Functional Series 200 – Programming Policy
Chapter 212 – Breastfeeding Promotion Policy

***This is a new ADS chapter.**

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212.1 OVERVIEW

Effective Date: 01/04/2002

a. Objective

The objectives of this chapter are to

- Define USAID policy and responsibilities related to breastfeeding,
- Provide references to updated guidance on best breastfeeding practices and breastfeeding program support approaches for USAID strategic objective areas, and
- Address breastfeeding programming as related to mother-to-child-transmission (MTCT) of HIV/AIDS and other infectious disease.

b. Overview

The goal of USAID-supported breastfeeding activities is to increase the percentage of infants that are immediately and exclusively breastfed, that receive appropriate complementary foods in addition to breastfeeding from six months, and that continue breastfeeding for two years or longer.

In 1990, the United States recognized the importance of breastfeeding by signing the **Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding**. The Innocenti Declaration calls on all governments to implement the **World Health Organization (WHO) International Code of Marketing of Breast-milk Substitutes** adopted in 1981 by the World Health Assembly.

Research has conclusively documented the very positive and cost-effective impact of breastfeeding on child survival, birth spacing, and aspects of maternal health. Breastfeeding provides low cost, high quality food for infants and young children and improves their health, immune system, and nutritional status, resulting in a multi-fold increase in survival. Breastfeeding lowers family expenditures for food and health care; improves micronutrient and protein/energy status, thus increasing productivity; contributes to fertility reduction; and is the safest form of young child feeding in emergency and disaster situations. Breastfeeding also is environmentally friendly, reducing the need for firewood to prepare **breastmilk substitutes**, as well as reducing pharmaceutical, plastics, and dairy industry waste. The workplace benefits because there are fewer absences due to family illness when children are breastfed.

212.2 PRIMARY RESPONSIBILITIES

Effective Date: 01/04/2002

a. Program managers in all sectors of USAID/W and in field missions are responsible for integrating breastfeeding promotion into broader health and related strategies as appropriate.

b. The USAID Mission Director is responsible for ensuring that the programs implemented through his/her mission conform to USAID's policy on breastfeeding.

c. The Bureau for Policy and Program Coordination, Office of Policy Development and Coordination (PPC/PDC) is responsible for overall compliance and reporting as needed.

d. The Bureau for Global Health, Office of Health and Nutrition breastfeeding experts are responsible for providing detailed guidance, technical assistance, and field support to Missions and other Bureaus as needed to reinforce the support, promotion, and protection of **optimal breastfeeding**.

212.3 POLICY DIRECTIVES AND REQUIRED PROCEDURES

Effective Date: 01/04/2002

212.3.1 Current Accepted Norms Concerning Optimal Breastfeeding

Effective Date: 01/04/2002

The pattern of breastfeeding that is associated with the best health outcomes is **exclusive breastfeeding** for the first six months of life, with continued breastfeeding and appropriate **complementary feeding** for two years or more. Adequate maternal nutrition is necessary to support breastfeeding. Breastfeeding should be initiated immediately postpartum. This pattern is sometimes referred to as optimal infant feeding, or the "Gold Standard."

Due to its nutritional value and immune-system boosting properties, USAID supports breastfeeding as the best staple in infant and young child feeding, especially in countries where infectious diseases continue to be the leading cause of mortality among children under five years of age.

The risk of mother-to-child-transmission (MTCT) of HIV/AIDS must be weighed against the risk of increased death and illness that occurs in the absence of breastfeeding. Of children born to HIV positive mothers, 14-36 percent will be infected with HIV -- approximately 20 percent through pregnancy and delivery, and 14 percent through breastfeeding. In some settings, non-HIV infant mortality will be 10-20 percent if the mother does NOT breastfeed. Therefore, decisions on infant feeding must be based on local circumstances, within the framework of informed choice and confidentiality.

Recent international conferences, including the WHO Technical Consultation in Geneva in October 2000 and the 28th session of UN Administrative Committee on Coordination

Sub-committee on Nutrition (ACC/SCN), have concluded that breastfeeding remains the best source of nutrition for the great majority of infants and should continue to be promoted and supported among mothers who are not known to be HIV-infected. They have also recommended that, when considering infant feeding options for mothers who test positive for HIV, **replacement feeding (RF)** (nutritionally complete breastmilk substitutes) should be considered only if acceptable, feasible, affordable, sustainable, and safe. Other international health documents stress that, in areas of high infectious disease burden, the accessibility, affordability, and services of the health care systems must be of sufficient quality to adequately address the increase in disease associated with less-than-optimal breastfeeding.

212.3.2 Agency Policies

Effective Date: 01/04/2002

a. USAID promotes optimal breastfeeding in programs that

- Address health and nutrition,
- Include MTCT, especially those that include voluntary counseling and testing (VCT), or offer counseling that includes other feeding options,
- Target infants and young children and/or women of reproductive age, and
- Might influence maternal and child behaviors.

b. In general practice, no USAID funds will be used to purchase or transport breastmilk substitutes or related materials such as baby bottles or nipples/teats.

c. If an exception is deemed necessary to increase child survival, or to support research that conforms with USAID policy on human subjects research (**22 CFR 225** as implemented), the USAID unit that agrees to fund the purchase or transport of breastmilk substitutes, replacement foods and related materials must

(1) Offer them in a context in which optimal breastfeeding is also supported (see Definitions, **212.6**),

(2) Notify PPC/PDC that an exception is necessary (see Mandatory Reference **Guidelines for Documenting Exceptions**).

(3) Document and keep on file

(a) The basis of the determination that the use of replacements could result in increased overall child survival,

(b) Steps taken to comply with the WHO International Code of Marketing of Breast-milk Substitutes as outlined in the Additional Help

document, **Cross-Sectoral Implementation Guidance for ADS 212: "Breastfeeding Promotion Policy"**, and

(c) Steps taken to ensure that breastmilk substitutes can be used safely, that preparation is affordable, and that substitutes will be properly prepared and given.

(4) If there is evidence of non-compliance with the above policies, both notify PPC/PDC and seek technical input from GH, or terminate funding.

212.4 MANDATORY REFERENCES

Effective Date: 01/04/2002

212.4.1 External Mandatory References

Effective Date: 01/04/2002

a. **22 CFR 225, as implemented, Protection of Human Subjects**

212.4.2 Internal Mandatory References

Effective Date: 01/04/2002

a. **Guidelines for Documenting Exceptions to ADS 212.3.2**

212.5 ADDITIONAL HELP

Effective Date: 01/04/2002

a. **Breastfeeding - USAID Background Paper, 2001**

b. **USAID Commodity Reference Guide, 1998 Edition, Guidelines for the Office of Food for Peace**

c. **Cross-Sectoral Implementation Guidance for ADS 212: "Breastfeeding Promotion Policy", 2001, developed by the Bureau for Global Health (USAID/GH)**

d. **Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding, 1990**

e. Internet websites of **USAID**, **World Health Organization (WHO)**, and **UNICEF**.

f. **Ten Steps to Successful Breastfeeding**

g. **UNAIDS/WHO/UNICEF HIV and Infant Feeding: Guidelines for decision-makers, 1998, "WHO Technical Consultation, New Data on the Prevention of MTCT of HIV and the policy implications: Conclusions and Recommendations, Geneva 11-13 October 2000" or update**

h. **World Health Organization (WHO) International Code of Marketing of Breast-milk Substitutes**

212.6 DEFINITIONS

Effective Date: 01/04/2002

The terms and definitions listed below have been incorporated into the ADS Glossary. See the **ADS Glossary** for all ADS terms and definitions.

breastmilk substitutes
Foods or liquids used as substitutes for breastfeeding, including use of powdered or liquid milks or formula, wet-nurses, etc. This does not include therapeutic formulas used under medical supervision. (Chapter 212)

complementary feeding
The appropriate addition of other foods while continuing breastfeeding, starting at about six months. (Note: Other foods given during breastfeeding prior to this time are considered "supplementary.") (Chapter 212)

exclusive breastfeeding
The infant has received only breastmilk from his/her mother, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines. (Chapter 212)

exclusive breastmilk feeding
May receive expressed breastmilk, in addition to breastfeeding. (Chapter 212)

optimal breastfeeding
Exclusive breastfeeding for the first six months of life, with continued breastfeeding and appropriate complementary feeding for two years or more. Breastfeeding should be initiated immediately postpartum. (Support of adequate maternal nutrition is an important part of breastfeeding support.) (Chapter 212)

replacement feeding (RF)
Breastmilk substitutes that provide all the nutrients the child needs. This would not include breastmilk substitutes such as powdered milks or animal milks. (Chapter 212)

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