Meeting Report

WHO/UNICEF Consultation on Breastfeeding Protection, Promotion and Support

20–22 June 2007
Manila, Philippines

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REPORT

WHO/UNICEF CONSULTATION ON BREASTFEEDING PROTECTION, PROMOTION AND SUPPORT

Convened by:

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NOTE

The views expressed in this report are those of the participants in the WHO/UNICEF Consultation on Breastfeeding Protection, Promotion and Support and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the WHO/UNICEF Consultation on Breastfeeding Protection, Promotion and Support, which was held in Manila, Philippines, from 20 to 22 June 2007.

SUMMARY

In spite of what is known about the great benefits of breastfeeding that accrue to children, mothers, families and society—and the risks of disease and morbidity associated with bottle-feeding—the practice of breastfeeding continues to decline in many parts of the Asia and Pacific region. Breastfeeding competes for mother's time, especially time she needs to earn income for the family, and breast milk is being made to compete against breast-milk substitutes. The clear inferiority of the substitutes is being masked by very aggressive marketing efforts of companies selling them. These campaigns often provide inaccurate information as well as incentives to health workers and professionals in clear violation of the national and international codes and agreements for marketing breast-milk substitutes. These tactics have undermined the efforts of governments, nongovernmental organizations (NGOs), individuals, and international organizations to provide mothers and families with accurate information to help them make the right choices for their children and themselves. The aggressive marketing of substitutes has also made it very difficult for concerned individuals and organizations to create environments that protect, promote and support breastfeeding.

To address these and related issues, a consultation on breastfeeding protection, promotion and support was organized by the WHO Regional Office for the Western Pacific and the United Nations Children's Fund (UNICEF) Regional Office for East Asia and Pacific. Participants from Australia, Cambodia, the People's Republic of China, Fiji, Indonesia, Japan, the Lao People's Democratic Republic, Malaysia, Mongolia, New Zealand, Papua New Guinea, the Philippines, Samoa, Singapore, Solomon Islands, Thailand, Timor-Leste, Vanuatu, and Viet Nam met in Manila, Philippines, from 20 to 22 June 2007. The consultation was designed to strengthen the regional network with new and better tools and human and knowledge resources for expanding and sustaining the region's breastfeeding culture.

The consultation objectives were to: share successful experiences and lessons learnt, and to analyse constraints to improving breastfeeding; discuss the status of the Baby-Friendly Hospital Initiative (BFHI) and future steps needed to strengthen and sustain the initiative; review the status of the adoption and implementation of the international and national codes for marketing breast-milk substitutes, and identify actions that will improve their effective implementation; and identify innovative ways to promote a breastfeeding culture and discourage a bottle-feeding culture.

The three-day workshop was divided into two main parts which were prefaced by presentations and discussions on breastfeeding in the context of the Regional Child Survival Strategy, the economics of breastfeeding, and country situation analyses (and available data tools). The first part aimed at creating an enabling environment (personal, societal and political) for breastfeeding by sharing experiences, looking for ways to strengthen BFHI, improving health worker skills, and effectively using communication tools to transform behaviour. The Cambodia case study was presented. The second part of the consultation focused on preventing a bottle-feeding culture from proliferating. The Philippine story was presented as an example which led to extensive discussions on how to better monitor and implement codes of marketing of breast-milk substitutes. Technical updates on breastfeeding in

emergencies, breastfeeding and HIV, breastfeeding the low-birth-weight baby, the long-term effects of breastfeeding and breastfeeding beyond six months concluded the presentations.

Throughout the consultation, emphasis was placed on the need to identify actions that participants would commit to taking after the consultation. Therefore, to conclude the workshop, lists of recommendations and suggested actions were compiled (based on discussions over the three days) and organized under the following areas: breastfeeding economics; use of data, communication and advocacy; strengthening the BFHI; creating an enabling environment; increasing health worker skills; and implementation of the Code of Marketing of Breastmilk Substitutes.

The participants were expected to return to their respective countries and to use these lists—as well as personal lists that they were asked to prepare—to guide them through a course of action that would strengthen and expand the breastfeeding culture in their countries. With knowledge gained from the consultation and the connections made with fellow participants, resource persons and representatives of national and international organizations, participants were expected to become effective drivers in their present and future spheres of influence.

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Key words

Child nutrition / Infant nutrition / Asia / Pacific Islands / Breastfeeding

1. INTRODUCTION

1.1 Background

In the Western Pacific Region, around 2100 children under age five die every day from common preventable and treatable conditions including diarrhoea, pneumonia and perinatal events. WHO and UNICEF have developed the Regional Child Survival Strategy, which was endorsed by the WHO Regional Committee in 2005 to place child health higher on political, economic and health agendas in Member States. The regional strategy focuses on the implementation of an essential package for child survival that includes breastfeeding as the single most effective preventive intervention.

The International Code of Marketing of Breast-Milk Substitutes, the Innocenti Declaration, and the BFHI are the most significant actions supported by WHO and UNICEF to promote and protect breastfeeding. In the 25 years since the birth of the Code and 15 years from the launching of the BFHI, breastfeeding rates and duration still need to improve. Breastfeeding rates have been on the decline in most developing countries in the region where only about one third of infants less than six months old are exclusively breastfed. The aggressive marketing and advertising strategies of the milk industry producing infant and follow-on formula have thwarted the early and promising gains of the BFHI and made the nationally adopted measures for regulating breast-milk substitutes insufficient. Hospitals that have been certified as "baby-friendly" have often failed to strictly follow the 10 steps required by the BFHI over the long term, and a system for regular assessment needs to be incorporated into quality assurance systems of routine health service. At the same time, it is increasingly recognized that women need support for breastfeeding within their own communities.

WHO and UNICEF convened a consultation to discuss common issues and challenges related to BFHI and the implementation of the International Code of Marketing of Breast-Milk Substitutes, and to identify strategic actions that will promote a "breastfeeding culture" and discourage a "bottle-feeding culture" among mothers and within the health community, with full health system support.

1.2 Objectives

The consultation objectives were to:

(1) share successful experiences and lessons learnt, and to analyse constraints to improving breastfeeding;
(2) discuss the status of the BFHI and future steps needed to strengthen and sustain the initiative;
(3) review the status of the adoption and implementation of the international and national codes of marketing of breast-milk substitutes, and identify actions that will improve their effective implementation; and

(4) identify innovative ways to promote a breastfeeding culture and discourage a bottle-feeding culture.

1.3 Organization

Viewing breastfeeding in the context of the Regional Child Survival Strategy, looking at possible ways to measure the economic value of breastfeeding, and analysing available country data for setting country action priorities, primed the participants for the two main parts of the consultation. In Part 1, group and plenary discussions on ways to create an enabling environment for breastfeeding by improving BFHI and health worker skills and performance, and changing behaviours with effective communication tools, followed a presentation on the successful baby-friendly community initiative (BFCI) in Cambodia. In Part 2, participants were urged to think of new ways to prevent a bottle-feeding culture from proliferating. The current battle in the Philippines' Supreme Court (and in the media) over the expansion of the coverage of the Milk Code and the launch of UNICEF's documentary *Formula for Disaster: Violations of the Philippine Milk Code* provided a real-time action framework for in-depth discussions on ways to monitor and enforce the Code, the importance of "doing the homework" (including technical updates) for advocacy, and the need to make clear commitments to achieve targets. (See Annex 1 for the detailed programme of activities)

1.4 Participants, resource persons, observers/representative agencies and members of the secretariat

Representatives from the following Member States participated in the consultation: Australia (1), Cambodia (3), China (5), Fiji (2), Indonesia (1), Japan (1), the Lao People's Democratic Republic (2), Malaysia (1), Mongolia (3), New Zealand (2), Papua New Guinea (3), the Philippines (5), Samoa (1), Singapore (3), Solomon Islands (1), Thailand (3), Timor-Leste (2), Vanuatu (1), and Viet Nam (4).

The resource persons were Ms Ali Maclaine of Emergency Nutrition Network (United Kingdom), Dr Audrey Naylor of Wellstart International (United States of America), Dr Marina Ferreira Rea of the Institute of Health of São Paulo (Brazil), Dr Julie Smith of the Australian Research Council (Australia), and Ms Yeong Joo Kean of the International Baby Food Action Network (IBFAN)/International Code Documentation Centre (ICDC)–Penang (Malaysia).

Observers included representatives from the Development Action for Women–Trade Union Congress of the Philippines, Employers' Confederation of the Philippines, People of the Philippines for Breastfeeding Coalition/ARUGAAN, Philippine Senate, United States Agency for International Development Philippines, International Labour Organization–Philippines, and the United States Centers for Disease Control and Prevention. Other observers included representatives from the Taichung Veterans General Hospital and the Bureau of Health Promotion in Taichung.

The secretariat was composed of representatives of WHO Headquarters and offices of the Western Pacific Region, Cambodia, China, Philippines and Viet Nam, and UNICEF Headquarters and offices of the East Asia and Pacific Region in Cambodia, China, the Philippines, Thailand, Timor-Leste, and Viet Nam.

See Annex 2 for the complete list of participants.

2. PROCEEDINGS

2.1 Preliminaries

2.1.1 Opening

Dr Shigeru Omi, WHO Regional Director for the Western Pacific, opened the consultation by outlining the benefits of breastfeeding and then asking why these benefits are not being taken advantage of—as shown in declining breastfeeding rates in the region—and how we might ensure that the benefits are not lost. He cited the WHO and UNICEF's Global Strategy on Infant and Young Child Feeding (IYCF) as identifying responsible groups and the roles they must play for promoting, protecting and supporting breastfeeding. To reverse negative trends in breastfeeding rates, Dr Omi called for "radical solutions" that would involve strengthening BFHI monitoring, expanding support for breastfeeding beyond hospitals, and using the media in a comprehensive communication strategy to promote breastfeeding.

> Scientific evidence tells us that breastfeeding is the single most effective intervention to prevent child deaths; and that all women, with very few exceptions, are able to breastfeed—if encouraged and supported. —Dr Shigeru Omi

Dr Stephen J. Atwood, Regional Advisor for Health and Nutrition UNICEF East Asia and Pacific Region, welcomed the participants on behalf of the Regional Director of the UNICEF East Asia and Pacific Regional Office. He asked why breastfeeding continues to be a subject so important as to require continuous WHO and UNICEF collaboration, a consultation of experts across the region with resource persons from around the world and media-grabbing attention. His answer: "we will be discussing nothing short of life and death." He suggested that adequate political commitment, community education and communication, counselling for women and families, and minimized or arrested influence of interest groups with agendas in conflict with breastfeeding support may be part of the "secret" to raising breastfeeding rates. Dr Atwood challenged the participants to act courageously and to hold each to "personal action that can be translated into change [in] institutions, communities and households."

Participants introduced themselves and elected office bearers for the Consultation: Ms Rokiah Don (Ministry of Health, Malaysia) as chairperson, Dr Yolanda Oliveros (Department of Health, Philippines) as Vice-chair, and Professor Colin Binns (Curtin University of Technology, Australia); and Dr Dai Yaohua (Capital Institute of Paediatrics, People's Republic of China) as rapporteurs.

Dr Tommaso Cavalli-Sforza, Regional Adviser in Nutrition and Food Safety, WHO Regional Office for the Western Pacific, reviewed the agenda and introduced the “Report Book.” Each participant received a blank booklet and was urged, after each session, to note on one page the recommendations that arose from the discussions. On the facing page, participants were to list actions they intended to take based on these recommendations. In the final session, participants would then identify the most important actions to which they would commit to doing in their respective countries and offices. Any suggestions to modify this tool were welcomed.

2.1.2 Breastfeeding: essential for child survival and development

Dr Marianna Trias, Regional Adviser in Child and Adolescent Health, WHO Regional Office for the Western Pacific, with Dr Atwood, presented issues related to breastfeeding within the context of the WHO/UNICEF Regional Child Survival Strategy. Basically, to improve child survival in the region the WHO/UNICEF strategy calls for scaling up efforts through greater political will and the provision of more financial resources. (Government budget allocation to child health in the region is the least among all regions of the world.) Dr Trias pointed out that breastfeeding is part of the essential package for child survival and the recommendations in the strategy for protecting, promoting and supporting breastfeeding can be applied in all settings throughout the region. She informed the participants that WHO has published a planning guide to help countries translate the global and regional strategy into national strategies and policy and action plans.

Dr Julie Smith, Australian Research Council Fellow, showed how putting a dollar value on breast milk makes visible its contribution to the economy as well as the cost of not protecting, promoting and supporting it. She suggested that economic analyses based on dollar values and costs can help motivate policy-makers to protect breast milk and also help bring about better understanding of the economic and financial incentives women and families face. A clearer understanding of these issues, she asserted, is needed to formulate effective strategies to improve breastfeeding practices. Dr Smith concluded that “Government action can restore and protect breastfeeding as the norm (e.g. Norway)” and presented a five-point action plan:

- have funding agreements with health system institutions to include BFHI;
- provide incentives for health professionals to improve outcomes on breastfeeding;
- raise marketing and community support to match commercial marketing and promotion budgets;
- implement paid maternity leave and other breastfeeding-friendly workplace practices and policies;
- include mothers’ milk production in food statistics and GDP.

In Northern Europe, supportive national policies mean nearly all mothers are still breastfeeding at six months compared with less than half in this region. We could do this here if the will is there and if we listen to producers (women) about what gets in the way of breastfeeding.

> Policy-makers may respond more to costs of illness, because it imposes more direct and politically visible costs on the health system than babies dying.
>
> Emerging literature highlights that feeding human infants on bovine milk is one of the biggest uncontrolled experiments in human history, and the results [infant deaths, chronic diseases, obesity] are only just now becoming evident in the data.
>
> —Dr Julie Smith, excerpts from *The Economics of Breastfeeding…*

Ms Karen Codling, Regional Nutrition Project Officer of the UNICEF East Asia and Pacific Regional Office, and Dr SM Moazzem Hossain, UNICEF Programme Officer for Infant Feeding, guided the participants through the Country Situation Analysis exercise. From the Problem Matrix (Annex 3) produced by the participants, it was evident that complementary feeding before six months, BFHI reassessment, and Code implementation were cross-country priority areas of concern; and late complementary feeding and the absence of NGOs were not considered problems by most countries. In addition, the following general observations on using data for comparisons resulted from the activity:

- it is important to ensure that you are comparing like with like;
- it is important to know the definitions and methodologies used;
- sometimes sample sizes are small and you cannot compare results with the results of previous (larger) surveys;
- comparisons across country may not be meaningful (depends on data used);
- it is best to use one good source for comparing across countries; DHS and MICS are the most standardized sources.

Dr Hossain presented a tutorial on Interpreting Data from Area Graphs of Infant Feeding Patterns by Age. He showed how area graphs could be used to quickly display problems and changes and how they could also be used for designing interventions. He uses software with which area graphs can be produced in one hour after data is provided.

2.2 Part 1: creating an enabling environment for breastfeeding

2.2.1 Case study: Cambodia

Ms Svay Sary, IYCF Coordinator of the Cambodian Ministry of Health, presented Cambodia's achievements from 2000 to 2005: 49% increase in exclusive breastfeeding, threefold increase in breastfeeding initiation within one hour (87% of new-born babies) and within one day (90% of new-born babies), and improvement in complementary feeding practices. The improvement in exclusive breastfeeding practices was due to a large decrease in the practice of giving water to infants. Government leadership played a large part in the success of breastfeeding promotion by supporting key interventions—training, multimedia campaigns, community-based interventions (one fifth of villages are implementing the Baby-Friendly Communities Initiative, or BFCI), and the BFHI. Ms Sary concluded her presentation with lessons learnt (e.g. relevance of community initiatives), challenges faced (e.g. support of working mothers), and further action to be taken: expand BFHI and BFCI, strengthen

policy and legislation, and continue training and communication programmes. Discussions that followed revealed that from 2004 to 2007, BFCI coverage grew from 35 to 2000 villages. The Cambodian strategy in the past few years has been to focus on promoting exclusive breastfeeding, and this year, emphasis (through a television campaign and roundtable discussions, for example) will be placed on early initiation. The multimedia campaign was seen to have been highly effective and samples of the television advertisements were shown to the participants.

2.2.2 Baby-Friendly Hospital Initiative

Dr Marina Ferreira Rea, Senior Researcher of the Institute of Health of São Paulo, defined the objectives of BFHI as implementing the Ten Steps to Successful Breastfeeding and rejecting donations of free and low-cost supplies of breast-milk substitutes in the health facility. She cited studies from around the world that confirm: BFHI is important for starting (United Kingdom) and continuing (Sweden) breastfeeding, to achieve exclusive breastfeeding (Brazil, Belarus, Switzerland) and to reduce morbidity (Belarus, an important study). She emphasized the importance of training to standardize BFHI in hospitals, of Step 4 which is now interpreted "as placing babies in skin-to-skin contact with their mothers immediately following birth at least for one hour…," and of providing community support for breastfeeding mothers (Step 10). Dr Rea pointed out the major revisions to the BFHI global criteria and tools and informed the participants that updated materials (except Section 5 for external assessors) are available on the Internet by searching in http://www.unicef.org .

In the discussion that followed Dr Rea's presentation, participants shared experiences in their own and other countries. Issues ranged from coverage (are China's 7000 baby-friendly hospitals significant in terms of percentage of all Chinese hospitals or percentage of all babies delivered in Chinese hospitals?) to the use of Wellstart International's training and monitoring software (it helps those already wanting to become baby-friendly but how do we convince hospitals that are not interested in becoming baby-friendly to change?) to the number of steps that should be implemented ("all or nothing" or "some is better than none"?).

General issues were also raised regarding monitoring, coverage and the need to recertify backsliding hospitals. Suggestions on how to address these issues included:

- using external professional associations for monitoring (successfully done in India);
- involving communities in monitoring hospitals and having them certified;
- using new technology for monitoring (e.g. using an SMS hotline to report violations and make queries);
- addressing underlying reasons why hospitals resist becoming baby-friendly (e.g. the pressure to be profit-oriented, to keep paying moms rested in private hospitals);
- making BFHI accreditation a necessary condition for hospital accreditation by government;

- providing policy-makers with more evidence of the benefits of BFHI, such as how it reduces morbidity and mortality;
- having BFHI hospitals post their annual certification status on a web site for full disclosure;
- making data collection more systematic.

> The efficacy of BFHI is clear but only a small number of hospitals have been accredited considering how long BFHI has been around: in 15 years, 20 000 hospitals. What a shame! When are we going to get the exponential jump? We can't use a linear approach. What's wrong? We have to grapple with the issue.
>
> —Dr Stephen J. Atwood

Dr Atwood asked for volunteers to form two groups of five members each, one group to defend and the other to oppose the following statement:

It's been 15 years, only 20 000 hospitals. I'm sorry. BFHI has had its chance. It's time to stop this initiative.

The following arguments (in summary) were put forward by the opposing panels:

Agree with statement: stop BFHI	Disagree with statement: proceed with BFHI
BFHI puts an extra burden on resources and on hospitals; sustainability (and starting) is a problem and expensive—hospitals can't afford this.	BFHI is cost-saving; the cost of BFHI is paid off eventually.
BFHI is already in place, numbers are adequate, focus on other programmes.	Need to revitalize breastfeeding in society or else it will disappear and be replaced by bottle feeding.
BFHI has not made much of a difference.	The problem is in implementation; let's fix BFHI before ending it.
Better to put efforts in community initiatives: in countries like Cambodia where most women give birth at home, should scale up BFCI instead, some countries with BFCI and no BFHI have reduced child mortality .	It is important for mothers to have skilled workers (such as in hospitals) present during deliveries—mothers' lives are also important; need to work to strengthen hospitals' link to communities.
Model mothers and traditional birth attendants (TBAs) delivering door-to-door messages are more effective than BFHI.	Mothers who want to breastfeed in hospitals will not be supported without BFHI.
Training and education can be done without BFHI; TBAs and midwives can be trained.	BFHI helps maintain training; BFHI educates (people will continue smoking if we don't put up barriers).
Most BFHI hospitals have not been reassessed, how can we be sure it will work? Arguments for BFHI are subjective.	In New Zealand, 20% of babies are exclusively breastfed after five years of BFHI, this was achieved with reassessment of hospitals; this is evidence.
BFHI includes the Code of Marketing and is against trade in this globalized world.	Breast-milk substitutes would proliferate if BFHI ended.
It is difficult for hospitals to implement BFHI because of facilities needed for rooming in, mothers not wanting to breastfeed.	WHO and UNICEF have developed good tools to implement BFHI; changes being asked of hospitals are based on physiology.
Using formula is a choice.	The "choice" to use formula may not be an informed choice; there is no choice about breastfeeding, the choice is whether to become pregnant or not.

Dr Rea concluded her presentation on BFHI with lessons learnt (e.g. many BFHI hospitals have reverted to pre-BFHI conditions) and suggested that more could be learnt by, for example, improving self-monitoring, avoiding “politics” in certification, reviewing the mechanics of external assessment, and making BFHI part of the country health system structure.

To end the session on BFHI, the plenary suggested further actions that could be taken:

- move into the community—where the problem is;
- show an increase in BFHI coverage; set a target for the region — we may be focusing on the wrong target;
- focus on national governments—get BFHI into national legislation and into the national health system—if a hospital is not BFHI-certified, it doesn’t open its doors; incorporate BFHI as part of a system, not a programme;
- [governments should] set standards; this way, even private hospitals can eventually be made baby-friendly;
- make the issue public;
- look further into what can be done with BFHI and find more creative ways to implement the initiative; the way BFHI is implemented is key and is dependent on us—health professionals.

2.2.3 Increasing health worker skills and improving performance for breastfeeding

Dr Randa Saadeh, Scientist for Nutrition for Health and Development of the World Health Organization, explained the rationale for the current emphasis on training as a way to address the many gaps highlighted in the Global Strategy for IYCF, the Innocenti Declaration 2005, and the planning guide on the implementation of the Global Strategy. Key training courses on IYCF are listed and described in a pamphlet, which Dr Saadeh distributed along with a CD for each country. Dr Saadeh cautioned participants that before introducing any courses, a comprehensive training plan must be prepared, which includes action steps and identifies trainees. She highlighted the integrated course for IYCF Counselling which was based on and brought together previous counselling courses, and was updated with new evidence and links with the Global Strategy. The integrated course addresses the urgent need to efficiently train large numbers of people.

Dr Audrey Naylor, President and Chief Executive Officer of Wellstart International, presented ways to strengthen preservice curricula by first identifying how the health profession acts as barriers to breastfeeding. These barrier include health professionals—when they believe that infant formula is “just as good” or even better than human milk as a result of the infant formula industry’s very aggressive marketing efforts—and the lack of knowledge of health workers on the benefits of breastfeeding, the physiology of lactation, and the skills to help mothers, babies, and their families. Dr Naylor proposed that preservice education could be effective in helping to overcome these barriers in ways that are sustainable, far-reaching, cost-effective, and transformational, from assessment to implementation to monitoring and evaluation. She identified elements that increase the success of preservice education

which include, formal approval by the institution, faculty involvement in planning, a multidisciplinary leadership team, and a coordinator who is given time for the responsibility. Dr Naylor also recommended the use of the *Lactation Management Curriculum: A Faculty Guide for Schools of Medicine, Nursing, and Nutrition* (4th ed., 1999) and *Lactation Management Self-Study Modules*, Level 1.

The group assignment, presented by Dr Naylor, involved having three groups develop recommendations on an issue assigned to them. The issues were: for Group 1, how to integrate in-service training as part of a country IYCF strategy; for Group 2, how to change preservice curriculum to include basic lactation management; and for Group 3, innovative ("out of the box") ways to train other than face-to-face. The group reporting session was chaired by Dr Yolanda Oliveros.

Group 1: Challenges faced by a country in implementing a training programme include the cost of the programme, the lack of trainers, the length of the course (five days may be too long), and how to train different groups using standards. To integrate the training programme, the country would have to increase its budget for training. It could then train one trainer for every institution, train one trainer at the regional level, and hold regular annual training programmes. There would be one standard course for training the trainers. Different tools (DVDs, CD-ROMs, paid online courses) could be used for different participants (e.g. doctors, peer counsellors). Training courses can also be taught in phases (although this could increase transportation and logistical costs for participants).

Group 2: For a country to change a preservice curriculum to include basic lactation management, its Ministry of Health would have to work with the Ministry of Education. Medical schools would need to champion these issues and chairs of obstetrics and paediatrics would need to be involved. Professional societies would also need to be involved to pressure the schools to change their curriculum. (In Solomon Islands, the message is taught in secondary schools.)

In Malaysia, the National Plan of Action for Nutrition has, since 1992, included breastfeeding education. The plan is implemented by collaborating agencies through a national coordinating committee under the Nutrition and Food Safety Council chaired by the Minister of Health. The Ministry of Women's Affairs (a powerful ministry) also supports preservice education.

Dr Atwood challenged WHO and UNICEF to give all professional staff a back-to-school week. All staff would go back to the institution where they came from and rekindle old relationships while championing breastfeeding and other issues.

Filling holes in existing courses, tapping professional associations, synergising messages from WHO and UNICEF to training and educational institutions, and translating messages for community practitioners were also suggested.

Group 3: The constraints of face-to-face training identified by the group were expense, time away from jobs, barriers from environmental factors being ignored, and the uncertainty of attaining desired results. A combination of methodologies and modes of following up should be used for breastfeeding training. Trainers should go

to the community where experiences are richest to reinforce the link with the community. A supportive environment and programmed communication using standardized messages should help give the community confidence to share experiences. Trainers should provide continuous support and follow up. Trainers could penetrate the community with messages using technology, e.g. telephone counselling, e-mail, radio, SMS messages, distance learning, teleconferencing, CD-ROMs.

Other suggestions and comments.

- Mothers of low-birth-weight babies, who spend much time in the hospital and learn a lot, can pass on that learning and be asked to help other mothers.
- Australia has a Lactation Resource Centre run by the Australian Breastfeeding Association which archives scientific articles on breastfeeding issues. This knowledge is combined with knowledge from the community for training breastfeeding counsellors. There is also a strong online training component.
- Norway has a breastfeeding competency centre with advocacy and media components.
- WHO has developed an Integrated Management of Childhood Illness (IMCI) tool which can modify IYCF training to become a computerized course and a distance-learning module.
- Need to increase communication between mothers and clinicians. A study found that mothers think clinicians are important in decisions regarding breastfeeding but clinicians don’t think it is their role to influence such decisions; clinicians said that they talked about breastfeeding with mothers but mother said that clinicians did not provide enough information.
- Some places cannot be reached by electronic means; use electronic communication for some areas so that you can use your time and resources to reach less accessible areas.

2.2.4 Communication and social mobilization

Ms Susan Mackay, Regional Programme Communication Specialist of the UNICEF East Asia and Pacific Regional Office, presented “Only Mother’s Milk! Harnessing the Power of Communication for Change.” Ms Mackay used examples from a remote village in the Lao People’s Democratic Republic and from the Philippines (an excerpt from the UNICEF documentary “Formula for Disaster”) to show the effects of infant-formula advertising and emphasized the need to be able to match industry marketing efforts with advertising for mother’s milk. Cambodia’s television spots, for example, were funded by the United Kingdom’s Department for International Development and developed by the BBC World Service Trust and the Ministry of Health, and were based on much research and pretesting and produced with much talent. Other materials included a television soap opera with breastfeeding stories and radio phone-in programmes. Ms Mackay elaborated on the following suggestions:

- develop a framework for monitoring and measuring impact (need to use a scientific approach to communication);

- engage the power of the community (use participatory methodologies);
- get creative (bombard with all kinds of media; use Create toolbox).

In answer to questions, Ms Mackay made the following comments and additional suggestions:

- Make arguments simple enough; “creatives” will then lift the arguments to another level;
- Be clever about who we use as spokespersons; work on clarity—there’s a real resistance of clever people to sound simple;
- The message is so compelling, we don’t have to do much to it;
- Be strategic: use the right tool for the right market (e.g. the Philippine Supreme Court “event”);
- There is a lot of pro bono interest. We should get together as a region and prove to donors that we can get results and they can get a lot for the money they invest.

> We have to be as good as the new media. We have great products and we can sell them just as well as others do. How can we get as good as they [infant formula marketers] are? —Ms Susan Mackay

2.2.5 Translating lessons (from previous sessions) into practice

Participants were asked by Dr Atwood to form three concentric circles to discuss three levels at which a supportive environment for breastfeeding can be created. The inner circle (1) was composed of persons with direct personal experience with breastfeeding who discussed the creation of the interior environment for the breastfeeding mother. Members of the middle circle (2) discussed the creation of the environment in society for breastfeeding. The outer circle’s (3) members discussed the creation of the political environment for breastfeeding.

Circle 1 (interior environment): education, government benefits, income support (job, non-discrimination in law), role model, doctor’s support, option to use a midwife, hospital and health worker support, husband’s support, mother’s support, smiling people, privacy, peace and quiet, time, access to baby, peer support, place to express milk, accommodating workplaces, someone to explain the pain with a personal touch, family support and absence of temptation (no formula).

Circle 2 (societal environment): space within the work environment, alternative schedule options, paternity leaves, community awareness to value mothers, community and peer support, health worker support, worker federations support, prenatal counselling for fathers and grandfathers, non-traditional partners support, baby cafés and other physical “havens”, visible support in commercial places (e.g. decals in stores supporting breastfeeding), and awards and incentives.

Circle 3 (political environment): maternity protection (guaranteed income, six months maternity leave, job security, breastfeeding and child care facilities in workplaces), protection from the social concept that formula feeding is the norm and misinformation about formula, start breastfeeding education in secondary schools and legislate to require breastfeeding education, regulation and accreditation of hospitals,

paternity leave and flexible schedules, formula only by prescription and not available in retail outlets and only through pharmacies for mothers who cannot breastfeed, tax rebates for breastfeeding-friendly workplaces and breastfeeding policy.

2.3 Part 2: Preventing a bottle-feeding culture

2.3.1 Philippine story highlights

Dr Yolanda Oliveros, Director IV of the National Center for Disease Prevention and Control (Department of Health, Philippines), presented “Reversing the Bottle-Feeding Culture in the Philippines.” In the Philippines, almost two thirds of deaths in children less than age 5 occur in the first 6 months after birth. Of these, 9 out of 10 deaths occur in infants not exclusively breastfed. In spite of these realities, breastfeeding initiation and exclusive breastfeeding rates continue to decline, while the economic burden of using infant formula remains heavy ($465 million, plus related costs for caring for sick and dying children). The Philippine response has taken the form of an IYCF National Plan of Action and Policy (May 2005) to ensure that wherever mothers are, they receive breastfeeding support. Local and international partners have been tapped to help the government implement the plan, which received a boost from the Accelerated Hunger Mitigation Program of the government (June 2007 to December 2008). The latter provides for IYCF training to cover 75% of all *barangays* (villages). In partnership with employer and retailer groups, the government has also set up some mother-and-baby-friendly workplaces and malls.

An attempt by the Department of Health to strengthen the National Code of Marketing by revising its implementing rules and regulations has resulted in a battle with the milk companies in the Supreme Court and on the streets of Manila. Milk companies spent nearly $100 million in 2006 for marketing and advertising breast-milk substitutes in the Philippines (but only $46 million in the United States). The industry uses health facilities for promoting their products and blatantly violates the Milk Code. The battle rages along many fronts: for example, the American Chamber of Commerce, endorsed by the United States embassy in the Philippines, wrote to President Gloria Macapagal-Arroyo on behalf of the milk companies. Related to this issue is the effort of the government to revive the Mother-Baby-Friendly Hospital Initiative (MBFHI). While 82% of government and private hospitals are accredited, compliance with Steps 1 to 10 is uneven. To overcome these barriers, the government has revised the MBFHI policies (June 2007) and will hold national and local seminars and training. This year, MBFHI compliance has also been made a requirement for a hospital to be accredited by the Philippine Health Insurance programme.

2.3.2 Code of Marketing of Breast-Milk Substitutes

Mr David Clark, Nutrition Specialist (legal) for UNICEF, and Ms Yeong Joo Kean, Legal Advisor for IBFAN/ICDC Penang, reported on and raised issues regarding the International Code of Marketing of Breast-Milk Substitutes in the Asia-Pacific region. They showed that with 36.6% market share, the Asia-Pacific region is a huge market for the baby-food industry and, as a result, marketing in the

region is far worse than in any other region in the world. They presented examples of Code violations in all forms. They also presented the status of Code in countries of the region—as a law, as voluntary codes, as a draft, among others—and the problems of implementation in each group. Growing concerns regarding the Code are inappropriate funding (such as sponsorship by milk companies of health professionals' events) and the intrinsic contamination of infant formula (public is not sufficiently informed and milk companies do not comply with the requirement to inform them of risks).

> Companies will do whatever they can get away with. The region's laws are not sufficiently strong. —Mr David Clark

For the group activity, six groups were formed and two groups each were assigned to one of three scenarios.

Scenario 1 entailed milk companies defending their materials for health workers to inform them about new infant formulas, and Food and Drug Administration (FDA) representatives reviewing the materials to see if they comply with the Code. Group 2 represented the milk companies, Group 1 represented FDA.

Group 2 pointed out that the materials say that they are for medical professionals only, use scientific data with recent references, and include a statement that breast milk is best for babies.

Group 1 pointed out words, images, data and claims on the materials that were not factual, promotional, or not backed by evidence. They found references to be old, irrelevant, or hard to read, and an attribution to be incorrect. Further, the statement in support of breastfeeding is smaller in type than statements promoting the product (not a balanced presentation). One of the materials had no notice on whom it was for.

Mr Clark pointed out that this exercise shows that the Code is not completely clear. The Nan (Nestle) material is more compliant with the Code but not all claims are substantiated. The other piece was more clearly unscientific and not factual and clearly promotional.

Scenario 2 had representatives (Group 3) from an infant food company claiming that the law on the Code hampers programmes to prevent the transmission of HIV to children, violates a mother's right to information on infant feeding, and is an obstacle to providing free infant formula to HIV positive women who need it. Group 4 represented the Ministry of Health and defended the law against these specific accusations.

Infant Formula Company (Group 3)	Ministry of Health (Group 4)
HIV virus can be transmitted through breast milk—mothers need safe alternatives. This law prevents this.	The interest of industry is to protect its shareholders' interests, not those of mothers.
Article 5.1 bans advertising—this conflicts principle of free speech.	
This law (Code) is 26 years old. Massive developments in terms of technology and	The object of the Code remains valid: to promote, support and protect breastfeeding. Evidence

scientific evidence shows our new formulas are as close as possible to breast milk. There are not the same risks any more from formula feeding—we need close contact with health professionals to keep them up to date—our products comply with the quality standards set by Codex.	shows that infant formula may not be safe and breast milk is still the best. World Health Assembly Resolution 59.21 (2006) states the risk of infant formula and condemns powdered milk.
The law is preventing us from providing free supplies to the hospitals, when the Code allows it under article 6.6.	
WHA calls for informed decision making by HIV positive mothers, and the law prevents us from sharing the necessary information.	Government is custodian of the Code and it is the responsibility of government to give mothers information.
Article 24 2(c) of CRC obliges government to combat disease and malnutrition through readily available technology and through the provision of adequate nutritious foods.	WHA Resolution 59.21 (2006) states the risk of infant formula and condemns powdered milk.
	There is no need to repeal the law.

Mr Clark reminded the participants that the WHA is clear: donations and low-cost products to health workers are not allowed. He pointed out that the Code is more relevant in the context of HIV because it makes sure that infant formula is prepared properly and is given on medical advice; it also protects infants of HIV positive women. With regard to ambiguities in the Code, Mr Clark recommended that governments should adopt good legislation to address them.

> We have to be prepared to defend the Code with evidence, references, etc. We have to know more than everyone else. We have to know our stuff cold.
>
> —Dr Atwood

Under **Scenario 3**, Group 6 represented a formula company offering to sponsor a paediatrics conference and donate some of its profits to the association if it endorses the company's formula. Group 5 represented the executive board of the National Paediatric Association which must decide to accept the offer or not in light of the International Code.

Group 6 cited several articles (e.g. 7.5, 7.2, 7.3) to show why sponsorship of a conference would not violate the Code. They also cited Articles 7.1, 8.2 and 4.3 to support their interpretation of the Code as allowing them to fund and be a partner of the breastfeeding campaign. Finally, they cited Articles 9, 10 and 7.3, to justify the correctness of the association's endorsement of their product.

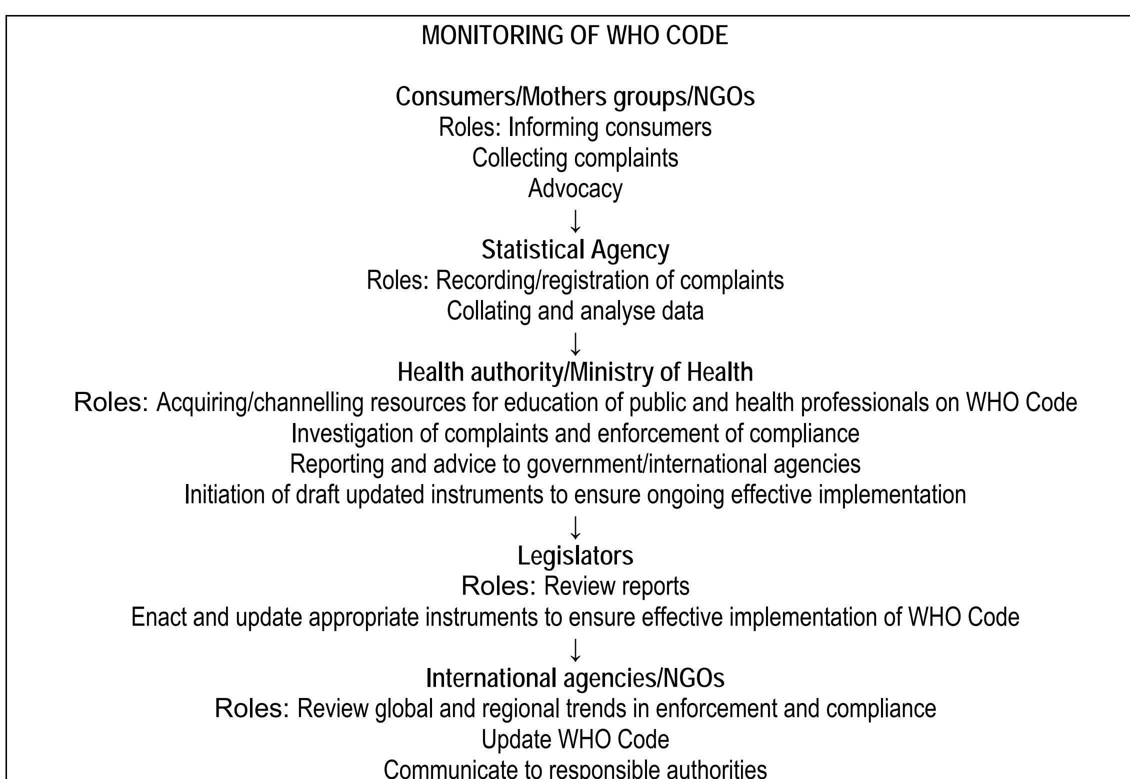
Group 5 declined Group 6's offer on the basis that accepting sponsorship from a milk company would undermine the association's responsibility to adhere to the Milk Code and promote breastfeeding. In their view, rejecting the offer avoids entering a possible conflict-of-interest situation, as accepting financial support and other incentives would create conflicts of interest.

Mr Clark agreed that for a professional health association to endorse a product is a violation of the Code and governments should be on the lookout for conflicts of interest. The sponsorship of conferences is not clear in the Code and countries again need to clarify these issues in their laws. Dr Cavalli-Sforza suggested annotating the

Code to update it. Mr Clark also informed the participants that UNICEF is organizing a regional Code workshop to start setting up a regional network.

Challenges	Suggested Strategies
Very little (or no) systematic monitoring and enforcement; violations are rampant in the region but no companies have been brought before the law; Code suspended in Thailand since 1997.	Step up efficiency and commitment; improve skills (training and technical support in law-making, monitoring); work on regional cooperation: cohesive policies; exchange of ideas, experience, information on Code measures and on IYCF.
Health care system used by companies to promote their products; sponsorship.	Steer away from dependence on industry.
	Find new advocacy platforms: HR approach, economic arguments, risk of artificial feeding.

For an effective monitoring of the Code, Dr Smith presented the following proposed division of responsibilities:



Selected comments from the discussion:

Dr Rea: The industry knows how to use the Code well. The industry people are the most prepared and have the best arguments.
Dr Smith: Never underestimate the power of public shaming.
Ms Yeong: Governments must take responsibility. You cannot abdicate.
Dr Rea: We have more allies than we think. They may just not know about the Code.
Dr Smith: Consumers need to be mobilized.
Mr Iellamo: We need to engage other groups, not necessarily in health.
Ms Codling: We should commit to training.

Dr Hossain: If you see something, say something (from the US Department of Homeland Security).

Should code violations be posted on a United Nations web site?

After the Clark/Yeong presentation, a discussion ensued regarding the posting of Code violations on the WHO web site. This is how, in summary, it unfolded:

Ms Don:	Malaysia informs WHO/UNICEF of violations hoping they can help, but it hasn't happened yet.
Dr Cavalli-Sforza:	WHO and UNICEF should consider responding to requests received from countries to publicize Code violations, by putting these complaints in the public domain, through their websites.
Dr Saadeh:	That is not the role of WHO but of governments.
Dr Atwood:	Why doesn't UNICEF publish violations?
Dr Smith:	From a community organization standpoint, we endorse the recommendation to put violations on a United Nations web site.
Ms Don:	WHO and UNICEF should settle the issue of what to do with reports of violations.

2.3.3 Technical updates

Ms Ali Maclaine showed how breastfeeding in emergencies needs to be protected, promoted and supported (mandated by Article 25 of the Convention of the Rights of the Child and within the scope of the Global Strategy on IYCF) because infants and young children are most vulnerable in emergencies and exposed to the high risks associated with artificial feeding. Child morbidity and crude mortality can increase by 20% in as little as two weeks in emergencies. In one emergency, it was found that infants who are not breastfed were 50 times more likely to be admitted to hospital with diarrhoea and 8.5 times more likely to die. Furthermore, formula, bottles and teats are often brought into emergency areas. Often, this formula is in the wrong language, near its "use by" date, or are specialized or medicalized formulas that are freely distributed to all mothers with no guidance. A study of breastfeeding practices after an earthquake in Indonesia revealed that one month after the earthquake many more infants (almost 15% more), who were being breastfed before the earthquake, were being fed formula by mothers who had received donations during the emergency. Data also showed a dramatic increase in the prevalence of diarrhoea in infants and children under age 2 after the earthquake—with the diarrhoea rate double for those who received formula, than for those who did not.

Training and reference materials on IYCF in emergencies (IFE) are available online (www.ennonline.net), in print, or on CD. The Operational Guidance booklet has also just been updated (Version 2.1, February 2007). The booklet is a nontechnical document with a basic set of "dos" and "don'ts," and would be useful for all levels of staff of national governments, United Nations agencies, NGOs and donors. A regional IFE meeting will be held in Indonesia, 6–8 November 2007, to determine practical steps and a strategy to support IFE. Steps to take include:

- translate and distribute key IFE material—especially the *Operational Guidance* booklet;
- investigate your country's IYCF policies, guidelines and materials for IFE;
- identify key players;
- provide country and regional orientation and training;
- ensure key players attend the regional IFE meeting in Indonesia.

> Donations of breast-milk substitutes or bottles and teats should not be accepted in emergencies—at all.
> —*Operational Guidance on Infant and Young Child Feeding in Emergencies*, V2.1 (February 2007)

Dr SM Moazzem Hossain, Infant Feeding Advisor to UNICEF, presented an update on HIV and infant feeding. The United Nations recommendations for breastfeeding for HIV negative women or HIV status unknown, is exclusive breastfeeding for six months and continued breastfeeding for two years or beyond. The most appropriate infant feeding option for HIV exposed infants (with HIV positive mothers) depends on individual circumstances, including consideration of health services, counselling and support. United Nations guidelines state that "when replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), avoidance of all breastfeeding by HIV infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life, and breastfeeding should be discontinued as soon as conditions are in place, taking into account local circumstances, the individual woman's situation, and risks of replacement feeding."

To help HIV positive mothers make the best choice, they should receive counselling that includes information about the risks and benefits of various infant feeding options, and guidance in selecting the most suitable option for their situations. A study showed that early (0–3 months) mixed breastfeeding is a risk factor for postnatal transmission and that early breastfeeding cessation could prevent a sizeable proportion of postnatal HIV transmission (68% of all postnatal HIV infections occurred after age 6 months). Another study showed that early mortality (through age 7 months) is higher in formula-fed than breastfed HIV positive infants on AZT; the predominant causes of infant death are diarrhoeal disease and pneumonia. The same study showed, however, that HIV infection at 7 and 18 months is higher in breastfed than formula-fed infants, despite 6 months of AZT, and at 18 months there is no difference in mortality and HIV infection between formula and breastfed infants.

> Governments and other stakeholders should revitalize breastfeeding protection, promotion and support in the general population. They should also actively support HIV infected mothers who choose to exclusively breastfeed, and take measures to make replacement feeding safer for HIV infected women who choose that option.
> —United Nations recommendation 2006

Dr Rosa Constanza Vallenas, Medical Officer for Child and Adolescent Health and Development of WHO, discussed the long-term effects of breastfeeding. Rigorous study has shown that breastfeeding is good for everyone and gives credence

to the early origins hypothesis that factors affecting the foetus and the young have long-lasting effects and are important causes of chronic diseases such as hypertension, diabetes and ischemic heart disease. Having been breastfed, modestly reduces blood pressure, somewhat reduces total serum cholesterol, and reduces by 22% the risk of being overweight or obese. Breastfeeding significantly reduces (by 37%) the risk of developing type 2 diabetes, raising cognitive development scores by 4.9 points, and is positively associated with educational attainment.

Dr Vallenas also reported on the feeding of low-birth-weight (LBW) infants—LBW being the direct cause of 27% of the 4 million neonatal deaths that occur each year. LBW infants should be breastfed or fed expressed mother's milk, donor human milk, or pre-term infant formula (not standard formula). They should be fed with a cup rather than a bottle.

Resources on these issues can be found on http://www.who.int/child-adolescent-health/publications/pubnutrition.htm .

Dr Randa Saadeh, Scientist for Nutrition for Health and Development of WHO, presented "Breastfeeding Beyond Six Months." She reported that for complementary feeding, a review of existing material was done and a good set of indicators for complementary feeding is being developed (now, only one general indicator exists). Dr Saadeh presented data on the current situation in the region (by country) in terms of the median duration of breastfeeding, continued breastfeeding at 12–15 months and 20–23 months, complementary feeding, and timely initiation of complementary feeding. She also reported on updates on recommended practices:

- exclusive breastfeeding for 6 months, with ongoing breastfeeding up to 2 years or beyond;
- appropriate complementary feeding of the breastfed child (guiding principles);
- appropriate feeding of the non-breastfed child age 6–24 months.

Dr Saadeh presented data showing that after exclusive breastfeeding and insecticide-treated materials, continued breastfeeding with complementary feeding is the most effective way of reducing under-5 mortality. Complementary feeding reduces the expected percentage of under-5 mortality by 6%. She also provided information on the energy requirements of children from all intake (including breast milk) and from complementary foods, the average recommended meal frequency, the feeding of children during and after illness, and other guiding principles for feeding breastfed and non-breastfed children.

2.3.4 General discussion on technical issues related to breastfeeding

Dr Naylor moderated this discussion which included questions on:

- positive effects of breastfeeding on women in emergency situations;
- feasibility of implementing AFASS for children of HIV positive mothers in the Asia-Pacific region (it's different for each mother);
- definition of "exclusive breastfeeding" (does it include "predominant breastfeeding?);

- effect of anaesthesia from caesarean section on oxytocin or prolactin;
- frequency of mixed feeding for this region;
- definition of timely complementary feeding;
- effect of continuous breastfeeding during pregnancy on the amount of colostrum for the newborn infant;
- reduction of the incidence of child abuse involving breastfed children (a study in Australia showed that abuse by mothers is more likely to be done by those who are away from their babies for 20 hours a day and did not breastfeed).

2.3.5 Recommendations and suggested actions

Dr Atwood summarized the recommendations and suggested actions that arose from all the discussions and presented these to the plenary for review and revision. The final version of this document, incorporating all changes agreed on by all participants of the consultation, is Annex 4 of this report (see also section 3: Conclusions). The recommendations and suggested actions were organized under the following headings:

- Breastfeeding Economics
- Use of Data, Communication, and Advocacy
- BFHI
- Creating an Enabling Environment
- Increasing Health Worker Skills
- Code of Marketing

2.3.6 Closing ceremony

Dr Richard A. Nesbit, as Acting Regional Director of the WHO Regional Office for the Western Pacific, re-emphasized the importance of this consultation, considering that breastfeeding is under threat in the Asia Pacific region with breastfeeding rates declining and industry continuing to introduce substitutes. He pointed out that many partners and stakeholders have come together at this consultation and have produced tangible outcomes in the form of recommendations. All participants should feel a part of the network of people and organizations for breastfeeding in the region and globally. Each is expected to implement the actions and recommendations agreed upon at this meeting in his or her country. Each is a driver of the efforts that touch all parts of society and everyone needs to work together. Dr Nesbit affirmed continued support from WHO and UNICEF and that these organizations will continue to collaborate on these efforts. He thanked all the contributors, resource persons and officers of the consultation.

Ms Don thanked all participants for the very enriching consultation which gave everyone the opportunity to share experiences from their countries. She urged all to bring the conclusions and recommendations to their countries as a guide and expressed the wish to see some participants in Penang for the IBFAN meeting.

3. CONCLUSIONS

In relation to breastfeeding economics, it was recommended that participants take steps to increase the visibility of the economic value of breastfeeding and the health costs attributed to artificially fed infants. They were also urged to use available data to show women's time investment in breastfeeding and how competition from baby-food producers and employers reduces the practice of breastfeeding. Actions to take included advocating the inclusion of breast milk in national production statistics; working with nutrition economists to develop arguments for employment equity with paid maternity leave; and implementation of BFHI by showing savings to the health system from breastfeeding. International and research organizations are to gather data to link industry marketing with declining breastfeeding rates. PROFILES was cited as a useful tool for calculating the benefits of breastfeeding.

In using data, communication and advocacy, recommendations made were to: use WHO indicators and definitions when using evidence to support IYCF practices; focus on priorities (see Annex 3); promote breastfeeding in popular culture by citing benefits of breastfeeding, as well as risks from not breastfeeding; use data to establish national goals; and to establish a stronger link to the Regional Child Survival Strategy. Suggested actions included: WHO/UNICEF to help countries do IYCF surveys; participants to commit to a timetable for addressing priority problems (Annex 3); and UNICEF/WHO to help countries find funding for breastfeeding communication plans.

To strengthen the BFHI, recommendations included: improving monitoring of hospitals; making BFHI part of the country health-system structure; and extending BFHI to the community. Actions to take included: WHO/UNICEF to disseminate the new BFHI package; UNICEF Country Offices to map technological reach for alternate monitoring tools; participants to advocate with ministries of health for BFHI certification as standard for all hospitals; participants to review the Cambodia experience and visit Cambodia to understand BFCI; WHO/UNICEF and governments to commit to BFHI certification of all hospitals by 2015; participants to work with NGOs and professional societies for BFHI external reviews; and participants to support governments to develop a web site to show status of BFHI every year.

For creating an enabling environment, recommendations were: guarantee quiet spaces for breastfeeding women; improve access of working mothers to their babies during working hours; increase access of breastfeeding mothers to supportive persons and groups; guarantee access to accurate knowledge on breastfeeding; ensure adequate maternity and paternity leave, a guaranteed income, and job security; make changes in society and educational systems to create a breastfeeding-positive culture; implement national regulations to control marketing of breast-milk substitutes; and advocate for breastfeeding from a women's and child's rights perspective. Actions to achieve these recommendations include: reviewing the status of present legislation for maternity protection and meeting with influential government officials about this (and also for advocacy); exploring possible links with appropriate workers' and employers' associations for changes in the workplace for breastfeeding; advocating with ministries of education for inclusion of breastfeeding education in primary and secondary education, based on a draft curriculum outline; and interviewing mothers of

LBW babies while they are in the hospitals to find out if they can become breastfeeding advocates.

To increase health worker skills, recommendations included: strengthening the complementarity of preservice and in-service training for various aspects of the Global Strategy; adapting preservice training to different educational cultures; using a combination of online and face-to-face training; linking with professional societies; and promoting integrated courses endorsed by WHO/UNICEF. Participants were asked to take actions that included: reporting the results of this meeting to senior representatives of government; and exploring knowledge transfer to online communities by various media. WHO and UNICEF were tasked with joining IMCI and IYCF training curriculum; finding ways to more clearly link breastfeeding and the Regional Child Survival Strategy through the Regional Committee meeting; investing in the development of interactive CD training programmes; and working with governments to develop a clear and detailed training plan for all relevant health workers, and to seek budget for this.

In relation to the Code of Marketing, the recommendations were: to build capacity in Code implementation; improve monitoring of Code compliance and violation; increase understanding by health officials and workers of conflicts of interest; improve knowledge of relevant groups on the Code; produce an annotated version of the Code; increase trade and labour organization involvement. To achieve these goals: organizations are to support participation (including of senior management) in the UNICEF-funded training in November at IBFAN-ICDC Penang, Malaysia, on the Code; WHO/UNICEF to facilitate regional cooperation and networking; IBFAN-ICDC to draft an annotated and updated guide for use of the Code; WHO/UNICEF to strongly promote institution of full laws supporting the Code in selected countries; UNICEF to share orientation modules on the Code; participants to accept personal responsibility for thorough self-knowledge of the Code and related issues; WHO/UNICEF to support governments in establishing codes of conduct for health professionals on issues related to the Code; WHO/UNICEF/IBFAN to develop a way to publicize reports on the Code for public use; and all to review the status of national monitoring systems of Code compliance and violations.

See Annex 4 for the complete Recommendations and Suggested Actions document.

4. ACKNOWLEDGEMENTS

The contribution of the following agencies to funding this consultation is gratefully acknowledged: Japan Ministry of Health, Programme for Technology Transfer, and AusAID.

ANNEX 1

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

UNITED NATIONS CHILDREN'S FUND
REGIONAL OFFICE FOR EAST ASIA AND PACIFIC

WHO/UNICEF CONSULTATION ON

WPR/ICP/NUT/2.2/001/NUT(2)/

2007.1
BREASTFEEDING PROTECTION,
PROMOTION AND SUPPORT

19 June 2007
ENGLISH ONLY

Manila, Philippines
20-22 June 2007

PROGRAMME OF ACTIVITIES

Wednesday, 20 June 2007

08:00 – 08:30	Registration
08:30 – 09:00	Opening
09:00 – 09:30	Coffee Break
09:30 – 10:30	Breastfeeding: essential for child survival and development
10:30 – 12:00	Country situation analysis
12:00 – 13:30	Lunch and press conference

Part 1: Creating an enabling environment for breastfeeding

13:30 – 14:00	Presentation: Case study in Cambodia
14:00 – 15:30	Baby-Friendly Hospital Initiative (BFHI)
15:30 – 16:00	Coffee Break
16:00 – 17:00	Strengths and weaknesses of BFHI (Panel discussion)
17:00 – 17:30	The future of BFHI
17:30	Informal Reception

Thursday, 21 June 2007

08:30 – 10:30	Increasing health worker skills and improving performance for breastfeeding
10:30 – 11:00	Coffee Break
11:00 – 12:00	Communication and social mobilization
12:00 – 13:00	Lunch
13:00 – 14:30	Translating lessons (from previous sessions) into practice

Part 2: Preventing a bottle feeding culture

14:30 - 15:00	Philippine story highlights
15:00 – 15:30	Coffee Break
15:30 – 17:00	Code of marketing of breastmilk substitutes

Friday, 22 June 2007

08:00 – 10:00	Discussion of the Code implementation scenarios (Group work)
10:00 – 10:15	Coffee Break
10:15 – 11:00	Report from the six groups and short discussions
11:00 – 12:00 and	Discussion of practical steps to improve Code implementation enforcement
12:00 – 13:00	Lunch
13:00 – 14:00	Technical updates
14:00 – 15:00	General discussion on technical issues related to breastfeeding
15:00 – 15:30	Coffee Break
15:30 – 16:15	Future plans
16:15 – 17:00	General conclusions and recommendations
17:00 – 17:30	Workshop evaluation
17:30 – 18:00	Closing

ANNEX 2

LIST OF TEMPORARY ADVISERS, RESOURCE PERSONS, OBSERVERS/REPRESENTATIVE AGENCIES, AND MEMBERS OF THE SECRETARIAT

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ANNEX 3

PROBLEM MATRIX

Indicator Problem/Countries

Practices

1. More than 5% babies never breastfed
2. Low initiation of breastfeeding (90%)
3. Use of water before 6months
4. Use of non-milk liquids before 6 months
5. Use of milk/formula before 6 months
6. Complementary feeding before 6 months
7. Complementary feeding started after 9 months

Current Programme

1. No national IYCF policy or strategy

2a. Low proportion of hospitals certified as Baby Friendly

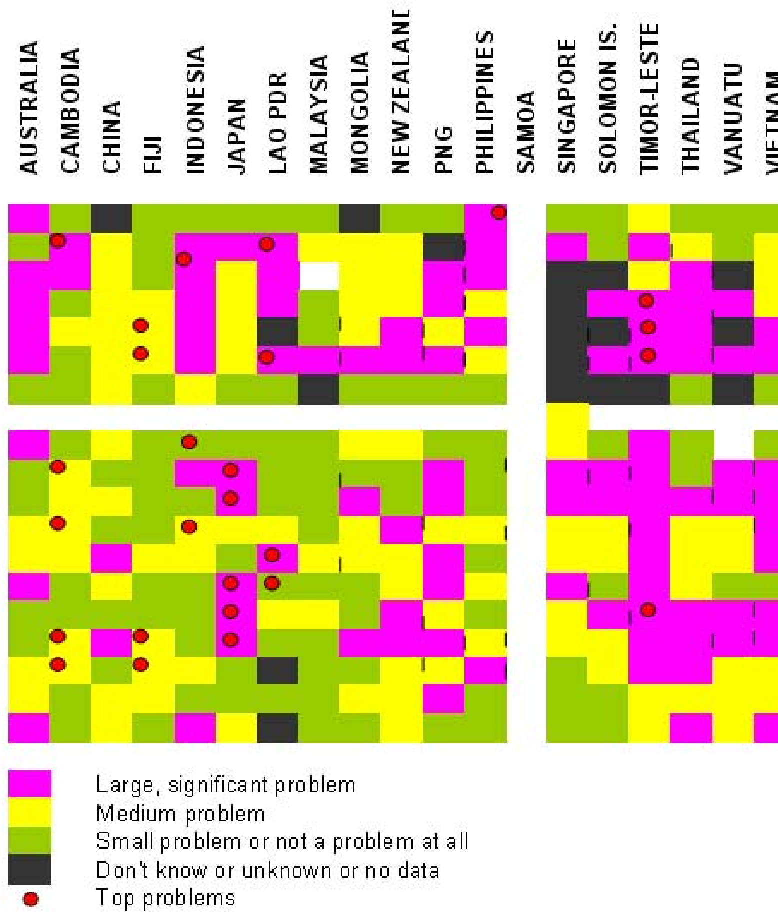
2b. Lack of/Poorly implemented re-assessment for BFHI

3. Low proportion of HWs training on IF/IYCF counselling/support
4. Absence of community acitivities such as mother support groups
5. No/insuffecient education campaigns to promote BF

6a. No legislation to control the marketing of BMS

6b. Legislation on BMS not enforced/high levels of marketing BMS

7. No/ineffective maternity protection
8. Absence of NGOs, CBOs, civil soceity working on BF promotion
9. No/Inactive IYCF Coordinating Committee (or similar)



ANNEX 4

RECOMMENDATIONS AND SUGGESTED ACTIONS

BREASTFEEDING ECONOMICS

Recommendations

1. Increase the visibility of the economic value of breastfeeding.
2. Calculate health costs attributed to artificially fed infants.
3. Use time studies to demonstrate the opportunity costs of time investment women make to successfully breastfeed.
4. Highlight that market competition by baby-food producers and employers reduces the practice of breastfeeding.

Actions

1. Advocate for the inclusion of breast milk in national production statistics: commission studies of contribution of BM to national food statistics and GDP.
2. Work with nutrition economists to develop and back-up arguments for employment equity with paid and protected maternity leave on the basis of national economic development.
3. Use economic arguments on savings to hospitals, health systems, and through decreased burden of disease throughout the life cycle to advocate for regulations to require all health facilities to implement BFHI.
4. UNICEF/WHO work with research institutions to gather and analyse data that show the links between infant formula marketing and the decline or stagnation in breastfeeding rates.
5. Familiarise ourselves with and consider best-use of WPRO-recommended PROFILES module for calculating the benefits of BF (available on the CD).

USE OF DATA, COMMUNICATION, AND ADVOCACY

Recommendations

1. Ensure use of WHO-recommended indicators and definitions in order to strengthen use of the evidence to support arguments for IYCF practices.
2. Focus efforts on improving priority elements from the matrix (day 1) that need the most work.
3. Based on data regarding practices and attitudes, promote breastfeeding in popular culture by focusing communication on both benefits of breastfeeding and risks of not breastfeeding.
4. Use data to establish national goals and targets.
5. Use data to establish stronger link with Regional Child Survival Strategy.

Actions

1. WHO/UNICEF to assist countries to do IYCF surveys using appropriate indicators; disseminate data to responsible authorities. Use IYCF Assessment Tool provided.
2. Each participant (by country) to commit to a timetable for advances on priority problems from matrix.
3. Link solutions to prioritized problems (from matrix) to accelerate implementation of the regional Child Survival Strategy.
4. WHO/UNICEF survey and disseminate information on number and location of Lactation Resource Centers, or similar facilities.
5. UNICEF/WHO work with countries to find funding for the development of breastfeeding communication plans including materials for communication tool kit for use by countries in national Breastfeeding campaigns.
6. UNICEF to share regional communication tool kit (CREATE) being used for Avian Flu, emergencies, etc., with all participants (www.keenpub.co.th/unicef).

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BABY-FRIENDLY HOSPITAL INITIATIVE (BFHI)

Recommendations

1. Improve monitoring of baby-friendly hospitals through a combination of self- and community- based monitoring with less frequent external monitoring every 2 to 3 years.
2. Include BFHI as part of the country health system structure.
3. Extend principles of BFHI to health facilities and the community.
4. Standardise the implementation of the new BFHI guidelines.

Actions

1. WHO/UNICEF to ensure wide dissemination of the new BFHI package, and encourage countries to use the self-appraisal and monitoring tools.
2. UNICEF Country Offices (with IT support) to map the technological reach of alternate monitoring channels (e.g. e-mail, SMS, internet) for monitoring IYCF / Code indicators in the country.
3. Advocate with MOH to establish BFHI certification as standard for all hospitals and as a requirement for time-limited (2-year) hospital accreditation.
4. All participants to review the Cambodia breastfeeding experience and/or arrange a country visit to understand the lessons of the baby-friendly community initiative.
5. WHO/UNICEF and government partners commit to achieving baby-friendly certification in all hospitals in all countries in the region by 2015. (Use *Total Maternity Hospitals* as denominator)
6. Work with accredited NGOs and/or professional societies to expand the ability to conduct the BFH external reviews.
7. Support governments to develop a Website where status of BFHI is reported and reviewed each year.

CREATING AN ENABLING ENVIRONMENT

Recommendations

1. Guarantee breastfeeding women a space that is personally and mentally quiet and non-distracting.
2. Improve the access of a working mother to her breastfeeding baby during working hours.
3. Increase her access to supportive role models who will offer her personalized, caring support (mother, husband, friend, mother-to-mother support groups).
4. Guarantee her access to accurate knowledge and understanding of breastfeeding.
5. Ensure adequate maternity leave (6 months), a guaranteed income, and job security to support breastfeeding.
6. Ensure adequate paternity leave.
7. Make necessary changes in society and in educational systems to create a breastfeeding-positive culture.
8. Implement national regulations to control marketing of breast-milk substitutes to protect communities and families from misinformation.
9. Advocate for breastfeeding from a women's rights and child's rights perspective.

Actions

1. Upon return, review status of present legislation for maternity protection and antidiscrimination legislation. Arrange meetings with appropriate (influential) ministry counterparts.
2. Organize a meeting with women and men in ministries of influence to examine potential for breastfeeding advocacy.
3. Educate ourselves on the ability and willingness of national and local trade union and employer groups to influence legislation and changes in the workplace for breastfeeding.
4. Create a draft curriculum outline (or use "model chapter" and related materials with evidence base) on breastfeeding and parenting in schools and communities (including prenatal visits) and use it to advocate with the Ministry of Education for inclusion in primary and secondary school curriculum.
5. Interview mothers of low birth weight babies during extended hospitalisation to evaluate their willingness to become community breastfeeding advocates.

INCREASING HEALTH-WORKER SKILLS

Recommendations

1. Strengthen the complementarity of preservice and in-service training for various aspects of the Global Strategy including BFHI, support, and counselling skills.
2. Adapt preservice training to different educational cultures of medicine, nursing, midwifery, nutrition, and public health.
3. Increase scale, reduce cost, and improve efficiency of in-service training by using a combination of online and face-to-face training methods.
4. Link with professional societies to get more breastfeeding content into post-graduate educational programmes (e.g., residencies, master's programmes, etc.).
5. Widen dissemination and use of a "model chapter" and related materials.
6. Promote the use of integrated courses endorsed by WHO/UNICEF.

Actions

1. Upon return, report to the senior representatives of government the results of this meeting in order to explore ways to mainstream breastfeeding material into existing courses.
2. Two countries to agree to explore knowledge transfer to "online" communities by multimedia routes (e.g., internet, e-mail, radio, video, phone, SMS, CD-ROM, distance learning, tele-conferencing, etc.), as complement to face-to-face training.
3. WHO/UNICEF to join Integrated Management of Childhood Illness with infant and young child feeding (IYCF) training curriculum.
4. WHO/UNICEF to develop a clearer demonstration of the link between breastfeeding and the Regional Child Survival Strategy to present at the Regional Committee meeting.
5. WHO/UNICEF to invest in the development of interactive CD training programmes for various aspects of IYCF.
6. WHO/UNICEF to work with governments to develop a detailed training plan for relevant health workers and seek budget.

CODE OF MARKETING OF BREASTMILK SUBSTITUTES

Recommendations

1. Build capacity in Code implementation.
2. Improve monitoring of Code compliance and violation at all levels.
3. Explain and increase the understanding by health officials and workers at all levels of importance of avoiding conflicts of interest.
4. Improve knowledge of lawmakers, communities, medical societies, *ourselves(!)* etc., on their responsibility with regard to the Code.
5. Improve regional cooperation.
6. Produce an annotated version of the Code incorporating resolutions, clarifying articles that would facilitate its use.
7. Increase worker involvement by establishing training and orientation programmes with trade or other labour organizations.

Actions

1. Organizations should support participation at the UNICEF-funded training in November at IBFAN-ICDC Penang, Malaysia on the Code of Marketing of Breast-Milk Substitutes. Encourage senior management participation.
2. WHO/UNICEF to use opportunity of this training to facilitate regional cooperation and networking.
3. WHO/UNICEF, in collaboration with relevant NGOs such as IBFAN-ICDC to draft an annotated and updated guideline for use of the Code.
4. WHO/UNICEF to strongly promote institution of full laws supporting the Code in selected countries.
5. UNICEF to share orientation modules on the Code for use at subnational level in order to facilitate Code awareness and improved monitoring.
6. All participants to thoroughly review the Code and related issues, and arrange meetings with colleagues to review lessons learned from this conference.
7. WHO/UNICEF to support government to establish Codes of conduct for health professionals in breastfeeding promotion, the Code, avoidance of conflicts of interest. Provide training for health workers on these responsibilities.
8. WHO/UNICEF/IBFAN to review national level monitoring systems of Code compliance and violations, and develop a method/process of sharing lessons learned.
9. WHO/UNICEF, in collaboration with relevant NGOs such as IBFAN-ICDC, to explore new ways to encourage infant formula companies' compliance with the Code, e.g. ways of making Code violations reported by countries better known to the public, awareness raising with media, reporting to the WHA.