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ADS Chapter 212

Breastfeeding Promotion

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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 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, and who continue to breastfeed for two years or longer.

In 1990, the United States Government 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. The workplace also benefits because there are fewer parental absences due to child illnesses.

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212.2 PRIMARY RESPONSIBILITIES

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- 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. **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 Policy and Program Coordination, Office of Policy Planning (PPC/P)**, is responsible for overall compliance and reporting, as needed.
- d. **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

Effective Date: 01/04/2002

212.3.1 Current Accepted Norms Concerning Optimal Breastfeeding*

Effective Date: 01/04/2002

Due to its nutritional value, immune-system boosting properties, and birth spacing effect, 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, a recent 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 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.

Each year, an estimated 600,000-700,000 infants and young children become infected with HIV, the virus causing AIDS, through mother-to-child transmission (MTCT). On average, HIV transmission through breastfeeding occurs at a rate of 0.74 percent per month, or a total of 13-18 percent if infants are breastfed for 18-24 months. However, the risk of HIV MTCT must be weighed against the risk of increased morbidity and mortality in the absence of breastfeeding ([replacement feeding](#) with formula or other [breast milk substitutes](#)). In resource-poor settings, more infants may die of other primary causes, especially diarrhea and pneumonia, if they are not breastfed, than will become infected with HIV if they are breastfed, particularly over the first months of life

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when infant mortality rates are highest. Exclusive breastfeeding also lowers the risk of MTCT as much as fourfold, compared to mixed feeding (breast milk plus solid foods and/or non-human milk) in the first months of life.

For HIV-negative women and women who do not know their HIV status, infants should be exclusively breastfed for the first six months of life. After that, they should receive nutritionally adequate and safe complementary foods with continued breastfeeding for two years or more. Mothers who test positive for HIV should be counseled to discontinue all breastfeeding, and replacement feed (RF) with nutritionally complete breast milk substitutes if it is individually *acceptable, feasible, affordable, sustainable, and safe* (AFASS), according to the following WHO definitions:

Acceptable – The mother perceives no barrier to choosing and implementing the replacement feeding option for cultural or social reasons, or for fear of stigma and discrimination.

Feasible – The mother (or family) has adequate time, knowledge, skills and other resources to prepare and feed the infant, and the support to cope with family, community, and social pressures.

Affordable – The mother and family, with available community and/or health system support, can pay the costs of purchasing/producing, preparing and using the feeding option, including all ingredients, fuel, and clean water and equipment, without compromising the health and nutrition spending of the family.

Sustainable – A continuous and uninterrupted supply and dependable system of distribution for all ingredients and commodities needed to safely implement the feeding option is available for as long as the infant needs it.

Safe – Replacement foods are correctly and hygienically stored and prepared in nutritionally adequate quantities, and fed with clean hands using clean utensils, preferably with cups.

Otherwise HIV-positive mothers should be counseled to exclusively breastfeed their infants until replacement feeding is individually *acceptable, feasible, affordable, sustainable, and safe* (AFASS). While WHO has recommended a number of replacement feeding options, including hand-expressed, heat-treated breast milk and modified cow milk, the best option for replacement feeding in the first six months of life is a fully fortified, quality infant formula, reconstituted with sterile water (e.g. boiled, chemically treated and/or filtered) and cup fed. Replacement feeding is also necessary when mothers have either 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 conditions that meet the AFASS standards, described above. Mothers should be counseled on how to safely feed non-breastfed children 6-24 months following WHO guiding principles (see **ADS 212.5**, reference j).

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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.

212.3.2 Agency Policies

Effective Date: 01/04/2002

- 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.¹
- 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 PPC/P a request for an exception to ADS 212 (see Mandatory Reference [Guidelines for Documenting Exceptions to ADS 212.3.2](#)).
 - (2) Offer them in a context in which optimal breastfeeding is also supported (see Definitions, [ADS 212.6](#)).
 - (3) Document and keep on file:

¹ A **complex emergency** is 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.

- (a) A copy of the memorandum to PPC/P 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 additional help document, [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 AFASS standards, as described above).
- d. If there is evidence of non-compliance with the above policies, either
- (1) Notify the Bureau for Policy and Program Coordination, Office of Policy Planning (PPC/P) 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

Effective Date: 1/04/2002

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. [Guidelines for Documenting Exceptions to ADS 212.3.2](#)

212.5 ADDITIONAL HELP

Effective Date: 1/04/2002

- a. [Breastfeeding - USAID Background Paper, 2001](#)

- b. [USAID Commodity Reference Guide, 2003 Edition, Guidelines for the Office of Food for Peace](#)
- c. [Cross-Sectoral Implementation Guidance for ADS 212: Breastfeeding Promotion, 2001, developed by the Bureau for Global Health \(USAID/GH\)](#)
- d. [Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding, 1990](#)
- e. [World Health Organization \(WHO\) International Code of Marketing of Breast milk Substitutes](#)
- f. [Ten Steps to Successful Breastfeeding](#)
- g. [WHO Global Strategy for Infant and Young Child Feeding](#)
- h. [WHO HIV and Infant Feeding: Framework for Priority Action](#)
- i. [WHO HIV and Infant Feeding: Guidelines for Decision-Makers](#)
- j. [WHO Feeding the Non-Breastfed Child 6-24 Months of Age](#)
- k. Internet websites of [World Health Organization \(WHO\)](#), [UNICEF](#), [USAID](#) and [LINKAGES](#)

212.6 DEFINITIONS

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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, 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 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)

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exclusive breast milk feeding

May receive expressed breast milk, in addition to breastfeeding. (Chapter 212)

lactational amenorrhea method

LAM promotes good breastfeeding practices and the transition to a modern contraceptive method in the first 6 months postpartum while the mother is exclusively or near fully breastfeeding and continues to be amenorrheic.

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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