WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE

SEMINAR ON PROTEIN PROBLEMS
WITH PARTICULAR REFERENCE TO
WEANING FOODS
Cairo, 4-8 November 1974

RECOMMENDATIONS

1. Detection of protein-calorie malnutrition

1.1 Efforts to detect early protein-calorie malnutrition should be a regular activity in all health centres. Such surveillance should also be extended to populations not attending health centres.

1.2 At risk groups should also be clearly defined by local health agencies.

1.3 Surveillance in MCH services or by private practitioners includes the following methods

- simple clinical examination
- body weight for age
- failure to maintain normal rate of weight gain between visits
- arm circumference for age

1.4 Such surveillance could be carried out by medical practitioners, other professional and auxiliary health personnel, and all field extension workers, women's and volunteers' groups. Training programmes should be organized for these workers.

2. Nutrition rehabilitation and supplementation

2.1 Nutritional rehabilitation programmes should include preventive as well as curative nutritional supplementation.

2.2 Health education on nutrition is an essential part of rehabilitation and supplementation programmes emphasizing the use of local foods, their preparation, the quantities required, etc.

2.3 Nutrition rehabilitation programmes should be functionally adapted to the resources available locally. Local facilities staffing and costs should be on a modest scale. Such programmes should be operated through existing health or other extension services.

2.4 Nutrition rehabilitation centres as such are particularly useful where there is a relatively high density of severely malnourished children. It will be an advantage if the centre can be conveniently used for training purposes for health and other personnel.

2.5 The essential ideas to be understood by the parents are that malnutrition is caused by incorrect feeding, and that it is treated and prevented by proper feeding, not by medication. Some degree of separation from the hospital environment (psychologically) is therefore desirable.

2.6 The programme of such centres should include broader aspects such as home gardening, care of small livestock, menu planning and budgeting, and group activity. Community leaders should be educated in the same centers for nutrition promotion.

2.7 Weight charts should be used to assess the catch-up weight of individual children and to evaluate the impact of the programme in the community.

3. Breast feeding and weaning

3.1 More detailed information should be gathered to determine the duration of breastfeeding in different socio economic strata, and the role of different factors tending to cause premature weaning.

3.2 In the light of such studies, governments should consider organizing campaigns to promote breastfeeding through educational action and through legislative action to prevent unwarranted promotion of commercial and food preparations and to facilitate breastfeeding by working mothers.

3.3 Professional associations and internationally sponsored advisory bodies should, through their codes of ethics and/or practices, call for restraint in the use of misleeding and inappropriate advertising and promotional materials, including those designed for specific markets elsewhere.

3.4 More prestige should be given to breastfeeding and it should be continued up to 2 years when possible, or at least until 6 months. The use of oestrogen containing contraceptive pills should be avoided during lactation. Use of local galactagogues could be encouraged, especially green leafy vegetables, provided they do not to mother or child. Maternity hospitals should provide a milieu which actively encourages breastfeeding. Adequate nutrition of mothers during pregnancy and lactation should be safeguarded, both by avoiding harmful restrictions and by supplementary feeding where necessary

3.5 Weaning should be gradual. Local supplementary foods should be introduced by 4-6 months in addition to breast-milk. From the beginning the baby's meal should consist essentially of multimixes: staple, legume or animal food, leafy or yellow vegetable, and adequate fat or oil.

3.6 From 4-6 months, foods should be mashed and sieved or finely ground; from 7-9 months, mashed only; from 10-12 months soft only. Throughout the second and third year of life, care is required to ensure that the child receives an adequate share of the family food (not merely the staple).

3.7 There is a place for inexpensive locally produced commercial weaning foods, particularly for urban low income families to be used instead of more expensive imported infant foods; and also for use in times of disaster, for rehabilitation purposes, and to reduce the importation of infant foods. Their production locally should only be considered where a firm government determination to support it and subsidize it heavily in the early stages, and to promote its distribution to needy groups. The ingredients should be low cost and mainly produced within the country (or neighbouring countries). More dialogue between government and commercial companies is necessary. The educational campaign in support of the consumption of commercial foods should put equal stress on the use of equivalent home-processed weaning foods.

4. Health education on nutrition

4.1 Education on the foregoing subjects should be undertaken in all health centres and hospitals, and at the community level, and also in the regular curriculum of schools (primary and secondary). Fathers should be included as well as mothers, and boys as well as girls. The role of grandmothers, housemaids and others has to be considered.

4.2 Such education should be adapted to local concepts, food availability and community resources. Detrimental practices (especially during illnesses) should be combatted or circumvented, but without directly attacking "hard taboos". "Soft taboos" on the other hand are already changing and this change can be hastened. Beneficial existing food practices should be promoted. Changes advocated should harmonize with existing beliefs and customs, and involve minimal change in them. The approach should be broadened, forming an integral part of family health and public health programmes.

4.3 The educational activities should be undertaken as far as possible in the context of community educational and development programmes. The educational methods should be varied and imaginative, using local idioms for communication and entering into the cultural patterns of the local community.

4.4 The role of mass media has to be studied and exploited.

4.5 Evaluation in depth of current programmes in this field should be undertaken with analysis of existing knowledge, attitude and practices, and the impact of the educational on these and on nutritional status.

5. Control of infections

5.1 Environmental hygiene, personal hygiene and food hygiene should be safeguarded as far as possible in the home and community.

5.2 Diarrhoeal diseases should be treated early (especially by oral rehydration including electrolytes). Cessation of breast feeding and adoption of starvation regime should be avoided and re-feeding started early.

5.3 Malaria prophylaxis by vector control measures and chemotherapy is essential in endemic areas, to prevent illness and malnutrition of both mother and child.

5.4 Immunization programmes will reduce the amount of malnutrition particularly for measles, tuberculosis and whooping cough. For measles vaccination, priority should be given to children who are identified as at risk and/or where epidemics occur.

5.5 Elimination of intestinal helminths is desirable where infection is heavy.

5.6 These activities should be regularly undertaken in conjunction with all nutrition programmes.

6. Training

6.1 In-service training for health personnel (including doctors) and other extension workers, with particular emphasis on nutritional surveillance, breastfeeding, weaning, nutritional supplementation, rehabilitation and education as indicated above, should be undertaken.

6.2 The above topics should be reinforced in the basic training of the same categories of personnel.

6.3 A Manual on infant feeding, modelled on the PAG Manual and adapted to local conditions in each country, would be an asset to all such training programmes.

7. Coordination and planning

7.1 Better planning and coordination of nutrition activities, between and within the ministries concerned, is essential to prevent confusion, overlapping and gaps in the programmes.

7.2 Food and nutrition planning should be undertaken in the framework of national health planning and overall socio-economic planning. Of particular importance is to reach policy decisions with the ministries concerned as to which foods are to be promoted and how, with particular emphasis on weaning foods.