INTRODUCTION

Adequate nutrition during infancy and early childhood is fundamental to the development of each child’s full human potential. It is well recognized that the period from birth to two years of age is a “critical window” for the promotion of optimal growth, health and behavioral development. Longitudinal studies have consistently shown that this is the peak age for growth faltering, deficiencies of certain micronutrients, and common childhood illnesses such as diarrhea. After a child reaches 2 years of age, it is very difficult to reverse stunting that has occurred earlier (Martorell et al., 1994). The immediate consequences of poor nutrition during these formative years include significant morbidity and mortality and delayed mental and motor development. In the long-term, early nutritional deficits are linked to impairments in intellectual performance, work capacity, reproductive outcomes and overall health during adolescence and adulthood. Thus, the cycle of malnutrition continues, as the malnourished girl child faces greater odds of giving birth to a malnourished, low birth weight infant when she grows up. Poor breastfeeding and complementary feeding practices, coupled with high rates of infectious diseases, are the principal proximate causes of malnutrition during the first two years of life. For this reason, it is essential to ensure that caregivers are provided with appropriate guidance regarding optimal feeding of infants and young children.

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Complementary feeding is defined as the process starting when breast milk alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed, along with breast milk. The target age range for complementary feeding is generally taken to be 6 to 24 months of age, even though breastfeeding may continue beyond two years. A review of feeding guidelines promoted by various national and international organizations has shown that there are inconsistencies in the specific recommendations for feeding infants and young children (Dewey, in press). Some of the feeding guidelines are based more on tradition and speculation than on scientific evidence, or are far more prescriptive than is necessary regarding issues such as the order of foods introduced and the amounts of specific foods to be given. To avoid confusion, a set of unified, scientifically based guidelines is needed, which can be adapted to local feeding practices and conditions.
The guidelines described herein were developed from discussions at several technical consultations and documents on complementary feeding (WHO/UNICEF, 1998; WHO/UNICEF Technical Consultation on Infant and Young Child Feeding, 2000; WHO Global Consultation on Complementary Feeding, 2001; Academy for Educational Development, 1997; Dewey and Brown, 2002). The target group for these guidelines is breastfed children during the first two years of life. This document does not cover specific feeding recommendations for non-breastfed children, although many of the guidelines are also appropriate for such children (except for the recommendations regarding meal frequency and nutrient content of complementary foods). Appropriate diets for children who are not breastfed (such as those of HIV-positive mothers who choose not to breastfeed), often referred to as “replacement feeding”, are the subject of other documents (WHO/UNICEF HIV and Infant Feeding Counseling: A training Course, 2000). It should also be noted that the guidelines herein apply to normal, term infants (this includes low birth weight infants born at > 37 weeks gestation). Infants or children recovering from acute malnutrition or serious illnesses may need specialized feeding, which is covered by clinical manuals (for example, the WHO manual “Management of the Child with a Serious Infection or Severe Malnutrition”, 2000). Preterm infants may also need special feeding. However, the guidelines in this document can be used as the basis for developing recommendations on complementary feeding for these subgroups.