Breastfeeding: Let's Invest in Creating an Enabling Environment for Mothers and Babies

2016

2ND WORLD BREASTFEEDING CONFERENCE

babies need mom-made, not man-made

CONFERENCE REPORT

DECEMBER 11 – 14, 2016

BIRCHWOOD HOTEL & OLIVER TAMBO CONFERENCE CENTRE

JOHANNESBURG, SOUTH AFRICA

Conference Hosts and Organisers

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

IBFAN
defending breastfeeding

bpni
putting child nutrition at the forefront of social change

GIFA

INTERNATIONAL CODE DOCUMENTATION CENTRE

Co-Sponsors

unicef

World Health Organization

FAO
FIAT PANIS

WFP

USAID
FROM THE AMERICAN PEOPLE

fhi360
THE SCIENCE OF IMPROVING LIVES

DST-NRF Centre of Excellence in Human Development
Individual and Society

Laerdal
helping save lives

mothers2mothers

Raising the future

SOUTH AFRICAN CIVIL SOCIETY FOR WOMEN'S, ADOLESCENTS' AND CHILDREN'S HEALTH
COALITION

CONFERENCE SECRETARIAT

IBFAN Africa
First Floor, East Wing,
Embassy House, Msakato Street
P. O. Box 781, Mbabane, Swaziland
Phone: (+268) 2404 5006
Email: wbc2016.ibfan@realnet.co.sz, ibfan.swd@realnet.co.sz; info@ibfanafrica.org.sz
Website: www.worldbreastfeedingconference.org

Department of Health
Ms Ann Behr
Republic of South Africa
Email: BehrA@health.gov.za

THE CONFERENCE ORGANISING TEAM

Chairperson: Ms Barbara Nalubanga, Regional Coordinator – IBFAN Africa
Vice Chairperson: Dr. Arun Gupta, Regional Coordinator – IBFAN Asia

Local Organizing Committee

Co-Chairs

Ms Moeng- Mahlangu Lynn	-	National Department of Health, South Africa
Ms Behr Ann	-	National Department of Health, South Africa

Members

Mr. Grundling Johan	-	National Department of Health, South Africa
Dr. Alison Feeley	-	UNICEF South Africa
Ms Wiedaad Slemming	-	University of Witts
Ms Nombulelo Leburu	-	National Department of Health, South Africa
Ms Pontsho Sepoloane	-	WFP Regional Bureau, South Africa
Dr. Mercy Chikoko	-	FAO South Africa
Mr Percy Chipepera	-	IBFAN Africa
Ms Nomajoni Ntombela	–	FHI360, South Africa
Ms Phyliis Baxen	–	FHI 360, South Africa
Ms Kubeka Zandile	-	National Department of Health, South Africa
Ms Sue Jones	-	Save the Children, South Africa
Ms Mantshi Teffo	-	Mother to Mother, South Africa
Ms Lenore Spies	-	KwaZulu-Natal Department of Health
Mr Howard Kgoa	-	National Department of Health, South Africa
Ms Diedre Smith	-	South Africa Breastmilk Reserve
Ms Gugu Xaba	-	Save the Children, South Africa

Members - IBFAN

Ms Terrie Wefwafwa	-	Chairperson IBFAN Africa Board
Patti Rundall	-	IBFAN UK
Dr. Ghada Sayed	-	IBFAN Arab World
Ms Elisabeth Sterken	-	INFACT Canada

Ms Marta Trejos	-	IBFAN Latin America
Mr. Zerbo Edouard	-	IBFAN Afrique
Ms Camiile Selleger	-	IBFAN-GIFA

SCIENTIFIC COMMITTEE

Coordinator

Dr. Maina Wamuyu	Regional Centre for Quality of Health Care, Uganda

Members

Dr. Laurence Grummer	-	Strawn - WHO Headquarter
Dr. France Begin	-	UNICEF Heaquarters
Dr. J.P. Dadhich	-	Breastfeeding Promotion Network of India
Dr. J Coenie Louw	-	Gateway Health Institute, South Africa
Dr Lesley Bamford	-	National Department of Health, South Africa
Professor Marina Rea	-	University of Sao Paulo/IBFAN Brazil
Dr. Geoffrey Bisoborwa	-	WHO Regional office for Africa
Dr. Joan Matji	-	UNICEF Regional office for ESA
Professor Alice Nte	-	University of Port Harcourt, Nigeria
Janet Guta	-	Ministry of Health, Malawi

SECRETARIAT

Mr John Musisi	-	IBFAN Africa
Ms Eva Rose Namulumba	-	IBFAN Africa
Mr Saul Oboth	-	IBFAN Africa

DISCLAIMER

The use of the proceedings of the 2nd World Breastfeeding Conference 2016 is for education or information purpose. Any part of this publication may be freely reviewed, abstracted, reproduced or translated, in part or whole, provided the source is acknowledged and provided that the final production is not for sale or commercial purposes.

This conference report of summarizes the presentations made, and the views expressed by speakers and other participants. The report thus does not necessarily reflect the views of the conference hosts and/or sponsors. Deviations, if any, in the report from actual expressions made at the conference are incidental and unintentional.

As a policy, IBFAN-Africa does not accept funds of any kind from the companies producing infant milk substitute, feeding bottles, related equipment's, or infant foods (cereal foods) or from those who have been ever found to violate the IMS Act or the International Code of Marketing of Breast-milk-Substitute or from organization/industry having conflict of interest.

TABLE OF CONTENTS

ACRONYMS

BAI	Breastfeeding Advocacy Initiative
BCC	Behaviour Change Communication
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMS	Breast Milk Substitutes
BF	Breastfeeding
EBF	Exclusive Breastfeeding
IBFAN	International Baby Food Action Network
ILO	International Labour Organization
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
M&E	Monitoring and evaluation
MIYCN	Maternal Infant and Young Child Nutrition
MOH	Ministry of Health
SDG	Sustainable Development Goal
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water and Sanitation Hygiene
WBC	World Breastfeeding Conference
WBTi	World Breast Feeding Trend Initiative
WHA	World Health Assembly
WHO	World Health Organization

ACKNOWLEDGEMENTS

The second World Breastfeeding Conference 2016 was a reverberant success through efforts and support of numerous organizations and individuals. Our utmost gratitude goes to the Department of Health, Republic of South Africa for partnering with us to host the conference. The Honorable Minister of Health, Dr. MJ Phaahla and Honorable Deputy Minister of Health, Republic of South Africa, as well as the office Executive Mayor of Ekurhuleni, whose valuable attendance enriched the Conference, are greatly appreciated.

We are thankful to all partner organisations for both their technical and financial support as well as members of Organising Committee for their valuable contribution. Special mention goes to USAID FHI-360, World Health Organisation (WHO), World Food Programme (WFP), United Nation Children Fund (UNICEF), Food and Agricultural Organisation (FAO), Mother2Mothers (M2M), University of Witwatersrand, Geneva Infant Feeding Action (GIFA), Department of Health SA (DOH), and the South African Coalition of Civil Society Organisations for Women and Child Health SAScoWACH).

The Regional Coordinating Offices of the International Baby Food Action Network and the Department of Health, Republic of South Africa that worked for over a year developing the programme for the Conference and ensuring participation of organizations, country representatives and other individuals. The Conference success is attributable to their unequivocal involvement in the planning process as well as the contribution of various individuals from various IBFAN country offices.

The conference saw the participation of over 500 individuals, whom we appreciate for putting in time and resources to join us in this momentous event. We particularly appreciate the representation of several governments from Africa, Asia, America, Europe, the Arab world and other parts of the globe.

We further thank all the individuals that participated in directing, moderating and chairing the various plenary, forums, symposia and breakout sessions at the conference as well as the rapporteur team that assisted in putting together conference proceedings every day.

We would like to express our appreciation for the management of Birchwood Hotel and Oliver Tambo Conference Center in Johannesburg, South Africa for providing a homely and exquisite setting that gave the conference such elegancy. We further extend our appreciation to IndiAttitude Events Pvt Ltd for the online management of the event and with utmost gratefulness to Conference Call the local event manager for the conference for their detailed and tireless efforts that ensured such a successful conference.

Lastly to Dr. Lesley Bamford for her tireless efforts in summarising the conference proceedings into daily recap reports and Dr. Maina Wamuyu for coordinating the entire programme, scientific committee and putting together a comprehensible report.

We are extremely grateful for their efforts that culminated into this report.

IBFAN AFRICA

1. CONFERENCE OVERVIEW

1.1: Background and Rationale

Global trends in exclusive breastfeeding rates in some regions are stagnating or even declining, while sales figures of infant formula and other baby foods are increasing annually. Available evidence indicates that violations of the International Code of Marketing of Breastmilk Substitutes, relevant World Health Assembly (WHA) resolutions but also national laws on the Code are continuing as baby food companies have continued to aggressively market their products against very under-funded national monitoring efforts. Sub-optimal breastfeeding practices contribute to 13% of all deaths among under-five children in the developing world as well as to the high prevalence of malnutrition, which continues to be a major public health challenge especially in Africa[1] as well as Asia.

Several cost-effective interventions for improving the health of mothers and their children have been identified by The Lancet series on Maternal, Neonatal and Child Survival[2]. Five of the ten most cost-effective interventions for helping the poor have been shown to be related to nutrition[3] by the 2008 round of the Copenhagen Consensus. Despite this evidence, nutrition programs remain chronically under-funded, the scarce resources are often not allocated to where they will have the biggest impact and are inefficiently spent with inadequate balance between spending on curative care and promotional care. There is thus need for increased financial and political commitments as well as compelling member states to invest in improving maternal, infant and young child nutrition in order to facilitate the move towards attainment of the 65th WHA 2012 targets by 2025. The need to invest in MIYCN is even more crucial now as the global community has ended the MDG era and has agreed on a new framework, the Sustainable Development Goals (SDGs).

It is against this background that the International Baby Food Action Network (IBFAN) in partnership with the Department of Health, Government of Republic of South Africa, proudly hosted the Second World Breastfeeding Conference with the theme *Breastfeeding: Let's Invest in Creating an Enabling Environment for Mothers and Babies.* The conference was held from the 11th to 14th December, 2016 at the Birchwood Hotel and Oliver Tambo Conference Center in Johannesburg, South Africa.

[1] Lancet 2013
[2] http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(13)60996-4.pdf
[3] http://www.copenhagenconsensus.com/sites/default/files/cc08_results_final_0.pdf

1.2: Conference aims

The conference aimed to call for committed action by providing a platform for breastfeeding advocates, governments, scientists, civil society organizations', UN agencies, international organizations, research institutions, public interest groups, and other stakeholders to:

1) Review the global investment promises for maternal, infant and young child nutrition in light of resolutions from the 65th World Health Assembly of 2012, discuss and share experiences as well as to generate ideas for further resource mobilization and/or strengthening of interventions.

2) Address breastfeeding in a human rights framework, emphasizing women's rights, children's rights, the right to food and nutrition, and maternity protection

3) Raise awareness on progress made so far in improving breastfeeding rates, challenges continuing to arise in the promotion, protection and support of breastfeeding and other IYCF interventions due to funding, structural, policy and political environment as well as the need to invest in breastfeeding as a practical solution towards protecting the environment and protecting mothers and children against the effects of climate change.

1.3: Conference Objectives

The conference set out to:

1. Engage, inspire, innovate and advocate in partnership with likeminded breastfeeding advocates and stakeholders for the attainment of Maternal Infant and Young Child Nutrition targets set by the 65th World Health Assembly;

2. Broaden the understanding on the persistent barriers that despite various global policy and advocacy initiatives over the past 30 years, continue to impede improvement in exclusive breastfeeding rates and violate the human rights of those affected;

3. Raise awareness about the inadequate and wide variation among member countries – both developed and developing, in the progress made towards improving breastfeeding practices, which is attributable to funding, structural, policy and political challenges;

4. Highlight the pivotal role played by the promotion, protection and support of breastfeeding in transforming maternal and child health since the 2012 World Breastfeeding Conference, and to build upon this momentum; and

5. Foster collective action, adoption and alignment of regional and country level strategies as well as plans towards targets set in the Sustainable Development Goals (SDGs), and advocate for increased investment for optimal breastfeeding and MIYCN.

1.4: Conference Structure

The three-day conference had its deliberations organized around the following sub-themes:

- Day 1 - Investing in optimal MIYCN to impact the present and the future
- Day 2 - Women, infants and children's rights to nutrition
- Day 3 - Mother, family and community support

To facilitate interactive information sharing, a wide range of topics was covered through a mix of presentation formats that included keynote addresses, plenary sessions, plenary forums, symposiums and technical sessions. These were further supplemented by a pre-conference human rights training for improved MIYCN, poster presentations and exhibitions as well as cinema events. A colourful opening ceremony set the stage for the conference. The conference ended with participants drawing up a Declaration and a Call for Action for every region to take forward. The detailed conference program is presented in Appendix 1.

2. PRE-CONFERENCE: HUMAN RIGHTS TRAINING

A preconference training was held to strengthen participants' knowledge on human rights and ensure their broad and systematic participation in different human rights processes related to MIYCN. The training which was attended by 98 participants covered topics related to

The Human Rights Training workshop was conducted as a preconference training for the 2nd World Breastfeeding Conference. This was a joint collaboration between IBFAN with support from GIFA, CoE-Human Development, University of Witwatersrand, University of Port Harcourt Teaching Hospital in Nigeria and FHI 360 South Africa.

The training aimed at; strengthening the participant's knowledge of national, sub regional and regional partners with regards to human rights in order to ensure their broad and systematic participation in different human rights processes related to maternal and child health and nutrition; acquiring basic background knowledge on Human Rights and understand the human rights framework from a health and nutrition perspective; understanding breastfeeding and the International Code of Breastmilk Substitutes as integral parts of the human rights framework; providing concrete examples of Code violations and their implications on Human Rights fulfillment; presenting the different Human rights reporting mechanisms and plan the submission of alternative reports on Infant and Young Child Feeding for 2016, 2017 and 2018; and presenting the process of elaboration of a new binding international instrument on TNCs and Human Rights and the work of the Treaty Alliance in support of this process.

The training targeted individuals from government, Civil Society Organizations, UN agencies, International Organizations, public interest groups; Post graduate students, among others around the world who desired to increase their knowledge on human rights in relation to breastfeeding, Infant and Young Child Feeding(IYCF) and the CODE.

The 6-hour period training was premeditated to strengthen the Knowledge of participants with regard to human rights in order to ensure their broad and systematic participation in the different human rights processes in which IBFAN is engaged (especially the alternative reporting to the CRC, CESCR and CEDAW Committees and the process of elaboration of a new treaty on transnational corporations and human rights).Tools to support the follow-up of human rights recommendations at country level were presented and discussed with participants.

The workshop used a human rights-based approach in programmes that are intended to ensure the rights of mothers and their infants to the enjoyment of the highest attainable standard of physical and mental health, which comprises of both health care and other

pre-conditions to health, such as adequate food and nutrition, clean water and sanitation.

Prominence in the training workshop was placed on interactive sessions though use of cards, experience sharing and group work so that participants could obtain significant insights in the complex nature of issues to be addressed. Participants provided examples of human rights and CODE violation in respect to breastfeeding, Infant and young child feeding from their own countries with linkages to policy- and decision-making.

At total number of 102 participants from 22 countries around the world attended training. Countries include; Australia, Bangladesh, Brazil, Chile, Gambia, Germany, Ghana, India, Kuwait, Malawi, Malaysia, Nigeria, Saudi Arabia, South Africa, Sri Lanka, Swaziland, Sweden, Tanzania, UEA Dubai, Uganda, USA and Zimbabwe

The training was facilitated by an international expert in Human Rights based in Geneva Infant Feeding Association (IBFAN-GIFA) as well as local expert – Associate professor from University of Port Harcourt Teaching Hospital, Port Harcourt, Nigeria and coordinated by IBFAN Africa. The list of participants is presented in Annex 2.

3. Opening Ceremony

3.1 Opening and Introduction to the Conference

Lynn Moeng, DOH South Africa

South Africa had successes and challenges and love to learn from other countries as SA struggling to achieve increase in exclusive breastfeeding rates especially changing the mind sets. Breastfeeding advocates have complicated the breastfeeding process and it is our responsibility to undo this. Take home recommendations- to have the breastfeeding conference in communities where all could attend without paying the registration fee.

3.2 Welcome Address

Maluleke – Mabaso, Acting Executive Mayor of Ekurhuleni

It is a fact that a women's journey of motherhood, but a point of commonality is the same. Choosing to breastfeed is an investment for the babies future

3.3 Address by the Board Chairperson, IBFAN Africa

Ms Terry Wefwafwa, Karibuni, Kenya

Appreciation went to IBFAN global for leadership and technical inputs in making the conference a success, all stakeholders and partners in making the conference a success.

3.4 Address by the International Baby Food Action Network

Ms Elisabeth Sterken, Co- Chairperson IBFAN Global Council

IBFAN is celebrating 37 years of promoting, protecting and supporting breastfeeding and destructing marketing of the marketing industries. IBFAN is unique, taking no funds from infant formula industry. The tireless work of IBFAN in holding infant industry accountable in increasing mortality and so much suffering was highlighted. IBFAN contributed in drafting the code in 1989, drafting of the innocent declaration in 1990. The Call for action from the first world breastfeeding conference in India 2012 in advocating for clear budget line, investment in MBFI, monitor and track progress in implementation of WBTi, supporting independent funding for breastfeeding and IYCF was highlighted

Areas that require strengthening were highlighted including adequate maternity benefits, much work needed for independent research including conflict of interest, need for financial support for creating enabling environment due to underfunding. Emphasis on a call for commitment to work with renewed energy was made. As long as gross inequality exits, none of us can rest quoting Nelson Mandela

3.5 Address by the USAID Representative

Ms Rebecca Krzywda

Mothers need support from family, friends, policy makers. Need for every action in ensuring every mother breastfeeding wherever they work, or regardless of their HIV status. Acknowledgement and shared work done in SA and support of FHI360, mothers to mothers, USAID, PEPFAR partners, launch of MomConnect with special thanks to Dr A Motsoaledi, Minister of Health.

3.6 Address by the UNICEF Regional Director for Eastern and Southern African region (ESARO)

Ms Leila Gharagozloo Pakkala

Much still need to be done to ensure that the rights to breastfeeding is mad an obligation. In ESARO alone, significant portion of children suffer from stunted growth, affecting cognitive development, and more difficulty in learning as they grow to be adults. Breastfeeding, single most important weapon against malnutrition, highlighting the number of children who can be saved through breastfeeding. The price we pay for not breastfeeding > 300 billion dollars lost due to stunted growth capacity, little progress in EBR over the last 15 years with 77 million newborns not breastfed in an hour after birth. There is a need to stand firmly in support of women who choose to breastfeed and collective action is required to increase BF rates, in ESA alone. Challenge remains in translating policies into practices. Given political commitment, strong policies and programmes, skills practical help, mobilizing trained counsellors, encouraging mothers to come to workplace with babies, adopting and enforcing international code.

BFHI supported by UNICEF is being scaled up in many countries and regions to minimize neonatal death. The important of adequate investment and collaboration between ministries of health, agriculture, water and sanitation should join hands in creating an enabling environment. The Conference is held during the time UNICEF celebrates 70 years of existence. UNICEF pledge unwavering commitments in following up on recommendation from the conference.

3.7 Address by the WHO Representative

Dr. Lawrence Grummer Strawn, WHO

Importance of breastfeeding goes well beyond infancy and has long term effects on the child, 20 000 maternal death due to breast cancer and loss of economic performance is due to lack of breastfeeding. The importance of collaboration was emphasized. The 3 days should be used to celebrate, look back to what is achieved, as an opportunity to learn from one another in improving programmes, how to make policies work, and to commit to the future in making a difference in organizations and countries

3.8 Launch of the global 84 country report on the implementation of the Global Strategy for Infants and Young Child Feeding

Dr Arun Gupta, Co- Chairperson IBFAN Global Council

South Africa was thanked for co-hosting the conference. IBFAN developed a tool to measure and generate actions, and help understand where we stand in terms of 10 indicators on global strategy for infant and young child feeding. Summary of the 84country report shows the following:

- National policy 17 countries on green
- BFHI – 2 countries on green
- Maternity protection- 22 countries in red, none in green
- State of health & nutrition care system
- Mother support and community- 6 countries in green
- Information support- 10 countries in green
- State of infant feeding in emergencies- 48 countries in red
- M & E - 10 countries in green

Copy of report at *www.worldbreastfeeding trends.org*/

3.9 Key Note Address

Deputy Minister of Health, Republic of South Africa

Theme is very relevant to all countries. Breastfeeding is the best invests, but not everybody has grasped these facts. The benefits of breastfeeding in reducing under 5 mortality preventing a million death, prevent Childhood obesity, reducing risk of none communicable diseases, protects mothers- reducing risk of breast and ovarian cancer, nothing else supersedes benefits in enhancing bonding of mother and infant pair was acknowledged. South Africa is challenged by poor BF rate, -40% mothers EBF for 1st 14 weeks, high levels of HIV prevalence. South Africa has made progress in reducing under 5 mortality, increase immunization coverage, MTC transmission of HIV including the MBFI,

use of technology to empower women launched by the minister in 2014, reaching over a million women, messages relating to especially EBF. With help of partners, launch of nurse Connect, receiving technical info on maternal and women health, initiated in May 2016 with up to 13 000 nurses registered, scaling up Human milk banks, with 37 milk banks established in the country in most neonatal units. 403 facilities with maternity beds who are MBF certified, improving practices supporting breastfeeding with > 80% in early initiation of breastfeeding in maternity units. BFHI was seen to be not entirely successful in sustaining breastfeeding. Better maternal health and support of skilled birth attendant is important.

Deputy Minister Launch a national campaign that aims to engage with communities in improve breastfeeding, under the theme "why not families, communities support mothers to breastfeed" Aim to encourage everyone to participate in supporting breastfeeding. The objectives of the campaign is to raise awareness of important of exclusive breastfeeding, facilitate more support for mothers to breastfeed, changing attitudes of all stakeholders, and re-establish breastfeeding as a norm. The campaign materials, posters were launched and showcased

First phase of campaign will utilized public places, buses, taxi ranks and other public places, and social media network. A special call for employers to establish comfortable places from employees to breastfeed was made. Participants were encouraged to exchange rich information.

4. CONFERENCE SESSIONS

4.1: Mimes/ Silent Theatre

ARUGAAN Group/ IBFAN South-East Asia

The Indonesian Breastfeeding Mothers Association (AIMI) made a presentation on the Importance of Mother to Mother Support. The team also presented a dance and silent mime done by Nia Umar, Farahdibha Tenrilemba and Nayla Hani Assegaf (a 21 months breastfed toddler).

Gara Gara Anakis a traditional dance from Jakarta, Indonesia with a Chinese and Arabic influence and the title meaning "Because of a Child" was presented by AIMI. The dance and mime tells about how parents are doing everything for the best of their children.

The presentation mix centred on the questions which mothers ponder within them among which include whether; their milk is adequate, good enough, the meals prepared are nutritious, time given to their children is adequate and most important of all whether they are good mothers.

The presentation brought out clearly the reasons as being not enough support from family and society, myth, unethical promotions from formula and food companies and not enough policy to support mothers. This brought out clearly the importance of mothers supporting other mothers as a way of improving breastfeeding rates and good feeding IYCF practices, and empowerment of mothers to believe in their own ability to feed their children.

4.2: Keynote Addresses

4.2.1: Global Action towards Nutrition Improvement – Progress, Challenges and Recommendations

Roger Mathisen, Alive and Thrive SE Asia, FHI 360

In his address, the presenter guided the participants through some of the recent global actions towards nutrition improvements, and highlighted some of the challenges and recommendations. The 65th World Health Assembly recognized that accelerated global action was needed to address the double burden of malnutrition back in 2012, and endorsed the comprehensive implementation plan for maternal, infant and young child nutrition. This plan specified a set of six global nutrition targets by 2025, and urged Member States to put the plan into practice.

He pointed out that the global nutrition targets we are now accountable to achieve among which included the following results:

1. 40% reduction in the number of children under 5 who are stunted from 162 million to around 100 million;

2. 50% reduction of anemia in women of reproductive age from 29% to 15%;
3. 30% reduction in low birth weight from 15% to 10%;
4. No increase in childhood overweight from the baseline of 7%;
5. Increase the rate of exclusive breastfeeding in the first six months up to at least 50% from the baseline of 38%;
6. Reduce and maintain childhood wasting to less than 5%.

He reported that in 2013, the 66th World Health Assembly also endorsed a global action plan for the prevention and control of non-communicable diseases, which has nine targets that include nutrition relevant targets. That same year, the Lancet Maternal and Child Nutrition Series also came also Pinpointing improvements in nutrition as an unfinished agenda and its evidence and recommendations contributed to a funding revolution in nutrition. The first global pledging moment took place the same year and more than 60 world leaders attended the Nutrition for Growth high-level event which focused on the importance of good nutrition for the growth of individuals, societies and countries. Leaders from governments, international organizations, businesses, as well as civil society organizations, development agencies and research groups, signed the compact and made concrete commitments to act for better nutrition globally over the next seven years.

The following year, in 2014, Governments came together at the FAO/WHO International Conference on Nutrition (ICN2) and agreed on a set of 10 commitments in the Rome Declaration on Nutrition and the accompanying Framework for Action. This was followed by the global strategy for women´s children´s and adolescents´ health reminded us that we need to focus on not only survival, but also to thrive to ensure health and well-being and to transform to expand the enabling environment. All the 6 global nutrition targets are mentioned in this strategy. The 17 SDGs were also adopted in 2015 at an historic UN summit and in 2016, the 71st UN General Assembly declared a Decade of Action on Nutrition.

This Lancet Series gave us powerful ammunition to continue our advocacy and support for policy change and to advance our work to promote and support breastfeeding in addition to the right-based arguments from the CRC and CEDAW. The two papers focused on 1) epidemiology, mechanisms and lifelong effects, and 2) why invest, and what it will take to improve breastfeeding practices. It also provided the first global map of breastfeeding prevalence. Most high-income countries have uneven or limited breastfeeding data, which makes it difficult to track progress and trends. The Lancet also highlighted that breastfeeding is a fundamental driver in achieving the SDGs citing examples from Vietnam, Bangladesh and Ethiopia which achieved rapid, large scale increase in breastfeeding practices in just a few years using a new proven framework

using multiple program components and targeting multiple stakeholders for scale and impact.

Participants were reminded that the 69th World Health Assembly also welcomed the guidance on ending the inappropriate promotion of foods for infants and young children. This guidance applies to all commercially produced foods marketed as being suitable for children 6-36 months. IBFAN, UNICEF and WHO also released the status report on implementation of the international code on marketing of breastmilk substitutes, and the conference would provide more details on the achievements and gaps.

The presenter informed participants that partnerships related to nutrition are also growing especially with the SDG partnerships; the SUN Movement includes now 57 countries and 3 states in India, the Global Breastfeeding Advocacy Initiative (BAI) chaired by UNICEF and WHO now got more than 20 member organisations, including the World Alliance for Breastfeeding Action who celebrated the 25th anniversary this year.

Challenges highlighted in the 2016 Global Nutrition Report were shared but the most outstanding was that the world is off track to reach global nutrition targets: caution here was that if we continue with business as usual, the world will not meet the global nutrition and NCD targets adopted by the World Health Assembly.

In conclusion, the speaker alluded on recommendations to **make the political choice to end all forms of malnutrition citing the** good examples like; reductions in malnutrition in Brazil, Ghana, Peru, and the Indian state of Maharashtra were fueled by governments and others that made commitments and kept them; and i**nvesting in nutrition information systems** to trigger and track progress towards the global nutrition targets and SDGs. His call to participants was that we need to focus on knowledge exchange and learning from each other as a key factor. The conference offered a good opportunity to tell such stories, but we must remember not just to talk to the echo chamber, but to engage beyond our normal crowd of already convinced, and reach out to health system stakeholders, legislators, parliamentarians, other sectors.

4.2.2: Positioning Women for Optimal Breastfeeding in the World of Work using a Human Rights Framework

Camille Selleger, IBFAN/GIFA, Switzerland

Sharing a historical perspective on breastfeeding and human rights, Camille Selleger was representing IBFAN-GIFA, the international liaison office of the IBFAN network in Geneva commended participants who are committed to protect, promote and support breastfeeding in a way or another. She reminded them about the importance of implementing and enforcing the International Code of Marketing of BMS at national level, and the deadly issue of unregulated marketing of BMS which still remains because

of a series of factors including the lack of political will to regulate corporate actors and in particular, to implement and enforce the Code.

Giving a history of the Code, the UN Code of Conduct on TNCs, was the result of concerted efforts to develop a binding system to put an end to the corporate impunity. The Code, which is crucial for breastfeeding protection against the commercial pressures of the baby food industry, was the first international instrument to regulate the activities of corporate actors.

Among the treaties and conventions cited and expounded, the presenter focused on three important ones. The International Covenant on Economic, Social and Cultural Rights (CESCR), adopted in 1966 and entered into force 10 years later; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW coming into force in the seventies; and the Convention on the Rights of the Child (CRC) the first and only human rights treaty which mentions the importance of breastfeeding in itself was adopted in 1989 entering into force one year later. These form the basis for the advocacy, lobbying and all work directed towards the approach of breastfeeding from the human rights perspective.

CESCR was a key UN treaty and the first international binding instrument to recognize certain fundamental rights, including the right to the enjoyment of the highest attainable standard of health, the right to social security and the right to adequate food. Even when it does not specifically mention breastfeeding at the time, this Covenant sets the basis of a human rights framework, which we use today to advocate for breastfeeding protection, promotion and support. In 1999, this Committee recognized that breastfeeding satisfies the dietary needs of infants and young children and constitutes an adequate food for them thus the consideration that breastfeeding should be protected by regulating the marketing of BMS. In 2008 the Committee took a strong stand with regard to maternity protection, urging countries to ensure that all women, including those involved in atypical work, are granted with paid maternity leave.

Despite being the first human rights treaty to mention lactation in its article 12, CEDAW constituted a weak instrument for breastfeeding protection. In March 2016, the CEDAW General Recommendation on the rights of rural women, urged countries to take specific measures to protect, promote and support breastfeeding. In particular, the Committee called for effective regulation of the marketing of breastmilk substitutes through the implementation and monitoring of the Code, but also called for wide dissemination of accessible information on breastfeeding and its impact on child and maternal health, as well as implementation of measures to allow women to breastfeed during working hours, and protection of rural girls' and women's right to education by ensuring that childcare facilities and breastfeeding rooms, as well as counselling on childcare and breastfeeding, are made available.

Article 24 of the CRC which recognizes child's right to the enjoyment of the highest attainable standard of health, calls States Parties to take appropriate measures to diminish infant and child mortality, to combat disease and malnutrition through, inter alia, the provision of adequate nutritious foods, to ensure appropriate pre- and post-natal health care for mothers and to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, and the advantages of breastfeeding.

Adopted in 2013, the CRC General Comment No 15 on child's right to the enjoyment of the highest standard of health indeed recognized that suboptimal breastfeeding practices are one of the major causes of neonatal mortality, and urged States parties to pay particular attention to ensuring full protection and promotion of breastfeeding practices in order to diminish infant and child mortality. Recalling that breastfeeding constitutes an adequate food for infants and young children. The General Comment also enshrined the 2002 Global Strategy on Infant and Young Child Feeding into the child's rights framework and reminded States that their obligations with regard to breastfeeding are defined by the 3-pilar framework 'Protect, Promote and Support'. It specifically called for the national implementation and enforcement of the Code and subsequent relevant WHA resolutions, and it urged States to strengthen their maternity protection systems by promoting breastfeeding support for mothers at workplace and community level and by complying with the ILO Convention No. 183 on MP. General Comment No 16 on State obligations regarding the impact of business sector on children's rights calls States to introduce family-friendly workplace policies that support and facilitate BF, including parental leave, and to implement and enforce the Code and relevant subsequent WHA resolutions. The Committee explains that States should enable access to effective judicial and non-judicial mechanisms to provide remedy for children and their families whose rights have been violated by business enterprises extraterritorially when there is a reasonable link between the State and the conduct concerned.

In their historic document published in November 2016, the UN Special Rapporteurs on the Right to Food and Right to Health, as well as the Working Group on Discrimination against Women in law and in practice, and the Committee on the Rights of the Child formally recognized that breastfeeding is a human rights issue for both the child and the mother and that it should be protected, promoted and supported for the benefit of both. The group of experts also urged States to take urgent action to stop the misleading, aggressive and inappropriate marketing of breastmilk substitutes by fully aligning with the Code and the subsequent relevant World Health Assembly resolutions, while they also recommended States to make use of the WHO Guidance on ending inappropriate promotion of foods for infants and young children.

It is very important to understand that breastfeeding does NOT constitute a duty or a moral obligation for mothers. IBFAN believes that in the large majority of cases, mothers

make what they think is the best choice for their child, with the information, support and protection available to them. The only duty bearers of the obligations related to breastfeeding are States. In such an enabling environment for breastfeeding, the implementation and strong enforcement of Code constitutes the very cornerstone, allowing all people including mothers, fathers and relatives to base their choice on reliable information, and protecting health workers from commercial pressures while carrying out their mandate.

She closed by reiterating that IBFAN remains fully committed to defend breastfeeding at all levels and we all need to continue advocating for the full realization of people's rights to live in an environment where optimal breastfeeding practices are the norm.

4.2.3: Strengthening Community Health and Nutrition care Systems for Protection and Promotion of Optimal MIYCN

France Begin, UNICEF

Complementary foods contribute to short and long term outcomes. It is important to emphasize timely introduction of complementary food to avoid malnutrition of children during the transition from exclusive breastfeeding as one of every three infants is waiting too long on his or her first solid, semi-solid or soft foods. Many children in the Latin and the Caribbean have been observed to have high food diversity than the rest of the globe. However, only one in every six children in the globe is getting a diet that has both the minimum diversity and frequency largely due to socio-economic and cultural factors.

To address this, some of the recommended interventions are Increase availability of quality local foods through nutrition education, agriculture diversification, income generation activities, vouchers/coupons, cash transfers and other social safety nets, and fortified complementary foods or home fortification, when needed. To be successful in achieving adequate complementary there must be enactment of legislation which is in line with the guidance on ending the inappropriate promotion of foods for infants and young children, stakeholder collaboration, evidence based communication, combination of multiple strategies and interventions as well as monitoring and evaluation systems to track progress.

4.3: Plenary Sessions

4.3.1: Implementation of the United Nations Decade for Action in Nutrition

Laurence Grummer- Strawn, WHO Geneva

Exclusive breast feeding was highlighted as a fundamental and part of the WHA Global Targets set in 2012 to be achieved by 2025. Some of the efforts made at the global level as well as organizations to help assist achievement of these targets include:

- Development of policy briefs and documents by UNICEF as well as other organizations that show breastfeeding is moving from a health issue to health, nutrition and agriculture issue to a developmental issue
- Hosting of the International Conference of Nutrition in by FAO and WHO in 2014 which had two main outcomes namely Rome Declaration on Nutrition and commitment to work on a Framework for Action. The Framework for Action has 60 actions on what governments need to do to achieve the nutrition outcomes. Eight of the recommendations are specific to breastfeeding
- Development of SDGs in 2015. Although not directly, these have breast feeding linked to all of them hence signifying its importance to the achievement of the SDGs.
- Declaration of the UN Decade of Action on Nutrition in 2016 led by WHO and FAO in collaboration with UNICEF, WFP and IFAD. The goals are linked to WHA Global targets, ICN, Framework and Action, NCD risk factors targets and SDGs. The commitment to the Decade of Action calls for WHA member states to make their commitments public to ensure WHO and FAO can hold them accountable. Commitments have been made SMART into 6 pillars and one specifically on breastfeeding. The work programme of these 6 pillars will include a leading partner organization and accountability mechanisms put in place with foras created for dissemination of progress in specific action steps. Decade of Action on Nutrition is thus an important opportunity to move our agenda from political statements into specific developmental issues using a multisectoral approach to achieve a lot in breastfeeding

4.3.2: Breastfeeding Advocacy Initiative: Progress Update

France Begin, UNICEF New York, USA

Participants were informed that early initiation and continued breastfeeding is neglected yet it is still very important. Evidence available indicates that less than 7million newborns globally are initiated early on breastfeeding whilst in some regions breastfeeding rates are less than the recommended 50%. Exclusive breastfeeding rates decrease as the children grow older and particularly in West and Central Africa where plain water is given to infants before 6months. This could possibly be attributed to inadequate delivery support from skilled birth attendants in Middle East, west and central Africa leading to low support for women to initiate breastfeeding in the first hour as recommended. Paradoxically, between 2000-2016 breastfeeding rates improves in south and eastern

Asia. In the developing countries, there is lack of data on breastfeeding and not much is being done to collect it.

The presenter emphasized that breastfeeding is not only for women but for all employers, policy makers and the family. Political commitment and investment is thus critical. However, lack of political commitment has been evidenced by insufficient global leadership and champions, lack of a unified voices, fragmented programmes, lack of persuasive communication on the importance of breastfeeding as well as aggressive marketing by breast milk substitutes (BMS) companies.

To address this dire situation, a group of 22 partners led by UNICEF and WHO came together to advocate for improvement of breastfeeding rates. IBFAN was mentioned as one of the most contributing partner to this effect. The group's vision is; *a world where all women and families are empowered and supported to breastfeed*. The advocacy calls for fostering leadership and alliances and effectively integrate and communicate breastfeeding message, mobilizing resources and promoting accountability as well as building knowledge and evidence to enhance breastfeeding policies, programmes, financing and communication. With respect to this, an audience research was successfully conducted key stakeholders in China, India, Nigeria, Mexico, US and the UK and development of an evidence-based communication plan initiated.

The initiative calls for action using the following 7 policies

i) Increase funding to reach the 2025 WHA GLOBAL TARGET

ii) Fully implement the international Code of Marketing of BMS and relevant WHA resolutions

iii) Enact family leave and workplace breastfeeding policies building on the ILO maternity protection guide

iv) Implement the 10 steps to successful breastfeeding

v) Improve access to skilled lactation counseling as part of the comprehensive breastfeeding policy

vi) Strengthen links between health facilities and communities

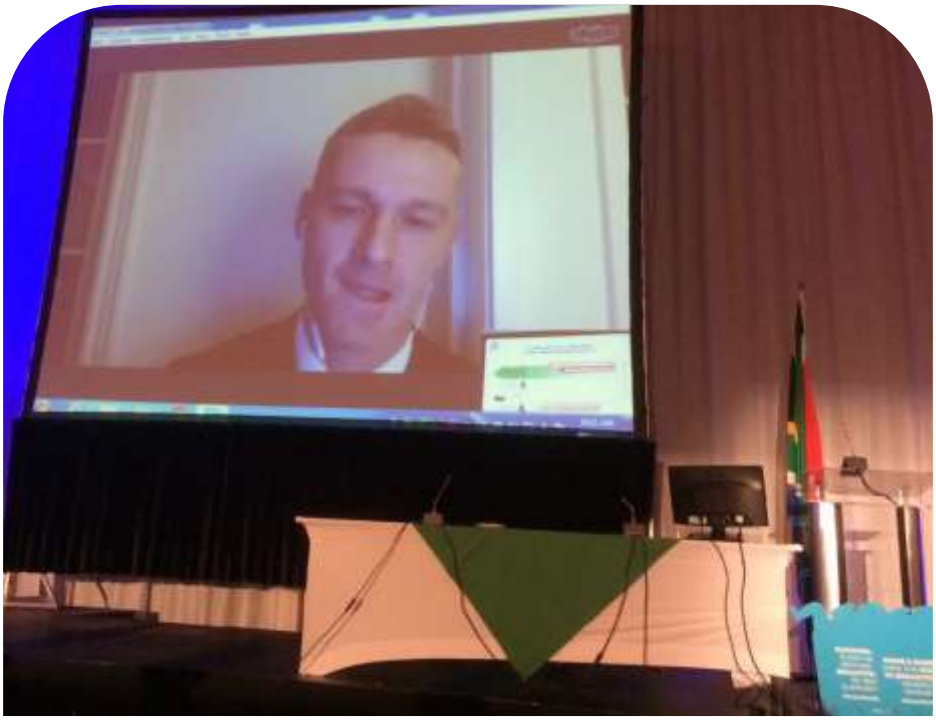
vii) Create monitoring systems that track progress of policies, programmes and funding

The next steps are to develop a road map for the next 2-3years, implement communication strategy, use call to action and score cards, support regional and country level advocacy, develop branding for the breastfeeding advocacy initiative (BAI) and continue to expand the BAI membership.

4.3.3: Investment Framework to Meet The Global Nutrition Targets

Dylan Walters, Consultant World Bank, Washington D.C

The framework sought to address the question: How much will it cost to reach WHA targets – particularly stunting, anemia, wasting and breastfeeding – and what will it buy? Did not address LBW and overweight/obesity. Estimated cost of scale-up (from current to full coverage) and the benefits of scale-up of these evidence-based interventions (11 interventions met criteria for inclusion in investment framework). Breastfeeding interventions namely IYCF nutrition counselling (3rd trimester to 6months); pro-BF social policies; national BF promotion campaigns; maternity leave benefits were also included (<6m).



Findings revealed that the total cost of scaling up was $5.8b over 10 years. This would result in 105m more children EBF over 10 years, 520 000 child deaths averted over 10 years with a benefit-cost ratio of 34.7:1, i.e. $34.7gained for every $1spent (based on reduction of cognitive losses and increased earnings in later life as well as deaths averted over 10 years); projection: 54% EBF in 2025 if implemented; *maternity leave cash benefits would add $24.1b to total cost.* A high cost: benefit ratio is favourable, i.e. low cost, high impact. In addition, approximately $70b investment required to meet 4 global nutrition targets (GNT). Overall, collective effort and political will be to reach GNT and to reach SDGs. In addition, research needed on scale-up strategies, data monitoring as well as efficacy and effectiveness of nutrition-sensitive interventions.

4.3.4: 84 Countries WBTi Report on Implementation Of The Global Strategy For Infant and Young Child Feeding – Key Findings

Dr Arun Gupta, IBFAN Asia

The World Health Assembly (WHA) adopted the Global Strategy for Infant and Young Child Feeding in May 2002 and UNICEF Executive Board endorsed it in September 2002. The WHA urges member states as a matter of urgency to develop, implement, monitor and evaluate a plan of action on IYCF. In 2003/2004 WHO launched tools to assess national policies and programme on IYCF. The WBTi assessment tool was adopted in 2004/5. It has 10 indicators with 10 points each and a total score of 100%. WBTi tool assesses and generates action by scoring items using color codes (red - lowest, yellow, blue and green-highest) which makes it easily understandable. It has so far been completed by only 4 countries. It is ongoing in other countries, however some are facing implementation problems due to political unrest or funding or other reasons.

Results indicate that Infant Feeding in Emergencies, BFHI, Maternity Protection and National Coordination indicators are getting lowest scores. WBTi brings change in countries by sparking debates, discussions and consensus building on local solutions. WBTi as a tool, has the potential for making headway for policy implementation by creating visibility and increasing the attention to the progress in implementation of the Global Strategy for infant and young child feeding and the Sustained Developmental Goals.

4.3.5: Cost Of Hunger in Africa - An African Union Led Initiative in Nutrition Implemented by Member States

Ms Wanja Kaaria, WFP AND ECLAC

Cost of hunger in Africa (COHA) is an African project led by the African Commission (AUC) implemented by Member States to improve the lives of Africa's children. The study compares the incremental risk of being stunted and its impact on education, health and productivity. Its aim is to help governments realize how much the economy is losing as nutrition is not just a health issue. In the June 2014 Malabo Declaration, it received a high level endorsement by African Heads of State and Government who requested a continental roll out.

Some of the key findings from the COHA study show that

- The annual cost associated with child undernutrition are estimated at 1.9-16.5 % of the equivalent of the GDP. All costs realized by COHA however are as a result of treating

pathologies in children, both privately and publicly e g the 74 % cost incurred for treatment is paid by families

- Most health costs associated with under-nutrition occur before the child reaches the age of one year.
- Stunted children are more likely to repeat grades in school or even drop out. Overall, between 1-18 % of repetitions to school are associated with stunting.
- Stunted children achieve 0.2-3.6 years less in school education
- Africa's share in the world's undernourished population has increased from 18-28 %

To address this dire situation, in addition to implementing the high impact nutrition interventions, there is need to rally efforts around AUC and member states for the adoption of Africa's renewed initiative for Stunting elimination (ARISE) by 2025, include more countries in COHA and expand the continental analytical capacity, expand partnerships with WHO, UNICEF, FAO, REACH /SUN etc., evaluate the cost of closing the gap and analyze the cost of obesity – double burden as well as continue with monitoring and evaluation activities.

Countries that have made progress after the COHA include the following

- Ethiopia - stunting evaluated every 2 years instead of every 5 years with DHIS and strongly recognized by the Ministry of Economics
- Uganda – stunting is recognized as the key development indicator and included in the draft National Plan 11
- Swaziland has done a gap analysis to prioritize interventions to address causes of stunting and develop national guidelines for a national stunting reduction programme.

4.3.6: Advocacy to Reduce Malnutrition Using Profiles and Nutrition Costing

Alice Nkoni, FANTA Malawi

PROFILES is an evidence based tool to support nutrition and estimates benefits of improved nutrition outcomes from advocacy ranging in measuring various nutrition indicators. PROFILES addresses various nutrition problems by analyzing selected nutrition indicators and population demographic data. The tool has successfully been used in countries such as Bangladesh, Kenya, Uganda, Tanzania and Malawi to address indicators such as wasting, stunting over a period of 10 years. Significant number of infant lives have been saved through breastfeeding and reduction of chronic malnutrition

observed showing impact of PROFILES leading to human capital gain. These results have been used to conduct nutrition costing and advocacy amongst various levels of multi-sectoral stakeholders. The advocacy process in particular is a powerful tool that leads in shaping programmes and policies in countries. PROFILES is thus a potential tool that can applied in many countries to scale up advocacy for nutrition initiatives.

Of recent, newer models within PROFILES have been developed to include examination of suboptimal BF practices on obesity, mortality in countries such as Zambia and are at proof of concept stage. FANTA created these models to clearly show how advocacy is important in programmes such as breastfeeding promotion and various nutrition programmes.

4.3.7: Innovative Approaches to Optimal Breastfeeding for Small & Sick Newborn Babies

Ute Feucht, Pediatrician, Tshwane District Clinical Specialist Team, South Africa

Small and sick newborns are a high risk group of neonates. Breastfeeding is not a medical condition, but rather a normal part of life whose barriers should be addressed through supporting women to balance many different, often conflicting demands. In South Africa, some efforts like emphasizing concepts of breastfeeding in neonatal care were put in place however, some people suffer from "neonatitis". In order to achieve zero separation of mother-infant pairs in the health facilities, KMC wards need to be put in place as a standard of care and human milk banking needs to be explored. The BFHI as part of the continuum of care should also be emphasized and the need for lodger-ward facilities in South African hospitals be discussed. In addition, capacity building of midwives need to be conducted emphasizing implementation of breast milk-only policies in neonatal wards/units. Benchmarking and healthy competition can do wonders in improving neo-natal care.

4.3.8: Ensuring Maternity Protection for all Women at National Level

Margaret Kyenkya, Founder IBFAN AFRICA, Advisory Council WABA

Society should make provisions for women to fulfill their reproductive roles without jeopardizing their economic security, their health and that of their children. The C183: Maternity Protection Convention (2000) applies to all women including those in atypical forms of work. This allows for 14 weeks compulsory leave but member states can extend. India has acted commendable in this regards by extending maternity leave to 26 weeks for those in formal/ organized work sector. Norway has most maternity and paternity leave benefits. Caesarian sections, LBW and need to establish successful

breastfeeding and prevent growth faltering should be reason for a medical certificate to support woman to extend her maternity leave.

Gender inequality and income gap makes it difficult for women to demand and make maximum use of maternity leave. Rights of domestic workers must be protected to ensure that they enjoy the same maternity entitlements as other workers. To do this, there is need to work together and speak same language at national level regarding this issue and start where we are. At the community level, there is need to link with women's groups that have high regard for maternity leave and protection and support of breastfeeding.

4.3.9: Improving Dietary Intakes & Nutritional Status of Infants and Young Children through Improved Food Security and CF Counselling - A global perspective

Mercy Chikoko, Food and Agricultural Organisation of the UN, Rome-ITALY

Breastfeeding and complementary feeding (CF) go hand in hand, however there are a number of gaps noted. Nutrition specific interventions are needed for reduction of malnutrition and nutrition sensitive interventions with a focus on agricultural policies and programs, WASH, social protection and addressing gender inequalities all do the same.

The UN Decade of Action on Nutrition 2016-2025 emphasized agricultural and food systems importance in addressing nutrition. Food security should be promoted through use of locally available resources. The FAO approach that entails diversification of agriculture and food systems, nutrition education and BCC approach translates into improved young child and family nutrition. A three pronged agricultural pathway of improved food security, income and gender empowerment improves nutrition.

Based on evidence, a collaborative research that aimed to study the effectiveness and impact of agricultural production/diversification and nutrition education on children's dietary intake and nutritional status was undertaken. Within these programmes, project specific approaches and program lessons based on each country's context were used on top of the agricultural and behavioural change practices. Stakeholder collaboration (central and local governments, NGOs and other private sector) play a great role in IYCF promotion and help see that program inputs are translated to improved breast feeding and complementary feeding practices, hunger reduction, and reduction in stunting prevalence. Social behavioural change communication should be included in all nutrition strategies as perception and attitude has a great influence on infant feeding practices.

4.3.10: Conflict of Interest in Nutrition Research & Programming: Recommendations for Action at Community Level – London Meeting on Conflicts of Interest

JP Dadhich, BPNI. India and South Asia Representative IBFAN

The introduction of the International code of Breast milk substitutes is slow and some of the challenges can be linked to rise in conflict of interest situations e g less tax based funding for public bodies and programs and mobilizing funds from non-traditional donors, corporate influence on standard setting (Codex, WHO), close relations with corporate actors under partnership/ stakeholder and non-state actor, paradigms research and program sponsorships from industries manufacturing BMS.

The 2015 Global capacity workshop was the first step towards recovering space on the corporate accountability by raising alarm and arguing for more effective conflict of interest safeguards. In addition, a checklist to identify conflict of interest is available. This has widely accepted definitions and conflict of interest regulations, a selection of references and web links.

4.3.11: *Codex, Trade and Child Health: Policy Coherence between Codex and WHO recommendations to Protect IYCF – Implications for Action at Community Level*

Elizabeth Sterken, INFACT Canada

The presenter opened with an introduction and definition to participants on what Codex Alimentarius means. She unveiled it as the joint UN body of WHO and FAO that sets standards for food commodities and food products. Codex includes safety or risk analysis of food additives, sets levels of contaminants for foods, microbial criteria for foods, labelling requirements and guidelines for nutrition and health claims.

The main purpose or mandate of the codex as laid out in her presentation was two-fold: to protect consumer's health and ensure fair practices in the trade of food commodities and food products. Secondary to this, the Codex Commission also acts in an advisory capacity through codes of practice, guidelines and other recommended measures. In effect, Codex harmonizes food products for international trade.

Participants to this committee among others are; member states, UN agencies, NGO Observers which include industry based NGOs and independent NGOs. At the recent CCFSDU on revision of FUF standard, the total number of delegates was 300 of which 132 were industry. The Government delegations totaled 197 of which 56 were industry; Observer delegations totaled 95 of which 76 were industry.

She went further to expound why and how IBFAN is involved in codex activities. IBFAN holds an NGO Observer status with Codex and submits written comments on relevant agenda items . During the physical sessions IBFAN comments on every aspect of the development of the standard, participating in electronic and physical working groups, briefings for member state delegates especially on industry influence at Codex. IBFAN involvement in Codex is mainly involved to ensure:

- The protection of breastfeeding and optimal family food based complementary feeding in the international trade of foods for infants and young children. This is because Codex standards are the benchmarks for the WTO and thus the need to include the International Code and WHA resolutions into the scope of the standards for infant formulas, complementary and supplementary food products;
- Infants who have a "medically indicated" need for artificial feeding also receive adequate consumer protection especially from aadditives, contaminants, to have safe upper levels of nutrients and appropriate ingredients specifically the sugar levels;
- WTO trade dispute mechanisms will not over-rule national legislation or regulation regarding the International Code of Marketing of Breast-milk Substitutes and

subsequent resolutions of the WHA and that the ability of national governments to regulate the marketing and labelling of these products is protected;

- Consumer protection for parents, pregnant and lactating women is through full and informative labeling of commercial food products for infants and young children. Focus on this is on the claims that are included only if permitted by national legislation and no comparisons should be made to breastmilk.

Currently, the regulation of marketing in developed countries and a trend to return to breastfeeding, is giving formula companies an incentive to shift their attention to developing countries in the Asia Pacific region where regulatory and health care systems are embryonic or weak, and maternity protection minimal. Women are being harnessed into formal employment by G20 policy priorities to address 'the gender gap' in labour force participation.

From Jan to April of 2016, 60,100 tonnes of infant formula were exported to China representing a 26% increase in import volume compared to the same period last year. From Jan - April 2016 the total value of imported infant formula was 833 million USD which represents a 27.3 % increase compared to the same period last year. Average price per ton also increased by 1.1% compared to the same period the year before (13,500$).

Impact on consumer health

- Marketing to compete with breastfeeding
- Compromises exclusive breastfeeding rates
- Compromises sustained breastfeeding to 2 years and beyond
- Compromises family food based complementary feeding
- Increased use of single approach product driven treatment of SAM and MAM
- *Obesity, cardiovascular disease, diabetes, cancers, infectious disease, auto-immune disease and IYC mortality*

She stressed the protection of breastfeeding and Codex as critical for national governments to implement the International Code and WHA resolutions, essential for national governments to have strict regulations on the labelling of products and prohibit nutrition and health claims and important for governments to have informed delegates to Codex.

4.3.12: Impact of the SUN Strategy of Engaging Business in Tracking Malnutrition and Market-led Approaches: Implications at Community Level

Patti Randal, Baby Milk Action

The SUN is a top down hybrid entity and its claim to be a social movement is a misnomer. SUN's current vision is not transparent, focusses on reduction on malnutrition led by government and there is no mention of the private sector who are strongly involved. Following IBFAN critique SUN started to claim that government is leading the SUN movement. The SUN movement needs to be monitored more closely to ensure governments' priorities are upheld.

SUN focus is not on the ground monitoring but focuses on Public Private Partnerships, raising consumer awareness on healthy diets, promoting fortified products. Private companies are focusing on advertising to sway mothers' decisions. Many mothers are stopping breastfeeding to commercial products due to the aggressive advertising

As such there is need to redesign and improve the SUN framework to remove aspects that put promotion of breastfeeding at risk. As IBFAN network and public organisations working in SUN countries we need to continue monitoring and ensure marketing of products is not widespread. There should be more emphasis in home complementary food, promotion and support for breastfeeding and more efforts to move away from marketing and use of commercial products. In addition, governments need to focus on food sovereignty and promote use and production of local foods to improve nutrition of the population.

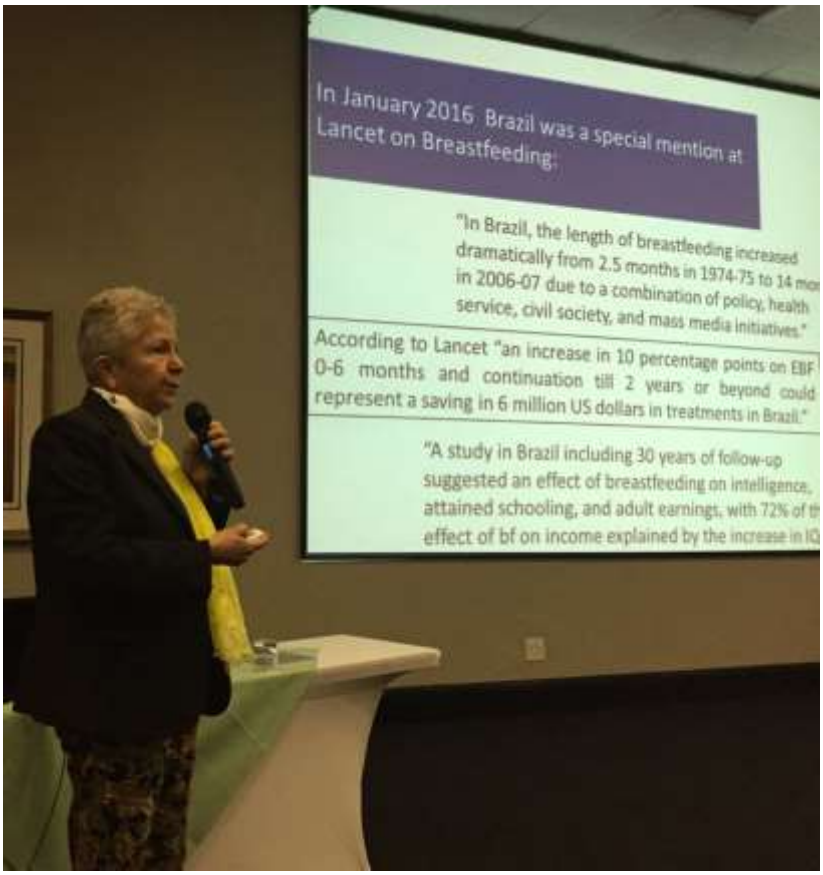
4.4: Plenary Forum

4.1.1: Enhancing Breastfeeding Rates: Progress Made Since 1st World Breastfeeding Conference 2012

Practical challenges regarding investing in breastfeeding were discussed in the plenary forum and different investment mechanisms and modalities for replication explored.

The recent Lancet Series on Breastfeeding presented by Laurence Grummer- Strawn (WHO Geneva) highlighted the general situation regarding breastfeeding in the 21st century and challenging the notion that developed countries are doing well regarding breastfeeding and focus should be put on developing countries. The series focused on practices of breastfeeding and impact of breastfeeding on MCH looking at both long and short-term impact. In addition, they synthesized where evidence exists on consequences on breastfeeding on various factors such as cognition, cancer, NCDs and where evidence is not strong enough such as on stunting, osteoporosis. The first world breastfeeding map clearly showed data existed in some countries but not in others. As such, the issue is not a lack of research or knowledge, but more a lack of political interest investment and commitment. Analysis of existing data point to the fact that approaches to promote breastfeeding would need to differ county by country.

Ms Barbara Nalubanga (IBFAN AFRICA) highlighted the progress made by 20 countries on the First World Breastfeeding Conference 2012 Resolutions. Generally progress low progress was being made in some African countries with respect to maternity protection, budget provision and research. Latin American countries on the other hand should improve access to information, publicize risk of artificial food and support to women.



Concerned by the lack of data showing how much carbon gasses is generated due to use of infant formula, a study was conducted selected countries of the Asia-Pacific Region to show the carbon footprint due to milk formula. Milk formula is an important source of GHG emissions and there is need to monitor GHG emissions from milk formula manufacturing countries. Projections show and increasing sale of these products with an increasing consequent of GHG emissions. The study results presented by Dr Dadhich (BPNI) revealed that emission of GHG calculated among the six 6 countries totaled 2.89M tonnes with high emissions from toddler formula compared to other milk formula.

Dr Shoba Suri (BPNI/IBFAN Asia) informed participants that the World Breastfeeding Costing Initiative (WBCi) Financial Planning and Budgeting Tool was developed for countries to plan, budget and cost interventions on GSIYCF, breastfeeding, health and nutrition programmes. It follows the principles and structure of the World Trends Initiative and was launched at the WHA in partnership with WHO 2014. Various regions have been trained and are utilizing the tool to estimate the cost of implementing all the key interventions at strategy level. WHO, UNICEF and governments were urged to promote the use of the tool as it will assist planners, MCH / nutrition coordinators, public health practitioners and finance personnel in developing/calculating budgets for specific or overall interventions.

4.4.2: Tackling Non-compliance with the International Code of Marketing of Breast-milk Substitutes: Assisting Countries with Code Legislation, Monitoring & Enforcement

Presenters in Plenary forum two divulged the continuing as well as new challenges being observed in code implementation and shared varied recommendations and experiences on how to address the issues.

The International Code on BMS was adopted by WHA in 1981 as a global recommendation and all Member States urged to incorporate into national legislation. To this end David Clark (UNICEF) informed participants that NetCode provides an opportunity to forge and strengthen alliances in support of Code implementation in countries and legal assistance must be made available to countries through collaborative and coordinated efforts Partnerships between UN agencies, NGOs and other relevant partners must be strengthened - avoiding conflicts of interest.

Lawrence Grummer – Strawn (WHO) highlighted that the monitoring framework for Implementation of the International Code of Marketing of Breast-milk Substitutes comprises of on-going reporting of violations of national law and the Code, for the purposes of taking immediate corrective action as well as periodic in-depth surveys to identify problem areas and map progress of Code implementation. Reporting is conducted at three levels namely at multiple government departments/ministries, public reporting and within the standard system. Assessment components include a survey of mothers of children 0-23 months, observation and interview with health care providers, observation and products in retail outlets as well as media monitoring. Monitoring is currently being piloted in Armenia, Bangladesh, Cambodia, Chile, Ghana, Kenya, Mexico and Oman.

Companies manufacturing, selling and promoting breast milk substitutes have established a social media presence:, through Facebook pages, interactive features on their own Web sites, mobile apps, YouTube videos, sponsored reviews on parenting blogs, and other financial relationships with parenting blogs. Yeong Joo Kean (ICDC) noted this has presented a new challenge as these are promotional practices were unforeseen. As such, the use of social media for formula marketing demands new strategies for monitoring and enforcing the code and should be considered as content for the upcoming World Health Assembly resolutions. One of the challenges is that there is lack of transparency in social media-based marketing. Breastfeeding advocates are challenged daily to compete with the brightest marketing minds in the world for the hearts and milk of nursing mothers. The same technologies can be used to fight back against the multi-nationals marketing BMS.

The Code clearly states that *"Products that function as breastmilk substitutes should not be promoted"* Roger Mathisen (FHI 360) however highlighted that varied challenges

exist such as with code implementation e.g weakening existing laws, trade and investment agreements as well as challenge involving conflict of interest. To address these challenges there is need to broaden responsibilities beyond Ministry of Health for more effective monitoring and enforcement as well as enhance advocacy and awareness raising.

Country experience in code implementation drawn Kuwait and Botswana presented by Hussein Tarimo (MoH) and Mona Al Sumaie (IBCLC) revealed that monitoring activities of health professionals as well as policy and legislation respectively had yielded positive results.

4.5: Technical Sessions

4.5.1: Enhancing Integrated Planning and Service Delivery for Optimal MIYCN in the Context of SDGs

Presentations from WHO Geneva, Brazil, USA, Southern Sudan, Uganda and India within Technical Session 1 brought to fore that comprehensive breastfeeding policies and interventions funded and supported by both governments and other stakeholders are highly beneficial for protecting, supporting and promoting breastfeeding.

WHO outlined the cost of achieving the WHA target for breastfeeding by unpacking the investment framework for nutrition. The results indicated that combining breastfeeding promotion and IYCF counseling is a more cost effective strategy in averting child deaths, preventing child mortality and cognitive losses to enhance greater earnings in adulthood.

Brazil illustrated how through government support, emphasis was placed on implementation of Primary Health Care services in addition to hospital care resulting in improvement of breastfeeding performance indicators between 1986 to 2013. In the USA, despite there being large disparities in breastfeeding among different cultural groups, policy change and legislation implemented within a framework of broad based multi-sectoral interventions as well as involvement of CDC playing a leading role in supporting BF policies was instrumental in improving key IYCF indicators.

Development of a Southern Sudan 2016-2025 MIYCN strategy was vital due as the country has the highest maternal, under5 mortality and PMTCT rates were the highest in the world. With government and NGO support, some strides had been made towards services provision and achieving the MIYCN goals despite the insurgency in the country. Uganda shared that to help meet its set MIYCN targets, a roadmap framework adopting the lifecycle approach in scaling up interventions targeted at maternal, infant, young child and adolescent was developed. Analysis of DHS data between 1990 and 2014 in the

Asian countries of India, Bangladesh, Pakistan and Nepal showed that children who are born in urban and rural areas with improved sanitation coverage and good WASH practices had lower risks of getting diarrhea.

4.5.2: Strengthening Evidence for MIYCN through Research and Program Monitoring

Presentations in Technical Session 2 highlighted that in a bid to see real improvement in breastfeeding practices, in addition to heightened accountability and policing of policy implementation by international and national government bodies and stakeholders, there is a need to use research to close the gaps that exist between policy and implementation.

The world breastfeeding trends initiative (WBTi) web portal for breastfeeding advocacy was illustrated as a convenient tool that can be used to study and compare national and regional trends. In India, an existent gap in supporting breastfeeding within families was identified as an opportunity for research and implementation. A computer tool called "Sales-force" was used to monitor child anthropometry and it is expected that findings of their study will be used to convince policy makers about the importance that breastfeeding support reduces malnutrition.

From South Africa, it was learn that in spite of new policies being put in place, the SANHANES 2013 report showed declining rates of exclusive breastfeeding from 8.2% to 7.4% in 2003 and 2013 respectively. A cross-sectional survey of health practitioners in Germany showed there is a need for integrated care that focuses on the family centered model in breastfeeding support. Similar results emerged from a study in Ecuador where the role of family and culture was found critical in supporting breastfeeding.

Research had also been useful in yielding evidence of additional benefits of breastfeeding such as in the case of Malaysia where research conducted showed that breastfeeding was associated with reduced risk of breast cancer.

4.5.3: Strengthening Care and Support through BFHI

Varied country presentations in Technical Session 3 showed that implementation of BFHI protocols to suit the local situation, linkage of BFHI to other health system interventions as well as appropriate support to breastfeeding mothers both at the health facility and community level helps improve breastfeeding trends.

From Brazil, it was learnt that the number of BFHI accredited facilities have increased since 1992 and a recent national survey during the immunization campaign found being born in a BFH was associated with timely breastfeeding initiation and longer EBF

duration. Data from Bangladesh showed that promotion of breastfeeding as well as high level political support had resulted in reduced infant and childhood mortality, improved GDP nutritional status trends. In order to reduce maternal deaths from first level facilities and traditional birth places, a policy was implemented in Mexico that obstetric care be done only in hospitals so as. The health policy has greatly impacted on women with low income status by increasing hospital births and improving baby friendly practices. A prospective cohort study by the Thai breast feeding foundation revealed that the socioeconomic barrier on duration of exclusive breastfeeding were highly improved by the revitalization of BFHI under the strong adoption of the CODE, parental classes, lactation clinic plus community support can alleviate.

Research conducted in selected health facilities in to address the decline in breastfeeding practices at mother baby friendly accredited facilities in Limpopo Province, South Africa revealed that a community mobilization intervention package that included of dialogues, door to door, stakeholder involvement and road improved community breastfeeding practices. In Uganda, local government ownership, strong health system linkages to key MCH aspects such as EMNoC, IMCI and eMTCT among others, changing health workers' mindset through capacity building, mentoring and coaching, behavioural change approach, formation of community support groups and breast feeding QI committees greatly impacted BFHI implementation.

4.5.4: Public Information Support and Advocacy for Improved MIYCN Campaigns

Mass communication was revealed by presentations in Technical Session 4 to play an important role in influencing consumer's choice, and promotion of exclusive breastfeeding.

In Niger, use of a video to promote MIYCN behaviours was found to have positive results on hand washing and responsive feeding. A study conducted in Senegal over a 3months period (March-May 2015) to assess advertisements directed to the public that could influence optimal infants and young children feeding practices related to breast milk substitute revealed that TV Viewers were more interested in breast milk substitute compared to locally produced complementary foods.

Use of different approaches such as media, pamphlets and drama to repeatedly conveyed the messages in Ethiopia also helped to increase exclusive breastfeeding. Testimonies from the mothers revealed "children are not getting sick anymore and they are not dying". Assessments by Journalists in South Africa similarly revealed that promoting breastfeeding through different media platform such as radio, print and social media (facebook, WhatsApp) can effectively reach both young and older people. I was

however noted that needs to be cautious to write their articles in a way that is not judgmental so encourage readers to read their stories and adopt positive practices.

There is a major progress in breast feeding as regards to the World Breastfeeding Week and the preparations for the coming years being in place is an indication of attainment of the SDGs come 2030. Social media in particular is playing a significant role towards reaching the young people.

4.5.5: Emergency Nutrition Response for Optimal MIYCN Programs

Technical Session 5 presentation illustrated that support to communities during emergencies helps to build their confidence, emotional well-being and collaboration among partners resulting in enhanced promotion, protection and support of breastfeeding and other IYCF practices in children to prevent malnutrition. In addition, it was expressed that vigilance is required as there's rampant violation of the code during emergency situations.

During emergencies women and children are the most exposed to attacks and therefore need support. It is against this background that World Vision created Women Adolescents and Young Child Spaces (WAYCS) spaces to provide communities displaced by the Typhoon Haiyan with varied nutrition, health and psychosocial support. As a result of the WAYCS, improved confidence and emotional wellbeing, increased knowledge and appropriate infant/child feeding practices were reported among the women. In addition, a strong peer system was established hence, reduced time for vices such as gambling and noted long term benefits of healthier children and thus healthier future.

In Bangladesh, a cohort of wasted children and their primary caregivers were assessed to compare the effects in either a psychosocial intervention added to standard nutritional treatment or a standard nutritional treatment alone This led to the establishment of baby friendly spaces aimed at creating private places for pregnant and lactating women to build their confidence to breastfeed, guide them on feeding infants and young children during emergencies and also reduce the effects of unsolicited and unmonitored distribution of breast milk substitutes. Results revealed that psychosocial therapy during emergencies greatly contributes to recovery of malnourished clients.

Nutrition and breastfeeding support was included in the emergency package provided to communities affected by Typhoon Yolanda in Philippines. During the support period, it was discovered that Nestle products were given to mothers as emergency kits to feed their infant, bottle feeding was practiced by some mothers and one mother with TB had been discouraged by the doctor to breastfeed which contributed to her child becoming SAM. On the whole, psychosocial support, collaboration with other sectors especially

WASH to prevent contamination and infections, community sensitization as well as use locally available foods was key.

It was believed that drought could impact the IYCF indicators and therefore a study on perceptions of pregnant and lactating women on breastfeeding was conducted during an El Nino drought in Lupane district in Matabeleland Province of Zimbabwe. Women reported that though nothing could be done to prevent the emergency, something can be done to prevent malnutrition. This pushed communities to come up with initiatives such as employment to get finances to feed families. It was also discovered that most mothers believed that breastfeeding was still the best for their children. Drought did not affect motivation to breastfeed though lactating women needed more support and nutrition emergency interventions should ensure that lactating women have access to food to ensure optimal breastfeeding.

All deliveries in Sweden are assisted by a skilled birth attendant and caesarean section rate is at 20%. To establish the risk factors of breastfeeding for a short duration, lactating women were asked whether they were supported hands on to initiate or attach the baby to the breast by a skilled health care worker and their first time breastfeeding experience after delivery. Results revealed that exclusive breastfeeding lasting less than 2 months post-partum was at 77%. Emotional distress, giving caesarean section and being first time mothers all independently influenced the risk of exclusive breastfeeding lasting less than 2 months.

4.5.6: Protecting, Promoting & Supporting Breastfeeding through Human Milk Banking

Technical Session 6 highlighted that there is growing evidence that donor milk has large benefit beyond mothers and babies such as healing eczema and low birth weight as well as to people with persistent GI disorders, cancer and leukaemia. There is hence increasing acknowledgment that human milk banks are very crucial in scaling up exclusive breastfeeding rates. Its acceptability is however still low due to differing perceptions and concerns of nutrient loss during pasteurization. Increased awareness and access to human milk banks is required to ensure their maximal use.

A call to provide donor milk for vulnerable infants, premature and low birth weight babies and immune compromised babies was given during the World Health Assembly May 2008. With its humble introduction in South Africa, babies with infectious diseases such as Aids, Tb, malnutrition as well as respiratory distress were given donor milk. They grew healthy (gained weight, eczema reduced, experienced less and less severe diarrhoea) and were eventually adopted. Despite the radical transformation in the babies' health, human milk banking is not yet wholly accepted and negative perceptions

of it still exist. There is thus need to integrate human milk banking education within breastfeeding promotion campaigns

To ensure that the donor milk, is safe and free of pathogens, pasteurization is required. There is a concern that heating may kill the good nutrients in the milk. It was acknowledged that there is a small loss of nutrients but a majority of them are maintained and that outweighs the cost of not giving breast milk at all.

Up to 40% of vulnerable infants in neonate wards are in need of human milk. To help ensure all babies everywhere receive human milk a comprehensive integrated model that includes quality control systems as well as breastfeeding promotion, linked with Kangaroo mother care breastfeeding promotion and provision of donor human milk through Human milk banks should be implemented. Human milk banks should be country specific and reflect the needs and resources of the region.

There is a booming market for Human Milk banks around especially in USA and Australia. Cost recovery is supported because processing is expensive but selling for profit is not recommended. It should however be noted that breastfeeding has more than a monetary value: it is every baby's right. Automatic pumping has made the milk more easily available and as demand grow donations to non- profit milk banks is decreasing. Milk is being bought for the wrong reasons e g by men, thinking it is palatable and will give them a strong body.

Human milk banks should be promoted, supported as effective approach especially in post-natal wards and neonatal intensive care units because more children are losing parents at birth and some abandoned while the wonders of HMB have been acknowledged. Safety, quality Information, management, advocacy, promotion and sustainability should be observed as the key pillars human milk banking.

4.5.7: Women & Children's Rights to Maternity Protection in Formal & Informal Sectors

Technical session 7 brought out that whereas maternity protection is prominent in most countries with different initiatives being provided, challenges exist in both developed and developing countries. Increased sensitization on relevant policies and guidelines, coupled with a collaborative approach of government including both the private and informal sector is key in advocating and enhancing maternity protection rights**.**

The Indian constitution supports maternity protection where the government takes responsibility however, women in the informal sector have less maternity protection with some getting back to work 15 days after delivery. Conditional maternity benefits targeting all pregnant and lactating women exist in some rural schemes.

The women workforce is quite high in Asia and women are forced to make hard breastfeeding choices. A partnership model for lactation program was employed with great involvement of big trading companies who are being used as champions for scale up. In addition, a big advocacy goal strategy was used to revitalize the process for policy change resulting in women now having friendly breastfeeding spaces in a number of workplaces.

Maternity protection is also more evident in the public than private sector in Kenya. A study conducted to inform effectiveness of workplace support for women in tea plantations found that there is poor adherence to the workplace guidelines as employers feel they are not binding laws but just policies on top of the lack of policy awareness. Implementation challenges exist in trying to incorporate casual workers as these have limited maternity protection and employer supervisor relationship is key. The Ministry of Health has partnered with various organizations and private sector on a workplace support project which seeks to achieve compliance with ILO convention 183, 2007 Kenya Employment Act and to review workplace policies. To date a lot has been done regarding breastfeeding in the workplace guidelines and structures coordinating the project. Research is still on-going so as to generate evidence for policy formulation.

In Luxemburg, 20 weeks of maternity protection difficult to argue against without getting into discrimination issues that are so sensitive in the country. Existing policies on maternity benefits of unemployed women and educational allowance have been abolished and advocates could not repel this abolition as they were labelled old fashioned and traditional.

4.5.8: Combining Targeted Food Security Actions, Intensive Nutrition Education & BCC

Research and programmatic experiences shared in Technical Session 8 illustrated the effects agricultural, education and behaviour change communication had on MIYCN.

Evidence from empirical research and programmatic experience from the IMCF project implemented in Malawi and Cambodia from 2011-2015 showed that a combination of food security and locally available foods and IYCF nutrition education improved breastfeeding, complementary feeding, mothers/women dietary diversity and Vitamin A intake. In Bangladesh, provision of cash and food following exposure to SBCC enabled purchase of diversified food from market and ultimately resulting in improved nutrition status.

Results from a study conducted in Kunje Area Council Abuja revealed extremely poor breastfeeding and complementary feeding practices amongst children aged under 5 years. With respect to breastfeeding, only 25% of the children were breastfed in line with

the recommendation, almost half of babies received pre-lacteal feeds, almost half received the colostrum and 18 percent of mothers use water to feed babies from 0-6 months.

International code of marketing underpins the use of replacement breastfeeding and complimentary foods. Marketing of these replacement feeds not only interferes with breastfeeding and many have misleading and deceptive nutritional claims that could mislead mothers. The chemical configuration and composition of the replacement feeds are very different from human milk leading to several risks such possibility of lower IQ in LBW babies, increased obesity and higher serum urea.

International code of marketing underpins the use of replacement breastfeeding and complimentary foods. Marketing of these replacement feeds not only interferes with breastfeeding and many have misleading and deceptive nutritional claims that could mislead mothers. The chemical configuration and composition of the replacement feeds are very different from human milk leading to several risks such possibility of lower IQ in LBW babies, increased obesity and higher serum urea.

4.5.9: Capacity Building for Pre and In-service Health Workers in MIYCN

Varied capacity building programs implemented amongst health professions were elaborated in Technical Session 9.

Updating of the 5-day training package in IYCF counselling for health workers developed by WHO started in 2014 in collaboration with UNICEF. For the implementation phase it was observed that IYCF trainings should be monitored to ensure that they are properly implemented, and also mentors for the trainings should be interchanged for effective results or outcome.

The 4 in 1 training session is an integrated course on breastfeeding, complementary feeding, infant feeding & HIV and growth monitoring counseling. It has been used in India for the past 12 years and other Asian countries. Based on the evaluation, the program facilitators realized the need for Infant and young child feeding counseling training was urgently needed in local hospitals and communities in all provinces in Indonesia.

The government of South Africa together with international stakeholders such as FHI 360 and USAID developed a harmonized BF training package which is in line with the national IYCF policy and SA context. It has diverse training tools, and also contains a guidance manual for trainers. Key challenges in the program were the lack of mentoring and coaching for trainees plus the duration of training is not practical for HCP as they need to take time out of work.

4.5.10: *Promoting and Supporting Breastfeeding in HIV Infection and Epidemics*

In Technical Session 10, policy guidelines as well as research were observed to be key in helping promote and support breastfeeding in HIV infection and epidemics.

The presentation on the update on infant feeding in the context of HIV has been very challenging time for a very long time. Guidelines have gone through a number of updates to make sure that also children born to mothers living with HIV benefit as much from proper and safe infant and young child feeding practices just like those born to HIV negative mothers. This has resulted in more concrete efforts in the universal promotion of breastfeeding.

Over the years, the counselling for mothers living with HIV and infant feeding recommendations have undergone major changes. The recommendation in the 2016 guidelines is 12 months breastfeeding and continue for 24 months or longer while supported for the ART adherence and continued infant breastfeeding.

Brazil is well known for the Zika virus. In February 2016 the WHO developed guidelines which stated breastfeeding recommendations remain in the context of Zika transmission. Mothers suspected of or confirmed of Zika infection during pregnancy or postnatal should be supported from health care to initiate breastfeeding. Because Zika is a new syndrome more research still needs to be conducted.

A study on breastfeeding practices and nutrition status of children born to mothers living with HIV in at Kawaala Health Center IV revealed that mothers had little or no information of the recommended IYCF practices, work related challenges negatively affected the breastfeeding practices of these mothers as mothers had to stop exclusive breastfeeding to go back to work and stigma was the key reason for the mothers who were practicing mixed feeding. Interventions to scale up nutrition in the context of HIV especially involving policy makers to avoid sub-optimal breastfeeding practices was recommended

4.5.11: *Implementation of the International Code of Marketing Breast milk Substitutes*

Presentations in Technical Session 11 showed that despite there being extensive effort to implement the international code of marketing breast milk substitutes, challenges are consistently being observed.

Infant formula was the main breast milk substitute (BMS) on the market and was promoted from birth with no upper limit. After 6 months, the mother who is not

breastfeeding will then also add the complementary food and continue with the formula. The 1981 the code of marketing of breast milk substitutes: prohibits companies from marketing BMS. Companies of the breast milk substitutes argued that the code was only covering infant formulas thus decided to include age limits into their follow-up products beyond six months of age therefore they continue promoting these follow-up products aggressively – installing the perception that the product is beneficial.

Key concerns about follow-on formula are identified-interference with breastfeeding, obesity and NCDs, conflicts of interest e.g. using health care to promote products. Since both the follow-up formulas and the infant formulas are packaged with similar packages, this promotion leads to *cross-promotion*. It has been observed that lack of legislation in countries give a conducive playground for the violators of the code. According to the Code monitoring report from WHO/UNICEF/IBFAN, in 2016 only 39 countries have laws that enact all provisions of the Code, however, a slight increase from 37 in 2011. Through the inclusion of the Code in the human rights framework, Code violations would be considered as cases of human rights abuses.

A situation analysis of the situation of the code and subsequent relevant WHA resolutions in the Arab World revealed that only 18 out 71 countries fully implemented the code with 41 out of 71 implementing the code at all. A lot of code violation was present such as BMS companies hi-jacking the breastfeeding initiatives such as World Breastfeeding Week using their logo to promote the commemoration.

The Brazilian code is based in the International Code 1981 and subsequent relevant World Health Assembly Resolutions. In 2015, IBFAN Brazil conducted a study to monitor the code in 19 cities of all 10 states (provinces). Overall, 227 irregularities or violations were observed in 52 companies with 19 companies agreeing that they were not complying with

the code. The use of internet and social networking pages is a matter of concern, and it has had a constant presence of marketing of products covered by our Code, what is difficult to monitor.

Despite recent progress, violations of national legislation and the BMS code persists in Indonesia. Parents are exposed to advertising & promotion of BMS products at health facilities, retail outlets and the media. There is no legislation that prohibits the promotion and advertisements of BMS for children aged one and above by BMS manufacturers, distributors or retailers in health facilities, retail outlets, mass media, and elsewhere. As a result is it is common to find promotions and advertisements of BMS for children aged one and above. There is need for Indonesia to explicitly prohibit all advertising and other forms of promotion of designated products to the general public, including contact with pregnant women and mothers, promotion through the internet, social media and other electronic means of communication, as well as within the health system. Furthermore, the country should strengthen its laws and regulations to enact all provisions of the International Code and its subsequent WHA resolutions as well as establish a monitoring and enforcement system.

4.5.12: Strengthening Care & Support systems for Breastfeeding and Nutrition of Premature and Low Birth Weight Babies

Individualised management and special care of premature and LBW babies especially in their first two years of life was emphasized in Technical Session 12 so as to handle complications if any as well as avoid death and infection. One of the key aspects of their care is appropriate feeding following their growth pattern. Training and psychosocial support is also given to mothers with LBWBs and premature so as to teach them how to handle the LBW infant, settle them and facilitate milk production.

Emphasis of KMC is on keeping mothers and premature babies together to ensure exclusive breastfeeding. Discouragement and advocacy to move away from incubators came strongly at the international prematurity conference. There is strong scientific evidence showing the benefits of KMC on where it is done well. Some of these include high initiation and longer duration of breastfeeding, temperature regulation of the premature infants, positive effects on neuro development, nosocomial infections reduced and improved immunity and better wound healing. Kangaroo nutrition, discharge and follow- up depends on a supportive environment including family and community. Given the beneficial effects of KMC on breastfeeding and other parameters, its implementation should be expanded in all areas.

4.6: Symposia

4.6.1: Infant Feeding in Emergencies and Epidemics

Symposium 1 raised attention that emergencies are increasing worldwide but most countries do not easily identify early warning signs of the disasters. There is a bigger return on investment when emergency planning is done earlier.

Breastfeeding is a key survival act for children in emergencies as infants and young children are most at risk of malnutrition. Countries need to take action before disaster strikes, hence governments need to invest early in routine programming for IYCF-E. Regrettably, IYCF-E has not yet received sufficient focus and should be recognized as a right. Capacity mapping for IYCF-E in Kenya, Somalia and South Sudan however revealed that it is constrained by human resource limitations, lack of prioritization in terms of preparedness, lack of funding, limited and delayed feedback as well as non-assessment of IYCF-E response performance.

The IYCF-E operational guidelines developed in 2001 were revised in 2007, to deal with some of the issues around the use of BMS in emergencies. It review is currently underway to help strengthen how to plan practical support/interventions that address the various types of the emergencies. During the review, it was noted that there are gaps related to the roles of the different stake holders /actors like WASH, Health, and social protection, the rights of the mother amongst others. Draft guidelines are available but there is an urgent need for stakeholders to make their input into their revision especially based on the experiences and gaps felt on the ground.

4.6.2: Support for Breastfeeding in the Labour Sector

The need to strengthen legislation on maternity protection, improve on communication and other interventions in the legislation was emphasized in Symposium 2.

The ILO convention recommends 14 weeks of maternity leave but this is not enough as the other week/s are taken before birth limiting the amount of leave time they can take after birth. Maternity leave, cash and health benefits, health workplace benefits, employment protection, right to return to work after giving birth and right to breastfeeding are part of the ILO convention. Resources such as documents on advocacy, breastfeeding and work, maternity and paternity parental leave and joint working papers with UNICEF have been developed in various languages to help countries in their campaigns for maternity protection.

Analysis of WBTi 15 indicators including 8 maternity protection sub indicators from 57 countries revealed that only 11 countries are providing protection for women working in

the informal sector. Furthermore, generally countries do provide information to workers on their entitlements on maternity protection but only 40% of the countries do monitor if this is being implemented. There is need to standardize entitlements that women receive in both public and private sector.

The CESCR convention covers various issues on maternity protection but the CEDAW convention of 1979 covers issues related to right to social security without mentioning maternity protection. It is only recently the CEDAW has taken initiative to include rights of women on right to payment to mothers in rural areas. Joint statement on breastfeeding by UN experts of 2016 mentions right to women on maternity leave without mention of duration. Gambia has strong recommendations related to maternity leave (6 months) compared to Timor and Benin.

In as much as maternity protection remains a challenge in Kenya, the country has adopted and integrated parts of the ILO convention 183 of 2000 in the national policy Employment ACT 2007, new constitution of 2010, Collective Bargaining Agreement. Breastfeeding stations have been passed in a new bill in 2015 and is a requirement for all employers

Although breastfeeding rates are high in Zimbabwe, women mainly stop breastfeeding due to having to return to work. Using the STEP (Support, time, education, place) approach, a pilot breastfeeding promotion at a local cement company LAFARGE and later expanded to other local companies.

4.6.3: Enhancing the Right to Nutrition through Exclusive Breastfeeding: Experiences, Best Practices and Lessons Learnt

Counselling, data driven programming and other multiple interventions were depicted in varied country presentation in Symposium 3 to enhance exclusive breastfeeding.

Time Targeted Counselling (TTC) outreach model carried out by community health workers in Uganda delivered targeted information to create demand for health facility services for pregnant and lactating women. Assessment of the outreach model revealed capacity of household decision makers particularly fathers was built, EBF and other positive child caring practices increased.

A study conducted in Brazil showed a positive association between longer exclusive breastfeeding and the intake of healthier diets in the first year of life. Through use of data to guide program set up in Vietnam, strategic partnership were forged to influence rapid, large-scale increase in exclusive breastfeeding.

A KAP study was conducted among women with children 6months and below in South Africa revealed that a great number of infants were cared for by their mothers with few being taken to day care centres as mothers went to work. However, some of the mothers were reluctant to breastfeed exclusively neither did they make arrangements for a constant supply for breast milk to their infants while in day care. To achieve best outcomes on promotion supporting and protecting of breastfeeding, the government of South Africa has been utilizing, simultaneous multiple interventions (e.g. capacity building, behaviour change communication, human milk banks, mother baby friendly workplaces among others). The country is however yet to reach their goals. Continued effort should be made to encourage mothers to breastfeed and/or to express breast milk and store it properly so that when mothers go to work can exclusively breastfeed without challenges.

4.6.4: Strengthening Care and Support Systems for Breastfeeding and Nutrition of Pre-mature and Low-birth Weight Babies

Symposium 4 highlighted that, for successful breastfeeding of premature babies, access to the breast milk, good communication as well as capacity building is essential.

The breastfeeding model and programme on "Mama Breast: Breastfeeding and growth" an innovation by *Laerdal Global Health comprises of training packages on* helping baby's breath to helping babies grow as well as the small baby's breastfeeding journey. Over 350,000 health personnel have been trained in 77 countries.

To improve the limitations of conventional tools, which were used to feed babies with breastfeeding difficulties, such as preterm infants, orphans, neurologic impairment and when the mother is ill or after the mother has gone through caesarean section, the nifty feeding cup was designed. The cup has been tested successfully in India preterm infants and infants with oral facial clefts.

South Africa Breast milk Reserve, (SABR) which establishes hospital based human milk banking under the Feed for Life Initiative, developed a key to lactation dubbed C.A.R.E i.e. Communication with the mother, Active lactation management, Regular stimulation/group expression and Education. Since the beginning of the SABR milk banking, the mortality rates in neonates have dropped greatly.

Great strides have been made in neonatal care in Tshwane district South Africa particularly in Kangaroo Mother Care (KMC) implementation. Staff have been trained this has helped to deal with practical issues like teenage mothers, language barriers, competing demands on mothers to mention but a few. After implementation of KMC, the focus will shift to clinical practice, strengthening health systems and implementing research.

4.6.5: *Supporting and Protecting Breastfeeding through the Baby Friendly Hospital Initiative*

The role of the baby friendly hospital initiative in enhancing breastfeeding was highlighted in Symposium 5.

After a 25 years of BFHI implementation, analysis of data from 174 countries by WHO and UNICEF revealed that coverage was highest in Mediterranean (45%) and lowest in the African region (9%) and South Asia (8%). Countries adapt the BFHI according their needs. BFHI is largely facilitated by social mobilization funding either from government or other donors. However, BFHI implementation remains voluntarily, Implementation of good quality services at the clinic, maintaining its momentum, funding, health staff workload, monitoring of the code implementation, operationalization and adherence to the ten specific steps is a challenge. It is thus essential to mainstream the BFHI onto the policies, protocols and health worker curricula; invest in health workers capacity, institute continuous monitoring and secure sustainable funding.

Update of the 2009 BFHI guidance is currently on-going. The key reason is the challenges that each countries are faced and there is a need to address the sustainability of this initiative so that each baby get the support and not the selected few from the facilities. Secondly, WHO has the new process that was developed a couple of years incorporate the new WHO process on how to set up guidelines. To help in re-evaluating baby friendly initiative, the focus will be maternity facilities in terms of promoting and supporting breastfeeding. Two key aspects to be looked at are namely guidelines on patient care implementation guidance for national programmes. It is expected that the new guidance will be available in 2017.

4.6.6: *Prevention and Control of Severe and Chronic Malnutrition*

Symposium 6 emphasized that tackling nutritional challenges must be handled with renewed urgency and "new" lens- Interaction model. With this regards, lessons learnt from South Africa showed that making the primary care giver the anchor in the multi-dimensional program of action against hunger and malnutrition is key.

In Malawi, WFP using a mix of interventions in its program to prevent stunting. Amongst others these included the social behavior change (SBCC) approach to develop culturally-appropriate and context-specific messaging; social-ecological model to design communications activities to reach beneficiaries at the individual, household, community, and district level; The Care Group model to reach individuals with messages at the household level; Capacity building of volunteer promoters in communicating key programme messages as well key community and household decision. To gather data,

regular monitoring surveys were conducted regularly three times annually. Results revealed increases in the minimum diet diversity, minimum acceptable diet data, improvements in wasting and underweight as well as reduction in morbidity: diarrhea and fever. A women-centric, gender sensitive SBCC strategy as well as regular monitoring contributes to the success of the stunting prevention programme.

CMAM programme uptake in Malawi is affected by lack of knowledge on malnutrition and its impact. Use of a variety on methodology in engaging the wider community is important to ensure maximum programme uptake hence increase in programme coverage. Community mobilization on fighting MAM and SAM can assist early identification of malnutrition and therefore lessen hospital burden.

4.6.7: Historical Overview of Induced Lactation, Re-lactation, Adoptive Breastfeeding: Current Research to Inform Clinic Practice

Infertility is a real challenge to women and feel they are failures in life. Assisted reproductive technology as well as adoption are some of the options available to address infertility. Third party reproduction including foster or adoption has increased in the US and other developing countries. Various guidelines on recommendations on surrogate parents and infertility counseling available to partners. Protocols for Induced lactation were developed in 1999 and released in 2002. Induced lactation usually caused by failure to conceive. Methods for induced lactation can be applied differently in different regions and traditional methods also work.

Re-lactation works easier for women in Africa compared to Europe as USA as African grandmothers are much younger. This calls for induced re-lactation in these societies. Most mothers are able to re-lactate and milk produced within a week Hormones affect production of breast milk during 3 to 4 days after birth but after that the removal of milk from breast influence production of breast milk.

4.6.8: Building Capacity of Community Health Workers and Members for Improved and Sustained MIYCN

CHWs assess, counsel and support for different groups, adolescents, children, pregnant and lactating women. Little or no incentives are given to CHW's and numerous factors including capacity, knowledge, working conditions among others affect their performance. CHWs play a critical role of PHC provision and linking clients to facilities thus ensuring continuum of care. There is thus need to build their capacity. However, even if their services are relevant, the community needs to demand for them.

Capacity building is a continuous process, bridging the gap between pre-service and in-service training. Building capacity requires a systems approach - building a strong

foundation, supporting the workers, and generating demand for their services. Detailed supportive supervision and mentoring is important to ensure the provision of quality breastfeeding counselling and lactation support. Evaluation and building/sharing the evidence around programs designed to increase the competency of community health workers is critical.

In Bangladesh, nutrition specific interventions have been streamlined and should take place at each of the levels of the system. Quality improvement initiatives are linked to MNCH services and focus is adopted to country context. It is done through partnership with government strongly supported by UNICEF. In a bid to strengthen IYCF Counseling during ANC and PNC for improved breast feeding varied approaches have been taken such as facility, community and workplace based to influence breastfeeding practices through promotion and support as well as strengthening capacity of health workers on IYCF counseling. Using these approaches, IYCF counselling significantly improved beyond the 2016 60% target. The community support enhances the care received at facility level but it needs more capacity building.

4.6.9: BFCI: Regional Implementation, Experiences and Results

Breastfeeding rates in infants 6 months of age is on the increase in Brazil. This is as a result of good co-ordination systems as well as having all program planning components are in place in Brazil. In addition, majority of hospitals in Brazil are BFHI accredited, even though the number of accredited facilities has declined due to some not offering maternity services. Some of the challenges faced are that most municipalities are not within reach and father involvement is limited. More social mobilization campaigns to help improve breastfeeding rates are thus needed.

A study was conducted in over 900 villages in Lalitpur district India to evaluate the effect of peer counselling by mother support groups (MSGs) in improving the IYCF practices in the community. Local resource persons were trained who in turn trained over 3000 village mothers to conduct home visits and counselling. Results showed peer counselling improved breastfeeding and IYCF IYCF practices in the district and could be sustained. In particular there was improved initiation of breastfeeding within the first hour of birth, exclusive breastfeeding for 6 months, initiation of complementary foods as well as reduced use of pre lacteal feeds. Peer counselling by Mother Support Groups (MSGs) is thus an important aspect that can be adopted to improve breastfeeding and IYCF practices and the use of local persons will see the success of such an intervention rather than bringing foreigners.

In Kenya, a Baby Friendly Community-based Initiative (BFCI) was developed to expand the 10th step of BFHI as well as promote, protect and support breast feeding, optimal

complementary feeding and maternal nutrition. The focus includes feeding of sick child, environmental sanitation and hygiene, early childhood stimulation, referral to MCH, HIV services. It works through: 1) Formation and training of mother support group and close links to health center's and local authorities. 2) Home visitations; 3) Community campaigns for MIYCN and 4) Strong link with nutrition sensitive programmes. Challenges faced in the initiative include human resources, incentives for Community health volunteers, integration, high expectations from members of communities mothers support groups, lack of commitment from other members, lack of resources as well as illiteracy at the community level.

Social return on investment (SROI) is an approach of evaluation that aims to account for non-financial outcomes using monetary values to represent them. It measures the value of social benefits created by an organization, in relation to the relative cost of achieving those benefits, expressed in a SROI ratio. The goal of the MIYCN project was to improve nutritional status and health of children in urban slums. The primary outcome was to increase the rate of exclusive breastfeeding for 6 months. Need results of the SROI study if available.

4.6.10: Experiences on Promotion, Protection and Support for Optimal IYCF

Since 2011, breastfeeding in South Africa has been suboptimal. The government works with civil society to promote breastfeeding so as to influence practices done at community level. Presenters in Symposium 12 shared experiences form selected specific activities conducted.

Several actions have been taken in South Africa to promote and support breast feeding. This include the Twane declaration, obtaining high level political commitment, development of national regulations on the code, promotion of human milk banks, moving towards making public hospitals and health facilities baby friendly as well as regulating provision on formula feeds in government institutions.

An electronic mobile system "Mom connect" was designed to help remind women on what should be done from pregnancy up to feeding their child. Services are offered in six local languages and clients retained for a year or more. In addition to mom connect, "Nurse connect" was launched to give nurses information through electronic system. These networks are for mothers and children as well as the whole community and primarily emphasize behavior change.

Over 1m women are part of the system and have largely positive comments. Complaints are only 2% which is negligible.

The EBF rates in Northern Cape were higher than the ones of the country at 62.8%. This is as a result of strong leadership and champions for nutrition, dieticians and nutritionists in key positions coupled with good ownership and accountability of nutrition programs. In addition, technology e.g WhatsApp was used for transmission of consistent and simplified messages on nutrition through social media as well as referral.

Kwa Zulu Natal was at the epicenter of the HIV epidemic and researches reflecting on HIV and infant feeding were done in the province because one would easily get their sample size and target population. A policy was made which changed implementation on IYCF in the province. The policy called for political commitment, evidence based research, strong partnership and integration, community based approach and quality assurance.

A project conducted by PATH in 4 districts in Northern Cape in part focused on engaging communities through CBOs to create awareness on early ANC booking, use of ANC service and childhood development. Activities included provision of sub grants and capacity building to CBOs, development of IEC materials on the 1st 1000 days coupled with dissemination of messages as well as household visits by CHWs. Engaging communities to mobilize and sensitize women on use of ANC services strengths health facility community linkage.

4.7: Cinema Events

4.7.1: TIGERS Film

Mike Brady, IBFAN-Baby Milk Action

Film Synopsis

The film revolves around the true life of a former Nestle baby milk salesman**,** Syed Aamir Raza, who blew the whistle on unethical practices in Pakistan with help of IBFAN. Struggling in life as a local drug sales man, he had inadequate sales due to consumer mistrust of product quality and validity. He was convinced to join one of the world's companies (Lastra/ Nestle) selling 'the best infant formula' as a salesman.

Using incentives, gifts, sponsoring of health professional dinners, competitions and favors to medical professionals, and the infant formula were easily adopted in hospitals, shops and pharmacies that doctors prescribed for patients. Through his passionate marketing strategies (Tiger-real growl), the formula was massively accepted and consumed by community and freely accessed in hospital. Babies born in hospitals become Lastra babies i.e. breastfeeding was replaced by formula milk.

After a few years of successful sales, one of his doctor friends returned to him and showed him the effects the formulas on infants that he passionately sold. Children breastfed were health compared to the ones feeing on formula from same mothers. The doctor explained the observed decrease in mortality in his hospital when they withdraw and banned the use of the formula in the hospital.

He was disappointed about the ill effect resulting into increasing child morbidity and mortality. Following a personal tour to the community, he observed how unhygienic this formula was being prepared and served to infants and children. He decided to resign from his job. With help from his father and doctor, he prepared a legal document to withdraw and recall all formulas from shops, hospital and pharmacies. Political threats and resistance from the government official alongside lack of cooperative obligation for the formulas was hindering this noble move. With support from concerned international organization this unethical behavior was legally publicized that lead to a successful ban on the use of the formulas.

The film has been used in the UK against bribery and sponsorship of doctors from baby milk companies as well as among medical professionals to make informed decisions against use baby milk formulas and advocate for breastfeeding. In addition it has resulted into formulation Baby Feeding Law Group that three times a year.

Conclusion

1) Corporations need to be held accountable for inappropriate marketing of breast milk. However, this requires legal readiness, true evidence and support from parties that are mandated to uphold human right and health.
2) Political involvement in sale of baby milk formula as well as lack of laws restricting the sale of these products is an indication that governments have not completely embraced breastfeeding among infants and young children.

4.7.2: MILK film

Elizabeth Sterken, INFACT Canada

Film synopsis

Milk depicts the universal perspectives on the politics, commercialization and controversies surrounding birth and infant feeding. It celebrates bringing a new life into this world with a strong call for action and reflection.

The film event was moderated by Noemi Weis an International Lactation Consultant Association but the fim was produced and directed by Filmblanc from Ottawa in Canada.

The movie revolves around an artistic and intimate look at the politics of birth and infant feeding around the world. It illustrates the excitement of giving birth to a child, the joy of bringing a more life, becoming a mother or father and the infant feeding practices as well as benefits of breastfeeding.

Giving birth results into a superwoman and humanity feeling. With prayer and assistance from midwives, a woman gives birth with a bright sound to a baby and they are bounded through breastfeeding. Midwives are with the mothers, assist during the natural birth, support initiation of breastfeeding.

However, changes in generation on how to become a good mother is a constrain to women. Social issues around breastfeeding has interfered with breastfeeding practices and raise in use of formula milk and bottle feeding that later results into malnutrition. Mothers indicate that they are not appropriately trained on how to feed their babies. Formula milk companies send people gifts through hospitals where they get their information from. Economic incentives given to mothers by formula milk companies do discourage breastfeeding. Communities do not distinguish between formula milk and regular milk. During emergencies, due to lack of milk children are given formula milks. There are no appropriate legislations against formula milk. Legislations against formula milk without sanction is like toothless bulldog. Without penalty, it is useless to the children that it's supposed to protect.

Through women empowerment to breastfeed, a country is empowered with a healthy population. However, this requires government's support against formula milk and companies that assume responsibility over children yet they sell the milk to replace breastmilk. Mothers should feed the future not the corporate. Every child has a right to basic nutrition, and a healthy long life which every government must give. Chronic illness can be stopped by starting good nutrition at a very young age.

Conclusion: The panel discussion on the film centred on how the movie be used in campaigning especially in raising awareness on breastfeeding through bringing the voice of the mothers instead of just hearing and used for education i.e. can be used as an education tool. The pilot program was completed in Ontario and program replication has been successfully done in Kenya which has resulted into increase in the national exclusive rates.

The movie has been used to re-launch BFHI in areas that indicate low performance. Mothers are booked, workshops and discussions made about maternal and infant feeding issues done and action taken and used to address poverty and hunger

Communities that have faced social disparity around giving birth, chaos, neglect of safe water and poverty share this valuable experience and support in maternal and infant feeding as a means of encouragement to other communities.

An analysis of key issues emerging during the session shows that motherhood in a social way of life. All mothers want the best for their babies, give birth normally and breastfeed however, this dream is shattered when mothers struggle to breastfeed and lack appropriate information about proper infant feeding which results into replacement of breastfeeding with formula milk. Companies strategically provide formula milk as incentives to mothers from hospitals especially those that are not baby friendly, and due to this fact that they allow formula milk to be used by mothers from companies as incentives and these economic incentives interfere with and discourage breastfeeding.

Government at times hinder publicity and documentation of truth. Screening of the film to many people in a cinema was interrupted due to censorship. A lot of money was paid to the government where it was produced to have an expedite review of the movie. Legislations about breastmilk substitutes without sanctions become impractical as they fail to protect the target population and this gives formula milk companies liberty to market and sell their milk indiscriminately.

Documentation of the truth about breastfeeding and infant formulas using this movie has proven important to support mothers who struggle during breastfeeding. Mothers which have been supported become advocates for the right to appropriate feeding of infants and young children.. Before there no milk banks that would provide a bridge for lack of human milk because there were no but now people have started donating after experiencing the benefits of milk donation.

4.8: Poster Presentations & Conference Exhibitions

Poster presentations were made by participants on all three days of the conference. A listing and content summary of poster presentations is provided in Appendix 2.

5. CLOSING CEREMONY

6. SECOND WORLD BREASTFEEDING CONFERENCE DECLARATION/ CALL TO ACTION

The theme for the 2nd World Breastfeeding Conference 'Let's invest in Creating an Enabling Environment for Mothers and Babies' builds on the 1st World Breastfeeding Conference "Babies need mom-made NOT man-made". This Breastfeeding Conference hosted in Africa, reflected on the progress made globally, regionally and at country-level on policies and programmes to improve breastfeeding.

Today, our world is threatened by multiplied armed conflicts increasing violence, climate change, forced migrations, deepening social inequalities, and increased greed of corporations. Enabling mothers to exercise their right to give birth and breastfeed as they wish and need undoubtedly contributes foster more equal societies, prevent violence and a more suitable use of natural resources, contributing to the preservation the life on the planet. Every breastfeeding mother are important actors for change.

The Special Rapporteurs on the Right to Food and the Right to Health (November, 2016). Made the call for the recognition of breastfeeding is a human right. Taking note of public health importance of breastfeeding and the need for multi-sectoral coordination, we recognize the need to heighten efforts to advocate and sensitize all levels of society, starting with mothers and their families with accelerate efforts to build political commitment at all levels but especially at the community level in making breastfeeding the social norm.

Deeply concerned with fragmented and weak implementation of breastfeeding policies and programmes in countries which undermine the efforts being undertaken by the national governments. We are concerned that implementation and lack of understanding at an individual and community level of International Code of Marketing of Breast milk substitutes is far from satisfactory, leading to unrestricted promotional activities of the baby food manufactures.

Acknowledging that the updated guidance on infant feeding in the context of HIV for the first time harmonises the breastfeeding recommendations for women with HIV and the general population and specifically recommends counselling and support, provides an excellent opportunity to revitalise the protection, promotion and support for breastfeeding with a unified message. At the same time, availability of ARTs and support for adherence and retention for breastfeeding women living with HIV is pivotal.

Emergencies whether man-made or natural are becoming a growing concern globally.

Noting that the recent WBTi report (2016) documents that attention to infant and young child feeding in emergencies is adequate, it is important that all countries and implementers should become better aware of the Operational Guidance on Infant feeding in emergencies, build capacity related to it for emergency preparedness, response and mitigation.

We the participants of the 2nd World Breastfeeding Conference 2016 call upon all concerned to take action and prioritize the following:

1. Implement a national coordination mechanism to deliver effective Breastfeeding and infant and young children feeding plans through engagement with other sectors outside of health, especially involving mothers

2. Develop legal framework that enables mother' to breastfeed their infants wherever and whenever.

3. Develop and strengthen implementation of guidelines and tools that protect policy and programme setting, as well as research from undue commercial influence to avoid and manage conflicts of interest.

4. Create child and women friendly workspaces and strengthen systems to support working mothers and mothers returning to work or adolescent mothers returning to school.

5. Explore country level feasibility of establishing human milk banks as an intervention to reduce morbidity and mortality among neonates and reduce reliance on breast milk substitutes, especially in circumstances where women are unable to breastfeed.

6. Establish regular publically funded monitoring systems and research providing feedback on evaluation in breastfeeding and infant and young child feeding implementation, free of conflict of interests.

7. Advocate for increase budgetary allocations at national level to ensure sustained efforts, based on costing analyses on breastfeeding promotion, protection and support.

8. Allocate specific resources for breastfeeding and infant and young child feeding including maternity protection for the next 5 to 10 years to make meaningful impact on early childhood nutrition and development.

10. Raise awareness and ensure the involvement of communities in the monitoring of the Code in line with the subsequent WHO resolutions and guidance on inappropriate marketing of Breast milk substitutes

11. Ensure that all settings where mothers and young children are cared for apply the principles of Mother-Baby Friendly practices, encouraging the involvement of fathers.

12. Create demand for breastfeeding support through clear communication and social behaviour change strategies, which include the voices of mothers and communities and extend breastfeeding capacity beyond the health system.

13. Implement policies and programmes that provide the use of safe feeding options that protect and support mothers and children in special circumstance, including HIV and emergencies.

7. PARTICIPANTS

A total of 457 participants drawn from 46 countries worldwide attended the 2nd World Breastfeeding Conference. The participants represented civil society organizations, local and international NGOs, professionals and professional bodies, academia and breastfeeding advocates development partners, UN Agencies and governments. Appendix 3 provides the detailed list of participants.

Countries represented included; Australia, United Arab Emirates , Bangladesh, Belgium, Brazil, Burkina Faso, Canada, Chile, Congo, Ecuador, Eritrea, Ethiopia, France, Ghana, India, Indonesia, Kenya, Kuwait, Luxemburg, Malaysia, Malawi, Mali, Mexico, Mozambique, Namibia, Nigeria, Norway, Oman, Pakistan, Philippines, Tanzania, Uganda, United Kingdom, Vietnam, Saudi Arabia, South Korea, South Sudan, Sri Lanka, Swaziland, Sudan, Sweden, Switzerland, Vietnam, Senegal, South Africa and Zimbabwe.

8. APPENDICES

8.1: Second World Breastfeeding Conference Programme

Session and Time	08:30 - 09.00	09:00 - 09.30	09.30 - 10.00	10.00 - 10.30	10.30 - 11.00	11.00 - 11.30	11.30 - 12.00	12.00 – 12.30	12.30 - 13.00	13.00 - 14.00	14.00- 14.30	14.30 – 16.00	16.00 – 16.30	16.30 – 17.00	17.00 – 18.00	18.00 - 20.00
11th December 2016		Human rights and breastfeeding training IBFAN-GIFA/ IBFAN AFRICA Registration									**Opening Ceremony** Minister of Health, IBFAN, WHO, UNICEF, USAID, Mayor Presentation and launch of the global report of 83 country Policy/ Programs Assessments (WBTi) – IBFAN ASIA			Breastfeeding Hour Together: Community Presentations M2M		Cocktail DOH IBFAN AFRICA
12th December 2016	***Day 1 Theme: Investing in Optimal MIYCN to Impact the Present and the Future*** **Mimes/ Silent Theatre** Indonesian Breastfeeding Mothers' Association Breast feeding and Relationships	**Key Note Address 1** FHI360 Global Action Towards Nutrition Improvement: Progress, challenges and recommendations	**Plenary 1:** WHO Implementation of the United Nations Decade for Action in Nutrition	**Plenary 2:** UNICEF Breastfeeding Advocacy Initiative: Position paper, scorecard and results of the audience research	**Plenary 3:** WORLD BANK Investment framework to meet the global nutrition targets	**TEA / COFFEE BREAK**	**Plenary 4:** IIBFAN ASIA World Breastfeeding Financial Planning Tool (WBCi)	**Plenary 5:** AU/ NEPAD Cost of Hunger Study Updates	**Plenary 6:** FHI360/ FANTA Advocacy to Reduce Malnutrition Using PROFILES and Nutrition Costing	**LUNCH VISIT TO EXHIBITION AND POSTERS**		**Technical Session 1:** Enhancing integrated planning and service delivery for optimal MIYCN in the context of the SDGs **Technical Session 2:** Strengthening evidence for MIYCN programs through research, M&E **Technical Session 3:** Strengthening care and support systems through BFHI **Technical Session 4:** Public information support and advocacy for improved MIYCN campaigns **Technical Session 5:** Emergency Nutrition Response for optimal MIYCN programs **Technical Session 6:** Promoting and Supporting Breastfeeding through Human Milk Banking	**TEA / COFFEE BREAK**	**Plenary Forum 1:** IBFAN AFRICA Enhancing breastfeeding rates: Progress made since 1st WBC of 2012 as well as resource and action requirements		**Cinema Event 1: TIGERS FILM** *Feature film based on the true story of former Nestle milk salesman, Syed Asmir Raza, who blew the whistle on unethical practices in Pakistan with the help of IBFAN* (Open to interested participants)

Session and Time	08:30 - 09.00	09:00 - 09.30	09.30 - 10.00	10.00 - 10.30	10.30 - 11.00	11.00 - 11.30	11.30 - 12.00	12.00 – 12.30	12.30 - 13.00	13.00 - 14.00	14.00- 14.30	14.30 – 16.00	16.00 – 16.30	16.30 – 17.00	17.00 – 18.00	18.00 - 20.00
Day 2 Theme: Women, Infants and Children's Rights to Nutrition																
13th December 2016	*Re-cap of the previous day's activities*	**Key Note Address 2:** IBFAN-GIFA Ensuring optimal MIYCN in the world of work using a Human Rights Framework	**Plenary 7:** IBFAN Innovative approaches to optimal breastfeeding for small and sick newborn babies	**Plenary 8:** FHI360 Ensuring maternity protection for all women at national level	**Plenary 9:** FAO Improving dietary intakes and nutritional status of infants and young children through improved food security and complementary feeding counselling	**TEA / COFFEE BREAK**	**Symposium 1:** Infant feeding in emergencies and epidemics Symposium to be coordinated by UNICEF **Symposium 2:** Support for breastfeeding in the labour sector Symposium to be coordinated by IBFAN-GIFA **Symposium 3:** Enhancing the right to nutrition through exclusive breastfeeding: Experiences, best practices and lessons learnt Symposium to be coordinated by USAID & FHI360 **Symposium 4:** Strengthening care & support systems for breastfeeding and nutrition of premature babies and low birth weight (LBW) babies Symposium to be coordinated by Laerdal Global Health **Symposium 5:** Promoting, Protecting and Supporting Breastfeeding through the Baby Friendly Hospital Initiative Symposium to be coordinated by UNICEF **Symposium 6:** Prevention and control of severe and chronic malnutrition Symposium to be coordinated by WHO, WFP & UNICEF				**LUNCH**	**VISIT TO EXHIBITION POSTERS**	**Technical Session 7:** Women and children's rights to maternity protection in formal and informal sectors **Technical Session 8:** Combining targeted food security actions with intensive nutrition education and BCC **Technical Session 9:** Capacity building for pre- and in-service health care workers on MIYCN **Technical Session 10:** Promoting, supporting and protecting Breast Feeding in HIV infection **Technical Session 11:** Implementation and reporting on the CODE **Technical Session 12:** Strengthening Care and Support Systems for Breastfeeding and Nutrition of Premature and Low Birth Weight Babies	**TEA / COFFEE BREAK**	**Plenary Forum 2:** WHO, UNICEF & IBFAN-ICDC Tackling noncompliance with the International Code of Marketing of Breast milk Substitutes: Assisting countries with Code legislation, monitoring and enforcement		**Special Session 1:** 2nd WBC resolution drafting committee meeting (Invited persons only) **Cinema Event 2: MILK FILM** *An artistic and intimate look at the politics of birth and infant feeding around the world* UNICEF (Open to interested participants)

Session and Time	08:30 - 09.00	09:00 - 09.30	09.30 - 10.00	10.00 - 10.30	10.30 - 11.00	11.00 - 11.30	11.30 - 12.00	12.00 – 12.30	12.30 - 13.00	13.00 - 14.00	14.00- 14.30	14.30 – 16.00	16.00 – 16.30	16.30 – 17.00	17.00 – 18.00	18.00 - 20.00
Day 3 Theme: Mother, Family and Community Support																
14th December 2016	***Re-cap of the previous day's activities***	**Keynote Address 3:** UNICEF Strengthening Community Health and Nutrition care Systems for Protection, and Promotion of Optimal MIYCN	**Plenary 10:** IBFAN Asia Conflict of Interest in nutrition research and programming: Post London meeting conflict of Interest recommendations for action at community level	**Plenary 11** IBFAN Canada Codex, trade and child health: Policy coherence between codex and WHO recommendations to protect infant and young child feeding - Implications at community level	**Plenary 11:** IBFAN UK Impact of SUN strategy of engaging business in tackling malnutrition and using market-led approaches: Implications at community level	**TEA / COFFEE BREAK**	**Symposium 7:** Induced Lactation: From Possibility to Probability Symposium to be coordinated by Health-e-Learning **Symposium 8:** Training of community health workers and members for improved and sustainable MIYCN Symposium to be coordinated by UNICEF and SPRING **Symposium 9:** Baby Friendly Community Initiatives (BFCI): Regional implementation experiences and results Symposium coordinated by IBFAN **Symposium 10:** Experiences from promotion, protection and support for optimal IYCF Symposium to be coordinated by DOH & Partners **Symposium 11:** Controlling the epidemic of childhood obesity **Symposium 12:** Conflict of interest in global nutrition research: Implications at community level Symposium to be coordinated by BPNI/ Centre for Women & Child Health, Bangladesh			**LUNCH**	**Technical Session 13:** Community management of acute malnutrition in infants and children **Technical Session 14:** Ensuring optimal child and maternal nutrition at community level **Technical Session 15:** Addressing local cultures, food beliefs and practices constraining and/or promoting MIYCN **Symposium 10:** *(Contd)*. Experiences from promotion, protection and support for optimal IYCF Coordinated by DOH & Partners **Technical Session 17:** Male and youth involvement and support for appropriate child care and development	**Closing Ceremony** **IBFAN, SACSoWACH, WFP, FAO, DOH** Presentation of summary of conference presentations and discussions Presentation and adoption of Conference **RESOLUTION**	**TEA / COFFEE BREAK**	**FREE EVENING** **DEPARTURE**

8.2: Conference Poster Presentations

8.2.1: Investing in Optimal MIYCN to Impact the Present and the Future

Presentation	Presenter	Objective	Conclusion
Sustainable Change: An ethnographic methodology to implement practice change immediately after birth	Kajsa Brimdyr, Healthy Children Project Inc. USA	To create sustainable change in implement practice change immediately after birth	Immediate skin-to-skin contact has been associated with both long-term and short-term effects on breastfeeding, and the mother-infant relationship. PRECESS has been shown to result in sustainable practice in a variety of setting for both caesarean and vaginally delivery settings.
The effects of early initiation of breastfeeding on child morbidity in Ghana; a critical analysis of 2014 demographic and health Survey	Emmanuel Ayire Adongo Ghana Health Services, Dept. of Health - GHANA	To identify the effects of early initiation of breastfeeding on child morbidity in Ghana using the Demographic and Health Survey, 2014. This survey study would help contribute to policy development on the promotion, protection, and support for exclusive and early initiation if breastfeeding in Ghana.	The study showed that early imitation of breastfeeding in Ghana is not optimal and that there are regional/ zonal variations rural/urban difference is negligible. Late initiation results in increased risk for cough in Ghanaian children. The observations underpin the need to appreciate the understanding of societal beliefs around breastfeeding practices especially in the period following child birth and to develop evidence based interventions to target the problem of late initiation of breastfeeding.
Implementing the WBTi: The United States begins the Journey	Karin Cadwell Centre for Breastfeeding USA	Developed by IBFAN Asia to provide a platform for the assessment of achievement and progress toward the goals of Global Strategy.	The USA does not have a national IYCF policy that has been officially adopted or approved by the government. The USBC links effectively with professional organisations, mother to mother support and advocacy organisations, state and local breastfeeding coalitions and federal state governmental bodies. The USA has a robust BFHI with more than10% of hospitals designated and 18% of babies born in designated hospitals. None the less, there has been no comprehensive action taken to implement the International Code of Marketing of Breast milk Substitutes and Subsequent Resolutions.
Implementation of the Human Milk Banking in KwaZulu-Natal Province	Ronal Sorgenfrei, KZN – Dept. of Health SOUTH AFRICA	To share experience of the KwaZulu Natal Dep't of Health in scaling up human milk banking focusing on the public health sector plans to establish a HMB in each of the 11-health district s of the province.	8 central HMBs in 7 districts and 5 satellites have been established in the province. Pasteurised donor milk is mainly used by facilities in NICU's. the scale required a focused and sustained intervention over years. The KZN DoH has provided vulnerable infants with an opportunity for a better start in life.
Employing the mobile platform to facilitate data management for Maternal Infant and Young Child Nutrition program evaluation:	Tumuhameho Andrew, World Vision UGANDA	To determine the feasibility and advantages of using electronic mobile data collection methods for evaluation of an integrated maternal and child health program.	The electronic data collection system provided automated question sequences, skip patterns and field validity, reduced on data entry time. This resulted into timely analysis and preparation of evaluation reports. In presence of adequate technical support, electronic data capture can be a plausible option that can save time and

Presentation	Presenter	Objective	Conclusion
Experience from World Vision funded project in Kitgum district, Uganda			improve the quality of program evaluation reports.
Comparison of Growth and Development Parameters between exclusively and partially breast fed children in the fifth month	Elamin O. Sidahmed, University of Sudan SUDAN	To compare the growth of exclusively and partially breastfed infants from birth to 6 months of life.	Exclusively breastfed infants start gaining weight slowly in the first 3 months, they finally catch up with partially breastfed infants after the fifth month. The body composition is the determining factor. The formula fed infants, store relatively higher percentage of fat(adiposity) which might appear as better weight gain but finally expose the infant to obesity, diabetes and cardiac problems in his or her adulthood.
Distinct Patterns in Human breast milk Microbiota and Fatty Acids Profiles core in healthy women from Europe, Asia And Africa	Elloise du Toit, University of Cape Town-SOUTH AFRICA	To identify the impact of four different geographical locations: Asia, Africa, North and South America on breast milk composition. Focused on the microbiome and fatty acid composition and impact of mode of delivery on breast milk composition across those locations.	Breast milk fatty acid and microbiota profile change between mothers in different countries. The impact of mode of delivery on breastmilk microbiota was apparent in all countries, and the impact on the fatty acid composition varied between the countries. There are distinct association between fatty acid composition and individual microbiota in breastmilk, suggesting an important role of lipids in the shaping the microbial profile. Further analysis (larger sample size and 165 sequencing) will allow for a better understanding of the breast milk microbiota and how changes in these profiles are associated.
Experiences from an integrated services delivery approach for improving infant and young child feeding in Mucwini and Lagoro sub-counties, Kitgum district, Uganda	Irene Mbugua, World Vision UGANDA		
ProPAN ASSESSMENT- Viwandani Slums: Nairobi Kenya	Luara Kiige, UNICEF- KENYA	To identify the problems related to breastfeeding and complementary feeding within Viwandani slums; define context in which these problems occur, barriers and facilitators of improved or “ideal” practices: formulating, testing and selecting behaviour - change.	ProPAN provides a comprehensive tool for capturing multi-faced factors that influence infant and young child feeding practises below age 2. It provides a more holistic approach to identifying barriers and facilitators of ideal practices in slums in order to address identified gaps.

8.2.2: *Women, Infants and Children's Rights to Nutrition*

Presentation	Presenter	Objective	Conclusions
Effectiveness of the Mentor Mother Model in promoting exclusive breastfeeding	Nomonde Ngada Mothers to Mothers SOUTH AFRICA	To demonstrate the effectiveness of the Mentor Mothers Model to successfully promote and support exclusive breastfeeding.	The Mentor Mother Model contributes positively in promoting exclusive breastfeeding at community level.
Factors Negatively Affecting Effective Infant and Young Child Feeding in Edati Local Government Area of Niger State Nigeria	Florence Oni UNICEF NIGERIA	To assess the current IYCF practices at household level and care giver characteristics that influence IYCF Behaviours. To determine current IYCF social and traditional norms and practices. To determine and recommend interventions and appropriate message concepts to address identified IYCF practice gaps.	Poor knowledge on appropriate IYCF practices, not believing that recommended practices are good and cultural practices are the main determinant of poor IYCF. Poverty could be a major determinant of poor complementary feeding.
Promoting breastfeeding in workplaces: Experiences with the Crèche at the University of Port Harcourt Teaching Hospital	Gracia Eke and Nte Alice University of Port Harcourt Teaching Hospital NIGERIA	To share the experience with the use of the Crèche by health workers at UPTH, Nigeria.	Provision of crèche alone is insufficient to promote and support optimal IYCF practices among working women. User education and support for optimal IYCF practices are also required. Access to Crèche services in all shifts and all days should be guaranteed. Improved record keeping is required. A purpose- built Crèche sited as close as possible to the wards is required to encourage its use especially at night. User fees introduction may improve the quality of service and its utilisation.
Findings of Countrywide Post-Orientation Dissemination on Breast Milk Substitute Act: Recent Observations from Bangladesh	Syeda Mahsina Akter Bangladesh Breastfeeding Foundation BANFGLADESH	To create awareness among country wide health-care professionals, stakeholders and civil societies on the BMS Act (2013) in Bangladesh	Since the post-evaluation score of the orientation program on BMS Act evidenced to be useful in increasing the level of participant's knowledge considerably, it deemed necessary to repeat it at regular basis to make people aware on implementing BMS Acts 2013.
Evaluating the 10 steps towards to successful breastfeeding regarding knowledge, attitudes, clinical skills and level of mothers satisfaction in a Obstetric ward in Cuenca - Ecuador 2015	Guillén Bayron Hospital Del Rio ECUADOR	To address the most common practices regarding breastfeeding of health personnel members in order to accomplish the stated policies that pursuit the 10 steps for a successful breastfeeding including its promotion in post-delivery mothers hospitalised at the obstetrics service in Vicente Corral Moscoso Hospital, 2015	Factors such as years of experience and the type of health member did not have any significant statistical relation with knowledge, attitudes and clinical skills.
Promotion of breast milk substitutes and commercially produced	Elhadji Issakha Diop Helen Keller	To assess the prevalence of point of sale promotion of breastmilk substitutes(BMS)	Whilst Manufactures should take responsibility for compliance with national regulations, strengthening legislation in Senegal to cover International Code

Presentation	Presenter	Objective	Conclusions
complementary foods in Senegal and Tanzania	International SENEGAL	including infant formulas, follow-up formula and growing up milks as well as commercially produced foods sold in Dakar, Senegal and Dar es Sallam, Tanzania.	provisions and subsequent resolutions including the new World Health Assembly Resolution 69.9 is warranted to prevent promotion that undermines optimal infant and young child feeding.
Risk factors for severe acute malnutrition in infants <6 months old in semi-urban Bangladesh: a prospective cohort study to inform future assessment/treatment tools	Nichola Connell Save the Children UNITED KINGDOM	To inform the development of assessment tools and treatment approaches for severe acute malnutrition(SAM) in INFANTS aged < 6 months	A range of risk factors are clearly associated with SAM among infants < 6m. successful future treatments should focus on a package of care, rather than single interventions. Breastfeeding support is likely to be an important but not an exclusive component of a package of care, as is support for mothers/carers needs to improve future outcomes. It is recommended that the vulnerability of infants is assessed using identified risk factors, rather than just compromised anthropometry.
The effect of oil massage vs kangaroo mother care on changes in the physiological and neurobehavioral parameters among Low Birth Weight babies	Abhilekha Biswal PG College of Nursing Hospital INDIA	To assess and compare the effect of oil message and KMC on the physiological and neurobehavioral parameters among LBW babies	The effect of oil massage and KMC together was found more significant in improving physiological and neurobehavioral parameters of LBW babies as compared with only oil massage, KMC and control groups.
Impact of on-site participatory training on Infant & Young Child Feeding and Hygiene Practices among the Health Care Service Providers in fifty selected clinics of Smiling Sun Network in Bangladesh	Syeda Mahsina Akter Bangladesh Breastfeeding Foundation (BBF) BANGLADESH	To determine the outcome of this training program in 50 Smiling SUN Network(SUN) Clinics on IYCF practices following global IYCF on time.	A significant increment in the knowledge of the trainee health care providers(HCP) was observed. The findings attest that such training on IYCF and hygienic practices was efficient and crucially-important for the improvement of knowledge and skills of the HCP.

8.2.3: Mother, Family and Community Support

Presentation	Presenter	Objective	Conclusion
Involvement of community volunteers in mobilization and conducting home visits for improved maternal, infant and young child nutrition: The experience from World Vision funded project in Kitgum district, Uganda	Andrew Tumuhameho World Vision UGANDA	To share experiences of Involvement of community volunteers in mobilization and conducting home visits for improved maternal, infant and young child nutrition	Community members of the district local government have been involved at all levels of planning with continuous feedback on activities. VHTs were selected from target communities, trained and mentored on weekly basis on the assumption that this can make them knowledgeable on maternal and child health care. Project closure processes have been gradually manged from parish level to sub county and district level to ensure smooth transition of the EAMNeCH role to the KDLG and VHTs.

Presentation	Presenter	Objective	Conclusion
Strengthen capacity for minority community in Cao Bang province for maternal, infant and young child nutrition	Nguyen Thi Bich Van Center for Public Health and Community Development - VIETNAM	To strengthen the capacity of minority mothers and her family for maternal, infant and young child nutrition.	The project changed the perception of health workers and mother on maternal, infant and young child nutrition, thereby optimal supporting of mothers.
Baby Friendly Community Initiative: Lessons learnt from implementing community support groups in Kenya	Justine Kavle PATH USA	To gain an understanding of BFCI To share how country-level actions and inclusion of key influential members of community aide in the implementation of BFCI To share lessons learnt and opportunities of BFCI programming.	Implementation of BFHI is a promising platform to improve IYCF with community engagement. Requires a multi-sectoral approach. Integration of MIYCN into health services is key. Involvement of men and grandmothers is important for uptake CSGs and M2MSGs are essential in improving the knowledge and skills of mothers and caregivers on MIYCN CSGs and M2MSGs improve health seeking behaviour e.g. increased ANC attendance. MCSP will be documenting rollout and implementation of BFCI, including a Baby Friendly resource centre, supportive supervision, monitoring, and assessment of infant and young child feeding practices.
Determinants of Infant and Young Child Feeding Practices among children 0-23 months of age in Gorakhpur	Prof K.P. Kuchwaha/ Neelima Thakur Breastfeeding Promotion Network of India - INDIA	To assess the status of IYCF practice using standard IYCF indicators.	The performance of IYCF practices was not satisfactory in the present study. The quality of knowledge and support to mothers has a crucial role in success of IYCF practices. Thus, mothers along with family members should be educated about IYCF practices and its role in maintenance of the child health. It is needed to improve counselling strategies to motivate people regarding education and encourage hospital deliveries.
Challenges with the process of conducting a systematic review of reviews to identify effective community based interventions to inform the breastfeeding action plan for South Africa	Belinda Kehlar North West University SOUTH AFRICA	To highlight the challenges that arose while conducting a systematic review of reviews regarding effective breastfeeding interventions in the home, family and community setting in low and middle-income countries, as well as to advise solutions to these challenges.	Challenges that arise during the process of conducting a systematic review of reviews should be addressed with methodological rigor and expert methodological advice in order to ensure a successful result. Countries should invest in capacity development and commission systematic reviews for researchers to gain skills and experience in conducting systematic reviews.
Strengthening Infant and Young Child Feeding counselling and support: Experiences from the Northern Cape, South Africa	Christel de Lange Department of Health – North Cape - SOUTH AFRICA	To strengthen capacity for minority mothers and her family for maternal, infant and young child nutrition.	The project has changed the perception of health workers and mothers om maternal, infant and young child nutrition, thereby optimal supporting mothers.
Findings from the study of current knowledge, Attitude and Practices, best communication channel to	Thompson Kobata Chimay Federal Ministry of Health NIGERIA	To determine Garki Ward exclusive breastfeeding rate and utilise findings to institute health and nutrition interventions in	91% knowledge of the importance of EBF did not translate to optimal NIYCF practices in Garki ward.

Presentation	Presenter	Objective	Conclusion
improve the behavioural practices of Garki Ward on exclusive breastfeeding and nutrition interventions in health facilities and Communities in Nigeria		health facilities and communities in Nigeria.	
"KwaZulu-Natal Initiative for Breastfeeding Support Project Baseline Survey Results"	Lenore Spies KZN DoH SOUTH AFRICA	To investigate breastfeeding practices at 14 weeks of age (91-111 days) in all districts in KwaZulu Natal. The baseline would be used to evaluate whether the broad range of interventions in the province to promote and support breastfeeding has impacted exclusive breastfeeding rates.	The KIBS project baseline survey has shown an exclusive breastfeeding rate of 45.1% at 14 weeks. Highlighted areas of action to be taken to ensure that further advances can be achieved to protect, support and support breastfeeding in KZN Province in an effort to continue impact heath outcomes.
Assessment of Ready- Made Garment Factories in Bangladesh and their readiness to support breastfeeding in the workplace.	Mayang Sari, UNICEF Bangladesh	The baselines assessment gathered data on; • The structural readiness of RMG factories to support breastfeeding • The knowledge and practices of healthcare/ day-care providers in selected factories. • Changes in performance among working women • The utilization, practice and satisfaction of the users • Early initiation and exclusive breastfeeding and timely introduction of complementary feeding practices.	While support for working mothers to breastfeed is available at RMG factories, the level of readiness and practices varies: Better oversight and enforcement is critical in partnership with factory management. There are no standards at factories need to uphold in providing workplace support for women- A set of common standard are needed. There are gaps in knowledge among factory managers and health care providers on the standards and regulation to support breastfeeding in the workplace. Orientation, training and communication materials are needed.
Effect of a Pro-breasting intervention on the maintenance of breastfeeding for 2 years or more: A randomised clinical trial adolescent mothers and ground mothers.	Elisa Regina Justo Giuliani, Cistiano Francisco da Silva, Leandro Meirelles Nunes, Renata Schwartz (School of Medicine, Unversidade Federal do Rio Grande do Sul-Porto Alegre, RS, Brazil)	To access whether the positive effects of a pro-breasting intervention aimed at adolescent mothers and maternal grandmother son the prevalence of breastfeeding observed in the first year of life were maintained at 2 years of children's age.	The positive impact on the presence of breastfeeding observed in the first year of life was not maintained at 2 years of age. Possible explanation for this are: long interval between the intervention and the outcome; the contents of the intervention may not have contemplated the peculiarities of adolescent mothers; some determinants of the maintenance of breastfeeding for 2 years or more differ from those of breastfeeding in the first year.

8.3: Participants' List

PARTICIPANTS: BREASTFEEDING AND HUMAN RIGHTS TRAINING

NO.	NAME	ORGANIZATION	COUNTRY	EMAIL ADDRESS	CPD/CEU NO.
1	Brooke Bauer	Nurture Project International	USA	brooke@nurtureprojectinternational.org	NA
2	Mona Alsumaie	MoH and IBFAN Arab world,	Kuwait	m.alsumaie@gmail.com	NA
3	Alfred Zerfas	Public Health	Australia	azerfas@gmail.com	NA
4	Rehema Mzimbiri	Department of Nutrition Education and Training / Tanzania Food and Nutrition Centre Dar es Salaam,	Tanzania	rmzimbiri@gmail.com	NA
5	Esmeralda Vilanculos	University of the Witwatersrand	South Africa	esmevilanculos@gmail.com	NA
6	Nalukenge Mariam	The Diet Clinic	Uganda	marnaluks@gmail.com	NA
7	Esther Joanita Naluguza	Elizabeth Glaser Pediatric Aids Foundation	Uganda	enimwesiga@gmail.com	NA
8	Mohammad Abdul Mannan	FAO	Bangladesh	abdul.mannan@fao.org	NA
9	Lutgard Musiime	UGAN	Uganda	musiimelutgard@gmail.com	NA
10	Eva Rose Namulumba	IBFAN AFRICA	Swaziland	enamulumba@yahoo.com	NA
11	Florence Oni	UNICEF	Nigeria	foni@unicef.org	NA
12	Kwanele Siyabonga Simelane	Swaziland Infant Nutrition Action Network	Swaziland	kwasiyas@gmail.com	NA
13	Sofia Rubertsson	Philani Maternal, Child Health and Nutrition Project	South Africa	sofiarubertsson@hotmail.com	NA
14	Thembekile Dhlamini	Elizabeth Ross Hospital - Free State Health,	South Africa	thembekile@galmail.co.za	DT0034711
15	Christel De Lange	Department of Health Northern Cape	South Africa	christeldl70@gmail.com	DT0013994
16	Portia Mageza Sambo	Department of Health	South Africa	psambo@yahoo.co.uk	DT0021563
17	Nomonde Ngada	Mothers2Mothers	South Africa	nomonde.ngada@m2m.org	NA
18	Jenny Wright	Human Milk Bank	South Africa	jenny@milkmatters.org	NA
19	Lenore Spies	KwaZulu-Natal Department of Health	South Africa	lenore.spies@kznhealth.gov.za	DT0002712
20	Sogo France Matlala	University of Limpopo	South Africa	France.Matlala@ul.ac.za	NA
21	Pumza Ngcingwana	FHI360, South Africa	South Africa	pumzangcingwana@gmail.com	NT0000779
22	Hellen Kgatla	Department of Health	South Africa	kgatlahellen@yahoo.com	NT0001040
23	Siduduzo Myza	FHI360	South Africa	smyeza@fhi360.org	DT0019356
24	Surina Enslin	FHI 360	South Africa	surina.barnardt@gmail.com /senslin@360.org	DT0027855
25	Chantell Witten	North West University	South Africa	Chantell.Witten@nwu.ac.za	DT0011568
26	Hlamalani Mabasa	Private	South Africa	hlamalani.mabasa@gmail.com	DT0013064
27	Shibe Selina Nailana	Department of Health	South Africa	hunadila@webmail.co.za	DT0036277
28	Ntombizanele Dididza Maganga	St. Barnabas Hospital	South Africa	zanelemaganga@gmail.com	DT0010693
29	Sayeda Sumaiya Islam	Bangladesh Breastfeeding Foundation	Bangladesh	sumaiyanice512@gmail.com	NA
30	Abhilekha Biswal	P.G College of Nursing Hospital	India	pgcon_bhilai@yahoo.co.in	NA
31	Michele Griwold	International Lactation Consultant Association	USA	michelegriswold@ilca.org	NA
32	Monene Grysel Mugashoa	W.F Nobel Hospital	South Africa	mampe@webmail.co.za	DT0023817
33	Micheal Mabasa	Private	South Africa	mabasaxm@gmail.com	PT 0052396
34	Manal Khorshed	MOH	Saudi Arabia	manalkhorsheed@gmail.com	01-R-M-5684
35	Anouk Jolin	Mothers Support Group	Sweden	anouk333@yahoo.fr/anouk.jolin@amningshjalpen.se	NA
36	Jacobus Coenie Louw	Advocacy and Direct service	South Africa	louwc@gatewayhealthinstitute.org	MP0395889

37	Tshifniwa Mashamba	Department of Health	South Africa	dengaM4@gmail.com	DT0016365
38	Nomonde Motsoeneng	Department of Health	South Africa	NomondeMotsoeneng@gauteng.gov,za	DT0013188
39	Siniketiwe Zwane-Mdaka	Swaziland National Nutrition Council	Swaziland	siniketiwe@gmail.com	NA
40	Modowa Kadeshe Mudiwah	International Lactation Consultant Association	USA	mkadeshe@dcbfc.org	NA
41	G.A.D Wimalawathie Ranatunga	IBFAN -Sarvodaya Womens Movement	SRI LANKEN	wimalasarvodaya@gmail.com	NA
42	Ousman Dem	MoHSIO	Gambia	ousmandem@yahoo.co.uk	NA
43	Aminata Sarr	UNICEF	Gambia	kollensarr@hotmail.com, asarr@unicef.org	NA
44	Malang N Fofana	NaNA	Gambia	kekendoo@yahoo.com	NA
45	Dexter Chawgena	MoHCC and Nutri@ctive	Zimbabwe	tungadex@gamil.com	NA
46	Tshameleni Sandra Mathebula	DoH	South Africa	Sandra.mathebula@echealth.gov.za	DT0027693
47	Shiko Andrew Mokgokone	DoH	South Africa	shikosa@gmail.com	DT0031763
48	Marion Beefarth	University of Pretoria	South Africa	B4th@boost.co.za	DT0007153
48	Maphaha Matodzi	DOH	South Africa	mutshidzim@gmail.com	NT0001066
50	Julian Moyahabo Motsopye	DOH	South Africa	jullianotsopye@gmail.com	DT0045802
51	Taghreed Hawsawi	King Faisal Specialist Hospital and Research Centre/ Jeddah	South Africa	tmhawsawi_s@hotmail.com	NA
52	Samah Soliman	Dr. Soliman Fakeeh Hospital	South Africa	mouha76@hotmail.com	NA
53	Al-Bandri Abdurahman Abonayan	MOH-Nutrition Department/ Breastfeeding program	South Africa	bandrio4@hotmail.com/ abonayyan-b@moh.gov.sa	NA
54	Eman Al-Zayed	MOH	Saudi Arabia	eman2075@yahoo.com	NA
55	Salma Harawn Abdel Magid	DHA	UAE Dubai	fleewa@hotmail.com	NA
56	Faiza Aljafer	NGHA	Saudi Arabia	Drfaiza88@hotmail.com	NA
57	Thakabasali Nkabane	NGO	South Africa/ USA	tnkabane@hotmail.com	NA
58	Ana Fravley		USA	apfrawgalies@gmail.com	NA
59	Leah Margulies	IBFAN	USA	kahmargulies@gmail.com	NA
60	Okoro Clementina Ebeere	FCT Primary Health Care	Nigeria	eberecee@gmail.com	NA
61	Heather Sedibe	University of Pretoria	South Africa	sedibemh@gmail.com	DT0018546
62	Nomulungelo Dlamini	University of Swaziland	Swaziland	nomulungelodlamini92@gmail.com	NA
63	Andile Nkonta	University of Swaziland	Swaziland	andymhlungwane@gmail.com	NA
64	Pamela Munjoma	FHI360	South Africa	pmunjoma@fh360.org	NA
65	Asha Hassan Salmin	MOH	Tanzania	asalmin208@gmail.com	NA
66	Cebile Ndwandwe	FHI360	South Africa	cndwandwe@fhi360.org	NA
67	Belinda Liana	Counsenuth	Tanzania	belindaliana@yahoo.co.uk	NA
68	Khanyisile Xulu	FHI360	South Africa	kxulu@fhi360.org	DT 0027413
69	Esnart Phiri	UNICEF	Malawi	ephiri@unicef.org	NA
70	Slyvester Kathumba	MOH	Malawi	kathumbaslyvester@gmail.com	NA
71	Fredda Mashilo	DoH	South Africa	freddahmashilo@gmail.com	RT0012157
72	Kholofeio Ramalepe	DOH	South Africa	gloriar@webmail.co.za	DT0029874
73	Kwena Yvonne Seanego	DOH	South Africa	ymanaka@webmail.co.za	DT0022705
74	Samalie Namukose Bananuka	MOH	Uganda	snamukoseb@yahoo.com	NA
75	Tabley Bakyaita	MOH	Uganda	Tabs2x2@gmail.com	NA
76	Ramosedi Mashala	Student	South Africa	ramashala@gmail.com	DT0028738
77	Gabriel Ganvaglo	Korle Bu Teaching Hospital	Ghana	gganyaglo@hotmail.com	NA
78	Paola Gaete	UNIVERSIDAD DE CHILE	Chile	pgaete@med.uchile.cl	NA
79	Issac O Koranteng	KORLE-BU Teaching Hospital	Ghana	Iaicd@yahoo.com	MDC/RN/04768

80	Charles F. Mazinga	Catholic Relief Services	Tanzania	Charlesmazinga@gmail.com	UD33825NU42402
81	Lizelle Payne	North West University	South Africa	lizelle25payne@gmail.com	DT0023442
82	Thandi Xaba	DOH	South Africa	thandimadlala@kznhealth.gov,za	DT0021626
83	Frederick Asare	ESOKO	Ghana	fredrick@esoko.com	NA
84	Rosin Stefanie	ELACTA	Germany	stefanierosin@gmx.de	NA
85	Matamela Makonsoza	University of the Witwatersrand	South Africa	makongozam@gmail.com	NA
86	Leana Habeck	IBLCE	South Africa	Leana.habeck@gmail.com	C-14440
87	Wafaa Falata	King abdulaziz medical city national guard	Saudi Arabia	fallatahwafa@gmail.com	05-R-M-4523
88	wafa Mega	Ministry of health	Saudi Arabia	fofi-1@hotmail.com	11-R-A-0036105
89	Nivin Youssef	IIUM	Malyasia	ne_youssef@hotmail.com	Malaysia63208/L36855
90	Asma Hawsawi	MCH	Saudi Arabia	Dr.anus09@hotmail.com	SCFHS-O3-r-m13849/L-41223
91	Nomajoni Ntombela	FHI360	South Africa	mtombela@fhi360.org	NA
92	Mohammad Abdul Mannan	FAO	Bangladesh	abdul.mannan@fao.org	NA
93	Seanego Kwena	DOH	South Africa	ymanaka@webmail.co.za	DT0022705
94	Portia Mageza	DOH	South Africa	psambo@yahoo.co.uk	NA
95	Marina Rea	IBFAN	Brazil	marifrea@usp.br	NA
96	Gofaone Jessica Mosweu	university of Witwatersrand	South Africa	gofaonemosweu@yahoo.com	
97	Kathryn Watt	University of the Witwatersrand	South Africa	kathryn.watt@wits.ac.za	
98	Patricia Martin-Wiesner	University of the Witwatersrand	South Africa	patricia@advocacyaid.com	
99	Linda P Siziba	North-West University	South Africa	sizibalinda@gmail.com	
100	Elloise du Toit	University of Cape Town	South Africa	elloisedutoit@gmail.com	
101	Chenoel Kelly	University of Witwatersrand	South Africa	chenoel.kelly@gmail.com	
102	Cynthia Ncube	University of Witwatersrand	South Africa		
	TRAINERS				
1	Camille Selleger	IBFAN GIFA	Switzerland		
2	Alice Nte	University of Uniport, Nigeria	Nigeria	Alice.nte@uniportedu.org	F12,151