of-trainers/training-of-advocates model. Participants from many countries came to Wellstart for the LME course. Most had some level of

[6] Clark D, 2002, Assessment of Code and Other Innocenti Goals.

involvement in breastfeeding activities prior to attending the course. The LME course taught them knowledge and skills of how to support and promote breastfeeding. Once they returned to their home country, graduate Associates were expected to conduct pre-service, in-service and continuing education training, as well as train trainers. It was also their expected role to organize breastfeeding activities in country, support designation of Baby-friendly hospitals, conduct research, or publish articles and reports relevant to breastfeeding practices.

The core components of the Wellstart LME programme involved multidisciplinary teams of senior health professionals; education and motivation; individualized programme plans; materials support before/after course; field visits by Wellstart's technical staff; continuing education opportunities; and programme expansion.

In the 15 years of its existence (1983-1998), Wellstart worked in 55 countries, developed 134 teams of 3-5 members each, and graduated 655 Wellstart Associates. By profession, these Associates are 60% physicians, 29% nurses/nurse midwives, 6% nutritionists, and 4% others.

In 2003, UNICEF requested Wellstart International to conduct a survey of outcomes. The survey was to determine if Associates were still involved in breastfeeding promotion; whether the LME had helped them in that effort; what obstacles they encountered doing so; and what Associates would recommend for the future.

Colleagues at the Centre for International Health at the Institute of Child Health in London collaborated with Wellstart on the design of a questionnaire. Investigators took a convenience sample of 136 Associates reachable by email. Of those, 40 completed the survey out of the 60 who indicated a willingness to participate. The findings are limited by the small sample size and sample selection.

Overall, the programme outcomes were very positive. More than three-quarters of the respondents indicated a high level of involvement in breastfeeding promotion and support now. Three-quarters of the respondents had conducted TOT courses on BFHI 18 hour and assessor training, 40 hour BF counseling, and other related courses. The Associates also reported producing research and publications. Sixty percent said LME had helped their hospital become BFHI certified. A high percentage regarded LME of "significant help" to them.

Breastfeeding Practice and Policy Course, CICH, London. **(See** Williams presentation**.)**
In 1992, the Centre for International Child Health, Institute of Child Health, University College London, began an annual, 4 week intensive Breastfeeding Practice & Policy (BFPP) course, in collaboration with UNICEF and WHO. In ten years CICH has trained 309 senior health professionals from more than 150 countries. Most are physicians. The funding for participants comes from many sources, with UNICEF and WHO Country/Regional offices the largest sources, (31% and 15% respectively).

In preparation for the IYCF Working Group meeting, UNICEF requested that CICH carry out a survey of course outcomes. CICH was asked:

- What have BFPP participants done since taking the BFPP course?
- What impact did BFPP have on participants' contribution to promoting breastfeeding and optimal feeding?
- How could BFPP be improved/developed to meet training needs?.

CICH prepared a questionnaire similar to Wellstart's survey instrument, and e-mailed and posted to all past participants. The response rate was 20% (62 out of 309). The interpretation of these findings is limited by the low response rate.

The respondents indicated that the CICH programme outcomes were also quite positive. The great majority (84%) reported that they were more involved in infant feeding related activities, doing pre-service and in-service training, policy work, BFHI, advocacy, Code monitoring, etc. Nearly all respondents had produced publications, conferences, presentations or research on infant feeding since attending the BFPP. Most of the respondents considered the course of "significant help" in doing their work.

Outreach of International Training Courses

The breastfeeding training courses provided by Wellstart International and CICH London greatly increased the numbers of people prepared to take an active role in promotion, protection and support of breastfeeding. In the period 1983-2002, the numbers reached via these two mechanisms combined is estimated to range between 428,000 – 516,000 persons.

This estimated outreach was accomplished through a pyramid of training. Based on survey responses, Wellstart estimates that each Associate "master trainer" returned to train an average of 100 trainers, who in turn, each trained an average of 50 participants in pre-service, in-service and TOT training courses. CICH survey investigators estimate that the educational "reach" of moderate to very active BFPP course graduates results in 360-600 participants in pre-service, in-service and TOT courses, who then train others.

Lessons Learned

The outcome assessment surveys of programme graduates document the effectiveness of these international training programmes in preparing participants to take an active role in protecting, promoting and supporting optimal feeding practices. Upper level intensive training such as that provided by Wellstart International and CICH London has provided:

- Countries with needed leadership for breastfeeding promotion campaigns;
- UNICEF offices with knowledgeable national consultants; and
- Specialists for the training of others using UN and other materials.

Training groups have offered to share their data base of ex-participant contact details.

With information on a decade of follow-up to training of leadership in breastfeeding, there now exist more specific expectations of what graduates will do when they complete their training. This makes it possible to update training content, tailor it to national conditions, simplify training and identify entry points for integrating IYCF into other funding areas,

Both training programmes had information on the outreach of their respective programme s with respect to the numbers of graduates and the numbers of workers trained by those graduates. However, it is not clear how many mothers were actually reached through the pyramid of training approach employed by Wellstart and CICH. Data are also lacking on how much it cost to reach a mother via these training pyramids.

Funding is a constraint for continuation of such international training. These capacity-building programmes are not self-supporting. To obtain donor support, future training programmes will have to attend to cost and outreach information.

III C 5. Arusha Meeting Outcomes: Harmonizing HIV and Breastfeeding (See Greiner presentation.)

Another impact of the Innocenti Declaration was the establishment of the World Alliance for Breastfeeding Action. Post-Innocenti, UNIVEF hosted a meeting of NGOs and others interested in seeing that the Innocenti goals were implemented. WABA was born at that meeting. I is an alliance of networks and organizations such as the International Baby Food Action Network (IBFAN), La Leche League International (LLLI), and the International Lactation Consultant Association (ILCA), and individuals to protect, promote and support breastfeeding. A significant contribution of WABA has been their recent leadership regarding breastfeeding in the context of HIV.

WABA's leadership had been very concerned that the balance of the benefits of breastfeed gin had not been fully taken into account by those trying to stem the tide of HIV. Many organizations, including UNICEF, were pilot testing the provision of breastmilk substitutes to HIV-positive women. WABA called upon UNICEF to evaluate its work in this area. As a result, many case studies and assessments were carried out, and brought together at WABA's ground-breaking meeting on HIV and Infant Feeding, held in Arusha in September of 2002. The international meeting and further follow-up by WABA's many partners and the UN community has resulted in the UN Framework for Action on HIV and Infant Feeding.

IV. THE *GLOBAL STRATEGY* FOR INFANT AND YOUNG CHILD FEEDING: POLICY AND ADVOCACY, HEALTH SYSTEM, AND COMMUNITY: Specific Activities and Steps to Implementation

This section is concerned with specific activities and steps that countries can take to support optimum infant and young child feeding through a variety of mechanisms: policy and advocacy, health system and community implementation. The issues and ideas come from the presentations, background materials, group discussions and recommendations of workshop participants.

IV A. GLOBAL AND NATIONAL POLICY AND ADVOCACY FOR INVESTING IN IYCF

IV A 1. The Code and Other Legislation to Protect Infant Feeding Information and Choices for Mothers and Families

Obstacles remain to effective Code implementation. There is insufficient awareness of purpose and importance of the Code among policy makers, health professionals and the general public. Lack of expertise and drafting capacity continues to hamper efforts to develop measures. Commercial interests are bringing pressure to bear on the process. Even if those obstacles are overcome, the legislative agenda is overburdened. The result is weak legislation and inadequate monitoring and enforcement in many countries.

Voluntary agreements with companies that market breastmilk substitutes have not been shown to prevent violations. International compliance with all relevant aspects of the Code was not part of the requirements of the BFHI in 1991. Omitting this criterion, trusting to industry assurance of universal Code compliance, proved to have been over-optimistic. Violations of the Code are reported in 2002 from most responding countries, even those that have the Code as national law.

The advertising and promotional activities -- along with the involvement of the infant feed, feeding bottle/teat and breast pump industries in policy, programme me and educational activities at all levels, including education of professionals -- has been negative for exclusive and sustained breastfeeding. New approaches to undermine breastfeeding have emerged, such as Code-violating website "information services" that suggest bottle feeding for infants who cry.

Complementary feeding of children 6-24 months also needs improvement. The role of manufacturers in marketing complementary foods is not clear. Are they marketing introduction of complementary foods too early so that it undermines breastfeeding? Does the marketing of specially processed foods for the young child affect a mother's use of appropriate foods from the household food supply? There is a dilemma inherent in both

urging manufacturers to improve commercial complementary foods, and at the same time attempting to control the marketing of those products. These issues will only grow in importance as countries try to go to scale with complementary feeding programme s.

The HIV pandemic and the rising levels of complex human emergencies have made Code implementation more urgent. In efforts to address the HIV pandemic, misunderstandings have led to decreased support and commitment to breastfeeding. Governments and organizations were alarmed by early studies of Mother to Child Transmission (MTCT) of HIV, and lost confidence in breastfeeding protection. Despite subsequent information with regard to exclusive breastfeeding, governments remain confused regarding safe practices in HIV and infant feeding. Countries are understandably reluctant to move forward without clear messages, based on scientific knowledge, concerning safety and feasibility of exclusive breastfeeding by HIV positive mothers.

Small NGOs are now implementing PMTCT projects and are not aware of the Code. As a result, some are bringing in formula for infant feeding. Development of the WHO/UNICEF/UNAIDS HIV and Infant Feeding Guidance and Framework are providing an opportunity for the UN agencies to agree upon a common policy with regard to providing supplies of infant formula to HIV-positive mothers. Although there has been no similar agreed upon policy within the NGO community, this could happen at the country level where there are NGO coordinating bodies.

Reliance on commercial breastmilk substitutes is especially a problem in emergency situations. Many relief groups use artificial feeding of infants and young children in the difficult circumstances of natural or complex humanitarian emergencies, not recognizing the negative potential of disrupting breastfeeding. The "Infant Feeding in Emergencies" working group of the SCN has begun to address this tendency with basic training modules now in field testing. These modules include guidance on how to support mothers and children in best feeding practices in these situations, utilizing mother- and baby-friendly environments to support families in these difficult times.

Recommendations for Future Directions

There are lessons that have been learned from the Code experience that could apply to the implementation of the new Global Strategy for Infant and Young Child Feeding. Countries can go to scale with the Code of Marketing by:

- Advocacy for national measures implementing the Code.
- Consistent messages to manufacturers regarding their obligations of compliance with Code in all countries.
- Training and technical consultation for relevant government authorities.
- Distribution of NGO reports relevant to Code implementation.

Legislation alone is not the key to Code compliance; informed vigilance and active measures of control in all countries are required to reverse trends in Internet website violations of Code, intensive marketing of expensive processed milk for mothers, and promoting of products within health systems and with health professionals.

Legislation must be accompanied by effective information, training, monitoring and enforcement systems to ensure compliance with the Code. Further monitoring is needed to obtain examples of best Code implementation practices. (The IGBM revised protocol can be used to assess Code compliance.) While UNICEF supports development of Code legislation and regulation, it is the purview of each country to monitor and enforce the Code. This is best achieved as a cooperative endeavor with NGO partners. The recent decision by UNICEF to make the post of Legal Officer/Nutrition a core position reflects the renewed commitment to this issue.

UNICEF's role is to increase advocacy, training and technical support to protect Code implementation, Specifically, UNICEF international, regional and country offices must accelerate training and awareness raising activities and increase emphasis on Code as a human rights instrument. UNICEF should also encourage pediatricians, pediatric societies and other concerned health providers to stand firmly behind the Code and avoid any implicit or explicit endorsement of commercial breastmilk substitutes.

It is recommended that UNICEF convene a core group of country infant and young child feeding specialists to consider whether a Code is needed for complementary foods. Countries may wish to consider controlling the marketing of specially processed foods for the ages 6-24 months, especially if such products are marketed to replace breastmilk or are shown to undermine the appropriate use of local foods (such as bananas, rice, carrots, egg, beans).

It is particularly urgent that UNICEF offices continue to emphasize the importance of the Code in the context of the HIV pandemic. Countries need to have Code in place before talking about making formula available. HIV/AIDS is an opportunity to remind countries that for women whose HIV status is negative or unknown, breastfeeding is the best choice for infant survival, growth and development. Code protects the right of every woman (HIV positive or negative) to have adequate information, not marketing practices, guide her decisions about infant feeding. UNICEF can lend support to studies of the problems of spillover of replacement feeding among HIV negative women or women of uncertain HIV status.

IV A 2. Advocacy Support for Investing in IYCF: Central to the success of the *Global Strategy*

The UNICEF Office has responsibility for advocating for the Code, for Baby-friendly Health Systems, and for the Community actions called for in the *Global Strategy* on Infant and Young Child Feeding. Governments, donors and other decision-maker, and well as those who staff the offices of multilaterals and NGOS are the audiences for this work. Such advocacy promotes commitment, resource allocation and appropriate legislation. The goal is to convince decision-makers that investing in IYCF will help them meet their goals in whatever sector they represent.

The "*Global Strategy* on Infant and Young Child Feeding", adopted by the World Health Assembly in 2002 and endorsed that same year by the UNICEF Executive Board, is the

foundation for UNICEF's action in support of optimal and young child feeding. The *Global Strategy* is predicated on a rights-based approach. Nutrition is a crucial, universally recognized component of every child's right to the highest attainable standard of health, and every woman's right to proper nutrition and to full information and appropriate conditions that will enable her to feed her child as she decides.

Indeed, wide scale adoption of IYCF will increase chances of meeting almost every one of the Medium Development Goals, to fulfilling child rights, and to promoting human capital. However, before advocating to others, UNICEF regional and country office staff must be convinced that IYCF speaks to all five MTSPs

IYCF Helps Meet Early Childhood Goals and National Priorities

IYCF is based on three key concepts: (1) Optimal infant and young child feeding is critical to the prospect that every child will both survive and thrive. (2) The IYCF approach promotes capacity building of human capital by building skills for women's empowerment that are self-sustaining. (3) IYCF is consistent with UNICEF's integrated approach to early childhood, and has a synergistic effect on giving every child the best start in life if integrated into priority programmes for children (IMCI, PMTCT, and child health in complex human emergencies).

IYCF is consistent with the IECD Key Goals for Early Childhood. :

- "In all countries: a cohesive national policy
- "In 80-100 countries with high under-5 mortality: Convergent service delivery and commodities for nutrition, child and maternal health, water and sanitation, and psychosocial care and early learning.
- "In countries without universal birth registration: More effective birth registration systems."

To carry out the role of policy advocate, UNICEF officers must understand how IYCF relates to country development priorities. In particular, advocacy will require UNICEF office commitment to integration of IYCF with country priority children's programmes. In addition, UNICEF officers must understand "what works" in infant and young child feeding in order to articulate to decision-makers and opinion-leaders the best practices to enable every child to survive and thrive.

The specific responsibilities that the UNICEF Office has, under the *Global Strategy* for Infant and Young Child Feeding is to advocate for governments to:

- Develop multi-sectoral national commitment to protect, promote and support optimal infant and young child feeding
- Implement health services and training reform fir Baby-friendly Health Care to assure that children under 2 years of age and mothers of young children receive appropriate breastfeeding and complementary feeding support at all levels of the health system.
- Provide communications/community/social advocacy programming that will create emphasis on community support for the mother and family for optimal child growth and development. Create societal support for IYCF, birth spacing,

Step 10, C-IMCI, Immunization Plus, HIV/AIDS programming, and nutritional guidance for children in exceptionally difficult circumstances.

- Address cross-cutting issues of capacity building in IYCF ; monitoring of the process of implementing IYCF interventions; and evaluation of impact of IYCF programming on key indicators.

UNICEF offices that understand IYCF strategies can articulate the potential impact of infant and young child feeding to decision-makers and opinion-leaders.

IV A 3. New Tools and Approaches Useful to Policy and Advocacy

New tools and approaches have been designed specifically for strengthening IYCF policy and advocacy. [7] Experience with two outstanding examples, the National Assessment Tool and the *Profiles* approach, was presented at the IYCF Workshop.

National Tool for Assessing IYCF Practices, Policies and Programs

WHO and the LINKAGES have jointly developed a tool designed to assist countries in assessing the strengths and weaknesses of their policies and programmes to promote, protect, and support optimal feeding practices.[8] (See Infant and Young Child Feeding, WHO.) The tool assists countries to determine where improvements may be needed to meet the aims and objectives of the 2002 *WHO/UNICEF* Global Strategy for Infant and Young Child Feeding.

UNICEF has provided input and review to the development of the Tool along with a wide variety of other organizations and experts. The Tool has been field tested in nine countries.

The IYCF National Tool consists of three sections. The first part assesses how well countries are doing on key IYCF practices by reviewing practice indicators and background data. The second part focuses on the key actions and a target identified by the Innocenti Declaration, and explores what steps countries are taking to implement the new *Global Strategy*. The final section focuses on other important aspects of a comprehensive national programme, (such as an active and sustainable BFHI, or research for decision-making, or HIV and infant feeding.)

The tool can create the consensus necessary for political and programmatic collaboration and action. It can be used by a team that is undertaking a "self-assessment" as a first step in formulating a plan to strengthen IYCF practices in country. Country planning for the *Global Strategy* can use the Tool as a companion document for needs assessment and planning purposes. Advocacy groups and donor organizations can use the Tool to pinpoint the areas most needing their support.

[7] See also the document Tools to Support the Implementation of the Global Stretgy for Infant and Young Child Feeding, Tables 1,2 and 5, UNICEF.

[8] "Infant and Young Child Feeding: National Tool for Assessing Practices, Policies and Programs", handout at IYCF Workshop, no date. no author

Once the assessment and analysis phase is complete, the results and recommendations for action should be presented to key decision-makers for review. It is their responsibility to prioritize the main areas for improvement in light of the new *Global Strategy*, and set into motion a process of resource allocation, detailed planning and implementation. It is suggested that the Tool be used every three to five years to track trends on IYCF indicators, and identify actions needing improvement, or new problem areas.

For further information on the Tool, please contact the World Health Organization, Department of Nutrition for Health & Development or the LINKAGES Project at the Academy for International Development.

Profiles: A Process for Nutrition Policy Analysis and Advocacy
(See Ross presentation.)
Profiles is a process for nutrition policy analysis and advocacy that was developed by LINKAGES, in collaboration with the Measures Communication Project, funded by USAID. It is an activity that can be carried out at national or regional levels to mobilize advocates for optimal infant and young child feeding. During two-week workshops, participants collect, review and analyze national or regional nutrition data and prepare advocacy presentations for various audiences on the consequences of malnutrition on the country's health, education and the economy.[9]

The *Profiles* process exposes participants to the most recent scientific evidence regarding the health effects of mild and severe malnutrition on a child's physical, emotional and intellectual development. They learn that malnutrition happens early in a child's life, and under-nutrition is a major cause of death among children around the world. Participants learn that optimal breastfeeding protects the infant's health and survival. They learn too, that optimal breastfeeding benefits child spacing and family economics.

Thus, when the workshop participants analyze national data on nutritional status and feeding practices, they have a greater awareness of the functional consequences of the nutritional situation in country. This knowledge and the consensus produced by the process, result in the preparation of advocacy communications that are focused on the consequences of malnutrition for the country. Advocacy presentations are addressed to different audiences: legislators, government officials, health professionals, journalists, NGO partners. The materials can be used in pre-service education as well.

More than 22 counties in Asia, Africa and Latin America have engaged or are currently involved in a *Profiles* activity. LINKAGES reports that evaluations of *Profiles* find:

- Increased awareness
- New policies in place or better implementation of existing policies
- Identification or realignment of priorities
- Establishment or reinforcement of coalitions and networks
- Consensus and coordination of activities in the nutrition sector
- Engagement of nutrition in other sectors

[9] World LINKAGES, July 2002, p. 2, LINKAGES/Academy of Educational Development, Washington DC.

- Increased confidence of nutritionists and nutrition advocates

The evaluations also found areas for improvement. Countries taking part in *Profiles* would be wise to carefully consider how to strengthen follow-up and facilitate subsequent programmatic action, (e.g. design, approval, funding and implementation.) It is also recommended that countries broaden participation in the *Profiles* process. In particular, a *Profiles* process should engage the private sector, and develop programmatic links with poverty reduction, education, women's empowerment, etc.

IV A 4. Recommendations for Strengthening Capacity in Advocacy for IYCF

UNICEF's technical partners at the IYCF meeting identified several steps UNICEF international, regional and country offices can take to strengthen the capacity of UNICEF offices in policy advocacy for IYCF, using existing and new approaches. The first step is to develop a strategy for internal and external advocacy, including "audience" research on the opinions and ideas of UNICEF representatives regarding IYCF advocacy in their assigned countries.

Another vital step is to carry out a systematic review of MTSP and identify entry points for IYCF. In this regard, the technical group noted that HIV/AIDS is dominating both funding and attention as countries struggle to control this devastating pandemic. Clearly, UNICEF offices will be expected to join with partners to develop policies and action strategies that will address infant feeding in the context of HIV/AIDS.

An Interagency Task Force will be needed to develop and monitor support for IYCF. The task of providing advocacy support to regional and country offices is too large for UNICEF alone. As evidence of the collaborative nature of the effort, a number of UNICEF's partners in IYCF have agreed to expand their IYCF activities; work with UNICEF to leverage resources; analyze relevant infant and young child feeding indicators; provide cost effectiveness data, and make available software and printed materials pertinent to achieving optimum infant and young child feeding.

Suggested Elements in an IYCF Advocacy Strategy

Griffiths presentation summarizes the elements in an Infant & Young Child Feeding Advocacy Strategy. It involves direct actions by UNICEF, indirect actions though partners/sectors, and programme sector advocacy at country level.

UNICEF offices can directly initiate a global push for IYCF by advocating for IYCF in the context of other efforts such as the Medium Development Goals, as well as advocating for IYCF itself. Indirectly, UNICEF can advocate for IYCF through partners and sectors. As described above, for best results, an advocacy strategy in a particular country should be tailored to the country's young child feeding problems, the "market segments" to influence, and the "sales agents" for improved IYCF practices.

For evidence-based advocacy, UNICEF officers will need a firm understanding of the evidence that exists for best practices in infant and young child feeding. It also is

desirable that UNICEF offices have cost estimates for various IYCF investment strategies. An Office can choose that strategy that does more with the money available.

In summary, the social marketing lessons tell us that in order to revamp the IYCF Advocacy Strategy, each UNICEF office must address leadership, collaboration, and tailoring the message. Overall there is little question about effectiveness of improved practices or our ability to bring about positive change in infant and child feeding practices. What is needed now is more cost information to show cost-effectiveness of integrated IYCF programming. To keep momentum, it will be important to continue obtaining evidence pertaining to questions regarding infant and young child feeding in the context of PMTCT, C-IMCI, and IECD programming.

IV B. HEALTH SYSTEM CHANGES: MOTHER-BABY-FRIENDLY SYSTEMS

In the 1990s, breastfeeding support was focussed on the health care provider in the maternity only. Nine of the Ten Steps of the BFHI took place in this setting, and was built on a process of in-service training with frequent reassessment for quality assurance. The BFHI approach has been shown to be extremely effective, increasing exclusive breastfeeding in urban areas. (See Wardlaw presentation.) Significantly, these increases are occurring in the face of increased advertising and higher HIV prevalence. However, the constant resource pressures of in-service training, and the assessment and reassessment framework used in the 1990s when BFHI was in its early days is proving very work and resource intensive in the new millenium.

IV B 1. Recommendations for Updating Baby-friendly

Workshop participants made suggestions to UNICEF for an integrated set of follow-up actions that might be pursued at international and country offices to make BFHI more cost effective and more relevant to the well-being of the mother-child pair beyond the hospital.

- UNICEF is urged to convene an international task force to review and recommend how to revitalize, expand and sustain BFHI.
- Redesign and test streamlined assessment process. Consider simpler assessment, monitoring and reassessment process. Explore and test applicability of quality assurance tools and techniques.
- Review training approach and materials and recommend redesign, including addressing HIV/AIDS, IECD.
- Consider extending and expanding BFHI to a *Mother*-Baby-friendly *Health Care System* Initiative. (This both extends beyond the hospital to clinics and the community, and expands to mother friendly.)
- Determine what tools and guidelines would be needed for a Mother-Baby-friendly Health Care System.
- Identify working groups on key tasks such as revisions of reassessment tools, practice guidelines (standards), training materials, job aids, and the scope and use of accreditation methods in the health care system.
- Involve community groups in assessment and possibly training.

- Develop indicators for measurement of impact.
- Recommend what advocacy is needed to take task force recommendations forward.

Participants suggested that UNICEF convene working groups to complete identified tasks and support implementation of the recommendations of the international task force, including

- Updating and testing tools and guidelines
- Developing and implementing an advocacy package.

UNICEF's technical partners also identified a need for UNICEF at the international level to assist countries to set standards for a Baby-friendly Health Care System, if the decision is to move "Baby-friendly" actions beyond breastfeeding. Similarly, if the decision is to expand to "mother-friendly" actions as well, then UNICEF international level could assist countries in setting standards for a Mother-Baby-friendly Health Care System.

The workshop participants suggested that at the country level, UNICEF offices convene a country level orientation meeting to disseminate updated recommendations on a Baby-friendly (or Mother-Baby-friendly) Health System. At a minimum, UNICEF country offices are encouraged to orient decision-makers that looking to the future, there is need to:

a) Expand breastfeeding-supportive services to include prenatal attention to the mother and to how the circumstances of delivery, at the hospital or at home, impacts on breastfeeding success; (See Kroeger presentation.)
b) Ensure that health systems are mainstreaming infant and young child feeding support into all parts of the system that come into contact with mothers of young children, including well visits, immunization contacts, and family planning services;
c) Find cost-effective ways to ensure quality,

IV B 2. Tools and Methods to Improve Care Delivery Systems

Existing tools and methods proven to improve quality of care delivery systems have the potential for adaptation to country programmes promoting optimum feeding of infants and young children. For that reason the workshop agenda set aside time for participants to consider alternative approaches currently being implemented to improve health care delivery. In particular, the Quality Assurance (QA) methodology and its relevance to the *Global Strategy* were discussed at the Workshop, along with information on a new adaptation, the Collaborative. [10]

Quality Assurance (See Koonitz-Booher presentation.)

Since 1990, the Quality Assurance Project has developed tools and methods based on quality management principles used in industry and applied them in the context of developing country health systems. Four core principles have emerged out of this experience:

[10] See also the document Tools to Support the Implementation of the Global Strategy for Infant and Young Child Feeding, Tables 3 and 4, UNICEF.

- Focus on the client: services should be designed so as to meet the needs and expectations of clients and communities
- Focus on systems and processes: providers must understand the service delivery system and its key service processes in order to improve them.
- Focus on measurement: data are needed to analyze processes, identify problems, and measure performance.
- Focus on teamwork: quality is best achieved through a team approach to problem solving and quality improvement.

Because these principles are consistent with the *Global Strategy*, it is very likely that application of QA tools and principles could strengthen infant and young child feeding programmes. QA activities can be performed as part of the accreditation of facilities, supervision of health workers, or other efforts to improve the performance of health workers and the quality of health services. A brief review of these principles may clarify QA's relevance to IYCF activities in the context of health systems.

Focus on the Client

A focus on the client examines how and whether each step in a process is relevant to meeting client needs and eliminates steps that do not ultimately lead to client satisfaction or desired client outcomes. The focus on the client can be achieved by gathering information about clients and then designing services to cater to those needs. For example, this could apply to the needs of the breastfeeding mother for information and support, or her needs for care when her nipples are cracked and sore.

A focus on clients not only involves people that receive health services, but also address the work-related needs of personnel involved in the delivery of health care: doctors, nurses, midwives, community workers, and hospital administrative staff. If they are able to perform their jobs better, they will better meet the needs of clients. For example, needs for additional training or motivational incentives might apply to community health workers making home visits to families with malnourished young children.

Focus on Systems and Processes

Quality management separates all work into *processes* and *systems*. *Systems* are arrangements of organizations, people, materials and procedures that together are associated with a particular function or outcome. (In IYCF, an example might be the systems associated with enabling a pregnant woman infected with HIV to make an informed choice about feeding her infant.) A *process* is the sequence of steps through which physical, financial and human resources lead to a service outcome. Tools such as a flowchart help people understand the steps in a process.

There are different types of processes in health care, usually occurring simultaneously:

- *Algorithms*: the processes by which decisions are made
- *Information flow*: the processes by which information is shared across the different persons involved in the care
- *Material flow*: the processes by which materials (e.g., drugs, supplies, food) are passed through the system

- *Patient flow*: the processes by which patients move through the health facility as they seek and receive care

QA activities can identify weaknesses in the processes and systems of care, and change processes in ways that make them produce better results.

Focus on Measurement
In QA, data are used to analyze processes, identify problems, test solutions, and measure performance before and after a change. Data may be quantitative in nature, such as service statistics, or qualitative, such as customer feedback or comments of health care workers.

Focus on Teamwork
Experience has shown that teams are important to quality assurance. (In IYCF, the term "team" is similar to the word "partnerships".) Different people are involved in a process. If the group working within a process is part of a team, they will understand the entire process better than one person will. A team can include key community members who bring insights about needs and perceptions of clients. A team also may involve persons who can advocate and build consensus around change. Mutual support and cooperation arise from working together on a project, and that discourages blaming others for problems. The accomplishments of a team often motivate the participants to improving organizational and individual performance.

Collaboratives to Improve Quality and Spread (Scale-up) of Care Delivery Systems
Recently, the Quality Assurance Project adapted a new development assistance model, pioneered by the Institute for Healthcare Improvement in Boston, to strengthen the care delivery systems in 13 countries. This model is the collaborative[11], and builds on the finding that teams are important to quality assurance. The collaborative offers a possible strategy for re-vitalizing and scaling-up BFHI.

The two principal objectives of a collaborative are:
- achieve rapid and significant improvement in the quality and outcomes of care through the initial prototype or pilot collaborative;
- Lay the groundwork for rapid spread (scale-up) of improvements to other organizational units or to the entire system of care.

Data presented by the QA Project indicate that collaboratives do meet these objectives.

The collaborative model has been implemented at the district level in Africa, Latin America and Eastern Europe. Usually significant results in the quality and outcomes of care are achieved in 12-24 months. Remarkably, the improvements have rapidly spread to reach populations as large as 2 million. The model relies on local leaders and teams. Given its cost-effectiveness.

[11] Collaboratives in Maternal and Child Health", Quality Assurance Project. Washington DC (no date, no author), background material furnished by Peggy Koniz-Booher.
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A collaborative consists of a number of volunteer teams/units. Participants are drawn from organizations actually involved in the delivery of care in district facilities. Usually there are 30-40 teams/units in the first collaborative. The collaborative is not the implementing agency itself, but is a structural mechanism to help organizations to interact or communicate and learn from each other.

In a collaborative, local teams/units test out new approaches, (developed by the participating teams themselves), to solve implementation problems on a small scale. Teams share results quickly with collaborative colleagues, using appropriate media (meetings, telephone, e-mail, list-serves, extranets/internet) Teams learn from both the successes and the failures of others in the collaborative. This shortens the time required to refine the model and adapt it to local situations in the country.

The work of a collaborative can be separated into three phases. The first phase is the period when the standards need to be worked out for the first time. The flow of activities usually is the following:

- *Establish Framework*: organize planning group; hire part-time staff; initiate leadership advocacy; select team/units;
- *Collect Baseline Data*
- *Learning Session 1: learn* improvement methods and develop action plan;
- *Action Period 1: de*velop, implement and monitor changes;
- *Learning Session 2:*review progress and make Action 2I work-plan;
- *Action Period 2:* further team work and monitoring of results;
- *Learning Session 3:* review results and plan for spread phase.

Phase 1 takes from 12-18 months.

Phase 2 consists of the first spread of successful models of care from the initial collaborative to other units in the system, or region. The spread (scaling-up) strategy is planned by the collaborative from the beginning, but is first implemented in Phase 2. Phase 2 is the second spread, when successful models are phased from one or more regions to all regions. This takes 12-36 months, depending on the size of the system of care.

A Collaborative draws on local creativity and minimizes external TA. The evidence so far is that the collaborative approach is cost effective. It achieves significant improvements in quality, and spreads improvements to other units, thus increasing the population's access to quality care. This methodology may be applicable to BFHI. Consideration should be given to testing whether the collaborative approach to quality care results in creating more supportive environments for breastfeeding in the country in which it is being tested.

IV B 3. The Need for Standards of Practice, Education, and Training for Improving Core Competencies and Scaling-Up Country-Wide IYCF Programming

The past ten years has seen the development and testing of materials and methodologies for capacity building of health care providers and community workers in IYCF. These tested materials have been used to train providers, policy makers, and partners to reduce specific infant and child feeding problems in a country or sub-region. To date, this has meant major investments in in-service training and continuing education of health care providers and community groups. Demand for expansion of IYCF programming calls for new approaches to traditional training. The challenge of this decade is how to create more breastfeeding resources, reach more mothers, and have a wider impact at a cost that is affordable. The Workshop participants reviewed the rationale for investments in training; the main approaches that have been used for capacity building; and some alternative methods for achieving coverage and quality. Based on this review, the participants identified actions that UNICEF could facilitate to maximize investments in education and training.

Why Invest in Training?

The importance, at the country level, of investing in training (pre-service, in-service and continuing education) can not be minimized. Considerable regional and national training and/or technical assistance related to IYCF will be required to achieve the MTSP priorities in advocacy, policy and legislation, health systems and community action. Training is a means of instilling or improving core competencies so that actions are more effective. Training also makes possible the spread or scale-up of infant and child health programmes without substantial loss of quality.

Different audiences will need different training. Decision makers (including UNICEF staff, governments and donors), will need a good understanding of the concepts of "survive and thrive", of skills for empowerment and sustainability, and of possible entry points for IYCF programming in order to develop a action strategy for internal and external advocacy. Policy makers will benefit from training in comprehensive IYCF Policy as well as Code, Maternity Protection, Codex, and marketing standards for fortified complementary foods. Even highly motivated and experienced staff in hospital and community work need technical updates and training in key messages, negotiation techniques with mothers, implementation of the mother-to-mother support strategy, and practice with IEC materials in individual counseling.

UNICEF's emphasis on integrated child development also affects training needs. Throughout the health care system there will be a need for technical knowledge and the communication skills to promote and support the integration of breastfeeding and timely complementary feeding in priority national programmes. These include HIV/AIDS, IMCI, Reproductive Health/Family Planning, Safe Motherhood, Newborn Care and Emergencies.

In-service Training and Continuing Education

To date, the majority of training offered by donors, governments, and technical assistance mechanisms has concentrated on in-service training or "refresher" training." Primarily the training has been directed to health providers, and to a lesser extent, community groups. The training has developed knowledge and skills for communicating key

messages on breastfeeding and complementary feeding. The objective has been to improve infant feeding practices in hospitals, and improve feeding practices in the home.

More quality training materials are available now to use in structured training for promotion and support of optimal feeding for infants and young children. For example, LINKAGES has developed training modules for short workshops, training of trainers, and methodologies for training of behavior support groups.[12] These tested materials have been replicated in many different settings, using structured training materials but adapted to the local context. Trainings have been evaluated and shown to have upgraded capacity of participants.[13]

In the past decade, through in-service training, hundreds of thousands of health workers have been equipped with the skills that promote and support individuals to adopt improved infant and young child feeding behaviors. Yet, despite the impressive achievements of in-service training, these numbers are insufficient to ensure widespread coverage and quality for promotion and support of breastfeeding and complementary feeding.

The obstacles to training sufficient numbers of providers include cost of in-service training; availability of qualified trainers/supervisors; and availability of trainees for a sufficient period; plus the scope of knowledge and skills required for achieving optimal infant and young child feeding. Realistically, countries must search for alternative, less costly, ways to ensure coverage and quality of IYCF programming. Are there other methodologies can enhance training gains, and possibly provide greater cost effectiveness than standardized training?

Pre-service Training, Job Aids and Supportive Supervision (See Mayer presentation.) This dilemma of assuring IYCF coverage and quality with the resources at hand points to several possible actions. First, attention has to shift to pre-service training. That is, schools of medicine, nursing, public health, and programmes that train field workers must introduce strong, evidence based curriculum for IYCF training, breastfeeding promotion and support. Unless schools graduate providers with the necessary knowledge and skills to offer quality promotion and support of infant and young child feeding, countries will always be trapped into costly and inefficient cycles of upgrading the entire service provider population.

Success of the pyramid training approach suggests that expansion could occur by stepping into a programme of cascade training within communities. If pre-service and in-service training would place emphasis on community extension practices and policies, it could result in a cadre of graduates to provide leadership for expansion and extension of IYCF into communities, other programme areas, and other sectors. Such a focus on community and integration is consistent with the goals of UNICEF.

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[12] Linkages, 2003, "Training Modules", Experience Linkages, Washington DC.
[13] See for example, Linkages, "Ghana" and "Bolivia" country reports in the September 2002 issue of World Linkages, Washington DC.

A third possible action is to invest in developing job aids that can enhance initial training. Job aids with supportive supervision make training gains potentially even greater. Practice guidelines, standards, and accreditation methods are other ways to raise quality of health system performance. Little is known about such tools in IYCF, such as the appropriate situations for use, cost-effectiveness, relevance to different health worker tasks, and possible links with other interventions. Similarly more needs to be known about supportive supervision of health workers, such as the tools and techniques that facilitate the greatest gains in the ability to promote and support breastfeeding and complementary feeding.

Cost and outreach data are both needed in order to calculate cost-effectiveness of the various training methods in reaching mothers in communities

Best Practices and Lessons Learned

Programmatic implementation knowledge is one of the most neglected areas of continuing education. Few programme managers just starting an IYCF effort in the field know what has worked in the past, and what has not worked. These managers are unable to pinpoint where the breakdowns might occur and what opportunities might be pursued to better achieve positive results. Tremendous effort is spent on upgrading the breastfeeding and complementary feeding knowledge and skills of individual providers. Much less effort is directed towards upgrading the programming knowledge and skills of the managers of IYCF field efforts, or of community leaders responsible for mother support efforts.

The need is to rapidly summarize and disseminate lessons from IYCF efforts taken to scale. There are lessons in design, management, training, phasing of activities, partnerships, referrals, monitoring and evaluation, etc. There are many ways to communicate. Sometimes information can be spread by field based workshops or by networking groups, as mentioned above in the section on cooperatives. To policy makers and advocates, the lessons can be disseminated in regional or national conferences or professional meetings. Print media has been used to present results and lessons learned of efforts to take IYCF to scale, (for example, the LINKAGES Experience series.) Increasingly the Internet is being used to rapidly disseminate programme experiences. List-serves enable participants to post queries and obtain information on the experiences of others working on the same problem. Examples of these are the PMCT list-serve (HIV/AIDS), or the *Hearth* list-serve (home-based treatment for malnourished children).

UNICEF' Role in Maximizing Country Investments in IYCF Education & Training

UNICEF's technical partners at the Workshop consider UNICEF to play a unique role in promoting quality and coverage of IYCF. They identified these potential contributions to country capacity building::

⇨ UNICEF as advocate for children, can play an important role in strengthening core competencies and expanding national coverage of IYCF programming. These include:

- Convene a country level orientation meeting to disseminate updated recommendations on infant and young child feeding.
- Sponsor a "lessons learned" conference to disseminate to public health authorities and health managers the lessons from IYCF efforts taken to scale.
- Convene a working group in country to review training approaches and materials and recommend redesign in light of lessons learned. The working group can determine what tools and guidelines will be needed to integrate IYCF into HIV/AIDS, IECD, and emergencies. Later, the working group can follow implementation and revisit integration through a review of lessons learned in such efforts at integration.

⇨ UNICEF can encourage discussions at the country level of the investments needed in training. Such discussion will call for understanding of training costs, financial constraints, lessons learned in previous training programme s, and alternative approaches.

⇨ UNICEF has a role, too, in generating attention to alternative methods of building operational capacity to promote and support better infant and young child feeding practices. Participants suggested UNICEF might assist countries through the following actions:

- Convene representatives from training institutions and governments to examine the adequacy of curricula to address breastfeeding and complementary feeding issues. This could stimulate the development of stronger nutrition curricula with materials to support competencies.
- Facilitate the gathering of field experiences with the use of job aids to improve promotion and support of breastfeeding and complementary feeding of infants.
- Convene a working group to define what constitutes supportive supervision in the local context – and whether tools might be developed to ensure supportive supervision in practice.
- Facilitate the involvement of the community in assessments of lessons learned when IYCF programming is introduced into a community.

⇨ UNICEF can bring attention to the value of lessons learned as a tool for upgrading programmatic knowledge and skills. Participants suggested that UNICEF could encourage donors, governments and providers to:

- Formalize the collection of lessons learned and best practices.
- Summarize key findings that impact on programme results
- Make that learning available to persons currently managing IYCF field activities
- Store collected lessons in designated facilities; and
- Institutionalize that learning within organizations engaged in programmes that promote and support optimal infant and young child feeding. .

Given this information, UNICEF country and regional offices will be in a better position to prepare a plan for phased activities that address the pre-service education and in-service training needed in core competencies related to IYCF. This plan should include obtaining in-house technical support skilled in the content of the IYCF strategy, and the provision of updated training, advocacy and job-aid materials for translation and distribution.

IV C. COMMUNITY AND SOCIAL CROSS-SECTORAL MOBILIZATION: BRINGING STEP 10 INTO THE FUTURE

A basis has been laid for implementing a global strategy to ensure optimal feeding for all infants and young children. The initial emphasis has been government adoption of nutrition and child health policies and programmes. Considerable effort has gone into health worker training, improving maternal care in health facilities, and creation of legislative codes and conventions that protect, promote, and support appropriate feeding of infants and young children

More attention is being directed to the mother-child biological and social unit. The focus is shifting from nutrition content to infant and young child feeding behaviors. The increasing number of people affected by complex emergencies, HIV/AIDs, and rising levels of poverty are forcing revised approaches and messages for optimizing infant and young-child feeding.

There are new operational targets to provide mothers with more effective and efficient ways to access quality IYCF support. More operations will be directed towards community-based strategies; advocacy, communications; and integration of IYCF in other prevention and care services.

UNICEF national and regional offices will find the new operational targets consistent with national goals and objectives. They will find the *Global Strategy for Infant and Young Child Feeding* respects national circumstances, local traditions and values. This new thrust offers many opportunities for UNICEF to facilitate and guide resources that can reduce inappropriate infant and young-child feeding practices. It draws upon UNICEF's outstanding record in advocacy for children, now broadened to include community mobilization and social action in support of mothers.

IV C 1. Communications Support and Social Marketing for IYCF

The Early Childhood Communications Strategy is designed to help UNICEF offices achieve the 2005 Key Goals for Early Childhood. (See Dube presentation.) It will proceed in two phases. In 2003 and early 2004, UNICEF's communication focus is on influencing decision-makers and opinion-makers, not the general public. There are two reasons for focusing on public policy. "Survive and thrive" is a new concept; and primarily, it is the decision-makers who will be responsible for public policy actions.

By early 2004 it is expected that decision-makers will be convinced of the integrated approach, understand the strategies and advocate for the policy and investment decisions that are needed to realize this approach. In early 2004, the strategy's next phase is to broaden to influence the media and public opinion. There will be a global campaign on the right of every child to both survive and thrive. In this way the campaign will be related back to the successful UNICEF-driven child survival revolution of the 1980's and 90's.

W. Gikonyo, Programme Communications Unit, UNICEF HQ, has outlined the potential of communications to support infant and young child feeding programmes. (See Gikonyo presentation.) Communications can generate support for IYCF among many different groups, with messages targeted to each specific group. It can create a more enabling environment for mothers who are breastfeeding or are providing complementary foods to the child under age two. Communications can be instrumental in changing perceptions and social norms related to IYCF. It can increase the knowledge of caretakers about the best feeds for infants and young children, given local conditions. Communications can reach the hard to reach.

The implementation of an effective communication intervention requires skills building with the health and social systems, the community, and family/caregivers. In the health and social systems, health and social workers can enhance their skills to communicate with families, given appropriate messages and support materials, and appropriate activities to build their skills in interpersonal communication. In the community, both formal and informal groups important to the functioning of the community can be involved in planning for and supporting IYCF programmes. Thus, groups such as religious leaders, farmers associations, women's groups, traditional birth attendants and NGOs can strengthen their skills in developing programmes that meet community needs. Given a few, concise, appropriate and do-able messages, family and caregivers can learn those actions that will most help the child to survive and thrive. And with supportive help, family and caretakers can learn skills for better outcomes in breastfeeding, and child growth.

Such is the potential of communications. How to make it a reality? Marcia Griffiths of the Manoff Group has drawn together social marketing lessons that could affect the future of IYCF in very positive ways. (See Griffiths presentation.) The application of social marketing principles and methodologies to IYCF will involve updating the way communications are done now.

The communications aspect of social marketing incorporates the familiar areas of (1) public relations advocacy, (2) advertising/behavior change communications, and (3) internal-programme communications. The question is "social marketing for what?" In breastfeeding, for example, there could be three reasons one chooses to do social marketing:

- "Get breastfeeding on the map" (Initiate training and legislation.)
- Improve breastfeeding practices (Increase "market share":)
- Change social norms (Create a culture of breastfeeding through all segments of the population).

The communications work of the past has enabled breastfeeding to get "on the map". And, as the DHS/Macro and MICS data show, breastfeeding practices have improved. (See Mukuria presentation and Mukuria presentation.) The social marketing tasks now are to keep breastfeeding central to infant health and development programmes, and

expand the penetration and spread of breastfeeding through all segments of the population.

IV C 2. Analysis of Obstacles to Promoting and Expanding Spread of IYCF
(See Griffiths presentation.)

The UNICEF office will face some obstacles in communications support and social marketing of infant and young child feeding. The promotion of breastfeeding is slowing down, due in part to the complexity introduced by HIV/AIDS. The focus on infectious diseases is squeezing out breastfeeding and complementary feeding.

Another issue is the lack of knowledge of how to go to scale with community support for IYCF. Community-based approaches still struggle with broadening population coverage. To move beyond the current "status quo" will require leadership, collaboration with others in redefining the problem, tailoring the message to groups with specific negative outlooks and practices, and revamping the IYCF advocacy strategy. UNICEF can bring leadership to this effort.

From a social marketing perspective, these obstacles can be addressed if there is a clearer definition of the problem. Take breastfeeding promotion as an example. The theme "the breast is best" is not such an issue today. A greater issue now is the need to understand why people want to breastfeed, and market to those reasons. This means a clearer definition of how people perceive the "product" (breastfeeding practice), the institutional and cultural norms governing initiation of breastfeeding, and the mix of breastfeeding and other feeding.

There also needs to be a clearer definition of the "market segments". Mothers are not all the same in outlook or practice. For example, the outlook and practices may differ for young/first time mothers, working mothers, or those exposed to more new ideas and outside influences. There may be differences according to location (urban/rural), or socioeconomic group. To expand the breastfeeding practices, more attention needs to be given to particular market segments, and an understanding of a particular group's outlook and practices as concerns breastfeeding and other feeding.

The UNICEF office will also need to clarify the definition of the IYCF "sales agents" in country. Different countries and regions will have different "sales agents" for IYCF. For example, the commitment to IYCF may differ in the medical profession, bilateral donors, companies, etc. Some groups may be more concerned with increasing breastfeeding practices, others will be more concerned with other infant feeding, and some will have little or no interest at all in IYCF. Role models, too, vary from one locality to another. The involvement of other family members in infant and child feeding decisions will also vary. From a social marketing perspective, these "sales agents" are the people who, in society, will promote, protect and support exclusive breastfeeding to six months, and breastfeeding and appropriate complementary feeding to two years.

UNICEF and its partners will need time to revamp a country's social marketing strategy: to clarify the goal, rework the framework, and redefine the strategy for IYCF advocacy,

the strategy for improved IYCF practices and the strategy for internal programme communications. Griffiths cautions that an Office will need to update audience research for advocacy. The times have changed. For example, Griffiths found the following recent responses in people's perception of the breastfeeding message: "We've done that", "The fanatics"' "Too complicated with HIV/AIDS", "No single issue causes." A revamped advocacy strategy can address these perceptions.

IV C 3. Community-Based Strategies in Support of Each Mother/Baby. (See Morrow presentation.) [14]

The rationale for community-based interventions as a new operational target comes directly out of the *Global Strategy* for Infant and Young Child Feeding, May 2002. Why community-based? Community approaches to health and development have more than a 50-year history. In recent years, however, the operational targets have been mainly health sector oriented. While advancements have occurred, the health sector strategy by itself is not resulting in the desired changes in feeding behaviors. So the operational target is being re-framed to provide women with access to greater family and community support for optimum child feeding behaviors.

This revised approach recognizes that a mother's need for IYCF support transcends the hospital or health care sector. A change in infant and young child feeding behavior requires a shift in cultural norms and expectations. Programmes in the next decade will engage the family, social support networks, opinion leaders, and the community at large, as well as the health sector. This approach may possibly also result in furthering two complementary objectives: women's empowerment and community development.

There are several mechanisms for increasing community-level support of exclusive breastfeeding and continued breastfeeding with complementary foods for children up to two years. Such strategies include:

- lay/peer counselors (volunteer or paid)
- women's groups
- village support groups

There is strong evidence from efficacy trials and demonstration projects for selecting community-based strategies as a new operational target. Such strategies can be highly effective in providing women with better access to IYCF support, resulting in positive changes in breastfeeding behavior.[15]

Lay/peer counseling

The strongest evidence base is for lay/peer counseling. These counselors are not health care professionals; they are community members trained to counsel mothers in appropriate infant and child feeding practices. Their supervision may be delegated to

[14] See draft review document Community-based Stratetgies for Breastfeeding and Support in Developing Countries, A Morrow author, LINKAGES Project, August 2003.

[15] For further information on community-based IYCF strategies, the reader can turn to two WHO publications: "Community-based Strategies in Breastfeeding Promotion and Support in Developing Countries" and "Guidelines for the Promotion of Infant and Young Child Feeding Through Lay/Peer Counselors

community committees, NGOs, or local health units. Examples can be drawn from evaluations of lay counselor programmes in Mexico and Guatemala.[16]. The data revealed that mothers who had support from community-based peer counselors were able to exclusively breastfeed infants longer than control group mothers. Note that in the Mexico City study, a mother who was visited more frequently by peer counselors was more likely to exclusively breastfeed the infant to three months. Similar findings are reported from Bangladesh.[17]

Women's support groups

There is also suggestive evidence for the efficacy of women's support groups as a way to increase the prevalence and duration of breastfeeding, including exclusive breastfeeding in the first six months of life. There are several models of women's support groups. The first is the Breastfeeding Support Group where mothers interested in breastfeeding meet together and support each other in that effort. An adaptation of that model is the Mother's Support Group, which has a broader purpose. An example of this is La Leche League's Mother-to-Mother Support Project in the peri-urban areas of Guatemala City. This is an innovative approach to child survival that involves trained volunteer breastfeeding counselors who provide home visits and one-on-one breastfeeding counseling to other women in the area, refers them and their children to health clinics, and organized mother support groups. LLLG staff trains, supervise and support the volunteers, in addition to establishing mother support programmes in the low-income communities. [18]

Research is limited but survey data suggests that participants in women's support groups have better breastfeeding outcomes. The evidence is that women's support groups can be remarkably self-sustaining on a volunteer basis with minimal resources. The main factors that appear to be key to the success of mother support groups are (a) high personal motivation of the various participants, (b) strong support structure, and (c) good coordination with local health facilities and authorities. [19] One caution is that this strategy reaches a self-selected group of mothers. Although women's support groups can reach many mothers, it does not reach all. There should be additional IYCF strategies employed at a population level.

Village support groups

The Baby-friendly Community Initiative in the Gambia (Burkhalter presentation) is an example of a community based strategy to improve IYCF that is built around village support groups trained in infant feeding. The programme acknowledges that in resource-poor communities, most deliveries occur at home, most mothers have little contact with the formal health system, and feeding practices are heavily influenced by traditional beliefs. Thus, the aim is to create an environment where nutrition becomes "everyone's business".

The Gambia programme is based on the 10 steps to successful infant feeding and involves everyone in the community – men, women and children. In fact, they found the

[16] Morrow et al. Lancet 1999
[17] Haider et al. Lancet 2000
[18] Burkhalter B and N Bashir, Innovative Approaches to Child Survival. Basics. July 1998 Washington DC
[19] Burkhalter and Bashir, op cit.

support of men is crucial to sustainability. Both men and women received the same knowledge about the nutritional needs of the mother and baby and could advise and encourage women and their partners in improved infant feeding practices. In addition, the village support groups taught mothers and caretakers the connection between maternal and infant nutrition and a clean environment and adequate personal hygiene.

An evaluation took place 12 months after the initiation of the intervention in 12 pilot communities in the Gambia and found that 100% of mothers were initiating breastfeeding within 24 hours of delivery, in contrast to the 60% at baseline. (See Jallow presentation.) The evaluator also reported that when the programme had started, no one believed exclusive breastfeeding was possible or desirable, but "today, when entering a community, there are no arguments".

IV C 4. Behavior Change Communication

Behavior change communication is particularly suited to large-scale intervention. It stresses concise, consistent messages and materials that promote small "do-able" actions within a community. The messages are developed through formative research within communities and disseminated via:

- mass, electronic and print media used by the population
- community events such as theatre, fairs, community gatherings
- interpersonal communication with lay counselors, health care providers and mother support or other community groups

Thus, key audiences or "targets" are saturated with the messages from a variety of sources.

The LINKAGES Program of the Academy of Educational Development employs this approach to change IYCF behaviors in approximaely10 countries and regions. Coverage is ranging from half a million to more than 6 million persons. Evidence for the effectiveness of the community-based behavior change communication approach can be seen in data from the LINKAGES project in Madagascar. As shown in the Sanei presentation, in comparison to control areas, the programme areas achieved a greater proportion of exclusively breastfed infants in the first 6 months of life. This effect was even stronger in the subsequent year's assessment.

Of course the reported change in IYCF behaviors is not due to behavior change communication alone. LINKAGES has a common package of programme interventions that has been brought to bear on changing IYCF behaviors on a large scale. (See Baker presentation.) Breastfeeding is an entry point into other maternal and child health interventions. Partnerships with the MOH, NGOs, PVOs, international agencies, community service organizations and academic institutions increase the reach and scale of impact. Community-based training and support groups are active at the local level, and they are engaged in intersectoral advocacy at the national level. Training is conducted at all levels, appropriate to each level of influence. Pre-service curriculum design results in graduates who are knowledgeable about infant and young child feeding.

Surveys in the countries with intensive large-scale integrated community-based programmes have clearly shown that breastfeeding behaviors can be changed, and

changed at scale, though not all countries were equally successful. (See Sanei .presentation.) In particular, surveys in Madagascar, Ghana and Bolivia document behavior change at scale, (with a programmecoverage at time of survey of 3.2 million, 1/2 million, and 1 million, respectively.)

Unfortunately, the country surveys did not document a sizeable change in timely complementary feeding behaviors. Still at question is the efficacy of community-based strategies in improving young child complementary feeding behaviors.

Abt Associates, Inchas carried out a Cost and Effectiveness Analysis if LINKAGES' breastfeeding interventions. LINKAGES presented some of the preliminary findings to the participants. The estimates indicate that the breastfeeding programme in Ghana is cost-effective, with the possibility that Madagascar results will show even lower costs and greater effectiveness. (See Sanei presentation.)

V. INTEGRATION OF IYCF INTO CURRENT HIGH PRIORITY FUNDING AREAS

Advocates for infant and young child feeding are agreed that service integration must become a new IYCF operational target. The experience to date is very positive. For example, the LINKAGES programme has five technical foci: breastfeeding, complementary feeding, maternal nutrition, the lactation amenorrhea method (LAM), and prevention of mother-to-child transmission (PMTCT) of HIV. (See Baker presentation.)

It should be possible to adapt successful UNICEF IYCF methodologies to strengthen other interventions. For example, BFHI has been proven to increase early and exclusive breastfeeding rates. This suggests that countries consider integrating BFHI 10 Steps into safe motherhood, family planning, and well child efforts. It is well known that early and exclusive breastfeeding contributes to successful outcomes in these areas. Further, it should be possible to address *home-based* maternity care with BFHI principles, adapted to local conditions.

UNICEF country office and health chiefs can better access funds for IYCF training if they understand where IYCF integrates into current high priority funding areas. At present there are four outstanding opportunities to promote and support optimal infant and young child feeding as part of another funding area. These areas are

- IMCI
- Early Childhood Development
- HIV/AIDS and Tuberculosis
- Complex Human Emergencies

With time, more opportunities may emerge, particularly as IYCF is mainstreamed within governments, multi-laterals, PVOs and NGOs.

V A. IYCF and Integrated Management of Childhood Illness (IMCI) (See Begkovian presentation.).

IYCF is a key component of child survival. WHO's IMCI programme addresses the main causes of death in childhood (diarrhea, pneumonia, malaria, measles, neonatal infections, and HIV/AIDS) and underlying problems of malnutrition. IMCI deals with three types of interventions: promotion of growth and development; prevention of disease, and response to childhood illness at home and health service levels. Depending upon the disease or child health problem presented at the clinic, the IMCI protocol promotes breastfeeding, complementary feeding and/or micronutrient supplementation as part of the actions in support of the health and development of the child.

NGOs have been active in adding a community component to IMCI. Surveys carried out in year 2000 in areas where health service and community IMCI programming exist indicate that these areas have healthier breastfeeding practices among other child-protective behaviors.

IMCI RECOMMENDED NUTRITION INTERVENTIONS

Growth Promotion and Development
Provide exclusive breastfeeding for 6 months
Introduce appropriate complementary feeding from 6 months
whilst continuing BF up to 24 months
Provide adequate micronutrients through diet or supplementation

Disease Prevention
Carry out proper disposal of feces, hand washing after defecation, before preparing meals and feeding the child

Home Management
Continue to feed and offer more food and fluids when child is sick

V B. Child Development: Relationship with Infant and Young Child Feeding (See Engle presentation.)

The first years of a child's life are a time of immense opportunity for growth and development. They are also the riskiest, especially in the first three years.[20] Substantial scientific evidence indicates that poor nutrition can harm the developing brain. Brain development is most sensitive to a baby's nutrition between mid-gestation and two years of age. A baby's brain size and birth weight depend on the quality of his or her mother's nutrition during pregnancy. After birth, brain growth depends critically on the quality of a child's nutrition. Infants six months of age and over need iron in their diets. Iron is

[20] See document Early Childhood. UNICEF, May 2003

deficiency has been clearly linked to cognitive deficits in young children. Children also need a high level of fat in their diets due to the rapid myelinization in early life.

Research has found long-term effects of nutritional deficiencies on schooling performance, and a child's social and emotional response to stress. Early childhood intervention programme promote healthy growth through giving children, especially disadvantaged children, access to basic nutrition, health care and stimulation.

More attention could and should be paid to the social and emotional development aspects of infant and young child feeding. The emotional and behavioral interaction that goes on between mother and child during breastfeeding, and complementary feeding is important to stimulate the child and give the child a sense of security and feeling of being loved. It is similarly important to the mother's physical and emotional well-being.

Traditionally, IYCF activities have concentrated on what and when to feed a child, and given less attention to how the mother feeds and cares for her child. Most often health professionals attend to the quantity and quality of a child's food, but seldom to the act of feeding itself – which is, to the quantity and quality of the mother/child interaction. Initiatives to bring together early child development and IYCF strategies could potentially help answer some persistent problems in the field. For example: What actions best support a depressed and demoralized mother in caring for her undernourished child? Are there strategies than can yield better outcomes in attempts to improve timely and appropriate complementary feeding behaviors?

UNICEF is laying the groundwork for an integrated approach in these areas. It has made available a manual providing guidance to child care workers on counseling the mother. This document includes how to assess the child's usual feeding and care for development of the child. It provides recommendations on counseling a mother regarding how to handle problems with child feeding, feeding during sickness, and care for development. The next step is to secure funding for projects that can answer whether integrated child development and IYCF activities yield better growth and development outcomes, and what works at the community level in urban and rural environments.

V C. HIV and Infant Feeding (See de Wagt presentation.)

Experts attending the IYCF workshop agreed that the controversy that has marked the development of infant feeding policy in the context of HIV AIDS is giving way to greater consensus. The nature of this controversy was well expressed by A. de Wagt and T Greiner:[21]

> "Ever since it was discovered that breastfeeding could transmit HIV, there has been debate on what interventions should be put in place to prevent this route of transmission, while also protecting, promoting and supporting breastfeeding for the majority of children who benefit from it. Even more problematic has been the question of how to decide which children would be at greater risk from breastfeeding or from not doing so. An additional difficulty has been the need to

[21] UNICEF 2003. HIV and Infant Feeding: A Report of a WABA-UNICEF Colloqium. Arusha., Tanzania.

encourage HIV positive mothers to choose either exclusive replacement feeding or exclusive breastfeeding, since neither is common in low-income countries."

As the presentations at the workshop made clear, the area of HIV and Infant Feeding is now developing very rapidly due in part to increased knowledge gained from scientific research and examination of the lessons learned from field experiences in early PMTCT projects.

Indeed, there has been a deliberate effort to bring differing groups together to promote consensus and enlarge collaboration. Foremost in these efforts was the HIV and Infant Feeding Colloquium organized by UNICEF and World Alliance for Breastfeeding Action (WABA).[22] The WABA/UNICEF Colloquium on HIV and Infant Feeding held in Arusha, Tanzania, proved to be a major bridging of the divide. This 2002 colloquium was extremely successful. It resulted in agreement on a structure or draft UN framework for HIV and infant feeding priority actions. Further, it identified gaps and challenges for the future.

Technical recommendations, based on recent programmatic experience and research findings, are clarifying the minimum package of care and overall strategies of a PMTCT programme:

⇨ With regards to infant feeding and HIV,

- Breastfeeding is recommended for the HIV negative woman and for those women of unknown HIV status.
- Replacement feeding is recommended for HIV positive women when affordable, feasible, acceptable, sustainable and safe.
- In HIV positive women, exclusive breastfeeding or exclusive replacement feeding is recommended. [23]

The UN agencies UNICEF, UNAIDS, WHO and UNFPA have collaborated on a revision of the 1998 Guidelines for HIV and Infant Feeding. [24] The document now generally follows the outline of the HIV and Infant Feeding Framework for Priority Action. More guidance is given for countries considering providing free or subsidized infant formula. The document also condenses information on prevention of HIV infections in infants and young children in general.

Experience of Recent PMTCT Programmes

Key findings from an extensive review of programmatic experience of recent PMTCT projects were presented at the IYCF workshop. (See QAP PMTCT review.) In 2002, UNICEF signed a MOU with the Quality Assurance Project /URC to prepare a compilation of programmatic experience related to HIV and infant feeding. [25] The

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[22]

[23] Lewis, S. "Keynote Address" WABA-UNICEF Colloquium on HIV and Infant Feeding, Arusha, Tanzania.

[24] DRAFT, February 6, 2003, HIV & Infant Feeding; Guidelines for Decision-Makers. UNICEF, UNAIDS,WHO/UNFPA

[25] Koniz-Booher, P., B Burkhalter, P Iliff, and J Willumsen (eds) 2003 "HIV and Infant Feeding: A Compilation of Programmatic Experience", University Research Corporation, Washington DC

investigators collected and reviewed over 100 documents from more than 17 countries. The documents included primarily unpublished materials, programme evaluations and field assessments. Most were fairly current, reporting on programme s initiated since 1998.

This extensive compilation found many technical and programmatic challenges facing these PMCT projects. The analysis of the programmatic experience is clustered around main themes:

- exclusive breastfeeding
- exclusive replacement feeding
- informed choices
- male involvement
- community stigma
- formula use

The intent of this compilation is to inform those working in HIV and infant feeding about the experience of these recent projects. It is not a set of recommended programme strategies.

The report lays out the main questions that these projects address (or fail to address.) It details the difficulties experienced in operationalising the necessary counseling and community support for informed choice related to infant feeding options. However, it also reports on beneficial program elements and expands knowledge on the factors influencing a mother's choice of method of infant feeding. It documents the harmful and far reaching effects of stigma these women face, and summarizes the experience regarding male support of the HIV+ mother.

The QAP/URC team also reviewed findings from 4 rapid assessments conducted by Horizons/Population Council in 2001. Of the 11 UN supported pilot PMTCT programmes initiated 1999-2000, assessments were carried out in four countries: Honduras, India, Rwanda and Zambia. The review of these findings underscores both the similarities and differences of PMCT projects implemented in different social, economic and cultural settings.

Community Mobilization and Spread of Programme

Botswana offered an example of a field programme that mobilised the community for IYCF in the context of HIV/AIDS. (See Kyenky-Isabirye presentation.) In so doing, they were able to effectively address community stigma, male involvement, informed choice, and secure community support for exclusive breastfeeding.

Of course, small PMTCT projects must eventually give way to expanded coverage if all HIV+ pregnant women are to have access to ARV prophylaxis and counseling regarding infant feeding. LINKAGES has been working on the implementation of a public sector PMTCT model that meets dual PMTCT and child survival objectives.[26] Their ground-breaking application of the model in Zambia was presented at the workshop. (See Baker

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[26] Baker J, 2003, "Strategy to Expand PMTCT Coverage in Zambia", LINKAGES, Washington DC

presentation.) The government of Zambia was interested in advice on developing infant feeding policy in the context of HIV/AIDS. In 1999 USAID/Zambia provided funding to LINKAGES to develop a model PMTCT programme in one district, later expanded to 4 districts. By the beginning of 2003, the programme covered an expected total of 13,615 deliveries a year, and was operating in several provinces of Zambia.

The Zambia programme works within the public sector framework and network. Key programme elements are: partnerships to increase service coverage and access as well as ensuring supplies and commodities; integrated services; comprehensive service package; emphasis on risk reduction; and multiple points of contact. LINKAGES has tracked and measured behavior change. Results are very positive.

V D. IYCF and Complex Human Emergencies (See Lung'aho presentation.)

More than 50 countries expect displacement and/or diarrhea and ARI outbreaks due to complex human emergencies. If this happens, children will be severely affected. Acute malnutrition is among the major causes of mortality in children in complex emergencies. Numerous published studies have assessed the nutritional status of children in complex emergencies and have documented the high prevalence of acute malnutrition. Iron and vitamin A deficiencies are more severe in refugee or displaced children. In addition, less common micronutrient deficiencies (such as vitamin C, thiamine and niacin) may affect large populations in complex emergencies, including the children. [27] Children in good nutritional status, whose food is not dependent on logistics systems, and who are protected against common infectious diseases, are much more likely to survive displacement and disaster.

IYCF should be seen as Emergency Preparedness. A strategy is needed to integrate IYCF in Emergencies, as well as materials to support such integration. WHO and UNICEF have collaborated on developing guidelines for infant feeding in emergencies. Module 1 is expected to be soon out to help all staff working in emergency relief address infant feeding issues. The document also addresses relactation and therapeutic feeding. Module 2 will be for those working with mothers and babies. Special support needs to be given to pregnant and lactating women. UNICEF should begin to draw attention to IYCF and emergencies, and advocate for studies and demonstration projects that can determine the efficacy of IYCF in reducing the mortality in children in complex emergencies and environmental disasters.

[27] Moss, W., M Remakrishan, A Siegle, D Storms, W Weiss 2003 "Child Health in Complex Emergencies: Report of the Working Group on Child Health in Complex Emergencies. CIEDRS, Baltimore MD

VI. MONITORING PROGRESS, IMPACT EVALUATION AND IYCF RESEARCH

UNICEF has committed to the Global Strategy on Infant and Young Child Feeding. Achieving optimal infant and young child feeding and related maternal nutrition and care is central to MTSP success. New assessment technologies and measurable process and output indicators are making possible greater evaluation of impact, and are opening new areas of IYCF research. More emphasis is being placed on strengthening monitoring and evaluation of the effectiveness of implementing structures, including enforcement of the Code.

The purpose of this section is to discuss current practices and issues in monitoring and assessing the effectiveness of these efforts, and to present participant recommendations to strengthen monitoring and evaluation of IYCF. This section closes with a brief discussion of practical research needed in infant and young child feeding.

VI A. Monitoring Internal Progress

Developing a plan to monitor and evaluate progress is one of the first activities that UNICEF country offices will undertake for each of its IYCF operational areas, (such as advocacy, policy, legislation, community, health services, HIV/AIDS, etc.) All programmes are expected to report on designated inputs, outputs and expected outcomes and impact.

The most basic task is activity monitoring. It is sound management practice to track at designated time periods whether a programme is following its work plan and time line and whether the country programme is meeting its targets. For example, are personnel in place and active? What legislation has occurred or in progress? What is the proportion of designated Baby-friendly hospitals to the number of hospitals assessed? And, is community action under development or fully implemented?

Specific components of the *Global Strategy* also need to monitor activities. For example, a designated Baby-friendly Hospital is expected to monitor progress on the Ten Steps. (The meeting's discussion on the BFHI assessment, monitoring and reassessment process, and suggestions for redesign has been placed in the chapter on BFHI.)

A related, but different question, is whether UNICEF is fulfilling its responsibilities under the *Global Strategy* on Infant and Young Child Feeding (2002). UNICEF's unique responsibility lies in fostering national level advocacy, and developing capacities of communities and households in support of optimal infant and young child feeding. Thus, UNICEF offices will need to monitor whether progress is occurring in fostering national level advocacy for IYCF in countries, and whether IYCF activities are enabling an increased number of communities and households to have the information and conditions necessary to support optimal feeding.

Monitoring will identify areas needing improvement and helps in planning actions needed. Some useful tools to support planning, monitoring and evaluating can be found in Table 6 of the UNICEF document Tools to Support the Implementation of the Global Strategy for Infant and Young Child Feeding. .

VI B. Impact Evaluation Issues (See Franklin presentation.)

Everyone agrees that assessment of impact is important, but what should we be assessing? And what is really feasible to assess? The question is not an easy one to answer.

Scientific research has shown that optimal infant and young child feeding and related maternal nutrition and care yield the best survival, growth, intelligence and development outcomes, reduce chronic disease rates, and where fully implemented, will cut under-five mortality in half. Of all these outcomes, information is usually available at country, regional and/or district levels for infant mortality, under-five mortality and less available for nutritional status and growth.

WHO maintains a Global Database on infant and child mortality. Measures DHS collects and analyzes anthropometric data on children within countries and regions. LINKAGES does not collect anthropometric data but relies on DHS to provide anthropometric results. Both DHS and MICS monitor levels and trends in childhood malnutrition. These data are not linked to breastfeeding and complementary feeding behaviors. There is need for more evidence, or better data, on the impact of optimal breastfeeding and complementary feeding practices on growth and survival of a population of children.

Research has shown that adequate nutrition is important to the developing brain, and that stimulation of the child during feeding has positive emotional effects on both the mother and child. However, in most countries of the world, information on intelligence and development outcomes is not available at a national level or within regions of a country. Also, due to the complexity and cost of following feeding patterns and outcomes among cohorts of children, few programmes in the developing world have evaluated the impact of optimal feeding strategies on emotional and intellectual development of a population of children.

For these reasons, currently it does not appear feasible to evaluate the impact of the *Global Strategy* on the physical, mental and emotional development of children. Instead, current practice is to assess the effects of implementation of operational areas (policy, legislative, service, community, etc.) on specified behaviors or practices that has been scientifically shown to result in child survival, growth and development. Similarly, emphasis is placed on assessing effectiveness of implementing structures.

The evaluation question will depend upon the particular operational area, strategy or implementing structure, and what it is intended to influence and achieve.

VI C. Assessing Effectiveness of IYCF Strategies

Measuring progress under the *Global Strategy* requires data to be collected periodically on key indicators and other programmatic concerns using a sample size large enough to detect significant changes in outcomes of interest. Repeated assessments make it possible to assess both levels and trends in desired behavioral and practice outcomes. The outcomes that received attention at the IYCF meeting included (a) changes in rates of breastfeeding and complementary feeding, (b) compliance with the Code, (c) quality of health delivery, and (d) expansion of coverage.

VI C 1. Measuring Progress in Changing Infant and Young Child Feeding Behaviors

The Global Strategy on Infant and Young Child Feeding recognizes that it is the right of every child to reach the highest attainable standard of health. Optimal nutrition is an important component of that right. "Optimal Infant and Young Child Feeding" consists of those interventions that best enable the child to "survive and thrive":

- Six months exclusive breastfeeding,
- Continued breastfeeding with adequate complementary foods and feeding for up to two years or longer; and
- Related nutrition and care for the mother.

A complementary intervention, spacing of births at least three years apart, also contributes to the best nutritional and survival outcomes.

In recent years there has been great scientific advance in developing an internationally agreed upon set of indicators for measurement of those feeding behaviors that are considered optimal. The indicators by and large have focused on breastfeeding and complementary feeding. Less work has occurred on indicators for the part of the *Global Strategy* that concerns the right of a woman to proper nutrition and to full information and appropriate conditions that will enable her to carry out her decisions about infant and child feeding.

UNICEF maintains a Global Database on breastfeeding and complementary feeding indicators.[28] Three sources provide the majority of such data: MICS, DHS and LINKAGES. UNICEF/MICS and Measures /DHS monitor global trends in infant and young child feeding. MICS and DHS data on breastfeeding and complementary feeding are based on household sample surveys, not just official government estimates.

MICS was established to measure progress towards the goals of the World Summit for Children. The breastfeeding indicators MICS tracks are

- *Exclusive breastfeeding rate* (Proportion of infants aged less than 4 months who are exclusively breastfed.)

[28] UNICEF and WHO have agreed that UNICEF will take the lead in updating the definitions used for breastfeeding, while WHO takes the lead in updating the definitions used in describing complementary feeding. For the internationally recognized definitions of "breastfeeding" in use today, see Definition of Breastfeeding, prepared by M. Labbok, UNICEF/HQ.

- *Timely complementary feeding rate* (Proportion of infants aged 6-9 months who are receiving breastmilk and complementary food.)
- *Continued breastfeeding rate* (Proportion of children aged 12-15 months and 20-23 months who are breastfeeding.)

Although there are huge gaps for basic indicators, the Global Database has entries for 122 countries, with regular updating with 140 UNICEF field offices.

UNICEF HQ commissioned analysis and presentation of the MICS and DHS breastfeeding data for the IYCF meeting. (See Wardlaw presentation and Mukuria presentation.) This was well received by participants because it provided new information on the impacts, in each region, of efforts to increase early and exclusive breastfeeding and timely introduction of complementary feeds.

LINKAGES has pioneered in measuring results of country projects that aim to increase optimal infant and young child feeding practices in the population within a relatively short period of time (20-24 months) and at a scale that could achieve significant public health impact.[29] Monitoring and evaluation are important to determine whether the efforts are working, as the time line is short and the expected coverage is large.

LINKAGES has taken a management approach to monitoring and evaluation. It has developed a set of M&E tools and methodologies, relying on baseline surveys, rapid interim assessments, and follow-up surveys to meet the challenges of data collection and rapid feedback of results. There are clear and focused impact indicators. Data milestones are identified. There is an integrated M&E team at its headquarters with field-based M&E officrs. (See Franklin presentation.)

LINKAGES uses a common set of breastfeeding and infant feeding indicators based on WHO definitions (1991) and Wellstart International's toolkit for monitoring and evaluating breastfeeding activities (1996).These indicators are:

- *Timely initiation of breastfeeding rate* (Percentage of infants less than 12 months of age who are put to the breast within one hour of birth.)
- *Exclusive breastfeeding rate* (Percentage of infants less than 6 months old who receive only breastmilk, and no other solids or liquids including water (based on 24-hour dietary recall), with the exception of drops or syrups consisting of vitamin or mineral supplements, and medicines.
- *Mixed feeding rate.* (Percentage of infants less than 6 months old who receive, in addition to breastmilk, other foods or liquids including water (based on 24-hour dietary recall.
- *Timely complementary feeding rate* (Percentage of infants 6 through 9 months of age who receive breastmilk and a solid/semi-solid food (based on 24-hour recall). Solid foods are defined as foods of mushy or solid consistency, not fluids.

Methodological problems in the indicators still exist, and fine-tuning of definitions continues. The picture of complex feeding behaviors is incomplete, even though

[29] LINKAGES, April 2003, "Results: in Experience Linkages, Washington DC.

interviewers receive intensive training on infant feeding questions. Nevertheless, there exists a tested and proven basis for evaluating infant feeding programmes in different countries, and over time within countries, as well as assessing progress in going to scale with IYCF programming.

Approximately seven percent (7%) of the overall LINKAGES budget for an infant and young child feeding project in a country is spent (or recommended) on monitoring and evaluation. Although M&E was supported originally from LINKAGES core funds, now the USAID country missions are contributing, reflecting their appreciation of the importance of M&E.

LINKAGES is making efforts to build M&E capacity in countries by hiring local M&E officers and training all local partners in M&E methods. Annual reports describing assessments and results are available on the LINKAGES website. More detailed reports eventually will be available on line.

VI C 2. Monitoring Compliance with the Code by Marketers of Breastmilk Substitutes

Recent work by Aguayo and colleagues presented at the IYCF workshop, and discussed earlier in the chapter on CODE, demonstrates another example of monitoring progress toward IYCF goals. (See Aguayo prestentation.) Their focus was on assessing compliance with the Code in health facilities, distribution points and news media.

The Code is concerned with the proper marketing and use of breastmilk substitutes, as reflected in three practices: provision of adequate information, appropriate marketing, and appropriate distribution. The investigators chose to construct indicators of non-compliance, or violations of the Code. These included:

- Health facility acceptance of donated milk substitutes (Percentage of health facilities that had received donations of infant formula in the six months prior to the survey)
- Health provider acceptance of donated or promotional gifts of breastmilk substitutes
- Mothers receiving breastfeeding counseling (Percentage of mothers who never received any counseling in breastfeeding from their health providers)
- Breastmilk substitutes violating labeling standards (Number of breastmilk substitutes found in distribution points that violate Code's labeling standards.)

The investigators carried out a multi-site cross-sectional survey to obtain their compliance data. Although this was a single study, it points to a possible direction for monitoring UNICEF's progress in advocating for national norms and standards in support of IYCF.

The Nutrition section of UNICEF monitors compliance with the Code on the part of media, health providers and manufacturers of breastmilk substitutes. However, monitoring of Code is not just UNICEF's role or obligation. A number of specialized NGOs have helped in monitoring of the Code. A recommendation was that UNICEF

continues to work with NGO partners to monitor Code in a variety of locations. A suggestion for consideration is that the "sentinel site" concept might be adapted to incorporate a number of NGOs, so as to achieve broader monitoring of Code compliance.

VI D. IYCF Research

There is still research that is needed to optimize infant and young child feeding. For example, advocacy efforts would benefit from more cost analysis of feeding options. Not much is known about costs other than the basic fact that there is a lower cost of breastfeeding as opposed to use of commercial breastmilk substitutes. More data or better evidence is needed on the cost effectiveness of different strategies of IYCF, such as BFHI and training.

Some work is already being done. WHO is developing a costing model for IMCI that includes the malnutrition component, LINKAGES has supported studies on IYCF costs, and expects to make that available shortly. LINKAGES and WHO have not yet coordinated on work with costing models, though that may come in the future when more is known.

HIV/AIDS is another area with pressing infant feeding research issues. WHO's approach to prevention of HIV transmission from HIV positive pregnant women to their infants is counseling and support for safer infant feeding. PMTCT programmes need further research on infant feeding practices (including formula feeding and early weaning), that impact on transmission and capitalize on voluntary counseling and testing. What influences an HIV positive mother's decisions about how to feed her child? Does a HIV+ mother encounter special feeding problems? How can a HIV+ mother who lives in an underserved area, receive the counseling, breastfeeding support and breast care that she needs?

Then there are research questions surrounding the nutritional status of the children who are HIV positive. What are the feeding recommendations for a young child who is HIV positive? Are there extra nutritional requirements for these children? Are there IMCI feeding recommendations consistent with management of the frequent pneumonia and diarrheas seen in the care of the HIV positive child?

Not all research necessarily involves fieldwork. Piwoz and Ross recently conducted one of the more innovative research analyses concerned with HIV and infant feeding. (See Piwoz presentation.) The authors argue that the IMR can be used to make rational policy decisions about appropriate strategies for preventing postnatal HIV transmission. The purpose of the analysis was to inform HIV and infant feeding policy of governments and donor agencies supporting PMTCT programmes. They were not intended for individual counseling of mothers. They used a spreadsheet simulation model to estimate the population level HIV-free survival at 24 months, under 4 different scenarios and in different settings characterized by IMR. The scenarios were combinations of breastfeeding status, HIV status, and postnatal intervention. The results of their analysis

led them to the policy recommendation that replacement feeding from birth should be emphasized for HIV+ women in countries /programme settings with IMR<40. In settings with IMR greater than 40, the recommendation is to emphasize breastfeeding to 5 months. This work was carried out under the USAID funded SARA and LINKAGES projects.

Another area where research is lacking is social support for optimal feeding. This concept differs from behavior change. More research is needed on an effective model for fostering the skills that are needed by communities to support optimal breast-feeding and complementary feeding by HIV+ mothers, or other vulnerable caretakers. Research could identify community models that are cost-effective and capable of expansion to new areas.

There are also few tested models of how to foster sustainability of programmes that support infant and young child feeding, at regional, district or community levels. "Best practices" indicate that interventions in communities be integrated, not parallel, with interventions in the health care system However, most community work done by NGOs in cooperation with communities and the health care system, is dependent on outside funds and donor interests.

VI E. Recommendations

Participants at the IYCF Workshop recommended the following actions on behalf of monitoring, evaluation and IYCF research:

- Involve community groups in assessment of community-based strategies and analysis of findings . It was recognized that to do so will require development and testing of a basic assessment tool or process that can be carried out at low or no cost by community members, particularly those living in rural or underserved areas. The assessment tool should also be capable of being taught by community members to other in the same or nearby communities.
- Aim for rapid publication of the MICS and DHS results, and dissemination of the information to the scientific community, governments, UN agencies and NGOs.
- Carry out further analysis of existing data in order to provide scientific basis for advocacy on IYCF.

VI. POSTSCRIPT: WORKING TOGETHER TO REVITALIZE INFANT AND YOUNG CHILD FEEDING

A follow-up to the successful April 2003 IYCF Working Session was held at UNICEF House on October 1, 2003. It was a productive day and demonstrated the interest and the willingness of the partners to work together to revitalize this important field for early child development and growth. As evidence of commitment, the one-day follow-up meeting was attended by many of the same organizations invited to the prior Workshop. Very few of the invited organizations were unable to attend. It was noted that virtually all promised material were produced and made available to the group.

The agenda had four areas of concentration:

Updates on progress since last meeting
Discussion of common technical issues
Discussion of structure and function of the group
Brainstorm on communications and advocacy for IYCF

There were three technical issues considered of greatest priority for attention. Participants were concerned about issues of transition and formula provision in HIV and infant feeding. Immediate cord clamping has become an important issue in Mother Child dyad care. Updates and expansion of BFHI was also considered a priority.

A remarkable outcome of the meeting was that the group entered into a mutual agreement for a partnership and developed a structure for the group. It was decided that this group of UNICEF partners in IYCF should be formalized, with an on-going Secretariat, housed at UNICEF for now, and a rotating Chair who will work with the secretariat to set agenda and ensure that issues of concern will be raised at each meeting. After much discussion of goals and objectives, seven objectives were identified::

1) Enhance Networking and Coordination
2) Support SCN
3) Create Advocacy for IYCF issues
4) Organize for Resource development
5) Serve in a Technical advisory function
6) Empower all members
7) Provide support to and partnership with UNICEF

The partners are still discussing the name for this structure. This group is not a network nor collaborative group per se. Nor is this a replacement for the Working Group of SCN. Primarily the group is formed as partners for action on infant and young child feeding.

The next meeting is tentatively scheduled for March 2004 to take advantage of the SCN venue. Given the results, the 2002 workshop "Working Session on the Global Strategy for Infant and Young Child Feeding" was clearly a move forward. The coming year will reveal whether the interest and energy of the partners is maintained. Early indications are positive: several promised follow-up actions are occurring and coordination is beginning on some of the technical and country issues raised.

ANNEXES

Working Session on UNICEF and the *Global Strategy* on Infant and Young Child Feeding (GSIYCF)

Understanding the Past – Planning the Future

8-10 April 2003
LaBouisse Conference Room
Lower Level B1
UNICEF HOUSE, East 44th (between 1st and 2nd avenues)
New York, New York 10017

Rationale

The *Global Strategy* on IYCF (GSIYCF) is being launched worldwide. In moving forward on this strategy, it is important to consider the knowledge and experience gained and to apply insights to future programming. In the 1990s, UNICEF had a major role in the implementation of the Innocenti Goals. Nonetheless, today, many UNICEF offices are no longer aware of the four goals. Starting from this base, it is now the time to implement the GSIYCF goals, which include the four Innocenti Goals and four additional.

This three-day workshop will explore key lessons from UNICEF programme experience based upon assessments of efforts to implement the Innocenti goals, reanalyses of available survey data, and field-based learning, as well as obstacles and circumstances encountered, including the impact of increasing emergencies and HIV on programming and resources. Together we will identify successes, challenges, and gaps, and develop recommendations to strengthen implementation of the GSIYCF. Discussion will include, but not be limited to, Advocacy and Communication, Health System initiatives and Community initiatives, considering the cross-cutting issues of human resources, political and financial support, special circumstances, evaluation needs, and technical, knowledge-based gaps. The result will be proposed future programming guidance for UNICEF HQ, regional and country teams, and our partners.

Purpose & Objectives -- What can we learn from the efforts of the 1990s that will inform planning and country office programming in the next decade and beyond?
Participants will share assessments and current innovations, and engage in informal problem solving in order to develop specific suggested activities for consideration by UNICEF officers in discussion with national liaisons. Specifically, meeting objectives include:

- Identify lessons learned in the implementation of the Innocenti Goals;
- Explore current innovations in programming, specifically related to the GSIYCF: Advocacy/Communication, BFHI/Health Systems, and Communities;

_ Recommend programme action steps to inform IYCF activities by UNICEF (within the UNICEF Medium Term Strategic Priorities especially IECD) and partnering organisations.

Tuesday 8 April 2003:

Objective: Review UNICEF's Progress on Innocenti Goals in the Last Decade

Moderator: *R. Gross & P. Engle*

Rapporteur: *P. Koniz Booher*

09:00-09:45 Welcomes *R. Gross*

Introductions, Objectives, and Materials *M. Labbok*

09:45-10:00 Current UNICEF Programming and Plans: How does UNICEF function? Role of MTSP and Role of the Country Program *P. Engle*

10:00-10:30 Summary of Outcomes of WHO/IYCF Meetings *UNICEF* and UNICEF's Comparative Advantage in IYCF

10:30-11:00 ***B R E A K***

11:00-13:00 Assessment of the Programmes of the Last Decade.

BFHI/ Innocenti Goals:

11:00-11:20 Country Questionnaire Findings *M. Labbok*

11:20-11:40 Arusha Meeting Outcomes *T. Greiner*

11:40-12:00 Response & Discussion

International Training Approaches:

12:00-12:20 Assessment of Trainees: Wellstart – San Diego *A. Naylor*

12:20-12:40 Assessment of Trainees: Breastfeeding: Practice and Policy Course, London *C. Williams*

12:40-13:00 Response & Discussion

13:00-14:00 ***L U N C H***

Moderator: *M. Zeilinger*
Rapporteur: *M. Kyenkya-Isabirye*

14:00-16:00 Assessment of the Programmes of the Last Decade Continued.

<u>International Code of Marketing of Breastmilk Substitutes</u>:

14:00-14:20 Assessment and Impact *D. Clark*

14:20-14:40 Country Experience *V. Aguayo*

14:40-15:00 Response & Discussion

<u>Analyses of a Decade of Surveys with Country Examples:</u>

15:00-15:20 MICS presentation *T. Wardlaw*

15:20-15:40 DHS presentation *A. Mukuria*

15:40-16:00 Response & Discussion

16:00-17:00 Working Groups on Lessons Learned in Last Decade: BFHI Impact, Training Impact, Code Impact

17:00-17:30 Working Group Report Out and Discussion

17:30-18:00 Presentation of Tools

- Profiles *J. Ross*

- Expanding BFHI *M. Kroeger*
- Job-Aids, Modules & Manuals *UNICEF*

18:00 – 19:30 Reception

Wednesday 9 April 2003

Objective: Define New Innovations and Implications for IYCF Programmes

Moderator: *R. Buijs*
Rapporteur: *M. Lung'aho*

09:00-10:20 IYCF in the Community

09:00-09:20 Gambia Baby-friendly Community Initiative *B. Burkhalter*

09:20-09:40 Models, Costs, Results *L. Sanei*

09:40-10:00 Assessment of Community Approaches *A. Morrow*

10:00-10:20 Programme Communication and IYCF *W. Gikonyo*

10:20-10:40 ***B R E A K***

10:40-11:00 IYCF in the Community – Response & Discussion

11:00-12:00 New Ways to Look at Programming - Rotating Groups

BFHI/ Health System

- Quality Assurance and BFHI: Is there an alternative to traditional assessments? *B. Burkhalter*
- BFHI Assessment Tools: Can we Simplify Further? *A. Brownlee*
- Training Alternative: Job-aids and Supervision *J. Mayer*

12:00-12:20	Rotating Groups - Report Out	
12:20- 13:00	Advocacy Approaches	
12:20-12:40	Social Marketing/Action	*M. Griffith*
12:40-13:00	Advocacy in UNICEF	*S. Dube*
13:00-14:00	***L U N C H***	
Moderator: Rapporteur:		*A. Morrow* *T. Greiner*
14:00-14:30	Advocacy Approaches – Response & Discussion	
14:30-16:30	Working Group: Advocacy, Health System, and Community: What specific activities and steps to implement make sense for UNICEF? For Partners?	
16:30-17:30	Working Group Report Out and Discussion.	

Thursday 10 April 2003 Objective: Define Plan of Action Steps

Morning Moderator: Morning Rapporteur:		*H. Sukin* *J. Ross*
09:00-09:30	Donors' Perspectives and Discussion of Donors	*Panel*
09:30-11:00	Cross-Cutting Issues	
HIV/AIDS:		
09:30-09:50	HIV Context	*A. de Wagt*
09:50-10:10	Mobilising to Programme for IYCF in the Context of HIV/AIDS: The Botswana Experience	*M. Kyenky-Isabirye*
10:10-10:30	Country PMTCT Approach and Data for Zambia	*J. Baker*
10:30-11:00	***B R E A K***	
11:00-11:30	Cross-Cutting Issues Continued	

HIV/AIDS Continued:

11:00-11:10	Use of Infant Mortality Rates to Guide Programming decisions on HIV and Feeding	*E. Piwoz*
11:10-11:30	Response & Discussion	

11:00-12:30 Cross-Cutting Issues Continued

Other Cross-Cutting Considerations:

11:30-11:50	Child Development	*P. Engle*
11:50-12:10	Monitoring & Evaluation of Community-Based IYCF Programs	*N. Franklin*
12:10-12:30	IYCF in Emergencies	*M. Lung'aho*
12:30-13:00	Response & Discussion	

13:00-14:00 ***L U N C H***

Moderator: *M. Kroeger*
Rapporteur: *A. de Wagt*

14:00 – 15:30	Working Groups defining specific Cross Cutting action needs: HIV/IF, Child Development & Emergencies, Monitoring & Evaluation, Capacity Building & Training What specific tools and materials are needed for Next actions by UNICEF? By Partners?
15:30-16:00	Working Group Report Out and Discussion
16:00 - 17:00	Presentation and Discussion of Conclusions, Recommendations, and Next Steps: Wrap-up and Farewells

Binders or Handouts:

- *Global Strategy* on Infant and Young Child Feeding
- Summary of UNICEF MTSPs
- Description of Function and Accountabilities of UNICEF HQ, Regional Offices, Country Offices
- Innocenti Declaration

- Chart/Progress on CODE
- Chart/Progress on BFHI
- Speakers' Notes on Early Childhood

Tools Available on Table:

- Profiles
- Expanding BFHI
- Job-Aids –*examples*
- One copy of Modules and Manuals
- Other

Participants List

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