SECTION II

PLENARY 9 AND 10
THEME OUTCOMES AND WORKSHOP REPORTS

PLENARY 11
CLOSING SESSION

THEME OUTCOMES AND WORKSHOP REPORTS

This section includes the outcome of each theme presented by theme coordinators on 27 September 2003, the last day of the Global Forum in Plenary 9: Moving Forward – Sharing of Workshops Outcome, which was chaired by Dr. Jairo Osorno and Anne Gaskell. Each theme presentation is followed by the workshop report.

THEME 1 – NATIONAL BREASTFEEDING MECHANISM

Theme Outcome by Dr. Arun Gupta

Good morning everybody. Theme 1 focused on national breastfeeding promotion mechanisms and issues:

- How to set a country agenda
- How to develop these plans
- How to assess these plans and
- How to have an accountability system in place.

The four workshops led to the sharing of stories and successes from various countries on these issues. One of the workshops had a lot of discussion and participation by those present on preparing a generic plan and the essential components within that plan.

During the four workshops, there have been several discussions, which led to action recommendations for us. Some of the recommendations directly relate to governments in their own country.

Action Recommendation 1: Building a strong partnership at the national level with the stakeholders

This is a very important lesson learned from countries that have breastfeeding support on the national level. We need to involve everybody who has a stake in it. Commercial enterprises do have a stake, but they do not have anything to do with the promotion of breastfeeding, so please take care of that clause which is build in on paragraph 44 on the global strategy for infant and young child feeding.

Action Recommendation 2: Advocate with Global Strategy on IYCF as the key document

Take hold of the "Global Strategy for Infant and Young Child Feeding" as the key document on the breastfeeding advocacy. You can prepare a document on this, which you can use as your advocacy document for your global strategy. Our group felt that this is key: if you carry only one thing from here back home, this will be the document that will be most useful for you in the next five to ten years.

Action Recommendation 3: Set national agenda using Code or breastfeeding prevalence

We learned from many groups that how you set the agenda, how you bring politicians and policy makers to think about this topic. It was very clear that using the prevalence rate on breastfeeding and implementation of the Code could be used to set an agenda in the country. These are two very important areas of work to set an agenda that draws the attention of all people - including policy makers and politicians.

Action Recommendation 4: Initiate action to have national IYCF policy and implement it within the existing structures

Action Recommendation 5: Use breastfeeding as an entry point in existing programmes

This was also brought up very clearly that we enter, not as a solo programme, but into the existing health programmes and use any programmes existing in the country level as a means to advocate for breastfeeding, rather than building a new breastfeeding programme in the country.

Action Recommendation 6: Action plans must be community oriented and have skills based capacity building components

It was clearly brought out that skills building and involving the community must be a key component of the national election plan.

Action Recommendation 7: Develop National plans that have clear goals, objectives and action plans with resource allocation

What are the further ideas in these headings? You can have a copy of the report that is available.

Action Recommendation 8: Build an evaluation/ assessment component as a part of the plan

That is very important. Unless we know what we are doing and can involve communities in the assessment of our work and get feedback to the nations only then

can we improve upon the existing plan. Initiate action to have national infant and young child feeding policies and implement them within the existing structures.

Action Recommendation 9: National plans must have a regular reporting mechanism in place
Finally, national plans must have a very strong reporting component. Some people want to see this monthly, some quarterly, or even annually. The recommendation is that a breastfeeding reporting mechanism must be in place.

Workshop Report

Preamble

The situation of breastfeeding is almost similar to what it was two decades ago. However there are certain areas where prevalence has marginally improved. At the same time, current environment provides wonderful opportunities to act during the next decade. Having national breastfeeding promotion mechanisms for protection, promotion and support of Infant and Young Child Feeding and setting accountability can play an important role in this movement. This should be viewed as for any other services available to people in the area of health and nutrition. This mechanism if established helps to move further from mere lip service presently being provided to breastfeeding or infant feeding under the current programmes.

'Innocenti Declaration', in 1990, set four operational targets and the first one is establishing national breastfeeding coordination. This implies that a country needs to have someone as a breastfeeding coordinator and work in a way to include all relevant sectors and helping them to understand issues from a breastfeeding perspective leading to ideas for action. Much has been done on the other Innocenti targets including BFHI, Maternity protection and the Code, however, which target national breastfeeding mechanisms has not received the attention it needs.

According to the information available, breastfeeding committees have been formed in many countries and the action plans have been approved, however it still lacks the government budget allocation for breastfeeding activities. For the committees to get truly involved the major challenge remains with the national groups. The need for a powerful committee to lead breastfeeding action cannot be undermined. This committee should find out the reasons when breastfeeding declines or is not going up and need to analyse and strategise action to improve it.

There is a long way to go to improve the global as well as national situation of protection, promotion and support of infant and Young Child feeding in light of the new Global Strategy on Infant and Child Feeding which sets additional targets complementary to the Innocenti targets and shifts the focus from breastfeeding to infant and young child feeding.

These four workshops provided opportunity for sharing and reviewing and attempted to answer some of the questions like whether such mechanisms do exist and how they function. The workshops also provided opportunities for discussion as to how best national breastfeeding promotion mechanisms can function and be held accountable. Each workshop had presentations from different parts of the world on efforts in this direction. UNICEF, WHO, IBFAN and WABA who, having been the major actors, played an important role in advocacy, and were key participants in these workshops.

Workshop 1 – Setting the Agenda: national plan of action for IYCF

Day 1, 23 September 2002
Facilitator: Dr. N.B. Kumta, Bombay BPNI, India
Rapporteur: Dr. C.R. Banapurmath, BPNI India

Dr. Arun Gupta of BPNI India introduced the core issue and launched these workshops. During workshop 1, presentations from Madagascar, Sweden and Norway were made with the different issues, effectively changing community behavior in Madagascar, using the Code in Sweden and using mother support as a key component of the national action in Norway. Issues like developing partnerships at the national level with the stakeholders including NGOs, professionals and others to resort to outreach activities, and bringing public attention to the code issues and need for comprehensive support to breastfeeding mothers were the key points emerging from the workshop.

A. Key Issues Discussed

- BFHI to create baby friendly community
- Governmental Involvement – funding, accountability, intersectional co-ordination
- Child spacing using LAM
- Promoting good and safe local cultural breastfeeding norms
- IEC: Consistent, accurate appropriate information at all levels

- International/National Code/ACT – vigilance and monitoring
- Use of the Mass Media, partnership and linking – networking existing health infrastructure.

B. Key Outcomes/Conclusions

- Effective change in community behaviour
- Reducing infant morbidity, mortality and malnutrition
- Promoting IYCF throughout the code monitoring
- Strengthening counselling skills of health workers and peer counselors in nutrition of mother and child.

C. Main Recommendations/Action Plans

1. BFHI implementation, especially step II and step X
2. Governments/private voluntary organisations/ NGO/University and educational groups – to take up outreach in existing health infrastructure
3. Creating critical mass of nutritional advocates at all levels
4. Powerful IYCF National Committee to be forced to being about policy changes
5. Periodic ongoing evaluation of behavioral change.

Workshop 2 – From Policy to Practice

Day 2, 24 September 2002
Facilitator: Dr. Raj Anand, ACASH, India
Rapporteur: Martha Cayad-an

Dr Raj Anand who facilitated this workshop, introduced the global strategy on infant and young child feeding. Dr Anand presented a paper by Randa Saadeh of WHO as she was unable to come. Arun Gupta presented the case study from India and Binta and Blanche from Burkina Faso shared the experience of IBFAN Francophone. This workshop lead to the recommendation to use global strategy as the universal document for advocacy at the national level for strengthening existing Innocenti targets as well as reviewing the national action plans.

A. Key Issues Discussed

- How to ensure EBF/IYCF to mothers working outside the home
- Heavy advertisement of Breastmilk substitutes in all forms of mass media
- Discrepancy of data proscribed

B. Key Outcomes/Conclusions

- Conduct national advocacy in IYCF strategy
- Operationalisation of IYCF strategy is a shared responsibilities (multi-sector responsibilities)
- National breastfeeding committee compensation must be multi sectored in nature
- There is a need to have conceptual inclusion from BFHI to mother and Baby Friendly Communities
- Letters to all hospitals (re: BFHI and work within five years)
- Maximise the use of networks to ensure the absence of advertisements of breastmilk substitutes in media
- Major strategies to the IYCF Strategy implementation are:
  - advocacy
  - Capacity building
  - Resource mobilisation
  - Regulation existing revisions and review of existing laws
  - Mobilising for evaluation.

Main Recommendations/Action Plans

1. All participants to advocate for the implementation of the ILO recommendation and the IYCF strategy which were unanimously ratified by all countries.

Workshop 3: Achieving Accountability

Day 3, 25 September 2002
Facilitator: Dr. Arun Gupta, BPNI. India
Rapporteur: Maaike Arts, UNICEF, Vietnam

A. Key Issues Discussed

For national plans of action

- Goals
- Indicators
- Action ideas.

B. Key Outcomes/Conclusions

With the use of VIPP cards, all participants contributed to identifying suggestions for goals, indicators, action ideas and suggestions on how to improve accountability. Please see detailed report for outcomes.

C. Main Recommendations/Action Plans

1. The goals, etc. can be considered suggestions for countries to include in their national plans.
2. The participants appreciated very much the real "workshop" this was with ample time and place for discussion and brainstorming.

Following is the outcome of the VIPP methods used for developing a generic action plan.

Objectives	Indicators
To have an IYCF policy in place	• A policy on IYCF is in place and is widely communicated to all stakeholders in the country
Ensure implementation of the International Code	• National Code based legislation in place and being enforced • Number of companies violating the national Code based legislation • Code/law monitoring system in place and monitoring carried out regularly
To achieve six months maternity leave	• Maternity legislation which complies with ILO Convention 183 in place • Number of women with paid work who takes maternity leave • Number of employers adhering to maternity legislation
To achieve that 80% of six months old infants receive exclusive breastfeeding	• Number of baby friendly hospitals • Initiation of breastfeeding just after birth • Time (months) of exclusive breastfeeding • Percentage of children receiving adequate complementary foods by age / at 6 months • Percentage of children between 6 & 9 months being fed at least 5 times per day, in addition to continued breastfeeding
To establish mother to mother support groups in all communities	• Number of mother support groups per community
To convince populations of the direct correlation between breastfeeding and nutrition	• Percentage of the population with knowledge on breastfeeding issues related to nutrition
To set realistic targets	• Number of advocacy activities at the policy & community level

Generic Action Plan

Overall Goal

Ensure optimal IYCF practices in 80% of households by 2005.

This can be divided into two sub-goals:

1. Ensure exclusive breastfeeding for the first six months, and continued breastfeeding for up to two years,
2. Ensure optimal complementary feeding.

Action Ideas emerging from this workshop

Coordination

- Multisectoral National Breastfeeding Committee in place
- Establish/strengthen National Task Force on IYCF to oversee activities
- Appoint a National Breastfeeding Coordinator.

Advocacy & Policy Development

- Conduct a seminar for policy makers on the Code and its importance
- National advocacy workshop for politicians/policy makers on issues and consequences related to IYCF
- Using the existing infrastructure of Government programmes already implemented
- Convergence with existing related programmes
- Integrated approach for mother and child health improvement
- Integration of health and nutrition programmes to make more efficient use of available resources
- Improvement of health and nutrition status of lactating mothers
- Planning policy for reducing maternal malnutrition
- Baby Friendly Hospitals
- BFHI Ten Steps incorporated in the Government quality assurance system for hospitals.

Training & Capacity Development
- Education
- Training of peer counsellors at the community level
- Training on IYCF & establishment of Community Support groups
- Developing training modules
- Breastfeeding counselling and lactation management included in pre-service training of all health workers
- Breastfeeding promotion included in the curriculum of schools at all levels
- Review & adapt health worker and school health curriculum on IYCF.

Resource Mobilisation
- Share National Plan of Action/donor proposals with the range of potential donors
- Earmark financial resources for IYCF/ Breastfeeding.

Communication & Social Mobilisation
- Sensitise communities (including fathers) to strengthen support systems for mothers
- Develop IEC materials on exclusive breastfeeding and disseminate it nationally
- Making target group aware of negative aspects of improper IYCF practices
- Include breastfeeding in all activities on mother and child health.

Community Action
- Promoting community participation
- Family and community support for exclusive and continued breastfeeding – community movement
- Involving community and panchayats (local governments) for monitoring and evaluation
- Implement Baby Friendly Community Initiative.

Monitoring & Evaluation
- Conduct baseline survey to enable setting of targets
- Conduct formative research (qualitative), also to assist setting of targets on Behavior Change Communication
- Research & Development.

How can we ensure accountability?
Following ideas emerged from the Workshop:
1. A task force to monitor the implementation of activities
2. Assign responsible personnel per each action – monitor & supervise – reevaluate
3. Set performance related targets
4. Reporting mechanism established for accountability & action
5. Get regular reports – monthly/quarterly/bi-annually, mid-term evaluation of the programme
6. Identify follow-up and corrective action to reports.
7. Health and nutrition councils at the community level can monitor implementation
8. Accountable body should have decision making power
9. Continuous political and financial support.

Workshop 4 – Assessment Analysis Action

Day 4, 26 September 2002
Facilitator: Dr. Jayam
Rapporteur: Dr. J. Kumutha

Arun Gupta made a presentation on GLOPAR, Bilijana Ancevska on the Experience in Macedonia, and Ann Brownlee and Linda Sanie on Infant Feeding Assessment Tool.

Discussion on the title of the workshop led to a change as it was thought to be misleading. The intent of the workshop was explained to involve communities for assessment and evaluation process in the national plans. Participants agreed on the need for assessment and the process to be applied. Infant feeding assessment tool as well as GLOPAR tool was appreciated for adaptation and usage locally. Bilijana made an impressive presentation on how the GLOPAR tool was used to assess progress on breastfeeding situation in the Macedonia.

Key Issues Discussed
- Assessment tool at national level
- Work with women's groups.

A. Key Outcomes/Conclusions
- Three studies were presented and discussed
- The WABA Tool was accepted as a tool for action at national level for future planning
- For Linkages – the tool needs modification for community level
- This should include economic and social modifications. This cannot be thought of as Assessment, Analysis and Action.

B. Main Recommendations/Action Plans
1. Action plans cannot be taken up with this tool, but should be expanded to include other issues like political and economic indicators.

2. There should be participation especially among the community, not only for assessment but also for planning and micro level implementations.

THEME 2: THE BABY-FRIENDLY HOSPITAL INITIATIVE (BFHI)

Theme Outcome by Pauline Kisanga

Workshop delegates noted that the global Baby-Friendly Hospital Initiative has made significant progress toward achieving the goals of the Innocenti Declaration and the 1990 World Summit for Children. They strongly recommend the vigorous continuation of BFHI as a fundamental means of nurturing the future of the world's children and their families in the 21st century. They were united in recommending that BFHI should go forward, as clearly set out in the WHO/UNICEF Global Strategy for Infant and Young Child Feeding (WHA 55-25).

Breastfeeding and the BFHI should be explicitly recommended in other UN and governmental strategic documents so that they will be given strong attention in policy, funding and programming decisions. BFHI remains essential and needs to be strengthened, expanded and sustained, with more facilities earning the BFHI award and continued re-assessment/monitoring of those already designated. Its principles of support also need to be extended throughout the health care system including primary health care and throughout communities.

The Baby-Friendly designation belongs to facilities providing maternity care that are assessed according to the Global Criteria. At the discretion of the National Breastfeeding Authority the phrase “Baby-Friendly” may be extended to other activities in support of breastfeeding that are assessed and periodically re-assessed using agreed national criteria.

The training and assessment documents for BFHI produced by WHO and UNICEF need some updating in the light of current knowledge of infant feeding and experience with the International Code of Marketing of Breastmilk Substitutes. In countries with high HIV prevalence, the BFHI needs adaptation to address the needs of HIV-positive mothers without compromising the needs of HIV-negative mothers or those who are untested. The UN agencies are urged to undertake this work without delay in consultation with governments and breastfeeding supportive NGOs.

To continue improving the care of breastfeeding mothers and their infants it is essential that the scientific principles of lactation management and the development of basic clinical skills be fully integrated into the preservice curricula of medical, nursing, midwifery and nutrition students. This will necessitate that faculty are prepared and that teaching hospitals where clinical skills are demonstrated and taught become Baby-Friendly. These actions are urgently needed.

While improvements in pre-service education will decrease the need for in-service training, currently practicing health care providers are inadequately prepared to support breastfeeding. Thus, in service training programmes for them must continue, always including practice of clinical skills. In addition, due to staff turnover and advances in knowledge a need will always exist for some in-service refresher and update training, there should be no funding for such professional education from commercial sources.

In addition to the BFHI, there is a need to develop and strengthen complementary programmes or initiatives, which affect breastfeeding. These include antenatal care, birthing, neonatal and paediatric care and community support. These may cover some but not all of the Ten Steps in addition to other practices.

Birthing interventions should be evidence-based, protect normality and include companionship during labour and birth, minimise invasive procedures and routine use of analgesia and anesthesia. In some settings, extension of hospital stays after delivery would help in providing adequate initial support for breastfeeding.

Hospital practices which affect infants requiring special care should include the opportunity for 24 hour contact with mothers, care by parents, kangaroo mother care, no unnecessary medical and nursing procedures, exclusive use of breastmilk, and other aspects of humane neonatal care. Relevant specialist groups could be invited to develop criteria for an assessment tool.

Step 10 of the BFHI should be effectively implemented. Development of community support for breastfeeding/infant feeding requires the identification of existing support systems; training consistent with that given in the health care system; and linkage to and support from primary health care staff. This should include fully addressing the needs of HIV-positive

mothers. The evidence for the effectiveness of community support is strong, and indicates that respect and remuneration are vital to sustainable programmes.

Obstacles to BFHI and breastfeeding programmes generally can be overcome with:
- Renewed political commitment from government
- Renewed commitment and vigorous advocacy from the UN agencies for BFHI as an essential component of the new Global Strategy for IYCF
- Adequate funding
- Coordination among all sectors (government, health care and nutrition systems, NGOs and communities).
- Education and communication that counteracts misinformation and emphasises that good breastfeeding technique may reduce adult to child transmission of HIV.

Workshop Report

Workshop 1: BFHI – Where are We Now? and Lessons Learned from Country Experiences

Day: 1, Date: September 23
Facilitator: Audrey Naylor, Pauline Kisanga and Helen Armstrong
Rapporteur: Felicity Savage

A. Key Issues Discussed
- Origins of the BFHI historically and programatically (Margaret Kyenka-Isabirye)
- Situation in Bangladesh (M. K Talukder)
- Situation in Norway (Anne Baerug)
- Situation in Madagascar (Agnes Guyon-LINKAGES)
- The development of the BFHI in these three countries was presented and factors leading to their success were identified.

B. Key Outcomes/Conclusions
Factors leading to successful development identified were:
- Strong political and government support
- Willingness of governments or agencies to invest financially
- Effective Training of helth care workers in breastfeeding facilities
- Strong co-ordination between various stakeholders
- Initial passion for the initiative to get it underway
- NGO Support at different levels
- Use of primary Health Care system to spread the messages
- Including International Code, No Free Supplies.

C. Main Recommendations/Action Plans
See Theme Outcome

Workshop 2: BFHI:Overcoming the Difficulties and Achieving Sustainability

Day: 2, 24 September 2002
Facilitator: Pauline Kisanga
Rapporteur: Peggy Koniz-Booher

A. Key Issues Discussed
- BFHI development in USA
- Constraints and Obstacles to BFHI Implementation, particularly in USA
- Revised course for Adminstrators and Policy Makers by WHO and Wellstart International. This course, a tool for strengthening BFHI, takes into account new studies, includes new topics like HIV, and has a new session on paediatric care, neonatal units and MCH
- BFHI tools for monitoring and re-evaluation.
- BFHI in the context of HIV – a case sudy of Zimbabwe in national capacity building
- It discussed constraints to BFHI 1997: such as:
  - confusion on BFHI messages in the context of HIV, health workers faced with dilemma;
  - HIV research programme/protocols create confusion over cessation of breastfeeding 3-4 months
  - introduction of financing for formula
- Lack of funding to retrain people/health workers.
- BFHI is no longer a priority for funding
- Need to strengthen and expand BFHI and develop strageties for BFHI

B. Key Outcomes/Conclusions
1. Discussed Way Forward to continue BFHI in the context of HIV (lessons from Zimbabwe):
- strengthen BFHI concept to sustain breastfeeding and provide support to infants on replacement feeding
- increase awareness on importance of exclusive breastfeeding
- Work to counter negative forces
- safeguard against spillover effects
- Increase community support

2. Lessons learned in sustaining BFHI despite the odds:
- rallying for UNICEF's continued support
- getting BFHI into the teaching hospitals
- dealing with problems of training of BFHI assessors
- updating Step 10 to facilititate its implementation, involving hospital adminisrators, in the planning stage
- Strengthening the Code as part of BFHI.

Workshop 3: BFHI: Does it Need to Expand?

Day: 3, 25 September 2002
Facilitator: Helen Armstrong, Audrey Naylor, Pauline Kisanga
Rapporteur: Felicity Savage

A. Key Issues Discussed
- Possible direction for BFHI expansion -Miriam Labbok
- Mother-Friendly maternity care and birthing practices – Mary Kroeger
- Humane neonatal care for pre-term and sick babies – Adik Levin
- Expansion to Baby Friendly communities – Nomajoni Ntombela
- Preservice eduation in Ghana – Veronica Gomez, Charlotte Acquah
- Should these and other situation (legislation, media, policies, etc.) also be part of an expanded Baby Friendly Initiative, or part of a wider breastfeeding programme of which BFHI is a central focus?

B. Key Outcomes/Conclusions

Important directions or dimensions in which breastfeeding as affected and which could be included in expansion are:
- Humane neonatal care, and kangaroo care, for which 11 Steps have been proposed, but which are not yet generally agreed
- Strengthening of Step 10 – adopt existing training for community health workers, TBGA has been done in a number of countries already
- Incorporate the BFHI concepts in preservice eduation for all relevant health care providers
- Integrate BFHI and PMTCT of HIV (ACT)
- Include Baby Friendly principles in Primary Care
- Include "Mother-Friendly" labour and delivery in BFHI.

C. Main Recommendations/Action Plans

Conclusions were not drawn, but some in the group clearly felt:
1. That BFHI should stay targeted on hospitals and other initiatives be part of a wider breastfeeding promotion activities, or maternity care
2. Eventual conclusion should relate to and be based on the new WHO Global Strategy for Infant and Young Child Feeding
3. It would be difficult to use the term "Baby-Friendly" if no universally applicable assessments and indicators are possible and agreed.

THEME 3: INTERNATIONAL CODE

Workshop Outcome by Annelies Allain

1. The International Code of Breastmilk Substitutes and subsequent WHA Resolutions have again been given a high profile at the Forum. There is a realisation that we feel is growing in this era of HIV – globalisation, trade liberalisation and increasing corporate influence that the Code and the resolutions must again be given greater significance. These tools are imperfect. They were born out of a compromise. However, they are the only tools we have available to combat unethical marketing practices, but we have to use them as well as we can. We must also insist that implementation at the national level of the code and these resolutions is of foremost importance and national levels and laws are going to improve on the International Code.

2. We had four workshops and I would like to stress three simple points about the Code that all of you should remember.
   i. The Code must always be read in light of subsequent resolutions. The Code by itself is just from 1981. We have to keep in mind that there are these other resolutions.
   ii. The Code is universal. It is universally applicable and it is a minimum standard.
   iii. The Code covers ALL breastmilk substitutes, and not just infant formula. This includes bottles and teats.

3. There were many questions in our workshops on the safety of GM foods and the labelling of such foods for unsuspecting mothers. We felt that even as recommendations from the workshops were made

that parallel efforts must be made at Codex Alimentarius to ensure that GM foods are properly regulated and labelled and that such recommendations are introduced into national measures that incorporate the Code.

4. Increasingly, we find, and this may be shocking, that we do not only have companies violating the Code, but we have governments and international agencies and organisations which seem to be detracting from the Code and resolutions. They seem to be ALLOWING violations to happen and encouraging violations to happen. Although the Code only applies to manufacturers and distributors, we must start linking the Code to the human rights framework. IBFAN will start and continue to do that. Anyone who is violating the spirit and the aim of the Code is cast as a human rights violator.

5. It is essential to monitor the Code. We know that this is officially allocated to governments, but we also all know that in practice it is the people's organisations that are doing the work and keeping track and watching over the companies at all and any level so that they can never be at peace. In our workshop, we have recommended that more people use the standard IBFAN monitoring protocol which is a new way of synchronising what we find at a national level and what is collected at international level, so that we can know at any time and place what a particular company has been up to.

6. There is an alarming trend of public/private partnerships. This does go beyond the Code, but it is something that we need to watch and act on. The UN systems and governments alike are building alliances with public sector to achieve, they say, public health goals. We question many of these partnerships and need to monitor the situation very closely. In relation to the Code, through the filter of this public/private partnerships, agreements are being lobbied for instead of binding laws. They are in fact pre-positioning that the foxes be invited to guard the chicken coop.

7. My last point is about sponsorship. We had a very long and animated workshop on this topic and the participants highlighted the weaknesses of the Code. The Code is very weak on sponsorship. There is a possibility that we have another WHA resolution to strengthen this. Although there are an increasing number of health professionals who refuse sponsorship, they still are in a minority. Public money is dwindling. There is an increasing gap or loopholes that the companies are quick to take advantage of.

Workshop Report

Workshop 1: Making the Code Work

Day 1, 23 September
Facilitator: Annelies Allain
Rapporteur: Jacquie Nutt

A. Key Issues Discussed

- Code in Brief
- WHA resolution and status of the Code
- Implementation of code e.g. Fully legislate in 24 countries
- Loopholes e.g. governments sometimes break the code themselves, also doctors
- National case studies, IBFAN and example of Mexico
- East Timor, world's newest country - needs help to start off properly
- Linking the Code with human rights laws.

B. Key Outcomes/Conclusions

- Industry fighting as hard as ever, and looking for loopholes (e.g. follow-on milks, logos, HIV). Good example of Brazil/Zimbabwe getting Gerber/Purity face dropped from jars. Information that Ghana was strongly targeted before law passed, now it's Cote d'Ivoire.
- Can use other regulations to strengthen Code, e.g. EU import laws, human rights laws (“Right to Life”/ “Right to Food” in India)
- Many countries still moving towards better implementation.

C. Main Recommendations/Action Plans

1. East Timor: help from ICDC/IBFAN
2. New expanded pro-breastfeeding campaign to be started – by whom was not discussed, but the suggestion came from IWCN.

Workshop 2: Code: Naughty Nestle, Wicked Wyeth

Day 2, 24 September
Facilitators: Annelies Allain and Yeong Joo Kean
Rapporteur: Ray Maseko

A. Key Issues Discussed

- Monitoring the code, compliance by BMS manufacturers and reasons for Code monitoring
- Monitor infant formula product labels if they adhere to the Code
- Promotion of breastmilk substitutes not to be done at health centres, direct to mothers, and improper advertising point of sales
- Explained Resolution (WHA 49-15) requiring transparent monitoring
- Explained about IBFAN Monitoring Protocols (IMP) – 1,2,3 and how the results are used.
- Introduced Standard IBFAN Monitoring (SIM) and how it is to be used.

B. Key Outcomes/Conclusions

1. Some understanding by participants of how the different forms are to be used. Form 1 to Form 5B. Eight forms in all
2. Participants got some understanding on how to differentiate between a violation and what is acceptable under the scope of the code even if it looks like a violation
3. Participants can now identify some loop holes in the CODE.

C. Main Recommendations/Action Plans

1. Countries encouraged to use SIM forms to continuously monitor Code compliance at National Level
2. Participants asked to contribute by providing Violation Information to ICDC so that ICDC can take necessary steps.

Workshop 3: Code: the New Frontiers

Day 3, 25 September 2002
Facilitator: Annelies Allain, Yeong Joo Kean
Rapporteur: H.H.T. Tarimo

A. Key Issues Discussed

CHALLENGES OF THE CODE:

- Internet Promotion and Authority Monitoring
- HIV/AIDS
- Globalisation and TNC, WTO agreements and Health
- Bio-Technology, low breastfeeding and GM Baby Foods
- Partnerships Public with Private
- Conventional Challenges – Lack of Resources and
- Violations of Rights of Child and commitments etc. Convention and the Code.

B. Key Outcomes/Conclusions

- WTO Agreement provides for governments to take necessary measures to protect human health thus health takes prevalence over trade issues
- Codex Alimentarius Commission have been tasked to improved safety and quality standards of foods for infants and children including an accurate labelling with regard to breastfeeding
- Partnership with the private is tantamount to inviting foxes to guard the child hood.
- Donations from Companies creates conflict of Interest
- Strategies to improve Code Implementation.

C. Main Recommendations/ Action Plans

1. The Code is critical in the context of HIV pandemic but more research is required with regard to HIV positive mothers and breastfeeding mothers should be empowered to make informed choices of feeding infants
2. Dangers of partnerships to be further discussed
3. Breastfeeding is human rights issue - citizen pressure should lobby for the implementation of the Code as human rights issue
4. Governments are the primary duty bearers on the implementation of the Code
5. Independent voluntary organisations should be counted with regard to violations to protect individuals
6. Concerns on UNICEF/McDonald partnership and UN secretary general's gift of latest technology Volvo car should be forwarded to UNICEF and UN
7. Research partnerships with the companies should be discouraged since these companies do influence the outcomes of the investigation bent to their advantage
8. International organisations should regularly make announcements and statements on strengthening code implementation
9. Governments should regularly report on Code implementation progress
10. Code implementation training should continue and be strengthened globally (WABA/IBFAN)
11. Governments should be the primary duty bearers holding corporations accountable
12. Code has important human rights implications, therefore it should be linked with the Convention of the Rights of the Child.

Workshop 4: No Free Lunch Sponsorship

Day: 4, 26 September
Facilitator: David Clark
Rapporteur: Maaike Arts

A. Key Issues Discussed
- What the International Code says about sponsorship
- Examples of sponsorship
- Examples of people/organisations who have declined sponsorship
- Case study of planned conference where organisers want to restrict sponsorship.

B. Key Outcomes/Conclusions
- International Code is not clear about sponsorship.
- There are examples of people/institutions who refuse it (India, Taiwan, UK) but it is very difficult.
- Re: the case study: the following was suggested:
  - transparency is important
  - a blind trust fund might be an option
  - setting up a database of sponsorship is useful.

C. Main Recommendations/Action Plans
1. If distribution of materials is allowed it has to be made sure that the Code is abided to. It is more effective to send Code violators out than to (ignore) it and let it happen
2. Also, see third point 3 on case study.

THEME 4: WOMEN AND WORK

Theme Outcome by Amal Omer Salim

Workshop 1: Maternity Protection in Action – setting up crèches at workplaces

Main recommendations
- Community-based/workplace crèches can be located close to or within the place of work or near the home
- Use an integrated early childhood development (IECD) approach to child care which promotes optimum development of child.
- Promote the development of appropriate crèches using natural/indigenous materials and community-based volunteers
- Train community-based volunteers in IECD skills to promote livelihood and development of new crèches in order to have a ripple effect.
- Mobilise resources for crèches according to cost-sharing principle to reinforce community responsibility
- Orient leaders/human resource departments within workplaces on the benefits of providing crèches for their employees
- Regarding the issue of safety, if you are in a hospital or a factory, ensure community participation in developing minimum standards for day-care/crèches in collaboration with relevant bodies who have information (community leaders, paediatric associations, occupational health, etc.).

Maternity Protection Campaign (Parts 1 and 2)

Main Recommendations/Action Plans
- Sensitise and advocate for maternity protection at all levels, local to global. We need to develop tools and build on existing materials, eg. MPC Kit and the Trade Union Kit
- Assess national and regional situations to determine the problem areas (e.g., informal sector, export processing zones, there are particular problems related to each specific issue)
- Nurture and develop regional networks to facilitate sharing of experiences, effective resource utilisation and maximisation of outputs (e.g.: the IBFAN Africa Group)
- Strengthen links between trade unions (we have had the pleasure of one representative), associations of formal/informal workers and "interest groups" at national, regional and global levels
- Work with all stakeholders at national level to get country to ratify ILO C 83 – Somehow we must make these people our allies
- Strengthen capacity in countries to improve maternity protection laws and policies at all levels – not only looking at ratification but also collective bargaining agreements and workplace policies.
- Urge the UN Agencies (UNICEF, WHO and ILO) to provide accelerated assistance to countries in their efforts to ratify and implement C 183, in accordance with the GSIYCF – We should not lose momentum!
- Women and Work Task Force should create more links between GIMS/GIFS to integrate in the long term issues related to:
  - practical and information support for working mothers

- Increased involvement of fathers and need for parental leave – it is very important to think about how we can involve fathers in the area of work. We are working slowly but surely with these goals
- place greater emphasis on statement that maternity protection is a societal issue and responsibility.

I would like to thank all the people who have been involved in this work: the Maternity Protection Coalition, IBFAN Africa Maternity Protection working group, and the WABA Secretariat who has allowed us to really work hard and provided the stimulus.

Workshop Report

Workshop 2: Maternity Protection at the Workplace

Day 2, 24 September 2002
Facilitator: Amal Omer-Salim and Chris Mulford.
Rapporteur: Elaine Petitat-Cote

A. Key Issues Discussed

- Informing about maternity protection at work. Defining women's work. Describing international, national, local instruments assisting women at work (HR instruments, ILO Conventions, national legislation, collective bargaining agreements, workplace arrangements). Explaining the ILO Convention process, C183 and R191 (seven key issues). Maternity Protection Coalition, its past and present work
- State of maternity protection in the world. General points about situation in Africa, in Asia, in Europe and in North America, with emphasis on length of leave and challenges
- Trade Unions and maternity protection at the workplace. General position of IFCTU in relation to maternity protection, ratification of C183. Specific situation of IFCTU work in Africa (including problems), in Kenya, and Export Process Zones.

B. Key Outcomes/Conclusions

- Many challenges to maternity protection legislation, several specific to region (How to finance? – Africa, USA); informal sector (Africa, Asia);qualifying criteria too high (Africa, Quebec, Canada); lack awareness of rights (Africa, Asia, Europe); discrimination (Africa, CEE); HIV/AIDS (Africa); breastfeeding breaks (Europe); political instability (Africa); political structure of country (Federation versus state, province)
- Work with allies is necessary: trade unions and women's groups in particular
- Raising awareness is necessary, especially in countries where women are poorly educated: awareness about human rights, maternity protection rights. Also, raising awareness of men is a necessity, including in trade unions
- Ratification of C183 is feasible in many countries around the world because their national legislation is not too far from that of the Convention (for example, trade unions in Africa aim for ratification in 10 countries in next four years).

C. Main Recommendations/Action Plans

1. Evaluate country situation to understand specific problems and advantages and thus strategise for campaign towards ratification, better laws, improvements in collective agreements, workplace policies (see first and last points in Key Outcomes) – IBFAN and WABA groups, IBFAN Africa, Women and Work Task Force
2. To campaign, make alliances with trade unions and women's groups, our natural allies (point II above) – IBFAN and WABA groups, Women and Work task force, IFCTU, PSI and other trade unions.
3. Elaborate awareness-raising tools (such as MPC kits and TU kits) to use both at local level and within trade union movement (point III above) – Maternity Protection Coalition
4. Begin/continue campaigning, including coordinating calendars with trade unions and regional ILO offices in order to present the breastfeeding perspective in their workshops and meetings (see last point in Key Issues Discussed) – IBFAN and WABA groups, IBFAN Africa.

Workshop 3: Maternity Protection Campaign (MPC Part 2): Action Steps

Day 3, 25 September 2002
Facilitator: Amal Omer-Salim
Rapporteur: Chris Mulford

Key Issues Discussed

- Brief background/summary of Workshop I. What is maternity protection (MP)? What is C183?

- Presentation of the preview MPC Action Kit
- The formal ratification procedure for an ILO Convention (example from Ghana)
- Description of actual campaigns:
  - regional strategising (IBFAN Africa),
  - practical action steps at national level (compiled by IBFAN Africa Working Group on MP)
  - example of action plan for one country (Zimbabwe).

Key Outcomes/Conclusions

- For a successful campaign, it is necessary to:
  a) know the issue,
  b) develop a network of allies,
  c) develop a strategy,
  and
  d) ACT.
- Different kinds of tools are needed: information tools, action tools, teaching tools
- The MPC Action Kit has two goals: a) for breastfeeding advocates to learn about MP and how to campaign, and b) to provide tools for educating others, especially trade unionists, employers, governments, and women's groups, about breastfeeding. It will contain information tools and action tools
- Working regionally can help move the MP campaign along. Groups learn from each other. A regional meeting gives incentive to national groups to start the process, so as to have something to share at the meeting. Many steps in the campaigning process are similar from one nation to another, and many issues apply widely in a region, for example the issue of financing of benefits in the African region
- To form a strategy, it is important to do a SWOT analysis of one’s own group and one's country situation. (Strengths, Weaknesses, Opportunities, Threats). This process should be repeated at intervals in a campaign.

Main Recommendations/Action Plans

1. At least two regions began or continued the process of planning MP campaigns as a result of activities at the Forum
2. African participants took advantage of the opportunity to meet with Roselinder Simiyu from ICFTU-AFRO to explore ways to link breast-feeding groups with Trade Unions
3. North Americans are discussing ways to bring US trade unions and US breastfeeding advocates together for consultation.
4. Canada has an interest in collaborating with a US MP campaign because weak MP in the US is a threat to Canada’s better MP laws under the NAFTA.

Workshop 4: Maternity Protection in Action: Setting up Creche at Workplaces

Day: 4, 26 September 2002

A. Key Issues Discussed

- The Arugaan experience of setting up creche in the workplace as a partnership with a government agency Philippine Information Agency highlighted mother-child friendliness on three points namely:
  a) creche programme for ten hours service daily that comprised child health care, custodial childcare, learn and play and natural food provision appropriate to the age and needs of the child (babies and toddlers) including breastfeeding and appropriate complementary feeding naturally
  b) creche center structural space creates the consciousness of communication space and mobility as well as risk free
  c) hands-on training for the childcare givers and child educators; the creche is a place for interactive learning for both staff and children to response sensitively to the unique needs of the child appropriately.

B. Key Outcomes

- The question of resources and staff ratio brought to an understanding that the setting up of creche works on sustainability thus it is pool of resources, continuous trainings of staff as a potential livelihood for women as future job or enterprise where they can pursue setting up a creche in the community or at the workplace or future income generating seminar trainings on childcare
- The appropriate minimum ratio of one trained caregiver staff to three children - one baby and two toddlers in addition to a child educator and a roving aide. Also, the space should be an open space for mobility and functionally creative
- Shared resources such as funds, materials, human participation and contribution are necessary to lessen the expenses and capital set-up.
- Livelihood for women
- Training is important for the staff to understand the child's world for an interactive learn and play. Also, food and health is the centerpiece of the creche as a preventive health measure.

C. Key Conclusions

- Setting up the creche for babies and toddlers and its whole day program is a specialised skill and expertise. Thus, creche programme training is very significant for its effective operations and management
- It was recognised to share the experience through country exchange, e.g. Swedish participants invited Arugaan to share in upgrading creche centers. Likewise, the Indian participants expressed the same seminar training exchange
- They agreed that childcare is a social responsibility just like maternity protection. Shared resources will generate sustainable action.

THEME 5: HIV AND INFANT FEEDING

Theme Outcome by Pamela Morrison

We had strong representation in the workshops from both the UN Agencies (Specifically UNICEF) and the WABA central committee, also from a large number of people from diverse areas who are actually doing the work. There was a lot of information presented (which I will not present, but will be available in the larger Forum II Report). We have managed to distill a few important points to share with you now.

There is quite a lot of talk about confusion, particularly in relation to research findings and what people should be saying to health workers and to mothers and fathers. We concluded in our group that there is also much clarity, even though there is a lot that needs to be worked out. There is therefore a lot that we can be moving forward with.

- Education and counselling in a research or well-supported programme setting make a difference to exclusive breastfeeding rates. That is established. It is doable, not just in the research setting. Making that difference makes a difference
- Exclusive breastfeeding (EBF) compared to mixed feeding makes a considerable difference to the outcome measures of transmission of HIV and infant mortality
- Commercial infant formula or modified cow's milk preparations currently are not feasible options for low-income mothers and babies in the Southern African region (and probably elsewhere in resource poor areas), in terms of financial cost, time expenditure and acceptability. It is not just a matter of providing free supplies.
- Expressing and heat-treating breast milk is safe and may be a practical option, in particular during the transition from EBF to not-breastfeeding. However, field trials testing acceptability have not yet been done and need urgently to be done
- Breast milk banking is feasible in relatively low resource settings, e.g. for "AIDS orphans", and has been used successfully for babies in South America. Acceptability in other settings needs to be assessed.
- Maternal health needs should be central to programming. It has been unfortunately left out in many PMTCT programmes, which have been set up, and are indeed running
- Mothers who are HIV negative and those of unknown status (a mother who is either unable to be tested or chooses not to be tested) should be included as full participants in PMTCT programmes
- PMTCT programmes should not be called 'programs'. We are trying to integrate PMTCT and infant feeding counseling into regular MTC work. It should not be labelled a programme.

There was quite a lot of passion expressed that was basically addressing the tension between the pressure on governments, ministries, international agencies, and health care workers to do something about the problem. The cemeteries everywhere are filling up with little graves full of little babies. There is intense pressure to do something about this – however, it was reported to us in the workshops that not doing this work well may do more harm than good.

Conclusion

- HIV and infant feeding counselling should be client driven and flexible, and requires considerable investment in training, re-training and ongoing support, monitoring and supervision
- PMTCT programmes without adequate HIV and infant feeding counseling may cause considerable harm
- Community mobilisation and involvement are essential for supporting HIV+ mothers, to increase EBF rates, to ensure the success of comprehensive PMTCT programme

THEME 6: BREASTMILK AND ENVIRONMENT

Theme Outcome by Sharyle Patton

We had some great discussions, as breastfeeding and the environment was a new field to very many people. We had a great exchange of ideas. I think people learned a great deal.

Main Recommendations

1. Importance of collaboration across movements. Many of us have information that will be useful to others. For example, health care workers in the US have developed a booklet called "Green Birth Days" about how we can get chemicals and the wrong kind of plastic out of birthing rooms and hospitals, which these groups would like to make available to breastfeeding activist groups.

2. Development of innovative ways to work in areas where there is commonality and agreement:

- Sharing of information – we exchanged materials regarding toxic chemicals and body burdens in breastmilk and heard some solid critiques of those. We plan to rewrite these brochures and make them available so that they contain the right kind of language and gets the message right about chemical body burdens, chemicals in breastmilk, and the importance to continue breastfeeding even though a particular chemical might be proven to actually exist.
- Continuing discussion on areas of concern, "getting the language right". We need to get the word out about toxic chemicals and chemical body burdens and health effects of these are discussed well in the right language.

Action Plans

1. *Redrafting of selected documents* incorporating suggestions and new visions of cooperation.
2. Email discussion about needed *policy change* to protect our bodies and breastmilk from chemical trespass.
3. *International:* Lobby governments to ratify Stockholm Convention, ILO C184. This is also known as a treaty to identify Persistent Organic Pollutants. Because many of these chemicals travel around the world, leap forging over national borders, there is a strong need to work internationally.
4. *National:* IBFAN is going to work on disaster preparedness kits, provide information for women concerned about chemical trespass and press kits to educate media. From this kit, we will develop press kits as well, so that we can help the media to understand the need to not always seize the most possible newspaper-selling headline; to educate them so that they know how to talk about chemicals in a way that is more supportive.
5. There is a need for a *fact sheet* on breastfeeding as a green activity. This will talk about how formula feeding is environmentally detrimental. The process of developing formula, the process of using baby bottles and using other such plastic equipment actually adds a lot of contaminants to the environment itself. Breastfeeding is actually a green activity.
6. Development of a *list of most common household and cosmetic products* containing toxic chemicals. We want people to have some basic information about what products to avoid. We know in the US that there is substantial research showing that using pesticides in households to get fleas off animals leads to childhood brain cancers. Such information needs to be put out more.
7. *Research:* more research is needed on capacity of breastmilk to mitigate effects of toxic exposure.

- Research on health effects, keeping in mind that we don't need to wait for proof before taking precautionary action – it is important to keep in mind that we should not wait for proof of cause and effect to get chemicals out of our bodies and out of our breastmilk.
- *Science panel*: identify and invite a select group of scientists to act as a resource that can help direct research, and provide us with information and quotes and a certain amount of scientific credibility as we move forward.

8. *General actions:*

- We want to institute an International day on breastfeeding and environment to celebrate and release developed materials. There has been a lot of discussion regarding the date. One suggestion is to do it during WBW. The theme for 2003 is "Globalisation" and as you can see, there is a lot of common ground between these two issues. The materials we will develop next year will be part of a press release package that would be used on this day of breastfeeding and the environment.
- We want to focus on the source of those contaminants. The chemical industries that we have as our adversaries whether we are environmentalists or breastfeeding activists, which we hold in common. These are the very powerful companies

that we are working to expose. We thus want to develop ideas for toxic trespassers, those industries responsible for production and dissemination.

- Breastmilk monitoring is currently being carried out by governments and other agencies. We thought it would be a good idea to write a "How-to manual" for exemplary breast milk monitoring. We need to find out how you do breastmilk monitoring in a way that is useful and does not undermine breastmilk advocacy campaigns. Such a study would include:
  - Community involvement and participation in design, implementation.
  - Full support for breastfeeding within the community, including BFHI, etc.
  - The breastmilk monitoring would be a small slice of a larger pie that would include all the components (educational materials, counseling, etc), that we have been talking about this past week.
  - Education of community which may choose from among a number of options which monitoring procedure answers their need for data.
  - Other materials to be developed by IPEN, WABA, IBFAN, will share these ideas with you so that we are not always reacting. We want to do this ahead of time.

Workshop Report

Workshop 1: Environmental Impact on our First Food

Day: 3, 24 September 2002
Facilitator: Penny Van Esterik
Rapporteur: Penny Van Esterik

A. Key Issues Discussion

- Need for inter-disciplinary approaches to work across groups
- Broad context for discussions of contamination is gender inequity and ideas of women's bodies as 'toxic'
- Chemical residues need to be considered in breastmilk and in water/milk/food/soy or milk-based infant formula
- Case study of entero-bacter sakazakii in infant formula
- Summary of endocrine disrupting chemicals
- Explore the potential impact of ILO C184 on health and safety in agriculture.

A. Key Outcomes/Conclusions

- review of history of relations between IPEN and WABA
- sharing of stories about contamination from India, France, Canada, US
- recognition that we all live in the same chemical neighbourhood
- we need to understand paradigm shift for evaluating toxicity and subsequent regulation (not that of the 85,000 chemicals registered for use, around 6% are tested).

B. Main Recommendations/ Action Plans

1. Need more discussion on shared language, dealing with the media and strategy for action to be done on Wed. Workshop

Workshop: Bosom Buddies: Working towards a Toxic Free Future

Day: 3, 25 September
Facilitator: Anwar Fazal
Rapporteur: Penny Van Esterik

A. Key Issues Discussed

- Anwar Fazal introduced the need/means for collaborating across issues
- Key differences in the way environment and breastfeeding groups talk about chemical residues
- Sharyl and Penny (Bosom Buddies) exchanged materials and critiqued the way the issue was presented in media
- Need for toxicologists to see beyond levels of toxins to health outcomes.

B. Key Outcomes/Conclusions

- Participants took an active role in bringing up examples of cosmetics, flame retardants, stories
- Need clearer definition of precautionary principle and its use in infant feeding
- Need for funding independence.

C. Main Recommendations/Action Plans

1. International:
   a. monitor/participate in UNEP regional workshops on implementing POPs treaty (IPEN)
   b. monitor/participate in meetings on implementing ILO Convention 184 on health and safety in agriculture (IBFAN)
   c. Find out and utilize opportunities for funding and programs through WHO – Global Fund-

Healthy Environments for Children (includes breastfeeding) – IBFAN and WABA

2. National:
   a. Develop "Disaster Preparations Kit" – With sheets for mother's media
   b. Prepare sheet on eco-friendly breastfeeding .
3. Research:
   a. On how breastfeeding conflicts/benefits which compensate for toxic effects from chemical contaminants
   b. List of experts who can review science articles and provide key quotes
4. General/Mobilisation:
   a. develop exemplary breastmilk monitoring study
   b. focus on source of pollutants (IPEN WABA IBFAN)
   c. one day to focus on breastfeeding and environment: WBW, PHM, Earth Day.

THEME 7: OUTREACH TO WOMEN'S GROUPS

Theme Outcome by Marta Trejos

It has been so interesting to have with us five of the major women's groups in the world. We have been discussing all week, and the most amazing thing is that we already have a common agenda. Now we have to move to a common action.

Breastfeeding is a human right – this means that it is the right of the woman and of the child.

- Breastfeeding SUPPORT means CHANGES in all social environments and policies. We cannot talk about successful breastfeeding if we do not change the relationships and the way the society has been organised.
- Gender Equity is basic to breastfeeding movement – we cannot talk about breastfeeding or breastmilk without talking about women, mothers and their everyday life.
- Right to life and survival is one of the main and basic rights of all human beings, especially a woman. Breastmilk is the best, first and most basic survival strategy.
- Right to choose free of commercial, medical and political pressure. We have started a process of discussion and will continue to explain what this means better. In these three levels, most of the demands for a woman are in these stages.
- Right to have access to food irrespective of race, class, caste, religion, region, age.

We cannot talk as a woman – as if all the women are the same. The discrimination that women face everyday is multiplied by the effects of the various categories.

Towards a Common Advocacy Agenda

Breastfeeding is a basic human right and it is agreed that protection of women's right to breastfeed is shared position of the women's movement and breastfeeding movement. Women can fully exercise this right only where there exists an appropriate social and political environment whereby women's contribution to productive and reproductive work including nurturing, is recognised.

There is need for social transformation at all levels to bring about gender equality.

Women's groups and breastfeeding groups have decided to put on their advocacy agenda the following demands:

- To recognise the common concern of the adverse effect of globalisation and privatisation especially on healthcare services and the increasing feminisation of poverty.
- Women's right to accessible, affordable, comprehensive, high quality and gender-sensitive women's health services. This means a real change in society and the way health services are being provided.
- Women's right to breastfeeding based on informed choice, free of commercial, medical and political pressure.
- Social recognition and value of women's work at home as care givers and nurturers.
- Implementation of maternity protection for women at paid work in the formal and informal sectors. (Here we are talking about paid work, but we also need to talk about working women even if they are not paid.
- Women's right to food, adequate nutrition, rest, safe water and shelter.

Strategies – Collaboration of breastfeeding activists and women's groups

Working out common activities for the following goals

- To improve women's status so as to restore their self-esteem and ensure their well being throughout their life cycle. We cannot talk only about mothers when they are pregnant or they are breastfeeding. Women are the mothers of the world. We are caring for our children throughout our lives. Someone in our workshop said "our children never grow".
- Common actions for ensuring the right of survival of both mother and child.

Goals

- Protection of women workers during pregnancy, childbirth, breastfeeding and caring. This is a time when all of society needs to understand that women need special care.
- Collaborating on research and monitoring studies to monitor quality and availability of breastfeeding services.

Petitions

- We are also distributing a copy of a petition to save the life of AMINA LAWAL. She is a breast feeding mother who has been condemned to death by stoning for allegedly committing adultery. Please sign this petition.
- We learnt from women at this conference that in a number of countries, the World Food Programme is selective about the people who benefit from their distribution of food. For example, in some African countries, those are considered workers, mainly men, and those who go to school, that is, children over five years old are given food. Mothers who work as much as 18 hours a day caring for the family, growing and preparing food even during pregnancy, breastfeeding the children for at least two years – these mothers are not considered workers and not given emergency food.
- We as supporters of breastfeeding urge the World Food Programme to feed all members of the community suffering from inadequate nutrition, beginning with women who are the carriers of new life and all life, and with the most vulnerable children, those who are malnourished or under five.
- Such food need not always be imported, but can sometimes be bought locally from subsistence farmers, mainly women, who have a surplus, which they cannot sell commercially because the prices are so low. An adequate price for such local producers can also encourage their farming work to feed others in dire situations.

Workshop Report

Workshop 1 – Breastfeeding Support in the Context of Globalisation

Day 1, 23 September 2002
Facilitator: Penny Van Esterik
Rapporteur: Lakshmi Menon
Speakers: Ana Maria Pizarro, LACWHN-Nicaragua and Paloma Lerma Bergua, IBFAN/LLI-Mexico

Key Issues Discussed

- Take globalisation beyond economic and political concepts to include fundamentalism in religion and politics.
- In Nicaragua, imposed neo- liberal systems have resulted in deterioration of environment, challenge to democracy and privatisation of healthcare systems.
- Reduction in access to services to support breastfeeding women.
- Governments will not work with women's groups and dismiss women's concerns.
- Rural women migrating into cities lose the advantage of support from extended family and food production.
- Several examples were cited about how globalisation destroys jobs, e.g. coffee plantations in South America.

Key Outcomes/Conclusions

- Military conflict creates direct problems for women and breastfeeding
- Groups working on reproductive rights will include breastfeeding
- Women produce 80% of food – then why should they be hungry?
- Rural and urban women have difficulties protecting themselves abuses of power.
- Answers to women's problems must come from within communities
- It is women's organisations who are mobilizing against globalisation
- Many reasons for not breastfeeding links to women's lack of confidence in their breastmilk.

Main Recommendations/Action Plans

1. Demand that World Food Programme place pregnant and breastfeeding women as first priority for food (not food for work or schools)
2. Training materials in simple, clear language for rural women

3. Buy from fair trade only
4. Develop links with the peace movement
5. Caring work of producing and feeding children is productive work
6. Ensure that all breastfeeding advocacy groups understand the struggle some women must overcome in order to breastfeed.

Workshop 2 – Women's Health, Reproductive Health Rights and Breastfeeding Support

Day 2, 24 September 2002
Facilitator: Lakshmi Menon
Rapporteur: Penny Van Esterik
Speakers: Rashida Abdullah, ARROW-Malaysia and Smita Bajpai, CHETNA-India

Key Issues Discussed

- Described the advocacy work of women's health groups in Latin America, Africa and Asia for women's rights to accessible, affordable, comprehensive, high quality and gender-sensitive women's health services.
- Explained concepts of reproductive health and reproductive health rights.
- Breastfeeding to be regarded as a reproductive health right where women can make decisions regarding their bodies and control their lives.
- Cultural and religious beliefs which are barriers to the attainment of reproductive health rights.
- Examined the CHETNA experiences in breastfeeding promotion through addressing women's reproductive health issues in rural and urban poor communities.

Key Outcomes/Conclusions

- Advocacy of reproductive health rights must be incorporated at all levels – the individual, family, community, healthcare system, the state and global level.
- Women must have appropriate information, services and support so they an make an informed choice on breastfeeding
- Breastfeeding information services must be recognised as an essential women's health and reproductive health service.

Main Recommendations/Action Plans

- Strategies for collaboration of breastfeeding activists and women's NGOs to include:

1. Breastfeeding activists genuinely take on advocacy for reproductive rights and women's health rights with breastfeeding as one component. This will demonstrate commitment on improving women's health and reproductive rights and assist women NGOs' agendas.
2. Women NGOs add breastfeeding services, advocacy on maternity legislation and support to their women's health agenda as part of reproductive rights advocacy.
3. Women's NGOs and breastfeeding activists could collaborate on research and monitoring studies which monitor quality and availability of breastfeeding services and women's ability and desire to make fully informed decisions on breastfeeding practice.
4. Regional women's NGO networks and programmes such as LACWHN (Latin American and Caribbean Women's Health Network), Amanitare (Africa) and ARROW (Asian-Pacific Research and Resource Centre for Women), meet with WABA and its partners to plan strategic alliances for common monitoring and advocacy agenda for women's health and reproductive rights.
5. WABA to be platform for dialogue on child's health rights, women's health rights and breastfeeding rights.
6. Breastfeeding rights and women's health rights should be “our” concerns, i.e. should be the concern of women's groups as well as of breastfeeding groups.

Workshop 4 – Towards a Common Advocacy Agenda

Day 4, 26 September 2002
Facilitators: Maria Zuniga Hamlin, Rashidah Abdullah and Marta Trejos
Rapporteur: Lakshmi Menon

Key outcome: Workshop Statement

“Breastfeeding is a basic human right and it is agreed that the protection of women's right to breastfeed is shared position of the women's movement and breastfeeding movement. Women can fully exercise this right only where there exists an appropriate social and political environment whereby women's contribution to productive and reproductive work including nurturing is recognised.

"Breastfeeding is a human right. Breastfeeding Support means Changes in all social environments and policies.

- Gender Equity is basic to breast feeding movement
- Right to life and survival
- Right to Choose free of commercial, medical and political pressure
- Right to Food, irrespective of race, class, caste, religion, region, age.

"Demands

Need for social transformation at all levels to bring about gender equality.

Women's groups and breastfeeding groups have decided to put on their advocacy agenda the following demands:

- To recognise the common concern of adverse effects of globalisation and privatisation on healthcare services and the increasing feminisation of poverty.
- Women's right to accessible, affordable, comprehensible, high quality and gender-sensitive women's health services.
- Women's right to breastfeeding based on informed choice, free of commercial, medical and political pressure.
- Social recognition and value of women's work at home as care givers and nurturers
- Implementation of maternity protection for women at paid work in the formal and informal sectors
- Women's right to food, adequate nutrition, rest, safe water and shelter."

Main Recommendations/Action Plans

Strategy: Collaboration of breastfeeding activists and women's groups.

Goals: Working out common activities for the following goals:

- To improve women's status so as to restore their self-esteem and ensure their well-being throughout their life cycle.
- Common actions on ensuring the right of survival of both mother and child.
- Protection of women workers during pregnancy, childbirth, breastfeeding and child caring.
- Collaboration on research and monitoring studies to monitor quality and availability of health services to protect breastfeeding.

THEME 8: GLOBAL INITIATIVE FOR MOTHER SUPPORT (GIMS)

Theme Outcome by Rebecca Magalhaes

The Mother Support Task Force (MSTF) wants to share with you the following recommendations from the GIMS workshops:

Direct-to-Mother Support

- Participants from the health professional area emphasised that support from mothers begins with listening, empathy, and respect for her culture
- Promote and strengthen the important role of the doula in the direct-to-mother support during the process of pregnancy, birth and breastfeeding.

Health Care System

- Take more advantage of every prenatal visit to inform the mother about breastfeeding information
- Promote a culture of care during birth
- Adapt BFHI to the home birthing setting.

Women who work outside of their homes

- Develop educational materials at all levels in the area of breastmillk expression, storage, and the mode of delivery of human milk.
- Broaden the available options for mothers to combine breastfeeding and working by:
  - Exploringg creative ways in which women can share their experiences at any social level
  - Sensitising and mobilising communities to support the working mother, with emphasis on the role of the father.

Social-Community Environment

- Ensure the provision of information on breastfeeding within the social-community environment that is consistent, accurate, updated, factual, practical, appealing and timely.
- Recognising the diversity of cultures, different economic levels, diverse geographical regions, and languages, the Mother Support Task Force is committed to:
  - Serve as a support resource to those interested in implementing GIMS in all countries
  - Strengthen the participative and proactive leadership for GIMS around the world.
  - Promote capacity building on support for the mother at all levels
  - Create an awareness of the value of the existing support and build on it.

– Disseminate information that mothers need support during pregnancy, childbirth and breastfeeding.

We invite you to include the concept of support in all your trainings, informational materials, conferences, and meetings, involving as many elements of support as possible.

We ask you to commit your personal involvement to create an effective supportive environment for mothers.

Workshop Report

Workshop 1 – Pregnant and Breastfeeding Mothers Receive Direct Support

Day 1, 23 September 2002
Facilitator: Rebecca Magalhaes
Speakers: Rosemary Gauld, LLL South Africa, Sallie Page-Goertz, ILCA, USA and
Dr. Raj Anand, ACASH/IBFAN/WABA, India

A. Key Issues Discussed

- Mother-to-Mother Support Groups: different kinds of mother-to-mother support
- The Lactation Consultants (LC): the only health professional trained solely to manage lactation issues, their expertise, and support they can provide.
- Health Professionals: the obligations and responsibilities of Health Professional bodies related to the WHO's Global Strategy for Infant and Young Child Feeding.

B. Key Oucome/Conclusions

- Each mother has a unique breastfeeding experience, and may need support from the different people who provide direct-to-mother support. Mother-to-mother support provides a mother with day-to-day help, helps to relieve her anxiety, the mother is comfortable with sharing her ideas, and mothers can relate to the information because it is coming from someone from within their community; the LC helps the mother with more complicated breastfeeding problems; and the health professional should give her a holistic perspective on her and her child's health.
- Developed catchy phrases such as:
  - Breast milk is good health
  - Mothers let's be proud of our own milk
  - Breast milk for life
  - Breast milk: the holistic care for infants
  - Breast milk is ever ready
  - Breast milk for cost-effectiveness
  - Breast milk creates love and reduces stress
  - "Mother is gold, her milk is life"
  - Welcome to hospital
  - Doc, learn to be a good listener [listen, doctor]
  - Mom, choose a 'baby-friendly' hospital for delivery.

C. Main Recommendations/Action Plans

1. Support Step 10
2. Support the Mother-Friendly Childbirth Initiative
3. Integration LC care into existing health care system
4. LC to teach TBAs/healers/wise women skills to help women with exclusive breastfeeding
5. Funding to provide essential LC skills/training in rural areas
6. Help mothers get more maternity leave
7. Let health professional bodies (doctors, nurses, etc.) collaborate to support mothers to breastfeed
8. Training of health workers in counseling skills.

GIMS Workshop 2 - Support for Breastfeeding within the context of the Health Care System

Day 2, 24 September 2002
Speakers: Mimi de Maza, LLL Guatemala
Dr. Sarah Vega, MOH, Peru
Sallie Page-Goertz, ILCA, USA
Rosemary Gauld, LLL South Africa

A. Key Issues Discussed

- Prenatal care
- Birth/Delivery
- Postpartum care
- Maternal/child illness

B. Key Outcomes/Conclusions

- SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) of the three topics
- Developed catchy phrases such as:
  - Develop baby-mother friendly communities
  - "Labor and birth- culture of care"
  - Care for mothers = care for a nation
  - Information is power
  - When sick don't separate
  - Separation when you are sick is stressful
  - Lonely mothers and babies get sicker
  - Don't separate us, we are ill!
  - Breast is best for sick babies too

C. Main Recommendations/Action Plans

1. Encourage pregnant mothers to attend prenatal classes with proper information on breastfeeding by adequately trained health workers
2. Health educators trained in breastfeeding and can talk to mothers before their appointment with doctor
3. Doctors need to counsel mothers-receive training in how to counsel pregnant mothers
4. Health workers – receive counseling skills in breastfeeding
5. Expand BFHI to cover entire hospital facilities
6. Health workers training/re-training
7. ARVs for HIV+ mothers
8. Strengthen the reference system
9. Bring in the culture of "CARE"
10. Adapting BFHI to the home birthing environment
11. Teach TBAs best practices for peer support
12. Develop guidelines from National level down to community for policy development
13. Policy development for GIMS with mechanisms of accountability for best practices
14. Inform mothers about their rights
15. Implement and broaden the BFHI
16. Educate health facilities, etc. about important documents.

GIMS Workshop 3 – Support for the Breastfeeding Woman Who Works Outside the Home

Day 3, 25 September 2002

Speakers: Gisele Laviolle, LLL France, Ines Fernandez, ARUGAAN, Philippines, Judy Canahuati, CARE, USA and Mimi de Maza, LLL Guatemala.

A. Key Issues Discussed:

- Educating and entertaining pop-art materials for working breastfeeding women
- Two work situations of two pregnant women wanting to breastfeed.

B. Key Outcome/Conclusions

- In rural areas, working and breastfeeding is also a problem. It is difficult for mothers to take their babies with them to work when they have to travel long distances or take the bus. One solution that is already in place in the Gambia is for fathers to build rest houses for the babies. The babies can rest there when the mother is working in the field.
- Another action taking place in some communities in the Gambia is a 'community maternity leave', during which the community works on the field of a pregnant or breastfeeding mother.
- Other ideas / suggestions-
  - written material helps mothers know it is possible to work and breastfeed. This opens their doors and gives them practical information.
  - email lists for working mothers
  - information needs to address the caretaker too. They need to know how to give breastmilk to babies. Information for caregivers at daycare.
  - mothers need support in the hospital, phone counseling, home visits.
  - a baby and mother friendly crèche in the workplace. Unique needs of babies and toddlers need to be met.
  - reach out to trade unions, companies- send out the message that it is possible to work and breastfeed.
  - teach mothers what foods they need to eat.
  - a curriculum on how to create crèches at workplace.
  - proper expression of milk. Have a hotline, pamphlets. In some places it is a taboo to express the milk.
  - information on how to hand express - at hospitals and clinics. But can't be taught in a group. Has to be individual- how to express, how to store. Technique can be in a group, but practice has to be one-to-one. Also management of expressed milk with caregiver/ mother.
  - address/response to taboos
  - every mother needs to learn how to express milk
  - overcome fear of breastfeeding and work compatibility
  - establish lactation progressively before expressing milk
  - need to involve the fathers and other community members – decision makers, people who give context to new technology
  - mothers have to find a friendly environment – the support person needs to lay the ground
  - advice to build up skills
  - avoid the bottle – there are other ways of giving expressed milk
  - involve the community
  - more research on certain climates and temperatures
  - consider all the different settings – need to develop options
  - maternity leave, need to be careful with this

because employers can fear employing women
– collect case studies and share them
– form men's groups to teach men to be supportive and caring towards mothers.

GIMS Workshop 4 – Support for Breastfeeding within the Social and Community Environment

Day 4, 26 September 2002
Speakers: Rosemary Gauld, LLL South Africa,
Anne Gaskell, LLLI, UK
Gloria Okemuo, Breastfeeding Awareness Network, Nigeria
Joan Schubert, LINKAGES, Ghana
Iman El Zein El-Salah, LABA, Lebanon

A. Key Issues Discussed

- Mother to Mother Support Groups
- Social circles
- Family and friends: indispensable pillars of support for a breastfeeding mother
- Media
- Educational institutions.

B. Key Outcomes/Conclusions

- Catchy phrases were developed:
  - Enjoy your motherhood
  - Breastfeeding education is the right root of life
  - Better breastfeeding with community support
  - When you give the breast, you give your best
  - Breastfeeding, sweet responsibility of all.

C. Recommendations/Action Plans

- There is need for internal support (family) and external (community and society)
- Information needs to be consistent, accurate, updated, factual, practical, appealing and timely
- Support from the media
- Special support from professionals
- Peer support groups
- Policy makers need to provide good information
- Experienced mentors.

THEME 9: GLOBALISATION

Theme Outcome by Elisabeth Sterken

Session 1: What did we learn?

We looked at what is globalisation, particularly with respect to the protection of breastfeeding. We had some very interesting discussions. We wanted to see how globalisation and the impact of globalisation could mean either increasing a bottle feeding culture, or increase a breastfeeding culture. We know that the process of globalisation is an intensification of all of the things mentioned by Annelies Allain with respect to the Code.

Globalisation means different things to different people. Globalisation priorities are economic, while human health, the environment, human rights are secondary and can often be pushed aside very quickly by the economic interests. We discussed that it is a shift in power from the governments ability to legislate and regulate, particularly in the area of breastmilk substitutes. We are shifting towards transnational corporations and their ability to market globally.

We looked at how globalisation increases disparity between the rich and the poor people and between rich countries and poor countries and between the South and the North.

- Globalisation increases environmental damage
- Globalisation reduces trade barriers – which could have an impact on how the international code is implemented on the national level.
- Globalisation can be a threat to the International Code and the protection of breastfeeding.

We learned about how the World Trade Organization is an implementing tool in this process and the various means by which trade is facilitated and how there are exemptions in the trade rules to protect human health, human rights and the environment. We, as NGOs, as health practitioners, and as a peoples movement, can use these protective mechanisms to assure that the protection of breastfeeding and the International Code could be integrated by using these particular mechanisms.

We learned how the status of the International Code must be protected in the trade facilitation process. This

is critical. The reason that the breastfeeding movement started looking at these trade mechanisms, particularly the Codex Alimentarius, was that it became an international threat to the International Code. The trade mechanisms of the WTO could supercede national legislation. That was our major concern. We thought it was critical that we integrated the International Code as much as we could into the globalisation process of setting standards that would be used for purposes of trade.

Session 2: Codex Alimentarius

We looked more intensely at the process of global standard setting for infant foods – infant formula and cereal-based foods for infants and young children, and how the breastfeeding movement – IBFAN and the Codex Alimenterius working group – is working to protect the International Code, the recommended practice of exclusive breastfeeding for six months and optimal complementary feeding practices at the Codex Alimentarius. I want to emphasise that this is a big struggle. As much as we struggled at the WHA, with the age of introduction of complementary foods, and the recommended age of exclusive breastfeeding, so at the Codex Alimentarius, that same struggle continues. The presence of the corporations that are opposed to this is very heavy at the Codex Allimenterius process.

We learned that the work at the Codex meetings combining our efforts at the national level and at the international level, the results have been very good. We have been able to include the International Code in the Scope of the infant food standards; we have been able to make labelling changes that increase warnings to parents about infant formula feeding; we have been able to insert the labelling provisions of the International Code into the labelling requirements of the infant formula standard. When we work as global movement for the protection of breastfeeding, we can do good things in that context of globalisation as well.

We also learned how the International Code and the Codex Alimentarius process are complementary and how the work in one affects the work in the other. We just heard this from Annelies as well. The resolutions that are proposed and passed at the WHA have impact on what we can do to implement standards on infant feeding at the Codex Alimentarius.

Continuous work needs to be done, especially in the area of health claims. Many of you working in the area of Code monitoring understand the very strong impact that health claims have on the ability of the formula and complementary industry to market their products. The labelling of six months for complementary foods continues to be a major issue that we all need to work on, both on the national and the Codex Alimentarius level. Restricting the infant formulas for special medical purposes is another item, coming up on the agenda that we need to be vigilant about. This can be used as a means by which the industry circumvents the International Code.

Session 3: Action Needed

We need to increase the linkages with the anti-trade groups so we can be more fully informed about the relationship of trade to the power of the infant foods companies. Many agreements, such as the free trade agreement in the US, in the EU, and other agreements that are evolving across the globe, a lot of NGOs are responding to this. It is important for us in the breastfeeding movement that we link with these groups. We can get a lot of support and technical help from those groups.

We also need to link issues with the People's Health Movement – which is a global, holistic movement for better health and use the People's Health Charter in the breastfeeding movement.

As the World Breastfeeding Week Theme for 2003 will be based on the topic of globalisation we also decided to use communications that will help to create both understanding of these issues as well action.

Workshop Report

Workshop 4: Globalisation: the Issues

Day 4, 26 September 2002
Facilitator: Elizabeth Sterken/Barbara Fienieg
Rapporteur: Lybrich Kramer

Key Issues Discussed

- Recapulation of key discussions and outcomes of preceding workshops
- Globalisation as the WABA WBW 2003 theme

Key Outcomes/Conclusions

1. Reactions on Recapitulation

- Globalisation: this term is very elusive. We should always call things by its name: e.g. corporations are taking over, or re-regulation to the benefit of corporation.
- We are talking about neo-liberal thinking. This is an ideology without book or beliefs, it is not tangible but has seeped into most of the corners of our life.
- Pay attention to who is benefiting from which process: for instance this e-mail/internet being positive: it is only available for a small amount of the worlds' people. Disparity is one of the saddest outcomes.
- Instead of being anti-globalisation, it is more helpful to show you are pro social-justice.
- The structure/actors is multi-faceted (not black and white).
- Concerns are privatisation of health care and BFHI focusing mainly on quality but not on accessibility of health care.
- Regarding what to do with WTO and the Code, do not focus on the code only, focus on health being more important than trade, on human rights.

2. WABA WBW 2003 Theme

- In Latin America the WABA theme Globalisation was not acceptable. The people that are doing WBW cannot work with it like that. Therefore we should try to use a different word. Take a clearer slogan that people can understand. For instance: "When corporations take over breastfeeding".
- What should be in the flyer: 10 reasons why WTO is dangerous for breastfeeding mothers. Maybe use another word as WTO or globalisation.

Main Recommendations/Action Plans

Preparation

- We need to define words like: private sector, NGO, civil society, partnership. Even at UN level they do not have any official definitions. We need to talk about the same things.
- Find out how we can give health and human rights a higher priority within, for instance, WTO.
- Find allies in other health or environmental or social justice organisations. For instance, PHM.
- Find out who are dealing with WTO in your country: who on government level and who in other levels.
- Find and communicate evidence.
- Industrialised countries: great responsibility to address policy makers. We have access more easily to them.

Communicate

- Try to transform it into understandable language.
- Prepare the contents of all communication very well. So be informed.
- Communicate it among health care, policy makers, and other sections of society.
- Start teaching on 'globalisation and health' (George Kent gives courses in various regions, see for instance the website www.ceu.hu)
- Write publications or papers on it.
- Do not only talk to the Minister of Health about the importance of breastfeeding, but also talk to your Minister of Trade! Or your national leaders.
- Use the People's Health Charter. Visit website: www.phamovement.org.

THEME 10: POPULAR MOBILISATION

Theme Outcome by Beth Styer

Goal

To review the essential skills of popular mobilisation, share best practices in community mobilising initiatives to support breastfeeding, and how to link breastfeeding global campaigns such as the People's Health Charter.

Essential skills

When we understand the total picture of breastfeeding, we realise the large number of skills needed.

We need to:

- See the Big Picture
- Connect with the people
- Identify wide range of skills needed
- Be Creative
- Have a Clear Vision
- Involve three generations.

For real changes to come about we need to:

- find the "CLICK" with people and their needs – a click is the place where you spark ideas
- ensure that all sectors of the community have a role
- involve the media from the start
- address fears and concerns and make clear and simple messages.

We were reminded that

We may be the experts and know the answers, but our role is to be an instrument of social action. Altogether

we are a team. We need to be flexible, open, act and LISTEN. We need to remember that all the problems and challenges in the breastfeeding mother's life are our issues.

Actions

- Involve the children as active players.
- Collect 1000 ideas of how to celebrate World Breastfeeding Week
- Involve men in all areas of breastfeeding campaigns
- Collect posters and images used in Campaigns to share with others.

Lessons learned from Best Practices

Examples from: Ghana, Madagascar, Mexico and The Gambia

Key lessons

- Best results with total community involvement
- Link to different movements and all sectors in society
- Active involvement of men in every moment.
- Breastfeeding not seen in isolation, but integrated into all health care programmes
- Involvement of all generations.

Examples:

- The programme in Ghana showed that significant changes in early initiation of breastfeeding, exclusive breastfeeding and the proper use of complementary foods can happen in a relatively short time if proper messages are used.
- The programme in Madagascar identified key players in health, family planning, nutrition sectors. They suggested to:
  - Focus with two or three priority messages and use small-do-able actions
  - Use varied dissemination strategies, e.g. ceremonies, religious, songs, dances, role plays, village gatherings, house to house
- The Mexico group counselling programme set up groups for pregnant women and mothers with different age babies – i.e. new borns to six months, 6-24 months, so that they can discuss the issues that they are dealing with specifically. They integrated Family Planning programmes as well as community mother -child programmes
- The Gambia- Baby Friendly Community Initiative
  - Helped to increase exclusive breastfeeding
  - Involved all sectors and trained men
  - Developed a 10-step plan for a Baby Friendly Community
  - Through the use of focus groups, including fathers and grandfathers, they discovered the traditional myths about colostrum and exclusive breastfeeding. Colostrum is now referred to as protective medicine.
- They listened to fears, concerns, and beliefs of all members of family and thus are able find solutions for community, e.g. building simple shelters in the fields for women farm workers.

Recommendations

1. Find creative ways to share stories.
2. Produce a Best Practices Booklet – with lessons learned
3. Use World Breastfeeding Week as a key annual mobilising tool for sustainability
4. Linking of the People's Health Movement and the PHA Charter with Breastfeeding Promotion
5. The Charter and Preamble are being translated and disseminated around the world with the key message: “Health as a Human Right.” Use the People's Health Charter as a tool to tackle all the issues that affect breastfeeding: economic challenges, political challenges and environmental challenges
6. Get involved with national and community “Working Circles” to educate others about how their issues connect to breastfeeding
7. Spread information about the PHA and the Charter through WABA networks
8. Use the World Breastfeeding Week as an opportunity to discuss the People's Health Assembly and the charter
9. Introduce the PHA charter into university programmes, including medical and nursing programmes
10. Participate in local actions next year, 2003 in celebration of the 25th anniversary of the Alma Ata Declaration
11. Use the story book from the PHA to encourage local initiatives, share stories with local communities and continue collecting stories.

Remember:

We cannot give power, but only support to create situations where community feels its own empowerment.

Workshop Report

Workshop 1 – Essentials of Popular Mobilisation

Day 1, 23 September 2002
Facilitator: Dr. Marcos Arana
Rapporteur: Beth Styer

A. Key Issues Discussed

- Understanding of breastfeeding issue helps us realise how many issues are involved in breastfeeding
- Popular mobilisation needs the big picture, connecting with people at all kinds of skills needed, creativity – learn from other movements
- Need a clear vision – justice, sustainability, participation, vibrancy, economics, productivity – need to involve three generations
- In order to bring about real change- need to "click" with the people and their needs. We cannot give power, but only support or create situations where community feels empowerment.

B. Key Outcome/Conclusions

- Participants of children, men, three generations
- Examples of how change can occur in a short time by addressing fears and concerns and making the messages clear
- Everyone needs to know their HIV status, be tested
- All sectors of community have a role and something to contribute
- Media involvement is helpful

C. Main Recommendations/Action Plans

1. Involve children in the transformation of the community as active participants in the change.
2. Collect 1000 ideas of how to celebrate World Breastfeeding Week
3. Train men in breastfeeding programmes
4. Collect posters and images used in campaigns
5. We may be the experts and know the answers but our role is to be an instrument of social action. Altogether we are a team. We need to be flexible, open, act and listen
6. We need to remember that all the problems and challenges in the breastfeeding mother's lives are also the issues for breastfeeding
7. Link to different movements
8. Work with children to transform the community.
9. Examples of work in Ghana showed that significant changes in early initiation of breastfeeding, exclusive breastfeeding and proper use of complementary foods can happen if proper messages are used.

Workshop 2 – Mobilising the Community for a Baby-Mother Friendly Culture

Day 2, 24 September 2002
Facilitator: Beth Styer
Rapporteur: Beth Styer

A. Key Issues Discussed

- Madagascar programme: improving breastfeeding at large scale through a community behavior change communication strategy
- Examples given of key players in Health Sector
- Pregnancy, postnatal and family planning, well child, delivery, immunisation, sick child, focus for community was on 2-3 priority messages on small doable actions. Program was also part of essential nutrition actions – creating of new community norms for infant feeding.
- Report from Mexico: working in community in Mexico- community has many languages, high domestic violence and low self esteem in women.
- Group counselling in the reproductive health programme: groups are set up by women with the same conditions:
  a. pregnancy: exclusive breastfeeding discussed and basic skills
  b. mothers with children under six months – ex: breastfeeding and newborn issues
  c. mothers with children 6-24 months – family planning, STDs, gender equality
  d. also work with hospitals about issues around reproductive rights
  e. new initiative during women and children friendly communities
- Report from the Gambia:
  a. baby friendly community initiative
  b. demonstrate how the Baby-Friendly Community Initiative (BFCI) was used to improve infant feeding practices in the Gambia through community participation
  c. 1993: BFHI introduced in the Gambia
  d. BFHI aims to increase exclusive breastfeeding, they have developed a 10 step plan to BFCI
  e. Addressed community problems, such as maternal nutrition, infant nutrition, environmental/sanitation, personal hygiene
  f. Through village support groups and surveys: discovered traditional myths about colostrom, exclusive breastfeeding

g. Discussions with men to understand concerns and then target them for behavioral change to be educators.

B. Key Outcomes/Conclusions:

1. Total community involvement
2. Use of health and nutrition and family planning programmes
3. Listen to fears, concerns and beliefs of all members of the family
4. Dissemination strategy very varied – house to house, clinics, village gatherings, ceremonies, religious, songs, dances,
5. In Gambia – colostrum is now referred to as protective medicine, e.g. breastfeeding translates into: the complete perfect breastfeeding." Example: breastfeeding improved from 17% in 1998 to 36% in 2000.

C. Main Recommendations

1. Need to share success stories
2. Best practices booklet developed
3. Lessons learned and how they can be incorporated
4. WBW is a key annual mobilising tool.

Workshop 3 – People's Health Movement and the PHA Charter

Day 3, 25 September 2002
Facilitator: Maria Zuniga
Rapporteur: Beth Styer

A. Key Issues Discussed

- People's Health Assembly – Importance of developing charter: how it is used
- Charter is a call for action
- What are the threats to primary care
- How to be involved in a process of the appointment of the new WHO secretary general
- Actions to be taken to expand the charter
- Stories of what is happening.

B. Key Outcomes/Conclusions

- The charter and preamble are being translated and disseminated around the worked: to make "health as a human right"
- A tool to be used to tackle economic challenges, political challenges, environmental challenges
- Community and national "working circles" set up to educate and adopt action plans
- Continue collecting stories of how the charter is being used.

C. Main Recommendations/Action Plans

1. Through WABA networks – spread information about the PHA and the charter and encourage involvement in working circles or set up working circles. Set up partnerships
2. Use this Forum as an opportunity to organise African Delegates to discuss follow-up
3. Use the World Breastfeeding Week as an opportunity to discuss the charter
4. Education – introduce PHA charter into all University Programs across disciplines
5. Participate in local actions in Commemoration of the 25th Anniversary of Alma Ata Declaration in 2003.

THEME 11: BIRTHING PRACTICES

Theme Outcome by Mary Kroeger

We had four workshops throughout this week. We had presenters from the four major regions: Zambia, Botswana, South Africa, Philippines, Bangladesh, Argentina, Chile, the USA and Sweden. Our presentations included clinical research, operations research on birth, hands on demonstrations, programme implementation examples, initiatives, advocacy activities and monitoring and evaluation tools. About 15 of us met this morning and we pulled together the threads of the week.

We established:

- Childbirth practices have a direct impact and influence on mother's health and well being, newborn health, and breastfeeding and must be addressed as part of WABA's global action plan for the next decade.
- The issues of care for the mother in labour, birth, and immediately after birth are included in the 1989 WHO/UNICEF Joint Statement which formed the foundation for the Ten Steps to Successful Breastfeeding.

Therefore:

1. The Baby Friendly Hospital Initiative (BFHI) should be expanded to the Mother-Baby Friendly Hospital Initiative. (Targeting childbirth care in maternity facilities, along with newborn and breastfeeding care).

Specifically:
- Expand BFHI Steps 1 and 2 to include childbirth care in the maternity facility's policies and in staff training.
- Expand BFHI Step 3 to include information to pregnant mothers on humane and evidenced-based childbirth practices.
- Expand BFHI Step 4 to include labour and childbirth management as it influence breastfeeding, newborn health, and mother's health and well-being.

2. Specific evidenced-based childbirth practices which should be encouraged are:
- Continuous support in labour, birth and immediately after with companion of mother's choice
- Oral hydration and nourishment that is locally available and appropriate (juices, soups, porridge, coconut water, teas, etc.)
- Non-pharmacological methods of pain management including: touch and therapeutic massage, walking and position changes, hydrotherapy, music, presence of a companion.

3. Routine (non-medically indicated) use of invasive and painful procedures should be discouraged. Such non-evidence based interventions include: enemas, perennial shaving, frequent vaginal examinations, AROM (artificial rupture of membranes), continuous electronic fetal monitoring, episiotomy, instrumental deliveries and cesarean delivery.

Expansion of Mother-Baby Friendly Hospital Initiative must consider home and community based health care. Traditional midwives and home birth attendants are uniquely poised to promote, protect and support both humanised birth and breastfeeding.

Training and follow up support for these community based health providers should be a priority. Global mother-baby friendly programming. Traditional programmes have often separated the mother baby dyad. WABA should support programs and new initiatives, which include maternal care, newborn care, and breastfeeding, care as a package. Gaps in the current monitoring and evaluation indicators should be identified. New indicators should be developed which will link childbirth, pregnancy and breastfeeding.

Workshop Report

Workshop 1- Continuous Support in Labor: Impact on Birth and Breastfeeding

Day 1, 23 September 2002
Facilitator: Banyana Madi (assisted by Mary Kroeger)
Rapporteur: Mary Kroeger and Banyana Madi

A. Key Issues Discussed
- Labor support improves birth and Breastfeeding Outcomes
- "Doulas" may simply be female relatives
- Fathers may be good labour support
- Many practices need to be changed
- BBI and RELALAHVPAN – two movements for MF/breastfeeding
- Indigenous practices like therapeutic massage help with pregnancy, birth and breastfeeding.

B. Key Outcomes/Conclusions
- Need to Disseminate research especially for low income countries
- Link NGO's on birthing practices
- BFHI needs to expand – step 3 and 1/2
- CD Roms of RH library edition 5 were handed out
- Plans to view videos from Argentina "Shut up and Push!" diverted to Thursday evening because of technical problems.

C. Main Recommendations/ Action Plans
1. Continuous support in Labour, Birth and After Birth should be standard of care and included in expanded BFHI.

Workshop – Birth Technology and Impact on Birth and Breastfing

Day 2, 24 September 2002
Facilitators: Anna-Berit Ransjo-Arvidson and Anne-Marie Widstrom
Rapporteur: Mary Kroeger

A. Key Issues Discussed
- Normal newborns have inborn hand and mouth movements that assist with early breastfeeding
- Medicine interferes.

B. Key Outcomes/Conclusions
- Minimise interventions in labour especially epidural anesthesia to optimise Breastfeeding Outcomes
- Premature babies are at risk and need extra support

C. Main Recommendations/Actions Plans

1. More research is needed to directly link birthing practices and breastfeeding outcomes

Workshop 3 – Expanding BFHI to Include the Mother

Day 3, 25 September 2002
Facilitator: Mary Kroeger
Rapporteur: Mary Kroeger

A. Key Issues Discussed

- Model of Baby Friendly and Mother Friendly care was tested in Zambia, and has been integrated into it
- BBI was presented including training approaches, monitoring and evaluation tools. Breastfeeding still needs strengthening in this project
- CIMS (USA present – Mother friendly Childbirth Initiative)
- Miriam Labbok gave the UNICEF perspective.

B. Key Outcomes/Conclusions

(see final Plenary Presentation)

C. Main Recommendations/Action Plans

(see final Plenary Presentation)

Workshop – Monitoring and Evaluation of Birth and Early Breastfeeding

Day 4, 26 September 2002
Facilitator: Uzma Syed
Rapporteur: Mary Kroeger

A. Key Issues Discussed

- DHS Survey data tracks breastfeeding certain birth issues, but rarely are correlated
- Breastfeeding Data were presented by country (Africa)
- Baseline survey on birth practices and Breastfeeding in Bangladesh presented
- CIMS presented the self-assessment, formal assessment and designation process.

B. Key Outcomes/Conclusions

- DHS surveys need to link birth, early initiation of breastfeeding and breastfeeding outcomes
- Saving Newborn Lives will share survey instruments with other countries and projects
- CIMS (USA) will share ongoing lessons learned in the development of final assessment tools.
- Mother Friendly Activities are assessed in Part 3 of NI and YCFA Tool.

C. Main Recommendations/Action Plans

1. Data linking Birth and Breastfeeding is needed and global indicators must be developed
2. Assessments of Mother-Baby friendly activities and programmes through BBI, CIMS and others should be shared through the WABA Health Care Practices Task Force.

THEME 12 – HUMAN RIGHTS

Theme Outcome by George Kent

Workshop 1 - Principles on Infant Feeding and Nutrition Rights

Key Issues: These are a summary of the issues we have discussed. It sounds like we could have invited the women's groups and the men's groups into discussion with a great deal of fruitfulness.

- Human Rights relevant instruments
- Human Rights is an important concept for the UN, for governments, NGOs around the world.
- Re-framing Code violators as human rights violators, this could be very helpful in our understanding of breastfeeding
- Mothers rights versus infant's right to be breastfed – there was passionate discussion around these issues
- Potential coercion of women if WABA accepts the infant's right to breastfeed
- Concern was expressed several times that the minority (in industrialised countries where informed choice in infant feeding the norm) may be imposing their views on the rest of the world.
- Implications for WABA and all of our various groups if we did affirm the right of infants to be breastfed
- Concept of claim holders and duty bearers in human rights
- Need to frame duties as wider than those of the mother so as to avoid judgementalism and patriarchal stance.

Workshop 2: Human Rights & Infant Feeding in context of HIV

Key Issues

- If infants have the right to be breastfed, what are the implications in the context of HIV? For this discussion, we accepted the fact that infants have the right to be breastfed, and extended it in this one particular case.
- Dilemmas were presented and shared: some infants already HIV+ at birth (20%), others become infected

through breastfeeding (15%), and others will not become infected (65%). When does a child have a right not to breastfeed and a right to replacement feeding?
- Is there sufficient evidence of health outcomes?

Key Outcomes
- UN Guidelines in this area are already based on human rights instruments
- They deal with the infant's right to the highest attainable standard of health (that is the way the infants human right is framed in those documents) but there is insufficient evidence as to how to realise this right for the infants of HIV+ mothers
- Difficult to deal with the human rights aspects without clear consensus on the technical side
- In the meantime, UN Guidelines provide best guidance on the basis of available evidence.

Main Recommendations/Action Plans
- Need for better research into health outcomes and survival according to infant feeding method, and not limited to HIV transmission before the Human Rights application can be clearly drawn out in this area.

The work we have done on Human Rights is not a few days old, but a few years old. In fact, it continues from the 1996 Global Forum. We have been reviewing the statement that came out of that Forum, reconsidering it, and examining the implication. In the in-between years, we have spent a lot of time through online consultation, and developed quite a substantial body of consensus – not just WABA but a number of people are interested in these issues. Out of these discussions arose a thorny issue that had to be addressed: is it the infan's right to be breastfed? What does that mean? We discovered very quickly, that different people understood it in different ways, and some people even wanted to avoid the talk about human rights because there is such a likelihood of it being misunderstood. We adopted the position that it would be far more fruitful to be very explicit about it and say that "we support the infant's right to be breastfed and it means this, that and the other thing and it does not mean what it does not mean." If we are clear on that, we should get good agreements. We have prepared a draft, and the copies have been circulated. The concept is that we are trying to say both what it is and what it is not. The importance can be understood in the following image: the old way of looking at this question was to look at it through a small frame, that of the mother and the infant. If anyone said, "the infant has the right" than it was all about the mother's duty. That is all we saw. However, our work has been looking at it from the frame of view of the society at large, that is to say that if the infant has the right to be breastfed, then that implies particular duties for all kinds of duties throughout the system – for not only the mother, but through the father, including the international agencies. We prepared, on this basis, this draft, trying to take the larger view that this is not just about a chore or a duty of the mother, but the involved duties of the society as a whole. In particular, it notices the Innocenti principles that there is an obligation on the part of society to protect, promote and support breastfeeding. We have taken it here to put it in the framework of more recent thinking about the right to food. There have been very important developments over the last few years.

I think it is very important to read the text when coming to a position. We are turning it over to the WABA steering committee to think about how this should be handled. It could be handled in a variety of ways. At the moment it is nothing more than workshop statement of the conclusions that we came to. We think that it might be a good way to handle it by having it adopted as some mechanism by WABA as a whole. Then, after agreeing on this statement, organise some kind of a group to prepare a supporting statement that would explain and elaborate what we mean. We can not put all of the extended narrative into the statement of principle, which is what this is intended to be. However, we understand that there is need for elaboration and explanation. I suggest we have some sort of adoption process in the short term, and then an elaboration of some process in the longer term under some leadership of the WABA secretariat.

Workshop Report

Workshop 1 – Principles on Infant Feeding and Nutrition Rights

Day 3, 25 September 2002
Facilitator: George Kent
Rapporteur: Magda Sachs

A. Key Issues Discussed
- Relevant Human Rights instruments
- Human Rights as important concept currently for reframing Code violators as human rights violators
- Mother's rights versus infant's right to be breastfed
- Potential coercion of women if WABA accepts human rights of baby to breastfeed

Draft Statement on The Human Right of the Infant to be Breastfed

In view of the fact that almost all countries have ratified the Convention on the Rights of the Child which affirms two fundamental principles: "the best interests of the child", and "children's right to survival and development", and the overwhelming body of evidence that breastfeeding provides unparalleled nurturing, nutrition and protection against disease, we recognise the human right of the infant to be breastfed.

This means that parties such as mothers, fathers, families, communities, governments and the international community have duties to respect, protect and facilitate the right of the infant to be breastfed. This is in accordance with the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (Florence, Italy, 1990).

In order for the relevant parties to fulfill their duties, their capacities must be strengthened where necessary. None of the parties, can or should be held solely accountable for the realisation of the right of the infant to be breastfed.

The way to assure the realisation of the rights of infants is to assure the realisation of the rights of all women. Coercion may not be used to press a mother to breastfeed. It is the duty of fathers, families, communities, governments and the international community to respect, protect and facilitate the mother to breastfeed in the framework of her own human rights.

Note: There are exceptional cases where breastfeeding is proven not to be in the best interests of the infant.

Arusha, Tanzania, 27 September 2002

- Concern that minority world – where informed choice in infant feeding is the cultural expectation – are holding majority to ransom
- Implications – for WABA – if state infants have human rights to be breastfed
- Concept of *claim holders* and *duty bearers* in human rights
- Need to frame duties wider than the individual mother so as to avoid judging and patriarchal stance.

B. Key Outcomes/Conclusions

- Draft statement on issue from workshop

C. Main Recommendation/Action Plans

1. Statement to go to steering committee. Process for taking forward issue/statement to be decided by steering committee.

Workshop 2: Human Rights and Infant Feeding in the Context of HIV

Day 4, 26 September 2002
Facilitator: George Kent
Rapporteur: David Clark

A. Key issues Discussed

- If infants have the right to be breastfed, what are the implications in the context of HIV.
- Dilemmas since some infants are already HIV+ at birth, others may become infected through breastfeeding and others will not become infected – but don't know which.
- When does a child have a right not to be breastfed and have a right to replacement feeding?
- Is there sufficient evidence of health outcomes related to infant feeding method?

B. Outcomes/Conclusions

- UN Guidelines based on human rights instruments.
- Dealing with the infant's right to the highest attainable standard of health, but is there sufficient evidence as to how to realize this right for the infants of HIV+ mothers?
- Difficult to deal with the human rights aspects without clear consensus from the technical side.
- In the meantime, UN guidelines provide best guidance on basis of available evidence.

C. Main Recommendations/Action Plans

1. Need for better research into health outcomes and survival according to infant feeding method, and not limited to HIV transmission.

Additional Workshop – Human Rights and Infant Nutrition

Day 5, 27 September 2002
8:30 hours to 10:00 hours

The human rights debate on this subject in the previous workshop was incomplete. The participants decided to continue their discussion by having an additional workshop. The outcome of this workshop was a draft statement on the human right of the infant to be breastfed.

THEME 13: INFANT FEEDING IN EMERGENCIES

Theme Outcome by Lida Lhotska

The Context of our discussions and workshops:

- Increase in emergencies up from 14 to 35 million in 15years (refugees & displaced).
- Negative impact on economic and social infrastructure.
- Affects water/sanitation, shelter, food security and health infrastructure.
- Reduction of coping mechanisms, increased vulnerability including psychological.

Main Recommendations/Action Plans

- Need to develop strategies for emergency preparedness in IFE.
- UN should assist with development of IFE guidelines at national level.
- More coordinated approach in emergencies in line with Operational Guidance.

We are calling on the UN system to assist in development of infant feeding guidelines and for more coordinated approaches. We have the operational guidance. Let's act on it.

- Closer collaboration and information sharing between relief and development agencies, and emergency and breastfeeding groups. We need to develop strategies for emergency preparedness. Again, just like in the discussion about HIV, if we do not globally express the issues about infant feeding, we will not ever be able to respond adequately in emergencies.
- Assessment instruments need to be developed for infants below 6 months. These are urgently needed. We have already had discussion about how we might go beyond just experiences with emergencies.
- HIV/AIDS: urgent need for general consensus and improved collaboration across sectors (modules do cover it in a manner consistent with the UN policy only in normal settings.)
- Include communities in decision-making and implementation of interventions – it is not only support and help in a traditional sense. We know that in emergencies, the psychological component is extremely important and the traditional support for breastfeeding mothers may not be adequate. Perhaps we need to think about new ways to help breastfeeding mothers overcome their problems.

Workshop Report

Workshop 1 – Infant Feeding in Emergencies: a Training Session

Day 1, 23 September 2002
Facilitator: Lida Lhotska
Rapporteur: Mary Corbett

A. Key issues Discussed

- Introduction and brief history of Issues, recommendations, training in Infant Feeding in Emergencies and presented operational guidance and modules 1 and 2.

B. Key Outcomes/Conclusions

- In long established refugee camps awareness of issues in IFE observed indicating improvement in appropriate infant feeding practices.
- HIV/AIDS and emergencies- issue, modules do cover but some not presented - no general consensus.

C. Main Recommendations/Action Plans

1. Monitoring – core group for IFE to consider adding a section on Monitoring implementation of interventions suggested by modules 1 and 2
2. Collect case studies and experiences in relation to infant feeding in emergencies and send to core group.
3. Identify speakers to assist in review of Module 2.

Workshop 2 – Infant Feeding in Emergencies: Experiences and Lessons Learned

Day 2, 24 September 2002
Facilitator: Lida Lhotska
Rapporteur: David Clark

A. Key Issues Discussed

- Experiences from 3 continents – Europe (Macedonia), Latin America and Sub-Saharan Africa (focus on Mozambique)
- Operational Guidance on IFE presented to the Group
- Assessment of the situation: how are infants fed? Are emergency relief workers trained in IF?
- Ten Steps for safe for infant feeding in emergencies (assessment tool)

B. Key Outcomes / Conclusions

- Absence of understanding of complexities and implications of IF methods in emergencies: misinformation, lack of knowledge, untargeted donations of baby foods, lack of coordination, poor monitoring.
- When mothers and health professionals able to make informed decisions, their practices change.
- Women need support in emergency situations.
- Need to improve exclusive breastfeeding in general population also as a part of emergency preparedness.

C. Main Recommendations/Action Plans

a. Need to develop strategies for emergency preparedness
b. Humanitarian agencies need to be informed about the Code
c. Need for even more coordinated approach in emergencies in line with Operational Guidance
d. UN should help with development of guidelines at national level
e. Need to monitor Code compliance in emergencies
f. Assessment instruments need to be developed for infants below six months (start made in Afghanistan) but also need to know what to do about the results (management of severely malnourished 0-6 months olds).
g. Need for closer collaboration and information sharing between relief and development agencies and emergency and breastfeeding groups.

THEME 14: RESEARCH

Theme Outcome by Ted Griener

Research: Natural Science

- Exclusive breastfeeding measured through 24-hour recall yields considerably higher figures than exclusive breastfeeding measured since birth (Sweden).
- Premature infants can be supported to breastfeed as soon as they are able to breastfeed and grow independently.
- One study explores the possibility of skin-to-skin contact as a way to inspire babies with difficulties latching on, to do so. The conclusion is that it is never too late to latch on.
- The physiological basis for exclusive breastfeeding without water is the very low renal solute load of breastmilk. This means that there is a very low concentration of protein and minerals.

Research: Social Science

- A study in England showed that frequent weighing of babies in England suggested negative influence on breastfeeding. Somehow, people assume that growth monitoring is a good thing. However, research shows that it might undermine mother's confidence and if the health visitors who did the weighing may have suggested something else.
- RAP of exclusive breastfeeding generated programme relevant findings.
- Two examples of planned research were presented. One researcher is planning to look at health outcomes for babies of HIV positive mothers. One researcher is going to look at how mothers are able to prepare formula and measure the contamination and dilution.
- Additional questions from participants contributed to the workshop. Many people were planning to do research. One person said he was interested in looking at the normalisation of breastfeeding. He hypothesised that focus groups could be one way to go. Someone else from another country reported doing the same thing. Good information was shared.
- One very useful report about DHS surveys – there are creative new indicators for complementary feeding. This would help us to understand complementary feeding better.
- There is a new WHO course on complementary feeding. This is a three-day course being performed in South Africa. A few concerns were raised in the audience. One concern was that three days are not enough. Another concern was that the course only deals with complementary feeding and not breastfeeding. The recommendation was that it really needed to mention exclusive breastfeeding and the importance of continued breastfeeding.
- Conceptual framework for understanding complementary feeding. This pointed to the possibility that the lack of exclusive breastfeeding may be a factor that contributes to the process of something. It was a reminder for us all that when we are addressing poor nutritional infant status, it may be a good idea to look both at breastfeeding and complementary feeding, and not just look at one of them.

Judging from the very good attendance every day, this workshop was thought to be useful.

THEME 15: INFORMATION EDUCATION, COMMUNICATION AND INFORMATION TECHNOLOGY

Theme Outcome by Dr. Rob Vincent and David Curtis

We had an interesting, diverse and lively strand of workshops in the Information, Education, Communication and Information Technology theme. We had images of breastfeeding, songs and lullabies, prop-making, use of websites, designing materials, essentially from what some might call 'traditional' to the very modern. Most sessions had a practical emphasis, but there were also some interesting discussions and key lessons for effective communication, that we have drawn out for feeding back to the forum. At the same time, all of the sessions highlighted that communication process between people, not necessarily the technology should be the central concern.

Several sessions looked at particular communication methods in breastfeeding promotion, such as using websites, songs, arts and drama. I want to outline the key lessons from these sessions first. Another two sessions used group work to come up with key issues in developing health communication materials, and looked at the QUEST process for developing locally appropriate and effective materials. I will come to these afterwards.

So, first the lessons from different communication methods:

- Websites can be powerful for making lots of information readily available but they are most effective when linked to wider forms of support and counselling and community activities and involvement.
- Email can foster diverse participation but it takes a lot of time to adequately deal with the volume of response it can generate. In discussion forums, quality of information is an issue, and the power of certain professional groups to dominate the discussion was another issue.
- Popular songs, such as those sung by 'Poopy' in Madagascar, can bring campaigns to life and give them credibility. They work best when integrated with a range of other activities.
- Consistency of messages is also important – this was identified in a variety of workshops and has been an issue for the forum throughout the week.
- Songs, art, and pantomime can all be effective because they are appealing and fun, but also because they connect with people experiences and are embedded in their everyday realities.

In a session that looked at breastfeeding images throughout the ages (some of which you may have caught earlier as you came in to the plenary) we saw that in many times and places, breastfeeding is a part of life, and the images we saw expressed people's experiences of breastfeeding. Today, we find that images are used by corporations much more to push a particular 'message'. This raises a question about how we use art in our communication activities:
Are we creating a space for reflection so that people can be moved to think critically about their lives, or are we deciding on the right messages that everyone else is expected to consume?

Developing effective health communication materials

In the other two sessions we focused on how communities can develop their own resources drawing on their own knowledge, needs and experience. We looked at how to promote a supportive environment for breastfeeding in the community – an issue that had already been raised at the colloquium. Both groups included people with many years of experience in a range of areas and campaigns, from video and songs to banner making and cartoons. Lively group work in both workshops identified the same key issues:

Geographical and communication barriers – how do you reach people in isolated settings?

Cultural beliefs and traditions: including roles, beliefs of partner or family members in supporting breastfeeding; social and community practices, norms and habits around breastfeeding and community and traditional beliefs.

Lack of knowledge of health workers and community: of the benefits of breastfeeding

Need for appropriate communication methods: appropriate language, appropriate approaches for low literacy, taking local language into consideration.

Consistency of messages: conflicting information was an issue here.

Lack of financial and human resources: including appropriate materials; lack of services; poverty.
Commercial Influences: negative information from artificial formula companies.

Gender imbalances; division of labour and power relationships.

The need for political will at all levels, (from national to local) including supportive laws: including political support; need to not rely on top-down approaches.

It is clear from this range of factors that focusing on individuals and seeking 'behaviour change' is not enough. Approaches to health communication are slowly changing to take into account the importance of social context and wider factors that influence people's actions and behaviour.

One recent example is Social Change Communication. Another interesting approach is the UNAIDS new communication framework for HIV/AIDS. These approaches recognise that to understand people we have to consider things such as: gender issues; poverty; government and policy frameworks; cultural issues; spirituality and religion. It is noticeable that all of these issues came up in our group work, and many have also been alluded to throughout the week at the forum.

We can no longer afford to act as if we are targeting isolated individuals who make simple calculated choices; all of the above factors need to be taken into account. And as we also heard in some of the plenary sessions, particularly from our People's Health Movement friends, the need to take poverty and the

realities of rural people into account is vital for any communication campaign to be effective. At the same time, where there is information that is seen to be essential, it must be sensitively placed into community dialogue, not just 'disseminated'.

After the group work we looked at ways of making sure we take this broad range of issues into account when designing campaigns. The QUEST process was designed to do just this, by guiding people through the stages and issues in resource development, a process relevant to all areas of health communication (see holding website http://www.e-quest.org).

Finally we all have a challenge. How many times have we been involved in health or communication campaigns that haven't been effective, haven't involved the community, which at best have done nothing and at worst, have done damage. Time and resources have been wasted. Now more than ever, it is vital that we learn the lessons from each other, so we can build on successes and learn from our mistakes. We have heard a number of appeals at this forum for collecting and sharing the lessons from our work.

Exchange for our part are engaged in pulling together many lessons from health communication activities to make a 'map' of what works and what doesn't. If everyone here at this WABA forum can share lessons and case studies to strengthen this process, perhaps through WABA, or Exchange's mapping exercise (http://www.healthcomms.org/feedback/index.html) we can make sure we learn from each other for the future.

We end with a slide from Anne Marie Kern's presentation on Breastfeeding in the arts. Many presentations at the WABA forum have highlighted the challenges of the increasingly unchecked power of global corporations.

This image gives us a sense of the forces we are up against (slide of an advertising campaign by McDonalds in Austria over the summer, of a baby suckling a burger bun).

Workshop Report

Workshop 1 – How to Develop Effective Health Communication Materials

Day 1, 23 September 2002
Facilitator: David Curtis & Dr. Rob Vincent
Rapporteur(s): Dr. Rob Vincent

Key issues Discussed

Participants shared experience of developing health communication materials. Collective experience of half the participants alone was over 130 years and covered development of a range of materials including: books, leaflets, pamphlets, patient materials, videos, poster, t-shirts, humour and cartoons, newsletters, greeting cards, training, community mobilisation, flip-charts, bill boards, songs, websites, packaging, radio. Participants also discussed a range of sample resources and what was good about them. Ones displaying clarity, realism, visual appeal and humour were consistently appreciated. Workshop participants brainstormed individually and then in groups to come up with between five and nine key issues for a campaign looking at: *Promoting community support for women breastfeeding*.

Key Outcomes/Conclusions

Key points were clarified and grouped, and then the core theme of each group drawn out. The key issues which came up included:

- Geographical and communication barriers.
- Cultural beliefs and traditions: including roles, beliefs of partner, family members in supporting breastfeeding; social and community practices and beliefs, deep-rooted traditional beliefs; beliefs norms and habits around breastfeeding.
- Lack of knowledge of health workers and community: of the benefits of breastfeeding.
- Need for appropriate communication methods: appropriate language, appropriate approaches for low literacy, taking local language into consideration
- Consistency of messages: conflicting information was an issue here.
- Lack of financial and human resources: including appropriate materials; lack of services; poverty;
- Commercial Influences: negative information from artificial formula companies.
- Gender imbalances; division of labour and power relationships
- The need for political will at all levels, (from national to local): including political support; need to not rely on top-down approaches.

Main Recommendations/Action Plans

- Good background research – Effective resources are based on accurate information about 'target audience' knowledge, attitudes, beliefs, behaviours, and social norms.
- Setting realistic objectives – Objectives should

be realistic, measurable and specific, and there should be a clear timeframe for achieving them.

- Participation of the target audience – Health resources are more likely to be effective if the 'target audience' participates in planning, implementing, monitoring and evaluating.
- Advocacy for change – this means combining activities aimed at changing individuals' behaviour with advocacy to change attitudes and the social environment.
- Social context is vital to communication
- Effective monitoring and evaluation – is essential to check effectiveness, provide feedback, and assess usefulness and impact, and should be planned at the start and continued throughout.
- Integration into programmes and linkage with services – Health resources are most effective when linked to other activities and backed up by relevant services.
- Enlisting support – Involving political, social and religious leaders
- Build on existing relationships and practices – make use of the communication practices and 'channels' already in use.
- Sustainability – ad hoc, unconnected messages that lack continuity are less effective than sustained activities that help keep issues on the agenda and in people's minds.

Workshop 2 – People's Media and Breastfeeding Arts

Day 2, 24 September 2002
Facilitator: Dr. Rob Vincent
Rapporteur(s): David Curtis and Dr. Rob Vincent

Key issues Discussed

Agnes Guyon described an essential childhood nutrition actions promotion campaign in Madagascar. As part of the campaign four popular songs were performed by well-known and popular singer 'Poopy' at a number of events and released, to promote breastfeeding. The campaign was conducted at several levels, from the local community to national. It was suggested that Poopy's songs made the messages more attractive and real. Impressive results of changed behaviour showed increased early initiation of breastfeeding and greater rates of exclusive breastfeeding.

Amara Peeris, President of the Sarvodaya Women's Movement in Sri Lanka described some experimental work using traditional lullabies to soothe both mothers and babies. While the words were supportive, the music could have a stimulating effect and encourage cognitive development. She wants to follow up the studies scientifically but had seen good results.

Anne-Marie Kern showed a number of slides showing images, paintings, sculptures and cartoons of breastfeeding throughout history, with a northern European emphasis (something Ann-Marie hoped to change in future). Images included women at work, religious images, a bank note, an official seal, an image of a bearded figure breastfeeding (to show men's support it was suggested), and a recent Austrian advert for McDonalds of a baby suckling a burger bun as breast.

Key Outcomes/Conclusions

It was noted that many arts emerged from peoples experience and did not necessarily have a specific 'message' in mind. In earlier history breastfeeding was clearly a part of life. In recent times the image were used to push a 'message' or sell a product. The songs or art needed to be attractive and enjoyable in themselves, not just giving a message. We also need to know more about what role any 'message' plays, and how much art provides a space for reflection and sharing of experience. The most memorable images for a number of people were the McDonalds advert and the person with a beard suckling a baby. Lessons from the Madagascar study were; that Poopy was a good choice due to her image as the ideal Madagasy mother; the songs were good, both in their rhythm and words; the songs were part of an overall strategy and did not stand alone; a multiple strategy of songs, interviews, press and printing was beneficial; successful program elements included harmonisation of messages from national to community levels and using all possible channels and media sources.

Workshop 3 – Using Information Technology in Breastfeeding Promotion

Day 3, 25 September 2002
Facilitator: Dr. Rob Vincent
Rapporteur(s): David Curtis and Dr. Rob Vincent

Key Issues Discussed

Chen Chao Huei raised some interesting issues in her description of the experience of a breastfeeding website and e-discussion group in Taiwan.

Issues/problems for the e-mail discussion group were:

- Many people sent the same questions without first

using the search function to check older 'posts' and contributions.
- Many people asked questions that were unrelated to breastfeeding but covered broader health topics and asked for health advice.
- It was difficult to monitor all the contributions to check on their quality (in one example a health worker suggested the need for babies to have water).
- Health workers tended to have a ‘know it all’ attitude and this came through on their contributions.
- It was not possible to provide the physical demonstrations of breastfeeding that many people wanted (though some photographs on the website helped this problem a little),

Benefits of the email discussion were:
- Ability for people to get quick answers to their questions
- Promotion of mother-to-mother support

Attempts were also being made to link the website and email to the activities of counselling and support groups, additional training and networking.

Denise Arcoverde from ORIGEM highlighted the ‘democratising potential’ of electronic communication, whilst acknowledging it was still largely the middle classes who had access. At the same time, in Brazil the problems of connectivity are not so daunting and Brazil had a history of the government using electronic communication for people's input.

Humour, art and links to many other breastfeeding organisations and resources made the website attractive and popular. NETPOP a feminist project to train women and men in computer skills integrated breastfeeding material into training of 17,000 people in two years. A ‘Milky Way’ project worked with community groups to build website, again integrating the electronic communication with training and wider community activities.

Key Outcomes/Conclusions

Both presentations demonstrated the potential of electronic communication and ICTs to bring information to many people and workshop participants were inspired by how much information the two presenters had made available to so many. At the same time, some of the limitations of the technology were also acknowledged. In both cases it was not possible to deal with the volume of email enquiries (which often asked for information already available on the websites). In both cases electronic communication to was linked to wider support and training and face-to-face communication.

Discussion affirmed the need for training and support to supplement the provision of information. The value of CD-ROMs where computers were available but not connected to the Internet was also highlighted.

Main Recommendations/Action Plans

A ‘Findings’ paper on the use of ICTs in improving health and fighting poverty published by Exchange. This provided some background research highlighting the need to integrate electronic communication with other communication methods for greatest impact. (http://www.healthcomms.org/findings/index.html).

Workshop 4 – Prop-making and Acting: the Pantomime Mums

Day 4, 26 September 2002
Facilitator: Dr. Rob Vincent
Rapporteur(s): Dr. Rob Vincent

Key Issues Discussed

Examined some basics of prop-making and how to use recycled or 'found' materials to make props, and the process of brainstorming a story, and what props were needed.

Key Outcomes/Conclusions

The group brainstormed a story to present to the plenary to highlight the challenges to breastfeeding. Five challenges were identified: disasters such as war, storms and earthquakes, the workplace, the pressure of the baby-food industry, domestic violence and poverty. The group worked out a drama and the necessary props (mainly using plastic bottles).
With the Pantomime Mums directing the participants presented a drama with audience participation to the final plenary outlining five challenges to breastfeeding.

THEME 16: INTEGRATED EARLY CHILDHOOD DEVELOPMENT

Theme Outcome by Miriam Labbok

Objectives

The participant will:
- Understand the general principles of Integrated Early Child Development (I/ECD).

- Explore how to introduce breastfeeding in discussion of I/ECD
- Explore how to introduce breastfeeding in discussions addressing the other four Strategic priorities.
- Understand the three sectors enhanced by Lactational Amenhoeral Method (LAM) (social marketing. This is a "hook" to bring in other sectors)
- Discuss the development of new "hooks" to increase interest in breastfeeding.

Brainstorm Group 1: How might we get other sectors interested in breastfeeding?

Girl's Education

- Cognitive and psycho-social achievement highly associated with breastfeeding
- Groups's idea: Educate girls for important role as future mothers: "An educated girl educates her family and society about breastfeeding"

Brainstorm Group 2: Breastfeeding in Other Medium Term Priorities (MTSP Strategies)

Immunisation Plus

- Breastfeeding provides first immune protection, and Vitamin A, among others, helps fight disease.
- Colostrum is the first immunisation
- Immediate contact reduces illness by regulating temperature
- Provides first doses of Vitamin A
- Disease-free = sanitary, and prevents spread of bacteria
- Visit is an opportunity to counsel on breastfeeding.

Brainstorm Group 3: Breastfeeding in Other MTSP Strategies

HIV/AIDS

- Strong nutrition link; EBF decreases transmission
- Counselling is an opportunity to talk with mothers about breastfeeding
- Use PMTCT sites to strengthen BFHI and to monitor Code
- Lactation management to prevent and treat breast health problems reduces transmission.

Brainstorm Group 4: Breastfeeding in Other MTSP Strategies

Child Protection

- Nurtured and breastfed children less likely to be deserted and abused
- Refugee situations must know about the dangers of breastmilk substitutes
- Violence in the home: mother-baby togetherness and support of relationship can protect baby
- Calming effect of breastfeeding for frustrated mother
- Food security: feeding mother is less expensive than artificial infant feeding, reducing financial stress, and
- Birth spacing leads to better family health.

Try to develop a new "hook"

- Select another sector (e.g., environment, food security, micronutrient programme, malaria, or other intervention area) that does not currently emphasize optimal breastfeeding
- Consider what intervention or concept could be "socially marketed" that would "hook" those from this other discipline that are not currently supporting optimal breastfeeding into being supporters of breastfeeding.

Individual Work: Creative new hooks

Everyone picked a discipline or sector that had nothing to do with breastfeeding directly.

- Malaria – Bednet to keep baby safe and breastfed: "safe inside and out"
- Environment – Breastfeeding has no waste products, no fuel, no commercial waste
- Breastfeeding takes less water during shortages
- Education – Psychosocial interaction that starts with breastfeeding leads to time spent with the child, story-telling and reading
- Micro-enterprise – Breastfeeding women are reliable and willing to work from home
- Credit Banks –Women who breastfeed have a track record of involvement and responsibility, and likely to pay back loan
- Peacekeeping – Children who are breastfed are more compassionate to others - some research supports this
- Others – Pharmaceuticals: With the increase in resistant pathogens, breastfeeding is important -- now more than ever. If a mother and child are exposed to an anti-biotic resistant pathonogin, the only thing that will protect the baby is breastfeeding.

Expand your ideas through teamwork!

Nutrition-related MTSP target indicators

- Reduction in anemia prevalence among women of reproductive age by 15%
- > 60% of children receive appropriate home care for prevention and treatment of malnutrition
- > 60% of pregnant women use adequate antenatal services.

Focus of I/ECD

This complex new vehicle of I/ECD is just an opportunity, not a constraint, to expand your ideas. They expand very well through this type of teamwork.

Workshop Report

Workshop: I/ECD: the New UNICEF Medium Term Strategy and the Central Role of Breastfeeding

Day: 1, 23 September
Facilitator: Martha Thomas

A. Key Issues Discussed

- I/ECD is not ECD
- Breastfeeding is central to I/ECD
- Integrated messages about how to incorporate breastfeeding into other programs and other sectors are an important tool.

B. Key Outcomes/Conclusions

- Better understanding of UNICEF's MTSP and I/ECD
- There are ways to encourage other sectors to support breastfeeding
- LAM is an example of such a "hook"
- We all can develop "hooks" or social marketing approaches.

C. Main Recommendations/Action Plans

Attendees feel more empowered to approach governments and other agencies that don't currently "prioritise" breastfeeding.

THEME 17: LACTATION MANAGEMENT

Theme Outcome by Jacquie Nutt

The focus of our workshops was on facilitating exclusive breastfeeding, and also where and how to get the required training and skills.

We discussed exclusive breastfeeding, or exclusive breast milk feeding, in situations like HIV exposure, prematurity and difficult breastfeeding situations. Since it seems that certain situations (mastitis, thrush, cracked nipples, mixed feeding) might be a route of HIV transmission, we tried to show how careful management of lactation could prevent or overcome these situations. Exclusive breastfeeding for the first half year is good for all babies, not just those exposed to HIV.

The case studies session received the greatest interest, allowing some participants to learn, others to teach and share their own experiences.

There was strong rejection of the use of gadgets and equipment in breastfeeding. It seems that the lactation consultants presenting, myself included, left the mistaken impression in the minds of some that we recommend the use of breastpumps and nipple shields an other gadgets. Admittedly, in some environments, breastfeeding is often so sabotaged before lactation consultants see the mother that unnatural methods may be needed to resolve situations. For example, mothers often need weaning from the nipple shields recommended by some health workers and pharmacies. Our sincere understanding is that these gadgets are not needed in general and are in fact largely undesirable.

Other common themes throughout the workshops were:

- National success in breastfeeding initiation and promotion comes with multilevel training and regular refresher courses in the institutions.
- Counselling training is a vital component of lactation management, as is on-going support for the mother in her community.

Our one recommendation was to call for more research into how to help HIV-exposed babies to return to full breastfeeding if exclusivity is breached. We discussed two different situations where HIV positive mothers had started formula feeding and could not continue. Obviously in these cases, the concepts of affordability, feasibility, acceptability, sustainability, let alone safety, had not been properly discussed. However this made their options very limited.

We wondered about using heat-treated breast milk for a short time to normalise and heal the baby's gut as much as possible until the mother could go back on to direct breastfeeding, but this is an area not yet covered by research. This research is what we are calling for.

Workshop Report

Workshop 1 – Breastfeeding Management Issues for Everyone Working with PMCT

Day 1, 24 September 2002
Facilitator: Magda Sachs
Rapporteur: Jacquie Nutt

Key Issues Discussed

- Mastitis and thrush are possible routes of HIV transmission when breastfeeding – up to 50%
- Early intervention/education can prevent these
- Research on counselling shows that even one counselling session can improve exclusive breastfeeding (EBF) rates (more are better)
- Training of all staff is key and good government commitment
- Time for counselling is paramount, as well as observing an entire food.

Key Outcomes/Conclusions

- All new members do better with an informed trained counsellor working with them
- This extra time must be allowed by hospital managers – maybe this needs more staff
- With careful follow up after early counselling, the conditions that make breastfeeding more risky will be reduced.

Main Recommendations/Action Plans

- Include counselling training for lactation /HIV counselling staff where enough time is given for mothers to be heard. This is an issue for hospital managers and trainers to tackle.
- Individual staff members have to resist the temptation to diagnose and prescribe.

Workshop 2 – Optimising Milk Production from Start (In pre-term babies)

Day 2, 25 September 2002
Facilitator: Jacquie Nutt
Rapporteur: Jacquie Nutt

Key Issues Discussed

- Early initiation (within ½ hour of birth) including family and health and healthcare workers help for positioning baby for suckling when mother has had a c-section.
- Avoidance and management of engorgement/ mastitis
- Suppression of supply if desired
- Pre-term infants can be tired of breast within ½ hour too. Weight of the baby not really relevant, follow the baby's behaviour and cues
- Even if breastfeeding fully, pre-term baby can not be trusted to wake up for feeds – this has to be the parents' responsibility.

Key Outcomes/Conclusions

- Great visual demonstration of bent expression and massage and also of holding and latching the premature baby – which is rather different to a full-term baby
- Long discussion of "human milk fortifier" which many participants felt was unnecessary
- Extracting fractions of mother's own expressed milk would be preferable, if necessary – only when pre-term infant really is not growing on maximum volumes.

Main Recommendations/Action Plans

- Participants felt strongly that the use of gadgets (pumps, syringes, tubes) was to be of absolute last choice, and only if the mother (or the breastfeeding counsellor, rather) could really afford it. Low-tech methods are best.
- Expensive milk fortifiers are unnecessary, especially where mother's own milk or banked milk of equivalent gestational age is used.
- Support of mother is very important in early weeks
- Kangaroo mother care is best for pre-term infants, and parents should be allowed to stay at the hospital if the baby is hospitalised.

Workshop 3 – Lactation Management Strategies to Facilitate Six Months Exclusive Breastfeeding

Day 3, 25 September 2002
Facilitator: Sally Page-Goertz, Rosemary Gauld and Jacquie Nutt
Rapporteur: Jacquie Nutt

Key Issues Discussed

- Observation is vital
- Careful history
- Empathy
- If breastfeeding starts off well and then falters after a couple of months, check for underlying illness
- Can an HIV-exposed baby on formula be safely returned to full breastfeeding?
- Inverted nipples can be overcome; misuse of nipple shield in hospitals

Key Outcomes/Conclusions

- No place for nipple shields/nipple formers (though mothers often use them before seeking help)
- There may be some place for heat-treated breastmilk on a short-term basis.

Main Recommendations/Action Plans

- Need for training for all people caring for pregnant and lactating women
- Need for pregnant and lactating women to have more support in a more secure environment.

Workshop 4 – Where to get Lactation Management Training

Facilitator: Jacquie Nutt
Rapporteur: Jacquie Nutt

Key Issues Discussed

- LLL's training for 1) peer counsellors and 2) leaders
- International Board Certified Lactation Consultants (IBCLC)
- Wellstart International
- Various UN training programmes.

Key Outcomes/Conclusions

- Participants took contract details for the programmes that seems to fit their needs

Main Recommendations/Action Plans

- Call for research into how HIV-exposed babies to return to full breastfeeding if exclusive breastfeeding is breached.

THEME 18 – WORKSHOPS ON OTHER ISSUES

1. MEN'S FORUM
Theme Outcome by Per Gunnar Engblom

Brothers and sisters, my new and very dear friends, I am to share about the Men's Forum outcome and statement on behalf of the 27 men and the task force we have created. I won't bother you with so many facts. I want to share, I want to combine mind with heart and try to share the outcome. You can look at this workshop summary.

Since a number of years ago, this was my dream: meeting fathers from different cultures all over the world. I wanted to talk about what was needed concerning fatherhood, to create a more compassionate world. My dream ended yesterday. It became true. Now, I have to make up new dreams, but I have many new friends to do that with. I am a father. My home in Sweden, I have three wonderful daughters: Maria, 20 years old, Hannah, 7 and little Lisa, four and a half. I also have the privilege to have the most fantastic woman, Nina. I could never ever ask for more. With her, I can be both weak and fragile, and when I can be weak and fragile, I can be much stronger. I love all of these wonderful human beings so much.

I have asked myself many times: what can I do as a small contribution for a better world? I want all my children, grandchildren, and great grandchildren to have a great life. I'm sure you all do to. So what can I do? I have come to the conclusion that first, I must take care of my own family. Sharing with my woman, the care taking of children, sharing the household work, and so on. After that, I can begin to think of what I personally want with work, ambition, and so on. I read newspapers and get to know about terrible things. Since 1998, I have dedicated my life to being a small contribution by working with fathers in my community. I have done, and am doing that, because I can't think of leaving this world not trying to do something. I want to tell you a story about my father. Back in 1991, he was laying on his deathbed. He had cancer and had two to four weeks to live. I had to confront him with some stuff. I learned that I was so loved, and yet he was never there for me. I played football, and my friends' parents were there. My father was not. I was at the summer place during the summer. My father drove the whole family to the summerhouse, and then drove back to town to work. He came only maybe at the end for a week. I asked him "How come, if you say you loved me so much, why weren't you there?" He said "Back in the 20's, where I lived in the north of Sweden, we were very poor and had to often beg for money to have something to eat. I promised myself along the way that my children would never ever be in that situation." He was successful in that way. I had everything I ever needed materially. I understood and forgave him, but now I want to work with preventing this happening too many times: children waiting for their fathers. I think this is bad for all of us: for mothers, children, fathers, society and everyone. The Men's Forum produced two documents. One is the workshop summary and one is our statement. Remember, this statement is like an infant, please do not bee too hard on us. This infant statement will grow into a healthy, grownup statement in a later stage. Please be gentle.

I am humbly taking on these tasks (listed in the workshop report) with these amazing and passionate

men and fathers. On the behalf of the focal persons mentioned on the summary and mine, I promise you all that we, together with WABA, will do our very best to serve the women and the children. We will do this through taking care of and supporting our own women and children and supporting other fathers in any way we can to do the same thing. Finally, I would like read a few lines from a book written by my role model, his holiness, the Dalai Lama:

> May the poor find wealth. Those weak with sorrow find joy. May the forelorned find new hope, constant happiness and prosperity. May the frightened cease to be afraid and those bound to be free. May the weak find power and may their hearts join in friendship.

Workshop Report

1. Men's Forum

Day 4, 26 September 2002
Facilitator: Dr. Charles Sagoe-Moses
Presenters: Mr. Obadiah Msaky, Dr. Tarsem Jindal
Dr. C. Sagoe-Moses and Mr. Per Gunnar Engblom

Key Issues Discussed

- The need for men to support women during antenatal, delivery and post natal periods.
- Men need to be supported to ensure that they can play their role efficiently as fathers
- Involvement of men through advocacy, education and networking
- Existing hospital practices do not encourage the involvement of men in supporting their partner during pregnancy and delivery

Outcomes and Conclusions

- The need to create a network of Father Support Groups to share experiences
- The need to change existing hospital practices to encourage the involvement of the whole family especially the father

Main Recommendations/Action Plans

1. The formation of WABA Global Initiative for Father Support (GIFS) to complement GIMS
2. The formation of a WABA-GIFS Task Force with representatives from all regions
3. The members of the workshop were to act as focal persons for their countries
4. GIFS to work towards changes in the hospital practices that hinder the involvement of families especially fathers
5. Release of Men's Forum Statement.

STATEMENT FROM THE MEN'S FORUM

- Recognisng the gender equality and complementality for optimal infant and young children's feeding.
- Acknowledging the existing international conventions of the right of the child.
- Appreciating the need to create opportunities for optimal growth, development and survival of children.
- Noting that the existing hospital – and health facility practices are not conducive to full participation of fathers and families in the caring and support of mother/baby during antenatal, delivery and postnatal period.

We the members of the Men's forum of WABA Global Forum II having considered all the above, hereby propose the following:

1. The creation of a WABA working group or task force to be known as The Global Initiative for Father Support (GIFS) to work in collaboration with GIMS.
2. Proposed Task Force Membership consisting of the following:
   a) Mr Per Gunnar Engblom – Europe
   b) Dr Arun Kumar Thakur – Asia
   c) Dr Charles Sagoe-Moses – Africa
   d) One person each from North America and Latin America
3. Participants of the workshop were identified as focal persons of their respective countries.
4. The convener of the task force will be Mr. Per Gunnar Engblom based in Sweden.
5. The task force shall come up with terms of reference (TOR) in three month's time.
6. GIFS shall operate through a network.

2. Healing Foods and Healing Touch

Day 2, 24 September 2002 at 4:00-5:30 pm
Facilitators: Ines Fernandez and Ellen Riva, Arugaan
Attended by 12 participants

Key Issues Discussed

- Common foods in the region were presented and the nutritional value at 100 grams as well as its medicinal properties and benefits were discussed.
- Healing foods were used to prevent or cure certain ailments through traditional knowledge of preparation.
- Case Study of malnourished 12 babies and toddlers where Indigenous foods were used to rehabilitate

them as a reinforcement with breastfeeding through wet nursing in a children crisis centre in the Philippines called Child Watch. Arugaan managed the rehabilitation for two months. Comparative photos were exhibited.
- Healing touch through therapeutic massage was an intervention used to address common body pains and ailments such as headache, stomache trouble etc. It highlighted the connection with food intake and slimming, releasing toxins, indigestion, increase appetite etc.

Key Outcomes/Conclusions
- It was a recognised fact that the indigenous foods knowledge and practices are endangered, its application is fast waning.
- The medical professionals and nutritionists in particular in many countries has little knowledge nor studied traditional foods, thus its non-application.
- The remarkable outcome of the use of indigenous foods and human touch and interactive care to rehabilitate the severely malnourished infants and young children. Special care on the abused and abandoned children as well as special management of staff to attend to the special wards are uniquely sensitive and different. It was an eye opener and challenge for the workshop participants.
- The healing touch massage was a hands-on lesson especially for headaches, back pain and stomach trouble. The therapeutic touch for asthma case was discussed.

Main Recommendations/Conclusions
1. It was recommended that the Forum should start expanding the issue of food particularly Indigenous Foods as an intervention in IYCF.
2. Both Healing Foods and Touch are powerful medium to address health and food security.
3. Traditional/Indigenous Foods should be a priority in the educational curriculum from school children to medical students.
4. Globalisation will contribute to the fast eradication and de-valuing of the knowledge and its practises. Recapturing back its power and innate resources.
5. The GF3 should make the issue on Indigenous Foods as the centerpiece because breastfeeding is the first indigenous foods.
6. Rediscovering Traditional Foods and repackage its appeal through IT and mass media campaign.

3. World Breastfeeding Charter

Day 4, 26 September 20 02, 2pm
Facilitator: Anwar Fazal
Rapporteur: Liew Mun Tip

A. Key Issues Discussed
- ESSENCE / CORE
- No business links / No global compact / No PPP / No corporate led globalisation
- Toxicant-free world
- Link with health people
- Education system school curriculum standards of breastfeeding education "Breastfeeding Education for ALL" (issues, techniques)
- Gender sensitivity: women empowerment and leadership
- Mom's sense of fulfillment and sense of achievement to be advanced
- Benefits of breastfeeding
- Pictures, illustrations
- Rights, Responsibility, Relationships.

B. Key Outcomes/Conclusions
- Developed the Charter/Objectives
  - As a popular expression
  - As an authoritative statement (bottom or/& top)
  - As a declaration
  - To be energising
  - To connect other/every aspects of breastfeeding
  - To ensure healthy moms, babies, families.
- Different Levels of Audience
  - Writing and adapting the Charter for different levels of audience:
  - Implementers: 21 ideas for 21st century – Project 2121.
  - Public: 99 doable things
    "WE": everybody, parents, babies
  - regional perspective
  - marginalised groups: people with disabilities.
  - Promotion
  - All levels
  - Through comics/ cartoons
  - T-Shirts etc.
  - Theme Songs – "singing the same song" for future WBW theme
  - "Lullaby International" / "From the mouth of babes"
  - Link with UNICEF's Golden Bow Initiative.
    Signing on process (people with disabilities e.g. Braille)

– Adapting/ versioning it for different types of audience, e.g. Braille.

C. Main Recommendations/ Action Plans

1. The World Breastfeeding Charter to be used in the following ways:
   - As poster
   - In textbook
   - Posted on website: www.worldbreastfeedingcharter.org
   - As a mobilising tool for 21st century
2. The Charter to be developed by:
   - Examining other charters (People's Health Charter, Earth Charter, etc.)
   - "Breastfeeding 101" poster made by INFACT Canada
   - Process is as important as product
   - Not one dimensional
   - Creating 10 easy steps so it can be popularised.
3. Target date
   - The Charter to be launched during WBW 2003.

PLENARY 9. DISCUSSION Q & A

Q. (Margaret Kyenkya-Isabirye) : I am surprised at how weak we are at the pre-service. We need to call on medical schools to be more accountable to implement the BFHI.

A: There was considerable discussion about this. It was included. I am concerned that you do not think it was strong enough, because it certainly was included. Improvements in pre-service education urgently need to be started and strengthened and eventually this will eliminate the need for continuing education. Your impression was that the point was not made strongly enough in the statement. We will take that into account.

Q: Is it possible now to combine the resolutions with the International Code so as to have one document? I've realised that the industry is now using the original Code and doing away with the subsequent resolutions?

A: Resolutions are put forward by governments. We have often been able to stimulate several governments to start thinking of an area where the Code falls short. We cannot expect in 2002 the 1981 Code to be sufficient. This is one area where there is some increasing awareness that we need to have some international regulations. WHA resolution is one way of doing that. Why not start here and have the delegation from Tanzania set something in motion? We would be delighted to assist in this process. It always starts with one. Remember that.

Q: In my country, the companies are training rural practitioners and community practitioners. Does the Code include anything about that?

A: If they do anything in terms of marketing breastmilk substitutes, anything that undermines breastfeeding, yes, there are certain rules that fall under them. I am not sure exactly what circumstances you are referring to.

PLENARY 9. DISCUSSION Q & A

Q: These are the people who have community access. They are the community leaders. The community often first goes to these people and then goes to other doctors who are qualified. They are not actually doctors. However, the companies organise meetings specifically for them. This exists in all remote areas.

A: The companies are using these people to distribute products?

Q: Yes. Companies tell about the advantages of their products over breastfeeding.

A: Definitely then, the Code applies. The Code applies to the companies that give them these products. They should be denounced and somebody has to stop this process. It is happening in Asia as well. They are using the traditional birth attendants in the rural areas to distribute products in the same way. It must be denounced – because it is criminal to go to remote villages and use that structure of trust to distribute products.

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PLENARY 9. DISCUSSION Q & A

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Q: Elisabet Helsing: As we all know, the Code is not perfect but it is good. It says something about the closure of donations to medical workers. I believe that, and I don't have the figures to support this, but the largest part of corporate budget in the area of promotion is for hidden promotion. That is to say gifts, subsides and support to medical workers – which are all very difficult to pinpoint and prove. Are there any plans on the part of the code monitoring responsible or volunteers to take on this issue?

A: Annelies: There were definite calls to include more restrictions on sponsorship in our workshops. We would love to propose resolutions to the WHO- but as NGOs, as people organizations, we need the governments. Any government official who is going to Geneva next may, let us work together with you to have some motion – if it is the government's wishes, it can be an added restriction that can be implemented and enforced through all of us.

Q: I would like to put this question to both the Globalisation and Code groups. Did you discuss about complementary food in terms of protection, promotion, and support? The time has come when we need to give support, protect and promote complementary feeding practices. The industries will definitely have a lot of scope to market this not only in terms of profit, but unethically as well. Therefore, I think that when we are going to formulate the policy at the national level of the IYCF practices, things will have to be considered with the national policy. Any thoughts from this Forum will be helpful.

A: Annelies Allain: The resolution of 2001, which pointed to six months which is the optimal length of exclusive breastfeeding, automatically extended that scope to these products and automatically asked governments, the mothers (consumers) to those limits – it is always six months with the complementary foods starting at six months, and breastfeeding continuing for two years and beyond. Regarding the promotion that is necessary to get mothers to prolong the duration of breastfeeding, much work needs to be done. We also need to watch the companies so that their products do not interfere with this practice.

Q: Nona – Regarding the Code and the subsequent WHA resolutions, I think we should really work on the prohibition of health claims on artificial milk and other complementary foods. Especially the health claims that these products contain components that can be found in mother's milk. I am really wondering where these companies get these components from if not from human breastmilk. Also, I think the

PLENARY 9. DISCUSSION Q & A

prohibition should extend not only to the labelling of the milk products on the cans, but also on medical journals, because the advertising companies put it so nicely. They make up terms like 'new generation protein' that I think some doctors are diluted into thinking that some of these medical claims are true.

Q: (unidentified person) My question goes to the presenters of theme 5: I need a few clarifications. On slide two, when you are talking about commercial formula and modified cow's milk, are not suitable for those in poor settings. You did not go any further than to clarify these recommendations. You'd say that this needs to be assessed and looked into. You did not go further to let us know whether what you discussed is...if let's say, somebody wants to donate, it's a poor setting because it is not available, but somebody donates – government buys – or somebody says that they want to provide the water and everything. Is this something that you are saying should be done. Also, the group was a bit silent about the need to adhere to the Code when talking about the issues of HIV and infant feeding. I do not know what the group felt about the issue of slide number two: the issue of poor settings and unsuitability of the use of commercial formulas.

A: Peter Iliff: What I presented, which was the consensus, was that commercial formula and other replacement feeds are not feasible not just from an economic point of view. The time constraints and the acceptability constrains are too extreme at the moment for serious consideration in most poor areas. As far as donations of formula, it would be logical that they would not be acceptable in those circumstances at the moment. The group would agree that this is a moving situation and things might change.

Q: Again, for the HIV presenter, there was a recommendation on maternal health needs and that it should be central to programming. I wonder if you could add nutritional needs as well.

A: Yes, absolutely. That could have been and should have been written in. Health includes nutrition – and was a central part of the presentation on research findings in regards to maternal health. Nutrition is of central importance. That should be added.

Q: Helen Armstrong: If I heard correctly, mothers who are HIV negative or of unknown status should be included as full participants in PMTCT programs. Can you clarify what that means exactly? Does that mean that if you are providing formula to HIV positive mothers then you would also provide it at will to HIV negative and of unknown status mothers?

A: No, absolutely not. The point is that those people are coming to Antenatal clinics where PMTCT work is being integrated. They tend to get abandoned. That was reported to the workshop that it is only the HIV positive mother who seems to get attention in the perinatal settings. There is a lot of help that can be offered to the HIV negative mother and to the mother of unknown status, and to

PLENARY 9. DISCUSSION Q & A

feed her baby in the appropriate way – which is exclusive breastfeeding for preferably Six months and up to two years or more.

Q: Annelies Allain: That would not blame the mother, that would not lead to all of this guilt on her for transmitting HIV. Stephen Lewis, in a very powerful speech, asked us to include those 80,000 or more children who are infected through sexual violence, rape and more. We put our heads together and came up with something short and crisp and accurate. What happened to it? Was this discussed in the working group? If it were not, I would like to propose it again. It was ACT: Adult to Child Transmission, in order to replace MCT – it has the big advantage of including the 10 percent of child victims who get infected through sexual aggression. I do think that as a forum, we should go away with not only the wish that we no longer put the blame on the mother, but that we come up with an alternative. ACT.

Q: Stina Almroth: I already received clarification that you wanted to include HIV negative women, and also women of unknown status. That is what you said on your slide. Then you said that it really was an issue of integrating this into existing services. I think it would be useful to combine these two points. I think we have talked a lot about exclusive breastfeeding, for example, and the need to promote that in general – not only in the PMTCT kind of intervention.

Q: Michael Latham: I am responding to the HIV task force on the question of terminology. At the colloquium, there was a lot of discussion and total agreement on the fact that MCT of HIV was an undesirable term, because it did seem to put blame on the mother. There is no other disease, as far as I know, where we include where the disease came from in the title of the disease. We don't put Mother and Father Sickle Cell Anemia – I do not know why we can not have a simple title like "Infant and young child HIV, or Pediatric HIV" – then in discussing it, we can assess where it came from - whether it came antenatally, natally or post natally. All other diseases are just called the name of the disease, not where it came from. I do not see why we should call it ACT – and I worry about us adopting a new term, which, 5 years from now, a lot of people say "this needs changing again." I would go along with saying "Infant and young child HIV" or "Pediatric HIV" is more desirable.

A: Ted Greiner – I am speaking on behalf of those who would be putting together the report. I would like to know if we can get agreement from the WABA forum as a whole that we will give a recommendation to the UN committee, that the term Maternal To Child Transmission be reviewed and that a better term be found.

Q: Alice Drito from Uganda: – Among the common advocacy general recommendations – something was specifically mentioned for implementation of Women's maternity programmes. I do not know why something similar on paternity leave was omitted. I think it could be included as well.

PLENARY 9. DISCUSSION Q & A

A: This is something that needs to be discussed. There has already been a lot of discussion in Latin America. In countries where this has been proposed, some men will come home to rest. This has to go together with the issue that we have real partnerships with men so that they come to the home and share the caring with the woman. It would be great.

Q: Dr. Raj Anand: In regards to the human rights statement about breastfeeding – I can understand the people who have drafted it. I have seen it only right before I reached here. The concern of the mother has to be kept in mind when talking about the right of the child to be breastfeed. We should also not blame the mother. It is the responsibility of others to see that she can do it. Somehow, I feel that this draft needs to be looked after a bit more carefully before it is adopted. I want to know if there is a mechanism (and if so, what it is) for making it final? Can this be discussed again before it is finalized? I feel that there is a lot of room for improvement. Although the basic tenant of the draft seems to be good, and one should respect it, I think a lot of rewording is needed.

A: George Kent: This question is one for WABA leadership. The Human Rights Task Force prepared this statement, and now we give it over to the steering committee. It is in a sense, no longer ours. The service we provided is preparing this draft. We have spent a lot of time drafting and redrafting. We have done what we can do. As far as the final adoption process, someone else will have to speak with how that ought to work.

A: (from WABA Steering Committee – Elisabet Helsing: We get enormous numbers of recommendations as to what WABA ought to do. WABA is a bit of a morphos entity. It is, in a way, helpful, because it tells us what are your concerns. As events play along, statements such as these can turn out to have value. Perhaps they are left sleeping for a while – but then they can be useful in some context. I can see this particular statement on the human rights of the infant as being part of the justification, when we start working seriously with the global strategy for Infant Nutrition, for Comprehensive Infant Nutrition Strategy. You need something that says Breastfeeding is the right of a new baby. But this is more or less, how it works – WABA is a people's organization. It is flexible.

Q: I want to say that adult to child transmission has to be taken because it begins with Adult Behavior. It is not a genetic disease like anemia. Secondly, in this forum, we should also discuss for the HIV people, when they are giving the foods, that bottles should not be introduced. Bottles can harm people more. I think that should also be included in the recommendation. Even if they are giving the feeds, it should not be given by bottle. It should be given by cup and spoon.

Q: Linda Sanaie – I was briefly seconding what Michael Latham was saying – I do not think we should assign a name that involves the rout of transmission. While it is in the minority, not all pediatric HIV is transmitted vertically.

Q: Urban Jonsson – I had a comment about theme 9 - Globalisation. I think that it would be wrong to become anti-trade in a world where Africa is suffering from not having a trade because of the agriculture subsidies in the US and in Europe of 180 billion dollars a year. The problem is not too much trade, it is unfair trade. Thank you.

Q: Comment for Annelies – I am talking about societies, Pediatric Societies and Peri-natal Societies around the world. When you visit these meetings, you see how great the power of the countries is all around the world. My opinion is that it is necessary to bring together all presidents from all peri-natal societies around the world and talk about the advertising of Infant Formula. It is very important. Local people have no power to fight with international meetings. This is my suggestion.

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Dr. Raj Anand: Two comments. The first is in regards to Stina Almaroth, who just presented on research. Years ago she told us that there was no need for water in exclusively breastfeed children. I thought that set the stage for exclusive breastfeeding. If there is any prize for breastfeeding research, I think it should go to her. (Applause)

Secondly, Miriam Labbok mentioned why breastfeeding is necessary in certain situations. One situation is children who have Glucose 6 Phosphatase deficiency. They can not be given certain drugs. It is our responsibility to keep them disease and infection free as much as possible so that we do not need to give drugs that may be needed for such infections.

Q: (unidentified man): I have three points. The first point is about HIV positive mothers. This point is not coming out very clearly to me. We are not exactly saying what we should do when a mother has been confirmed as HIV positive. My second point is about dissemination of information on breastfeeding. On our opening day, we had very good songs and poems by the Tanzanian primary school children expressing breastfeeding messages. Also, we had very good drama from the Philippines. During Rob Vincent's presentation, I may have wanted to see a clear presentation on how we can disseminate breastfeeding information through schools – specifically in primary school programs. In that way, I feel like it will spread like a bush fire and become more integrated in the community. Another idea is that it can come through Miriam Labbok's I/ECD programme, or through an UNICEF program or and a school's programme. If we spread this message through our children, then we know it will grow. My last point is about breastfeeding. I must congratulate the Filipino woman who came with her baby. I think I would rather say I should have expected more of our delegates to come with their children and breastfeed before us. I think if we talk the talk, we should also walk the walk. I am advocating for the possibility that in the third WABA conference, we should be seeing more breastfeeding moms.

A: Rob Vincent – Your point is well taken. I think it is very important to link up with whatever existing channels and situations you have. There are important child-to-child programs that exist and many other potential channels that are already established. Sometimes it is appropriate to work through schools. However, I think we have to remember that many children do not go to school. In some places, school is actually a threatening environment. It is a case of doing it where it is appropriate, I think.

Q: Audrey Naylor: I wanted to get a clarification from Miriam Labbok. In one of the slides that you put forth – and I may have read it wrong – you said something about breastmilk being disease free. I wanted to share my thought about the fact that breastmilk is not sterile. It is filled with normal bacteria that come from the skin and the ducts of the mother. This is a

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very important part of the biologic adaptation of the infant that has to be colonized. As a newborn, it should becoming from a very sterile environment, and ordinarily is, unless there is an unusual infection at birth. The baby is born sterile and is colonized with mother's organisms. The miraculous aspect of this early breastfeeding is this modulation – the combination of the immunoglobulins and the normal bacterial environment that the baby will grow up in, and becomes infected with, but not sick from. I wanted to make sure that that was clear.

A: Miriam Labbok (A): Two things – normal pathogens are normal pathogens, not disease. The other part of it is that we were brainstorming about a quick phrase that would get attention. Clearly, if we were getting into the details of all the ramifications of breastfeeding then you can be sure it would have been more spelled out properly.

Infant Feeding inEmergencies

Q: I would like to make a comment about infant feeding and emergency. I think it would be good to add a communication and community participation component to this strategy. What we often see is that the people focus on saving the babies, but they completely ignore the rest of the population, even though this population is a very important component of the child survival strategy.

A: (Lida Lotska): I want to acknowledge the comment. That is well taken, and we have not yet gotten around to discuss all the facets that need to be discussed in a situation like that. I think everybody who was in the working group would agree that this should be taken on board.

Q: (Unidentified woman) My worry was with the research group that highlighted work from a study from England – about mothers taking babies for weighing…."I am worried that a statement like this will reduce the beneficial effects of growth monitoring.

A: Stina – It seems like an opportunity and something that could have beneficial effects. For example, one study in India on growth monitoring demonstrated that there was not any particular beneficial effect of all of these growth-monitoring efforts.

Q: Michael Latham – I think all of the reports were really excellent, but I feel like something has slipped through the cracks and I think probably it could have been in the lactation management report. Coming out of the colloquium, I think that one of the things several of us thought we learned more about than we know about before is that good lactation management that would treat or prevent mastitis and other breast conditions could in fact markedly reduce post natal transmissions of HIV. This is cheap, relatively easy – but a very important part of lactation management in the era of HIV and HIV positive

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mothers. I thought it was worth mentioning.

A: Jackie Nutt – Michael, I apologise. That was brought up in our very first session and covered quite well. We talked about the treatments and prevention of mastitis and thrush. That was my error in omitting it.

Q: Margaret Kenkya-Isabirye: I feel very moved by all of these presentations. I would like to go back to a presentation that I made this morning. I feel even stronger this afternoon. We have called upon a number of people to be accountable, to be held responsible (especially companies and organizations) I still feel that we are letting those who are still churning out mistrained nurses and health workers go.. the information is here. What is their responsibility to ensuring that what is being said here is being translated. Must we always be looking for resources to do in service training? To un-train those who have been badly trained. I do not know if there is anyone here from WHO, but I know that for years they have been trying to change textbooks – how far have they gone? I think it is high time that we stop begging and requesting them. There are duty bearers that have a responsibility to ensure that everybody comes out well trained in what we are talking about.

Q: Maria Hamlin-Zuniga – I want to comment about what was said during popular mobilisation. I want to comment about the Code this morning, and on what Margaret just said. By popular mobilisation, in Latin America, our people's candidate was elected to the director of PAHO - instead of the person that represents the interest of New Liberalism. This was done by people working all over Latin America, talking to their delegates, to the PAHO Meeting, so that they would vote for Dr. Rosas from Argentina. Let's give a hand to Argentina, and Latin America and what I wanted to say was that if we want accountability, and we want to get our things through WHO and accountability, we, as people's organisations, have to pressure our health ministries in the new election for the new director general of WHO. As you know, Dr. Brundtland has resigned and so the people's health movement is going to suggest that there be a debate between the candidates before the election in January at the executive board meeting. Those countries on the executive board, we suggest you pressure for this in those countries that can be sympathetic to this. We will be giving you more information – but we ask WABA to join in this popular mobilization around accountability in the election of the new Director.

Q: Elvira – I would like to announce to you that recently, during WBW in the Philippines, we got the cooperation of the department of education and health. This is regarding breastfeeding in schools. We had gotten the commitment, and they sealed it with a kiss, and they had promised AARUGAN, that by next year they would introduce breastfeeding in schools, as well as sex education. When you teach children about sex, I think it is also important that you teach them how to take

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care of the baby that they make in that act. We need to make the girls conscious that their breast is for nurturing and not for playing or for display – and for the men, that they learn to respect the female breast, and not to pressure the females to just have voluptuous breasts that are so interesting to see and touch. Breasts are more for the babies. Thank you.

Q: I want to comment on the HIV mothers. I think that as a breastfeeding promoter, we need to support the nutritional status of the mother more than we need to interfere with breastfeeding or exclusive breastfeeding. We know that in most of our countries it is very difficult to recommend another option. We are not sure that another option will be feasible, affordable or safe. I think that when we go back, we will need to abide by to the support of the mother rather than interfering with the breastfeeding choice. Point two – I think that all of us agree that training means including people with information and skills – this is a component of all of these nice policies to turn it to reality. We need a grand movement of training on all levels. Without that, all of these nice policies are going to lead to a negative outcome. The political and social will is not the problem. The actual problem is how to ask for money. If you come and ask for money, you are going to get a negative answer from UNICEF, WHO or any other funding organisation because each country has their own priorities. Although these groups are funding this forum, they say that their priorities are peace or something like that. In order to bring this to reality, I request that WABA to mobilize resources at the national level so that we can turn these policies to realities, as breastfeeding activists.

Q: Meera Shekar from UNICEF. We have sat through a week and a half of deliberations on breastfeeding and I think that I have learned a lot. A lot about the details of programming and projects for breastfeeding – I just wonder, that as we look at these details, if we have somehow lost the big picture in some ways. We all know that most of the countries that are represented here today, third world countries are faced with a new pandemic. That is the challenge of health sector reform and the poverty reduction strategies. Have we deliberated about how we have positioned breastfeeding in the context of health sector-reform? If we do not do this, there is a big risk that as the pandemic sweeps the countries, that breastfeeding projects, or all projects, whether it be breastfeeding projects, nutrition projects, etc. that they will die a natural death. Long term sustained large chunk funding programs in health and nutrition are so closely linked to sector reforms, to poverty reduction strategy papers, to debts, the HIPC initiative, it is still a question in my mind. I am not sure I have an answer to that.