ADS Chapter 212

Breastfeeding Promotion

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

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 the Human Immunodeficiency Virus (HIV) and other infectious diseases.

b. Overview

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

In 1990, the United States Government (USG) 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 established the positive and cost-effective impact of breastfeeding on child survival, birth spacing, and maternal health. Breastfeeding provides low-cost, high-quality food for infants and young children, improving their nutritional status, immune response, health, and survival, especially in places where the infant and child morbidity and mortality rates are high. Breastfeeding improves micronutrient, protein, and energy status and promotes growth and development, all of which lead to later gains in academic performance and adult productivity. Breastfeeding contributes substantially to child spacing, and it is the safest form of young child feeding in emergency and disaster situations. Breastfeeding lowers family expenditures for food and health care.

212.2 PRIMARY RESPONSIBILITIES

Effective Date: 09/12/2011

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

b. USAID Mission Directors are responsible for ensuring that the programs implemented through their Missions conform to USAID's policy on breastfeeding.

c. The Bureau for Global Health (GH) infant and young child feeding (IYCF) 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

212.3.1 Current Accepted Norms Concerning Optimal Breastfeeding

Effective Date: 09/12/2011

Due to its nutritional value, immunological benefits, and effect on birth spacing, USAID supports breastfeeding as the best method of 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. In fact, analysis suggests that, among all preventive health and nutrition interventions, improved breastfeeding has the greatest potential to reduce under-five mortality – up to 13 percent (G. Jones et al., Lancet 2003; 362: 65-71).

The pattern of breastfeeding that is associated with the best health outcomes for mothers and children is exclusive breastfeeding for the first six months of life, with continued breastfeeding and timely and appropriate complementary feeding for two years or more. Adequate maternal nutrition and health are important for the breastfeeding mother. Breastfeeding should be initiated within one hour of birth.

Breastfeeding and HIV/AIDS

The WHO has called for national or sub-national health authorities to decide upon a single strategy that will most likely give infants born to HIV-positive mothers the greatest chance of HIV-free survival: (1) breastfeeding with antiretroviral (ARV) treatment or prophylaxis, or (2) avoidance of all breastfeeding and replacement feeding from birth. Health services should principally counsel and support mothers to follow the national strategy unless the mother individually chooses to opt-out.

This national decision should be based on international recommendations and consideration of the:

- Socio-economic and cultural contexts of the populations served by maternal, newborn and child health services,
- Availability and quality of health services,
- Local epidemiology including HIV prevalence among pregnant women,
- Main causes of maternal and child undernutrition, and
- Main causes of infant and child mortality.

Each year, as many as 500,000 infants are infected with HIV, the virus causing AIDS, through mother-to-child transmission (MTCT). Depending on the availability of interventions to reduce MTCT during pregnancy and delivery, HIV transmission through breastfeeding can account for 30%-60% of all MTCT in children. However, the risk of postnatal MTCT must be weighed against the substantially increased risk of morbidity and mortality if infants are not breastfed or are weaned early (i.e. replacement fed with formula or other breast milk substitutes).

Multiple studies have shown that, in resource-poor settings, there is no benefit to HIV-free survival when providing exclusive formula feeding from birth or early weaning and extended replacement feeding – any reduction in MTCT is more than offset by increases in mortality from other primary causes, especially pneumonia and diarrhea, associated with not breastfeeding. In addition, studies have shown that exclusive breastfeeding lowers the risk of MTCT in the first months of life as much as fourfold, compared to mixed feeding (breast milk plus solid foods and/or non-human milk). Public program provision of formula has often resulted in mixed feeding, not exclusive replacement feeding, with the perverse result of increased MTCT.

All women in antenatal care should be HIV-tested so they can be appropriately counseled and, if HIV-positive, enrolled in a program to prevent MTCT and provided with antiretroviral treatment or prophylaxis, as appropriate.

In countries where health services counsel and support breastfeeding as the national strategy, mothers known to be HIV-infected (and whose infants are HIV-uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first 6 months of life, introducing appropriate complementary foods thereafter, and continue breast-feeding for the first 12 months of life. Breastfeeding should then stop only when (and if) the mother can provide a nutritionally adequate and safe diet without breast milk. Recent studies have established that the risk of postnatal MTCT through breastfeeding is significantly reduced (<5%) if mothers are on Highly Active Antiretroviral Therapy (HAART) for their own health (CD4 <350) or if ARV prophylaxis is provided to mothers or infants for the duration of breastfeeding.

Every effort should be made to accelerate access to antiretroviral drugs for both maternal health and also prevention of HIV transmission to infants. While ARV interventions are being scaled up, national authorities should not be deterred from recommending that HIV-infected mothers breastfeed as the most appropriate infant feeding practice in their setting. Where breastfeeding is the national strategy, even when ARVs are not available, mothers should be counseled to exclusively breastfeed in

the first six months of life and continue breastfeeding thereafter unless environmental and social circumstances are safe for, and supportive of, replacement feeding. In circumstances where ARVs are unlikely to be available, such as acute emergencies, breastfeeding of HIV-exposed infants is also recommended to increase survival.

Even in countries that have opted for breastfeeding as the national strategy, replacement feeding may be necessary when mothers have died or are unable to breastfeed for physical or other reasons. In all such cases, support should be provided so that infants are replacement fed under the following conditions (referred to as AFASS standards—affordable, feasible, acceptable, sustainable and safe—in the WHO 2006 recommendations on HIV and infant feeding, and recommended in the 2009 WHO HIV and Infant Feeding: Revised Principles and Recommendations):

- Safe water and sanitation are assured at the household level and in the community, and,
- The mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant, and,
- The mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhea and malnutrition, and,
- The mother or caregiver can, in the first six months, exclusively give infant formula milk, and,
- The family is supportive of this practice, and,
- The mother or caregiver can access health care that offers comprehensive child health services.

HIV-infected mothers who stop breastfeeding before two years should be counseled on how to safely feed non-breastfed children 6-24 months following WHO guiding principles (see **ADS 212.5**, reference g).

Where the appropriate health authority has adopted a strategy of replacement feeding, the best option for replacement feeding in the first six months of life is a fully fortified, quality infant formula, reconstituted with sterile water (boiled, chemically treated and/or filtered) and cup fed. WHO has also recommended hand-expressed, heat-treated breast milk as an interim feeding strategy, particularly in conjunction with weaning and in the post-weaning period for as long as it can be sustained.

While USAID funds can be used to purchase or transport breast milk substitutes only in exceptional circumstances, funds can be used to aid the national strategy. For example, USAID funds can be used to support counseling, supply chain security, immunizations, oral rehydration therapy, and zinc supplements.

Breast Feeding and Family Planning

With regard to breastfeeding and family planning, the lactational amenorrhea method (LAM) is highly effective (98.5 percent) at preventing pregnancy when three conditions are met: a) a mother is exclusively or nearly exclusively breastfeeding, b) she is

amenorrheic, and c) the infant is less than 6 months of age. Studies have shown that LAM also can increase transition to use of modern contraceptive methods, while those who do not practice LAM are much more likely to become pregnant within 12 months postpartum. Promoting LAM provides an opportunity to increase contraceptive use among postpartum women and increase child spacing, as well as support healthy breastfeeding practices that benefit infants and young children, while reducing mother-to-child transmission associated with mixed feeding in the first six months of life.

212.3.2 Agency Policies

Effective Date: 09/12/2011

a. USAID promotes optimal breastfeeding in programs that

- Address maternal, neonatal, infant and young child health and nutrition, especially with child survival programs;
- Prevent mother-to-child transmission of HIV (antenatal and postnatal counseling and support);
- Promote the lactational amenorrhea method for family planning and child spacing; and
- Provide basic support for infant and young child feeding in complex emergencies.

b. As a general practice, you must not use USAID funds to purchase or transport breast milk substitutes or related materials, such as baby bottles or nipples/teats.

c. If an exception is 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 breast milk substitutes, replacement foods, and related materials must:

(1) Submit to the appropriate Regional Bureau, with clearance from the Global Health Bureau's Assistant Administrator (or his or her designee), a request for an exception to **ADS 212** (see **212maa, Guidelines for Documenting Exceptions to ADS 212.3.2**).

(2) Document and keep on file:

(a) A copy of the memorandum to the appropriate regional Bureau requesting an exception, and a record of the AID/Washington approval of the request;

(b) Steps taken to comply with the WHO International Code of Marketing of Breast Milk Substitutes, as outlined in the **Cross-Sectoral Implementation Guidance for ADS 212: Breastfeeding Promotion, 2001, developed by the Bureau for Global Health (USAID/GH);** and

(c) Steps taken to ensure that breast milk substitutes can be used safely, that preparation is affordable, and that substitutes will be properly prepared and given (i.e., meet the AFASS standards, as described above).

d. If there is evidence of non-compliance with the above policies, either

(1) Notify the appropriate Regional Bureau and seek technical input from the Bureau for Global Health (GH), or

(2) Work with the USAID Contracting or Agreement Officer to advise the contractor/grantee of its noncompliance with **ADS 212**, and request that corrective action be taken to bring the contractor/grantee into compliance.

If the contractor/recipient fails to take corrective action, the USAID Contracting Officer or Agreement Officer may terminate in accordance with applicable law and regulation.

212.4 MANDATORY REFERENCES

212.4.1 External Mandatory References

Effective Date: 1/04/2002

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

212.4.2 Internal Mandatory References

Effective Date: 1/04/2002

a. **ADS 212maa, Guidelines for Documenting Exceptions to ADS 212.3.2**

212.5 ADDITIONAL HELP

Effective Date: 09/12/2011

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

b. **ADS 212sab, Breastfeeding - USAID Background Paper, 2001**

c. **Infant and Young Child Feeding in Emergencies**

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

e. Internet Web sites of **World Health Organization (WHO)**, **UNICEF**, **USAID**, **LINKAGES**, and **IYCN**

f. **USAID Commodity Reference Guide, 2003 Edition, Guidelines for the Office of Food for Peace**

g. **WHO Feeding the Non-Breastfed Child 6-24 Months of Age**

h. **WHO Global Strategy for Infant and Young Child Feeding**

I. **WHO Guiding Principles for Feeding Infants and Young Children in Emergencies (2004)**

j. **WHO HIV and Infant Feeding: Framework for Priority Action**

k. **WHO HIV and Infant Feeding: Guidelines for Decision-Makers**

l. **WHO HIV and Infant Feeding: Revised Principles and Recommendations RAPID ADVICE (2009)**

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

212.6 DEFINITIONS

Effective Date: 09/12/2011

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

Breast milk substitutes
Foods or liquids used as substitutes for breastfeeding, including use of powdered or liquid milks or formula, 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)

complex emergency
A humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an

international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country program. (Chapter 212)

exclusive breastfeeding
The infant receives only breast milk 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 breast milk feeding
May receive expressed breast milk, in addition to breastfeeding. (Chapter 212)

lactational amenorrhea method
The use of breastfeeding as a contraceptive method based on the physiologic effect of suckling to suppress ovulation. It is effective in the first 6 months postpartum while the mother is exclusively or near fully breastfeeding and continues to be amenorrheic. (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)
The use of breast milk substitutes that provide all the nutrients the child needs. This would not include breast milk substitutes such as powdered milks or animal milks. (Chapter 212)

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