

W B T *i*

World Breastfeeding Trends
Initiative (WBTi)

The State of Breastfeeding in 33 Countries 2010



g b i c s



Tracking Infant and Young Child Feeding
Policies and Programmes Worldwide

World Breastfeeding Trends Initiative (WBTi)

The State of Breastfeeding in 33 Countries 2010

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The State of Breastfeeding in 33 Countries

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REPORT WRITING AND PRODUCTION

- **Writing & Edited by:** Arun Gupta, Radha Holla and J.P.Dadhich
- **Reviewed by:** Marta Trejos and Joyce Chanetsa
- **IT and Graphics Support:** Beena Bhatt
- **Design & Layout:** Amit Dahiya
- **Photo Credits (Cover):** IBFAN Africa, UNICEF Egypt, WABA, Ines and Nupur Bidla

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BPNI / IBFAN Asia

BP-33, Pitampura, Delhi 110 034, India. Tel: +91-11-, 27343608, 42683059

Tel/Fax: +91-11-27343606. Email: info@ibfanasia.org

Website: www.ibfanasia.org

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Dr. Arun Gupta, MD FIAP
Regional Coordinator, IBFAN Asia

Acronyms

BPNI	Breastfeeding Promotion Network of India
DALYs	Disability Adjusted Life Years
gBICS	global Breastfeeding Initiative for Child Survival
Global Strategy	Global Strategy for Infant and Young Child Feeding
GLOPAR	Global Participatory Action Research
IBFAN	International Baby Food Action Network
ICDC	International Code Documentation Centre
ILO	International Labour Organisation
IYCF	Infant and Young Child Feeding
MDGs	Millennium Development Goals
Norad	Norwegian Agency for Development Cooperation
RCO	Regional Coordinating Office
Sida	Swedish International Development Agency
UNICEF	United Nations Children's Fund
WABA	World Alliance for Breastfeeding Action
WBTi	World Breastfeeding Trends Initiative
WHO	World Health Organization

Coordinators

The World Breastfeeding Trends Initiative (WBTi) assessment of 2008-09 was coordinated by the following IBFAN Regional Coordinators/Representatives from Asia, Africa and Latin America.

REGIONAL COORDINATORS/REPRESENTATIVES (RR)

Region	Regional Coordinator/RR	Email
Africa	Joyce Chanetsa	ibfan.jchanetsa@realnet.co.sz
Latin America and Caribbean	Marta Trejos	cefemina@sol.racsa.co.cr
East Asia	Kim Jaiok	jokim@consumerskorea.org
Southeast Asia	Ines Fernandez	innes.sea@gmail.com
South Asia	Arun Gupta	arun@ibfanasia.org

COUNTRY COORDINATORS

Country	WBTi Country Coordinator	Email
Afghanistan	Dr. Zarmina Safi	zs_health@yahoo.com
Argentina	Fernando Vallone	fervallone@gmail.com
Bangladesh	Ms. Aklima Parvin	aklima_bbf@yahoo.com
Bhutan	Ms. Ugyen Zangmo	ugyenzangmo@health.gov.bt
Bolivia	Micaela Mujica	aisbol.medicamentos@gmail.com
Brazil	Rodrigo Vianna	vianna@ccs.ufpb.br
Cape Verde	Milene Cristina Lopes Delgado	limamilene@yahoo.com.br
China, PR	Zhang Shuyi	shuyi_zhang@163.com
Colombia	Patricia Amezcua	pat_ned@yahoo.com
Costa Rica	Marta Trejos	cefemina@racsa.co.cr
Dominicana, Rep.	Clavel Sánchez	clavelsanchez@gmail.com
Ecuador	Rocío Caicedo	funbbasic.ibfan@gmail.com
Gambia	Bakary J.S. Jallow	bakaryjallow24yahoo.co.uk
Ghana	Wilhelmina Okwabi	waokwabi@yahoo.com
India	Dr. J.P. Dadhich	jpdadhich@bpni.org
Indonesia	Nia Umar	nia@aimi-asia.org
Korea, Rep.	Kim Jaiok	jokim@consumerskorea.org
Malawi	Janet Guta	janetnyachulu2000@yahoo.co.uk
Maldives	Ms. Nasheed Hanan Ahmed	hانا_nasheed@hotmail.com
Mexico	Marcos Arana	observatoriosalud@gmail.com
Mongolia	Gochoo Soyolgerel	gsoyol@hotmail.com
Mozambique	Mércia Cristina Paulo Tembe	merytembe@yahoo.com.br
Nepal	Dr. Prakash Sundar Shrestha	shresthaps@hotmail.com
Nicaragua	Ninoska Cruz	ncruzibfan@gmail.com
Pakistan	Dr. Zareef Uddin Khan	kzareef@hotmail.com
Peru	Ana Vazquez	postmast@cesip.org.pe
Philippines	Ma. Ines AV. Fernandez	arugaan@mozcom.com
Sri Lanka	Mrs. Seelawathie Ebert	seelasarvodaya@sltnet.lk
Taiwan (ROC)	Leh-Chi Chwang	lechwang@yahoo.com
Uganda	Gerald Onyango	gponyango@yahoo.co.uk
Uruguay	Florencia Cerruti	florencia.cerruti@gmail.com
Vietnam	Dr. Bui Hong Van	hongvan910@gmail.com
Zambia	Raider Habulembe Mugode	rhmugode@yahoo.com

Foreword



*"As trees turn to the sun, babies turn to their mother's breast.
Such is nature's way..."*

(anon)

Ideal medicine, the unbeatable nutrition, the sound economics of a free good, the deep ecology of no waste and, last but not least, the sheer joy of the bonding of mother and child - these five petals of the power of breastfeeding make it one of the basic pillars of what the late economist Galbraith called 'The Good Society', one that nurtures its future caringly, competently and completely!

This natural way of nurturing the future was unfortunately wickedly, irresponsibly and even, some would say, criminally undermined by those whose unceasing hunger for profits promoted so-called "breastmilk substitutes" carelessly and callously all over the globe. Many thousands of babies die each year because they did not enjoy the benefits of breastfeeding, and multiples of thousands more grow up deprived of the many wonders of this special gift of God, of nature, and of the mother.

Today, thanks to brave mothers, assertive civic leadership, responsible health professionals, knowledgeable academics and many others galvanised the peoples of the world and manifested themselves through progressive governments. The sheer power of civic action, including the longest continuing boycott, took the issue into the United Nations, particularly the United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO), moving into actions supporting a magnificent turning back to the natural way!

Supported by United Nations frameworks such as the *International Code on the Marketing of Breastmilk Substitutes* and the *Innocenti Declaration* and their subsequent 'upgrades', and the Baby-friendly Hospital Initiative and work place mother and child friendly initiative supported by organisations like the International Labour Organisation (ILO), civil society organisations all over the world are now able to advocate global standards and monitor and celebrate the gains and challenge and expose the bad practices everywhere.

This kind of proactive, systematic and continuous vigilance is so necessary if we are not to be dragged back by those whose greed is a constant and powerful threat in this age of free and unfettered market globalisation. It requires the courage to "name and shame" the corporations and the countries who do not live up to their commitment to the spirit and letter of the globally accepted frameworks. The International Baby Food Action Network (IBFAN) and its remarkable International Code Documentation Centre (ICDC) through its amazingly researched and truly impactful "State of the Code" red and blue reports have made it difficult for non-compliance to go unnoticed and unchallenged. The World Alliance for Breastfeeding Action (WABA) brought out a very creative and participatory "bottoms up" methodology called "Presenting Problems - a guide to reporting breastfeeding in your country", which lead to a series of attention getting "Report Cards"!

Today there is a great need to continue to be even more vigilant and to synergise and consolidate these and other monitoring initiatives into a overarching mapping and advocacy tool that can mark another surge in the work and enlarge the impact of breastfeeding movement.

This report "The State of Breastfeeding in 33 Countries-2010", that is part of an excellent initiative on World Breastfeeding Trends, and covers 33 countries, is a most welcome step in our journey to that destination where breastfeeding, the natural way, becomes the norm again!

Professor Anwar Fazal
Director, Right Livelihood College,
Chairperson Emeritus, World Alliance For Breastfeeding Action, Penang, MALAYSIA.

Preface



When the World Alliance for Breastfeeding Action (WABA) launched its Global Participatory Action Research (GLOPAR) project in 1993, it certainly met its objective and confirmed its philosophy; when people look at their own data or situations, they get together, identify gaps and find solutions. Seeing the impact of GLOPAR, the Breastfeeding Promotion Network of India (BPNI), then a fledgling organisation, conducted the Indian assessment in mid nineties with the involvement of the Indian Medical Association. The stimulus provided by this experience, was further enhanced when WHO and UNICEF provided the tools to assess national policies and programmes. Combining the two resulted in development of APPAR, the Asia Pacific Participatory Action Research tool.

At the time of the Asia Pacific Conference on Breastfeeding, held in India in 2003, a young IT student came up with the idea, “Why not make it web- based - a tool that can be easily understood and demonstrated?” He in fact helped us in developing its first web -based version and presented . Though very basic, it was very powerful visually. Later, when we heard from our friends in Africa and Asia who were involved in testing the WHO tools for assessment that it could be made simpler and color- coded, we simply got into action.

We adapted the tools and questionnaire from the WHO tool, and developed a guideline for scoring and colour rating the assessment findings, which the young IT student put into a web-based application. The network of south Asia decided to use the tool in eight countries, and that's when the excitement began. Country after country showed not only enthusiasm but used the tool to mobilise partners and do an assessment of their policies and programmes. The use of the gaps, thus found, in advocacy resulted in national action. This was not just very encouraging, but also provided a powerful stimulant for more action on our part.

Nothing succeeds like success! We wanted that WBT*i* moves beyond south Asia, and other countries should start using the tool to assess their policies and programmes. APPAR now became the World Breastfeeding Trends Initiative (WBT*i*).

We shared the findings and the resulting actions at every possible opportunity. We took it to several Global Breastfeeding Partner's Meetings organized by the WABA; we presented to IBFAN's coordination council's meetings. And the finally, we took it to IBFAN's strategic planning meeting in 2006. Monitoring and evaluation of programmes on infant feeding became a priority area of IBFAN globally. In 2008-09 it became an integral and central part of the Global Breastfeeding Initiative for Child Survival (gBICS) a joint IBFAN and WABA initiative to enhance and generate new momentum on infant feeding worldwide.

Breastfeeding advocates and leaders of the movement around the world came out with words of appreciation as we started preparing for a global launch. IBFAN regional coordinators took it upon themselves to introduce WBT*i* in their regions. The new challenge had begun with developing a global team of IBFAN to take on World Breastfeeding Trends Initiative (WBT*i*). Translations into Spanish, French and Arabian languages created more thrill as it was another stimulant for us. The team from IBFAN Asia, along with the team members from the regions of Latin America, Africa including Francophone Africa, and Arab World, prepared the training manuals , did translations, developed guidelines for trainers and organized training on WBT*i* across each of these regions. With each training WBT*i* was now getting localized. National coordinators now had the capacity to launch national level action, which they have successfully done so far in more than 70 countries. When reports began arriving in our office, each report served as

another dose of stimulant, and helped us to organize better to respond, analyze, create report cards, and provide guidance if needed. Today, we can proudly say that the WBT*i*, the global idea, has evolved into a success! The core value of WBT*i* is not about collecting data but together analyse, advocate to bridge gaps and raise the bar of implementing the *Global Strategy* in each country.

The challenges ahead are many, including paucity of funds and lack of data or documentation of individual indicators. Resistance to share data, conflicting data, have been some of the other constraints. In spite of these limitations, the national core groups were able to reach a consensus. The fact that several groups got involved; an average of nine partners in each country, collaborated in the process is a validation of the fact that the tool generates consensus and partnerships across various sectors of stakeholders.

The tools are there, right on the web, <http://www.worldbreastfeedingtrends.org>, the portal is the result of this work as well. What all is there at the portal; you can visit and see, as well as provide us feedback to improve. Apart from being able to download each country's report, the portal also provides you the service to generate maps and graphs you need. This can be done for each area of action or all together and you can save these in your files to use in reports. You can also compare with other countries. You just need to register as a member, and find out much more about the WBT*i* and how it works.

The Web tool simply colour codes the performance of a country with Red, Yellow, Blue and Green in order of achievement from worse to good, through objective scoring for each achievement. Each country programme/policy is measured against a score of ten.

The 33 country report has enabled participating countries to analyse the gaps and make specific recommendations, which should be of interest to policy and programme managers of these countries. This is our major output, and concrete results of this work have begun to appear as you see in the impact section. Donor organizations can use the report or individual reports to commit resources to bridge specific gaps. People's organizations, UN agencies and all other international agencies can make use of the report for advocacy to mainstream the component of infant and young child feeding in various nutrition, health and development programmes meant for women and children.

The report will be particularly useful as a benchmark and repeat assessments will reveal the level of improvements, enhancing the advocacy value of this work.

The WBT*i* is a dynamic tool; today we report for 33 countries that have finished the work; tomorrow we hope to reach all over the world. We invite any country interested in implementing the *Global Strategy* to join this exciting initiative and make logical action plans. They can then commit resources where they are most needed, e.g. that are in areas that in Red to move to the next level and aspire for Green. Re-assessments will help them keep track of where they stand and where they want to go.

As more nations join the WBT*i*, we hope that by 2012, resources will become available to get a global picture of "Where do we stand: Where do we go". The tool and its web portal will hopefully prompt a much-needed change and momentum, in how we look at our breastfeeding patterns and the ways to improve breastfeeding practices and rates, allowing us to look beyond the health sector.

Dr. Arun Gupta, MD FIAP
Regional Coordinator, IBFAN Asia
Chair, global Breastfeeding Initiative for Child Survival (gBICS)
Member-Steering Committee, WABA

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Executive Summary

The “State of Breastfeeding in 33 Countries”, is a report of the assessment done in the countries, as part of the World Breastfeeding Trends Initiative (WBTi) of their infant and young child feeding policies and programmes aimed at enabling women to successfully breastfeed their babies as well as manage to provide good complementary feeding with continued breastfeeding after the age of six months. The report has been generated through an IBFAN led country process involving governments and civil society organizations.

WBTi is an assessment and analysis of the 10 areas of action of the Global Strategy for Infant and Young Child Feeding conducted nationally within a participatory framework by several stakeholders including governments, professional organizations and civil society. The process allows countries to identify gaps and build consensus on actions to bridge them. The assessment also documents five optimal infant and young child-feeding (IYCF) practices as recommended by WHO. The initiative, launched jointly by IBFAN and WABA in 2009, has been introduced in 73 countries and is the driving strategy for the global Breastfeeding Initiative for Child Survival (gBICS), a worldwide civil society-led initiative aiming to accelerate progress in attaining the health-related Millennium Development Goals (MDGs), especially Goal 4, reduction of child mortality, by scaling up early, exclusive and continued breastfeeding.

Currently, the assessment has been finalized in 33 countries, and this report is based on the detailed national reports of these countries, which can be downloaded at <http://www.worldbreastfeedingtrends.org/>.

The indicators for the 10 areas of action include:

- National Policy, Programme and Coordination
- Baby Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding)
- Implementation of the International Code
- Maternity Protection
- Health and Nutrition Care Systems
- Mother Support and Community Outreach - Community-based Support for the Pregnant and Breastfeeding Mother
- Information Support
- Infant Feeding and HIV
- Infant Feeding During Emergencies
- Monitoring and Evaluation

The indicators for five optimal IYCF practices include

- Initiation of Breastfeeding (within 1 hour)
- Exclusive Breastfeeding (for first 6 months)
- Median Duration of Breastfeeding
- Bottle-feeding (<6 months)
- Complementary Feeding (6-9 months)

The WBTi tool helps score each indicator on a scale of ten (10) and provides a colour code to reflect achievement of each indicator in Red, Yellow, Blue or Green in ascending order of performance. Thus, policy and programmes are scored out of a maximum of 100, and practices out of a maximum of 50. However, while describing the findings of IYCF practices, actual figures in percentage or duration in months are used. Emphasis will always remain on policies and programmes, which will result in optimal feeding practices.

Where Countries Stand?

It is now well understood that universalising the coverage of IYCF practices, especially optimal breastfeeding practices, is one of the most effective interventions to reduce infant and young child mortality, morbidity and malnutrition. Total scores received by countries in the WBTi assessment, conducted by themselves, reveal (Table A) that while Sri Lanka and Malawi are top performers on IYCF with scores of 124 and 121.5 out of a possible 150 respectively, none of the 33 countries have yet succeeded in fully implementing action in the 10 areas as set out in the *Global Strategy* for universalizing optimal IYCF practices. The majority of the countries are in yellow, indicating that there are several gaps in planning and implementation that need to be bridged. Nine countries are in blue, and two Cape Verde and Taiwan are in red, showing that these countries have a very long way to go in creating the enabling environment needed to improve their breastfeeding rates.

Key findings of this assessment reveal that there are major gaps in both policies and programmes in all 33 countries and in all the 10 areas of action. The average score for each indicator on policy and programme ranges from 2.73 to 7.58 on a scale of 10 (See Fig-A). The report highlights the need to act in a comprehensive manner on all areas of action. Table B provides the average of each of the 5 IYCF practices reported in 33 countries.

Analysis

The average scores also indicate that women are not universally supported either at the level of the facility or at the community to carry out optimal breastfeeding practices. This is reflected in the low rates of breastfeeding practices. The low average rate for exclusive breastfeeding 46%, which requires that the mother is in close proximity with the infant for the first six months of life, as well as the suboptimal median duration of breastfeeding at 18 months, are a clear reflection of the lack of support to women to breastfeed successfully. This may be in terms of skilled counselling and accurate information for IYCF at the facility and community levels, adequate paid leave or financial compensation, or crèches at the community and worksites with an adequate number of paid nursing breaks.

The splitting up of each indicator into subsets reveals that while overall scores for certain indicators appear to be high, very serious gaps remain in the area of implementation. The assessment of the subset of questions on the International Code of Marketing of Breastmilk Substitutes reveals that while this indicator has received the highest score, there are serious gaps in its implementation in almost all the countries. A similar assessment of the National Policy, Programme and Coordination indicator reveals that while policies and programmes may exist, scarce financial resources are made available as specific budgets in any of the countries for their implementation. Maternity protection gets a low score because most countries are today challenged with resource constraints to provide maternity entitlements to all women. The report highlights the need to go beyond the health sector in order to achieve a rise in breastfeeding rates.

The way forward

The WBTi assessment of 33 countries clearly shows that there is very limited concern about support to women for breastfeeding. To ensure proper infant feeding practices,

Table A: Ranking of WBTi 33 countries in 2008-2009

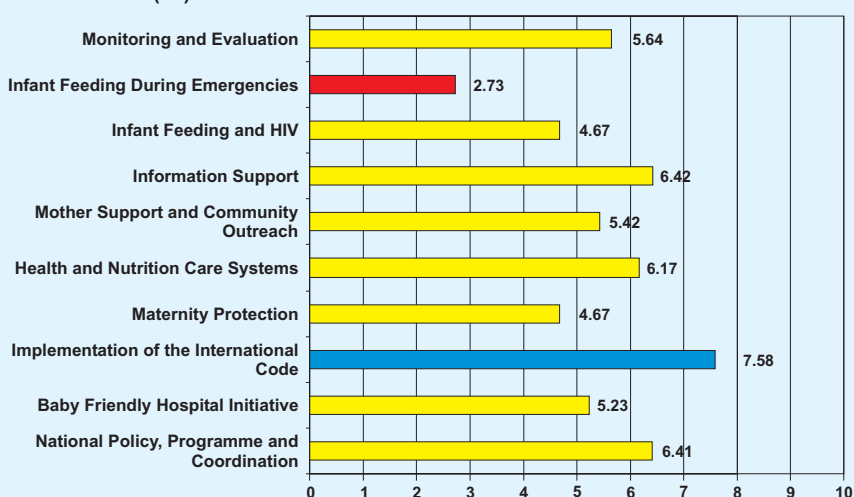
Countries	Scores on a scale of 150 & Color-coding	Ranking
Sri Lanka	124	1st
Malawi	121.5	2nd
Maldives	119	3rd
Zambia	111.5	4th
Mongolia	107	5th
Ghana	105.5	6th
Mozambique	100.5	7th
Nicaragua	99	8th
Costa Rica	95	9th
Bolivia	90	10th
Pakistan	88.5	11th
Bangladesh	87	12th
Afghanistan	86.5	13th
Uruguay	85.5	14th
Argentina	85	15th
Uganda	81.5	16th
Brazil	81	17th
China	80.5	18th
Nepal	80.5	18th
Peru	78.5	19th
Colombia	77	20th
Gambia	77	20th
Vietnam	76	21st
Philippines	75.5	22nd
Republic Of Korea	73	23rd
Bhutan	72	24th
India	69	25th
Ecuador	65.5	26th
Dominican Republic	58.5	27th
Indonesia	57.5	28th
Mexico	49	29th
Cape Verde	43.5	30th
Taiwan	32.5	31st

Note: If the score of 2 countries is similar, we provide same ranking

Table B: Average rates for the 5 IYCF Practices in 33 countries

IYCF Practices	Average
Early Initiation of Breastfeeding (28 Countries having data)	51.2%
Exclusive Breastfeeding for first 6 months (30 Countries having data)	46.0%
Median duration of Breastfeeding Rates (28 Countries having data)	18.6 months
Bottle-feeding Rates (25 Countries having data)	31.0%
Complementary Feeding Rates (30 Countries having data)	67.7%

Fig-A: Average score for indicators on Policy and Programmes in 33 countries on a scale of Ten (10)



women need to be provided with support at all levels. Most importantly, the need for strong policy support for a budget to ensure multi-sectoral coordination, implementation of the International Code of Marketing of Breastmilk Substitutes, provision of universal nutrition counselling outreach to all women both in facilities and their homes, as well as adequate and appropriate maternity entitlements cannot be overemphasized. These four steps can go a long way in ensuring a situation of better infant feeding practices. In addition, having a universal coverage of accurate information and counselling, and protecting mothers

from undue pressure from the commercial sector is critical.

Having done the analysis in the current context, with the available scientific evidence, and knowing that coverage levels of interventions on IYCF are on the low side as confirmed by the Countdown to 2015 report also; a set of general recommendations is provided for donors, the global community, the UN and other international organizations below. Specific recommendations on policy and programmes are directed to national governments. If taken up comprehensively, this could rapidly achieve a high coverage of key IYCF interventions. Putting these recommendations into action has an extensive potential for change as has been demonstrated in the impact section.

Recommendations

Global Recommendations

1. Primarily, the UN and donors should commit financial resources and **invest on 'early nutrition'** in a substantial way in order to universalize key interventions related to breastfeeding and complementary feeding. These include implementation of the Code of Marketing of Breastmilk Substitutes, coordination, reaching out to all women with counselling, and maternity protection.
2. Secondly, donors can support action in countries by prioritising those that are most in need, identified using the WBTi's ranking as well as commit to areas of action that need most support.
3. Programme managers with all international, regional or national organizations dealing with women and children have to understand the nature of support needed for women to be successful in carrying out their nurturing role. This support includes 'skilled breastfeeding counselling and support' in health sector, maternity entitlements such as leave or cash benefits, crèches and breastfeeding rooms at work places. The key element of action is that this should be directed to all women.
4. WBTi assessments need to be included as a key input for global monitoring processes on child health and nutrition in order to enhance participation of countries identified by the Countdown to 2015 report. In this respect, 18 of the 33 countries in this report are a part of countdown process. See the ranking in the Table-A.

Specific recommendations for national governments

Countries participating in the current assessment have developed several recommendations in each area of action to improve their breastfeeding rates. Several of these recommendations are common to almost all countries. These relate to both policy and strengthening of specific programme areas. (For details of recommendations for each country, see national reports at <http://www.worldbreastfeedingtrends.org>). The

common recommendations that emerged from the analysis were as follows:

Policy Action for Prioritising Nutrition

1. Mainstream infant and young child nutrition in all areas of governance, through the creation of a comprehensive written policy that includes all the ten areas of action highlighted in the *Global Strategy for Infant and Young Child Feeding*.
2. Set up a Breastfeeding /IYCF Committee with representation from sectors such as health, nutrition, welfare, labour, and legal affairs. This body can also screen all IEC materials for consistency.
3. Create a coordination mechanism for planning and supervising the implementation of the policy in an integrated manner at all levels, from policy making to service delivery at the grassroots level.
4. Invest in breastfeeding interventions; create a budget line with adequate resources for effective implementation of all the ten areas of action; and increase human resources in all areas for effective action.
5. Set a timeline for achieving results.
6. Ensure that all health and nutrition personnel at all levels have the necessary skills to provide counselling and correct information to support women to breastfeed. Integrate quality training on infant and young child feeding in pre-service and in-service training.
7. Monitor key breastfeeding and complementary feeding indicators regularly and use the results to make policy and programmes more effective. Monitor exclusive breastfeeding rates at six months for a truer picture of the situation, rather than from 0-6 months.

For Maternity Protection and Support to Women

1. Enact legislation to provide all women with adequate paid maternity leave/ financial compensation to carry out exclusive breastfeeding of their infants from birth to six months.
2. Provide adequate number of paid nursing breaks during the period of exclusive breastfeeding, when the infant needs to be fed on demand.
3. Ensure that all women have access to health and nutrition care during pregnancy and lactation.
4. Ensure that all women have access to correct information and skilled nutrition counselling services during pregnancy and lactation, with a special focus on supporting women on key infant nutrition practices.
5. Ensure that all women have access to safe childcare facilities managed by trained personnel at the workplace and in the community.
6. Find innovative methods for compensation of maternity entitlements for women.

For Providing Universal Access to Women for Accurate Information and Skilled Counseling on IYCF

1. Create a corps of health and nutrition workers trained in skilled counseling at the level of the health facility and in the community to provide support to women on IYCF.
2. Provide adequate and consistent funding for the programme.
3. Integrate infant and young child feeding in the training of administrators and other government personnel to mainstream nutrition in the whole establishment.
4. Resurrect the BFHI by encouraging hospitals to adopt the 10 Steps to Baby Friendly Hospital Initiative and a strong community component.
5. Conduct regular monitoring of the status of BFHI hospitals.
6. Ensure that all staff that interacts with women admitted in hospital is adequately trained to protect and promote breastfeeding, and have the skills to provide support to the woman to initiate breastfeeding within one hour of birth.
7. Integrate BFHI into the health system and link it to outreach programmes and mother support in the community.

For Effective Implementation of the International Code of Marketing of Breastmilk Substitutes.

1. Adopt the International Code through the creation of National legislation with rules and regulations that are justiciable.
2. Strictly enforce the International Code/National legislation.
3. Provide funds for the implementation of the International Code/National legislation.
4. Strengthen the International Code/National legislation to ensure the inclusion of ending all promotions of baby foods for children up to 2 years.
5. Create effective mechanisms to address violations.
6. Train government personnel on the implementation of the International Code/National legislation and on mechanisms addressing violations to enable them to take proper action.
7. Create public awareness on the International Code/National legislation and redressal mechanisms for violations.

For Infant Feeding in the context of HIV

1. Integrate infant feeding in HIV in national infant and young child feeding policies and plans of action.
2. Conduct operations research to determine the number of babies that get HIV through breastfeeding.
3. Put systems in place to monitor and determine the outcomes of prevention of mother to child transmission (PMTCT).
4. Harmonize national guidelines on HIV and Infant feeding with the current global recommendations.

For Infant Feeding During Emergencies

1. Integrate infant feeding during emergencies in the national policy on infant and young child feeding.
2. Incorporate infant and young child feeding in national disaster management policies and plans.
3. Train relief workers in infant and young child feeding, especially in providing skilled counselling to mothers, and in establishing relactation.
4. Strictly enforce the International Code to protect, promote and support breastfeeding during emergencies.

Introduction

The World Breastfeeding Trends Initiative (WBTi) report “The State of Breastfeeding in 33 countries” presents detailed findings on the 15 indicators of the tool, 10 of which relate to policy and programmes on infant and young child feeding and 5 on the resultant practices. The national teams used the WBTi tool and questionnaire to assess their country's status on the implementation of the *Global Strategy for Infant and Young Child Feeding*. They found gaps in the implementation, and used these for advocacy and to initiate new action.

The report provides background information on the issues such as the role of breastfeeding and complementary feeding as key interventions to enhance nutrition, development and survival of infants and young children. The section on 'About WBTi and the Process', describes in detail how it works. The Section on findings gives micro detail of each indicator in all countries with mapping and colour coding. The report focuses on policies and programmes and provides objective scoring of the achievement of each indicator. The findings are based on country assessments conducted and agreed upon by the respective national teams, this being a unique feature of the process. There is also a description of how this was made possible. Further, the report analyses these findings in the context of current science and global guidelines, the state of policy and programmes, and presents a way forward and recommendations. The section, which describes the impact of the process, shows how the initiative had been an instrument of change in South Asia where the region repeated the exercise in 2008 showing trends. Lessons learnt from the WBTi are also shared.

The 33-country report reflects work carried out in 2008 and 2009. The next report expected in 2012, would be based on nations taking action in the phase 2 and those who would have studied their trends in infant feeding.

On the WBTi portal, however, changes could be seen more dynamically as and when country information is received.



Photo Credit: Arun Gupta

Background

On average, more than 24,000 children under five years of age still die every day from preventable causes and according to UNICEF's *State of the World's Children 2010*, undernutrition contributes to more than one-third of these deaths. Undernutrition, particularly in children under two years of age, prevents them from reaching their full development potential. Optimal breastfeeding not only saves the lives of more than one million children under five, it also improves children's quality of life.

Today, 90 per cent of the undernourished women and children live in 24 countries of Africa and Asia; Sub-Saharan Africa and South Asia are, in fact, the two regions where the under five mortality rate exceeds 50 per 1000 live births.¹ (Table-1)

Optimal infant and young child feeding practices include initiation of breastfeeding within one hour of birth, exclusive breastfeeding for the first six months of life and addition of appropriate and adequate family foods for complementary feeding after six months, together with continued breastfeeding for two years or beyond. These practices can be viewed in the context of the state of child health and nutrition in the 33 countries described in this report.

Table 2 gives the mortality and nutritional status of children under 5 years of age.

On examining the Table 2, we find that, except in Zambia, Mozambique and Ghana, a high

proportion of the deaths of children under five years of age in the countries occur in the first year of life. Several of these countries have extremely high rates of neonatal mortality compared to under 5 and infant mortality. This clearly reflects the need in these countries to improve rates of timely initiation of breastfeeding and exclusive breastfeeding for the first six months of life.

The MDG Report 2010 released in June 2010 notes that "...Halving the prevalence of underweight children by 2015 (from a 1990 baseline) will require accelerated and concerted action to scale up interventions that effectively combat undernutrition. A number of simple and cost-effective interventions at key stages in a child's life could go a long way in reducing undernutrition; these include breastfeeding within one hour of birth, exclusive breastfeeding for the first six months of life, adequate complementary feeding and micronutrient supplementation between six and 24 months of age..."²

The world today is striving hard to improve child survival in order to achieve the Millennium Development Goals 1, 4 and 5. Over the last few years, ample scientific data listing evidence-based interventions to improve child survival has become available. Breastfeeding has emerged as a single and very viable public health intervention. The *World Health Statistics Report 2009*³ recognized that poor infant feeding i.e. not being exclusively breastfed for the first months of life - is a risk factor for survival of the child. Evidence presented in the *Lancet* series on child survival 2003⁴, *Lancet* series on

Table 1: 80 percent of the developing world's stunted children live in 24 countries

24 countries with the largest numbers of children under 5 years old who are moderately or severely stunted

S.No.	Country	Prevalence of undernourished (stunting) (%)
1	India	48
2	China	15
3	Nigeria	41
4	Pakistan	42
5	Indonesia	37
6	Bangladesh	43
7	Ethiopia	51
8	Dem. Rep. of the Congo	46
9	Philippines	34
10	United Republic of Tanzania	44
11	Afghanistan	59
12	Egypt	29
13	Viet Nam	36
14	Uganda	38
15	Sudan	40
16	Kenya	35
17	Yemen	58
18	Myanmar	41
19	Nepal	49
20	Mozambique	44
21	Madagascar	53
22	Mexico	16
23	Niger	47
24	South Africa	27

Source: Tracking Progress on Child and Maternal Nutrition: A survival and development priority. UNICEF 2009

Note: Estimates are based on the 2006 WHO Child Growth Standards, except for the following countries where estimates are available only according to the previous NCHS/WHO reference population: Kenya, Mozambique, South Africa and Viet Nam. All prevalence data based on surveys conducted in 2003 or later with the exception of Pakistan (2001-2002).

Table 2: Situation of Children Under Five in Countries Who Completed WBT/ Assessment

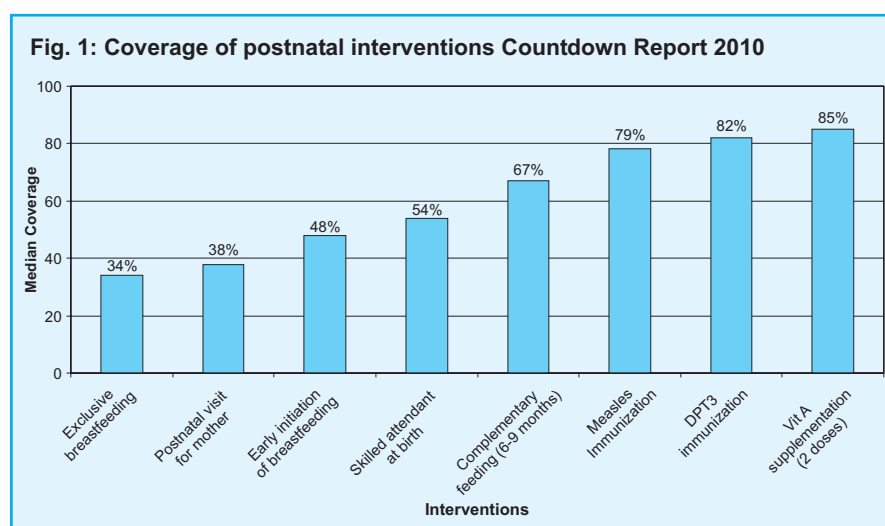
S.No.	Country	Under-5 mortality rate	Infant mortality rate (under 1)	Neonatal mortality rate	% of under-fives (2003-2008) suffering from:				Stunting (WHO)	GDP (millions of US Dollars)
		2008	2008	2004	Underweight (NCHS/WHO)	Moderate & severe	Severe	Wasting (WHO)		
1	Afghanistan	257	165	60	39	33	12	9	59	10624.0
2	Argentina	16	15	10	4	2	0	1	8	328465.0
3	Bangladesh	54	43	36	46	41	12	17	43	79554.0
4	Bhutan	81	54	30	19	14	3	3	48	1283.0
5	Bolivia	54	46	24	6	—	1	1	22	16674.0
6	Brazil	22	18	13	—	2	—	2	7	1575151.0
7	Cape Verde	29	24	9	9	—	2	7	12	1592.0
8	China, PR	21	18	18	7	6	—	—	15	4326996.0
9	Colombia	20	16	13	7	5	2	2	15	243765.0
10	Costa Rica	11	10	8	5	—	0	2	6	29664.0
11	Dominicana, Rep.	33	27	18	4	7	2	3	18	45541.0
12	Ecuador	25	21	13	9	6	1	2	23	54686.0
13	Gambia	106	80	44	20	16	4	7	28	811.0
14	Ghana	76	51	43	—	14	3	9	28	16653.0
15	India	69	52	39	48	43	16	20	48	1159171.0
16	Indonesia	41	31	17	—	18	5	14	37	510730.0
17	Korea, Rep.	5	5	4	—	—	—	—	—	929121
18	Malawi	100	65	26	21	15	3	4	53	4269.0
19	Maldives	28	24	24	30	26	7	13	32	1261.0
20	Mexico	17	15	11	5	3	—	2	16	1088128.0
21	Mongolia	41	34	18	6	5	1	3	27	5258.0
22	Mozambique	130	90	35	18	—	4	4	44	9846.0
23	Nepal	51	41	32	45	39	11	13	49	12615.0
24	Nicaragua	27	23	16	7	6	1	1	22	6592.0
25	Pakistan	89	72	53	38	31	13	14	42	164539.0
26	Peru	24	22	11	5	6	1	1	30	129109.0
27	Philippines	32	26	15	28	21	5	6	34	166909.0
28	Sri Lanka	15	13	8	—	22	4	15	18	40565.0
29	Taiwan (ROC)	31.9	4.6	2.71	NA	NA	NA	NA	NA	5.2
30	Uganda	135	85	30	20	16	4	6	38	14326.0
31	Uruguay	14	12	7	5	5	2	2	15	32186.0
32	Vietnam	14	12	12	20	—	5	8	36	90645.0
33	Zambia	148	92	40	19	15	3	5	45	14314.0

neonatal survival 2005⁵, and the *Lancet* series on maternal and child under-nutrition 2008⁶, clearly pointed out the importance of exclusive breastfeeding for the first six months of life which could save more lives than any other intervention studied while enhancing nutritional status. The analysis pointed out the effect of nutrition related interventions on mortality; 99% coverage with 'breastfeeding promotion' may lead to a proportional decrease in deaths under one year of age by 11.6%, and may also avert 21.9 million DALYs. In 2003 it was presented that exclusive breastfeeding, if universalized, could save 13% of all under five deaths, (an estimated 1.3 million in the 42 high mortality countries). Further analysis in the *Lancet* series 2008 has revealed that, a large disease burden was attributed to suboptimum breastfeeding, Most of the attributable deaths (1.06 million) and DALYs (37.0 million) were found to be due to non-exclusive breastfeeding in the first 6 months of life, accounting for 77% and 85%, respectively.⁷ To add to this, the *Lancet* commentary emphasized that 'breastfeeding counselling' stands the test of "admissible evidence" as one of the top three nutritional interventions, thus giving us the scientific basis of the means to enhance breastfeeding rates.⁸

The Countdown to 2015, Maternal, Newborn Child Survival, Report released in May 2010, monitors 20 core interventions¹⁰. In this report coverage of early initiation of breastfeeding within one hour was 48%, exclusive breastfeeding for the first six months was 34% and complementary feeding was 67%. See Fig-1 on the coverage of 8 'postnatal interventions' in the same report, showing that feeding and care indicators still have a long way to go and these were at the lowest end among all. The bottom 5 indicators needed to reach more than 80%.

In spite of the recognized importance of infant and young child feeding, UNICEF's *Tracking Progress on Maternal and Child Nutrition: a survival and development priority* noted that less than 40% of all infants in the developing world received the benefits of immediate initiation of breastfeeding. Similarly, just 37 % of children under 6 months of age were exclusively breastfed. Less than 60 per cent of children 69 months old received solid, semi-solid or soft foods while being breastfed. In addition, the quality of the food received was often inadequate, providing insufficient protein, fat or micronutrients for optimal growth and development. All these factors put infant health, nutrition and development at risk.

It is a decade ago that the World Health Assembly (WHA) adopted a resolution to give effect to the policy for infant and young child feeding in the year 2001. The state of implementation of this strategy is the subject of this 33 Country Report. The WHO-UNICEF *Global strategy for Infant and Young Child Feeding*⁹ called for action in essentially 10 areas to promote optimal infant and young child feeding practices. These areas are reflected in the WBTi assessment tool. .



Although, there have been attempts by international agencies and national governments to include breastfeeding in health and nutrition programmes, no concrete effort has been made to put it in an operational framework. Breastfeeding indicators such as exclusive breastfeeding rates during 0-6 months, now do find a place in major international and national reports, however, what is missing is information about policy, programmes and their implementation. Given its documented role in child survival, nutrition and development, breastfeeding now

assumes greater importance than before. Programmes and policies that are required for universalising breastfeeding, and their implementation need to be monitored in order to identify gaps and take action to bridge them.

Such a need was highlighted in a recent article published in *PLoS Medicine*¹¹, where the heads of eight global health agencies underlined the urgent need for data that “accurately track health progress and performance, evaluate the impact of health programs and policies, and increase accountability at country and global levels”. In the 2008 report, *Tracking Progress in Maternal, Newborn & Child Survival*, “Countdown to 2015” team found that “The power of the Countdown depends on the quality of the coverage data in the priority countries”¹².

The World Breastfeeding Trends Initiative (WBTi) steps in to fill in the need of assessment of policy and programmes that impact infant and young child feeding practices. Conscious of the importance of improving the quality and availability of relevant data, the International Baby Food Action Network (IBFAN), under the leadership of the Breastfeeding Promotion Network of India (BPNI), put together a participatory, action oriented tool, called the World Breastfeeding Trends Initiative (WBTi)¹³, to assess infant feeding policy and programmes at country level. The tool was developed using and adapting indicators developed by WHO and UNICEF in 2003¹⁴.

The World Breastfeeding Trends Initiative (WBTi) steps in to fill in the needs of assessment of policy and programmes that impact infant and young child feeding practices.

It is important to take note that the Convention on the Rights of the Child (CRC) obliges state parties to take appropriate measures to combat child malnutrition and diminish infant & young child mortality. Action includes education on breastfeeding. The Box below on Human Rights Related to breastfeeding gives details of such obligations.

Human Rights Related to Breastfeeding

Infants have the right to ...

- Enjoyment of the highest attainable standard of health (Art. 24(1) CRC, Art. 12(1) ICESCR)
- Adequate nutritious food (Art.24 (2)(c) CRC, Art. 11(1) ICESCR)
- Primary health care (Art. 24(2)(b) CRC)
- A standard of living adequate for the child's physical, mental, spiritual, moral and social development (Art. 27(1) CRC)

Mothers have the right to...

- Health care services and appropriate post-natal care (CEDAW 12.2, CRC 24)
- Education and support in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding (CRC 24.2(e))
- Appropriate assistance in their child-rearing responsibilities (CRC 18)
- Adequate nutrition during pregnancy and lactation (CEDAW 12.2)
- Paid maternity leave or other equivalent, including job protection (ICESCR 10, CEDAW 11.2(b))
- Safeguarding of the function of reproduction in working conditions (CEDAW 11.1(f))
- Decide freely and responsibly on the number and spacing of their children and to have access to the

- Information, education and means to enable them to exercise these rights (CEDAW 16.1(e))

States Parties are obliged to...

- Ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff, as well as competent supervision (Art. 3(3) CRC)
- Ensure to the maximum extent possible the survival and development of the child (Art. 6(2) CRC)
- Take appropriate measures to diminish infant and child mortality (Art.24 (2)(a) CRC)
- Ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care (Art. 24(2)(b) CRC)
- Combat disease and malnutrition, including within the framework of primary health care (Art. 24(2) (c) CRC)
- Take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children (Art. 24(3) CRC)
- Take [in accordance with national conditions and within their means] appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programs, particularly with regard to nutrition.(Art.27 (3) CRC)

Source: Kaia Engesveen. (2005). *Strategies for Realizing Human Rights to Food, Health and Care for Infants and Young Children in Support of the Millennium Development Goals: Role and Capacity Analysis of Responsible Actors in Relation to Breastfeeding in the Maldives*. SCN News (United Nations System Standing Committee on Nutrition). 30: 56-66.

About WBTi and the Process

The World Breastfeeding Trends Initiative (WBTi) is an innovative initiative of the International Baby Food Action Network (IBFAN), spearheaded by its Asia regional office, for tracking, assessing and monitoring the *Global Strategy for Infant and Young Child Feeding* in response to the global need for focus on infant nutrition and survival. The initiative aims at strengthening and stimulating breastfeeding action worldwide.

Using the tool, stakeholders in a country assess their own implementation of the *Global Strategy*, identify gaps and build national consensus around actions that are needed and priorities accorded to them. The WBTi assessment is not conducted by an external agency, but by the people in countries themselves. The WBTi team at IBFAN Asia receives findings from the national team, and initiates a process of verification, particularly sources of the information supplied, and then looks for a national consensus. Once the national team agrees to the assessment findings, the WBTi team helps them with uploading on to the web-tool that provides the score and rating/colour coding.

Objectives of WBTi

The following are its two objectives:

- Firstly, it is intended to help countries assess whether the action they have taken so far in the various programme areas is inadequate or adequate, and the finer detail of the various criteria on which each programme is assessed helps them to identify exactly where action is needed.
- Secondly it is intended to assist countries initiate national action to improve their performance based on the gaps thus identified.

This is achieved by diverse national stakeholders working together on the assessment. This creates a sense of national ownership and pride of the exercise and strengthens national partnerships for effective action to bridge the existing gaps.

A tool designed to have a positive impact on infant feeding practices

The WBTi is designed to assist countries in assessing the strengths and weakness of their policies and programmes to protect, promote and support optimal infant and young child feeding practices. Countries and regions are able to document the status of implementation of the *Global Strategy* using WBTi. It clearly identifies gaps to help governments, donors, bilateral, UN agencies to commit resources where they are most needed. It helps advocacy groups to define areas for advocacy and thus focus their efforts. It helps to effectively target strategies that can improve infant and young child feeding.

It clearly identifies gaps to help governments, donors, bilateral, UN agencies to commit resources where they are most needed.

The WBTi uses the methodology of Global Participatory Action Research (GLOPAR) developed and promoted by the World Alliance for Breastfeeding Action (WABA) in 1993 to track targets set by the *Innocenti Declaration* of 1990. It encouraged groups to assess breastfeeding and infant feeding practices in their own areas and use information thus collected for advocacy to impact the policy. The GLOPAR initiative had shown positive results in stimulating breastfeeding action as several groups in the participating countries where there was hardly any work going on, got involved in a global movement to protect, promote and support breastfeeding. The WBTi is an extension of GLOPAR as it also requires countries to track additional targets set by the *Global Strategy*.

The WHO in 2003 provided *Infant and Young Child Feeding: A tool for assessing national practices, policy and programmes*. The WBTi has used the questionnaire and other materials from the WHO's tool. It has been adapted based on the feedback from countries

in all regions including Latin America, Asia and Africa.

By requiring that countries themselves identify gaps and needs, the WBTi is designed to have a real, positive impact on infant feeding. Each assessment generates a set of recommendations that corresponds to the identified weaknesses.

A tool to motivate policy makers to act

WBTi is also a powerful, Internet-based information tool. It uses simple visual techniques like graphics and mapping designed to easily understand as well as attract and maintain interest throughout the three phases of the process. A web portal www.worldbreastfeedingtrends.org serves various purposes: (1) it presents the results of the analysis conducted; (2) it spurs decision makers to act and introduce improvements; (3) it creates emulation among countries and regions by sharing strategies that have worked to strengthen infant feeding policies.

How WBTi Works?

The WBTi involves a three-phase process.

Phase 1

The first phase involves initiating national assessment of the implementation of the *Global Strategy*. The WBTi guides countries and regions to document gaps in existing practices, policies and programmes. Multiple partners, including governments, professional bodies and civil society organisations, involved in the process use national documents to assess and analyse the situation in their country for each of the 15 indicators included in the tool, 10 of which relate to policies and programmes, and five to resultant practices. The assessment helps to identify gaps and to develop general as well as specific recommendations to bridge them.

WBTi has Five Components

- A:** Action
- B:** Bringing people together
- C:** Consensus building and commitment
- D:** Demonstration of achievements and gaps
- E:** Efficacy, improving policy and programme

The WBTi thus helps in the development of a practical baseline, demonstrating to programme planners and policy makers where improvements are needed to meet the aims and objectives of the *Global Strategy*. It thus helps in formulating plans of action that can effectively improve infant and young child feeding practices and guide allocation of resources.

As the WBTi process includes consensus building, the multiple stakeholders become committed to the action and to giving it the priority it deserves. For the WBTi, national perspective is prime, and it encourages cross checking and provision of sources of information besides having a consensus.

Phase 2

During the second phase, WBTi uses the findings of the national assessment and provides scoring, colour based on *IBFAN Asia's Guidelines for WBTi*.

Each indicator related to policies and programmes has a subset of questions, based on the *Global Strategy*, that the country must answer, with documentary proof for the answer. The maximum score for each indicator is 10. Numeric values that are national in scope are used for the indicators related to feeding practices. The web-based tool kit objectively scores, colour rates and grades each indicator as well as the entire set of indicators.

- Red or Grade D (*bad*),
- Yellow or Grade C (*insufficient*),
- Blue or Grade B (*needs improvement*), and
- Green or Grade A (*acceptable*)

The results of Phase 1 and Phase 2 make good tools for advocacy to improve breastfeeding/ IYCF practices.

The 15 Indicators of the WBTi

The WBTi is based on a wide range of indicators, which provide an impartial global view of key factors. There are 15 indicators, divided into two parts.

Part-1: Indicators related to policies and programmes. These include ten (10) indicators and cover the areas of:

- National Policy, Programme and Coordination
- Baby Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding)
- Implementation of the International Code
- Maternity Protection
- Health and Nutrition Care Systems
- Mother Support and Community Outreach - Community-based Support for the Pregnant and Breastfeeding Mother
- Information Support
- Infant Feeding and HIV
- Infant Feeding During Emergencies
- Monitoring and Evaluation

Part-2: Indicators related to Infant and Young Child Feeding Practices. This part has five (5) indicators, recommended by WHO for global use:

- Initiation of Breastfeeding (within 1 hour)
- Exclusive Breastfeeding (for first 6 months)
- Median Duration of Breastfeeding
- Bottle-feeding (<6 months)
- Complementary Feeding (6-9 months)

Each indicator has following components:

- The key question that needs to be investigated;
- Background on why the practice, policy or programme component is important;
- A list of key criteria as subset of questions to consider in identifying achievements and areas needing improvement, with guidelines for scoring, rating and grading how well the country is doing.

Phase 3

In the third phase, WBTi encourages repeat assessment after 3-5 years to analyse trends in programmes and practices as well as overall breastfeeding rates in a country, report on programmes, identify areas still needing improvement. They can also help in studying the impact of a particular intervention over a period of time as well as the study of trends.

What Resources are Required?

Resources that are essential to carrying out the assessment include

- Human resources: a team leader to coordinate, and small group of experts to carry out the assessment by studying documents, conduct interviews and analyse the findings and produce a first draft report and a larger group representing multiple stakeholders to study the draft report, critique and validate as well as make recommendations based on identified gaps.
- Documentation on policy and programmes.
- Secondary data (which is national in scope) on breastfeeding, complementary feeding and bottle-feeding.
- Financial resources for organising meetings, the coordination, the assessment, preparation of report, dissemination, and advocacy.

Why to Study Trends?

It is recommended to carry out the assessment every 3-5 years. An important role of the tool emerges from re-assessments. A country that has done well during an assessment may slide down next time; the scores are figures that are meant to show how far the country has progressed on any one issue. If today it has taken two steps, then it will get a

higher figure than if someone has taken only one step. For example, India's grading has come down for national guidelines, because no steps were taken between 2005 and 2008.

Why WBTi is efficient?

- Firstly, it can be used at regular intervals for countries to assess the improvement in their implementation.
- Secondly, as each indicator is detailed, moving from broad existence of policy to the finer details, it allows policy makers and programme managers to identify specific gaps for which actions can be initiated.
- Thirdly, the colour coding motivates countries actions to improve their levels, as it is simple and easy to understand and stimulate to move to the next colour level.
- Fourthly, being web-based, WBTi allows sharing of information and allows countries to compare their rankings with other countries, and after reassessments, to identify what actions were most effective.
- And last, but not least, it encourages peoples' groups and governments to work together through developing consensus.

How did we do it?

IBFAN adopted WBT*i* as a part of its global work for assessment and monitoring of the *Global Strategy on Infant and Young Child Feeding*, which became a priority in 2003. The following actions led to success in 33 countries:

1. IBFAN Asia prepared a set of guidelines of training materials for implementation of the WBT*i* at the National level.
2. A set of tools used for the 2005 assessment in South Asia were circulated to the Core group of global Breastfeeding Initiative for Child Survival (gBICS) for comments and for purpose of updating.
3. A Curriculum for training of an international team was developed by IBFAN Asia team. The first training was organised in June 2008 at Geneva to prepare an international team for the launch of WBT*i* in the different regions of the world. A questionnaire was updated at this time to reflect both WABA and IBFAN perspectives and include global developments on 'maternity protection' and 'mother support'.
4. IBFAN regional coordinators/ representatives organized local WBT*i* trainings; South Asia, East Asia and Southeast Asia in August 2008, African region and Latin America and the Caribbean region (LAC) organized their training in September 2008. A total of 51 countries were thus involved. The LAC region translated all materials into Spanish. IBFAN Asia team members moved around the world to support these trainings. These sessions helped develop national plans for WBT*i* assessments.
5. Following this, the national IBFAN leaders arranged local meetings, developed linkages and partnerships with governments, established core groups and coordinated the assessment process through out the year 2008-09. This process led to the completion of work in 33 countries. Later in 2009, 22 more countries were trained for this work, in Arab World and Afrique region.
6. The country coordinators then provided their findings and reports to IBFAN Asia for the team to analyze and verify. The IBFAN Asia team sought clarifications and helped them finalise their reporting.
7. The national groups finally reached a consensus on the findings and developed a set of recommendations based on the gaps found.
8. Regional coordinators shared the final findings with IBFAN Asia for feeding into the web tool kit that provided objective scoring and colour coding on the status of implementation of each indicator, and all indicators together. WBT*i* portal shows where these 33 countries Stand!
9. As many as 297 partners were involved in all the 33 countries for the assessment exercise and consensus building. The level of participation as one can see from the list shows governments were almost always a part to the process. Secondly the list of partners also demonstrates that it is possible to do this work together, and build a strong platform for joint advocacy.



International WBT*i* training in Geneva

WBTi training at Different Places



Arab World



East Asia & Southeast Asia



Afrique



South Asia



Latin America and Caribbean



Africa

PARTNERS IN 33 COUNTRIES

297 Partners including government organizations involved in WBTi assessment process in 33 Countries

1. **AFGHANISTAN**
 1. Ministry of Public Health
 2. UNICEF
 3. BASICs
 4. WHO
2. **ARGENTINA**
 5. Ministry of Health
 6. CLACyD Foundation
 7. UNICEF Argentina
 8. Argentina Pediatric Association
 9. LLL Argentina
 10. IBFAN Buenos Aires, Mendoza, Córdoba, Neuquén, Salta, Corrientes, Santa Fe and Chubut
3. **BANGLADESH**
 11. Ministry of Health & Family Welfare
 12. Institute of Public Health and Nutrition
 13. Institute of Child and Mother Health
 14. Director General of Health Services
 15. National Institute of Preventive Social Medicine
 16. National Nutrition Programme
 17. Institute of Nutrition & Food Science
 18. Integrated Management Childhood Illness
 19. Mother and Child Health Training Institute
 20. Bangladesh Breastfeeding Foundation (BBF)
 21. Bangladesh National Nutrition Programme
 22. Director General of Family Planning
 23. Helen Keller International
 24. Obstetrics and Gynecological Society of Bangladesh
 25. United Nations Children's Fund (UNICEF)
 26. World Health Organization (WHO)
 27. Food & Agriculture Organization (FAO)
 28. World Vision-Bangladesh
 29. Save the Children USA
 30. Save the Children UK
 31. Plan Bangladesh
 32. Care Bangladesh
 33. CONCERN Bangladesh
 34. BRAC
 35. Eminence Associate
 36. Nutrition Foundation of Bangladesh
 37. Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders
 38. Bangabandhu Sheikh Mujib Medical University
 39. Home Economics College
4. **BHUTAN**
 40. Nutrition program, DoPH
 41. Information Unit, DoPH
 42. Paediatrician, JDWNRH
5. **BOLIVIA**
 43. International Action for Health AIS BOLIVIA
 44. International Baby Food Action Network for IBFAN Bolivia
 45. Defense Committee for Consumer's Rights CODECO.
 46. Foundation for Nature and Life FUNAVI
6. **BRAZIL**
 47. IBFAN Brazil
7. **CAPE VERDE**
 48. Ministry of Health
 49. National Nutrition Program-Cape Verde
 50. INE (National Institute of Statistics of Cape Verde)
8. **CHINA**
 51. Ministry of Health
 52. WHO China Office
 53. UNICEF China Office
 54. China Advertising Association, Legal Services Center
 55. China Consumer Associate
 56. China Preventive Medicine Association, Society of Child Health
 57. Capital Institute of Pediatrics
9. **COLOMBIA**
 58. Ministry of Social Protection
 59. Secretary of Health of Bogotá
 60. Guillermo Fergusson Foundation
 61. IBFAN Colombia
 62. Colombian Institute for Family Welfare
 63. Profamily
 64. National Institute of Health
 65. Antioquia University
 66. PAHO Colombia
 67. UNFPA Colombia
 68. UNICEF Colombia
 69. Institute for Surveillance of Medicines and Foods INVIMA
 70. Javeriana University
 71. Bogotá District of Health
 72. District Group for the Promotion, Protection and Support of Breastfeeding
 73. Corporation Promoter of Health - Saludcoop
10. **COSTA RICA**
 74. Ministry of Health.
 75. Ministry of Public Education.
 76. Ministry of Economy, Industry and Trade.
 77. National Breastfeeding Commission.
 78. Costa Rican Social Security Entity.
 79. Costa Rican Institute for Research and Education on Nutrition and Health.
 80. School of Nutrition at the University of Costa Rica.
 81. Costa Rican Union of Associations and Chambers of Private Enterprise.
 82. National AIDS Program.
 83. National Emergency Commission.
 84. Feminist Center for Information and Action CEFEMINA.
 85. WABA Focal Point for Latin America and the Caribbean.
 86. Association for Breastfeeding Promotion APROLAMA.
 87. United Network for Mother, Babies and Nutrition (RUMBA).
 88. International Baby Food Action Network (IBFAN)-Costa Rica
11. **DOMINICAN REPUBLIC**
 89. State Secretariat of Public Health and Social Assistance.
 90. State Secretariat of Environment.
 91. State Secretariat of Women.
 92. Dominican Institute of Food and Nutrition.
 93. National Breastfeeding Program SESPAS.
 94. National Breastfeeding Commission.
 95. International Baby Food Action Network IBFAN Dominican Republic.
 96. PAHO Dominican Republic.
 97. State Secretariat of Education.
 98. State Secretariat of Industry and Trade.
 99. State Secretariat of Agriculture.
 100. Dominican Social Security Institute.
 101. Autonomous University of Santo Domingo.
 102. Dominican Republic Pediatric Society.
 103. National Council for Childhood.
 104. Dominican Republic Caritas.
 105. La Leche League.
 106. Maternal-Infant National Research Center CENISMI.
 107. Project Hope.
 108. Sexually Transmitted Diseases and AIDS General Direction.
 109. General Emergencies Direction
12. **ECUADOR**
 110. Nutrition Coordination of Ministry of Health
 111. Direction of Public Health of Guayas
 112. Nutritionists DPSG
 113. FUNBBASIC. Foundation
 114. International Baby Food Action Network (IBFAN)-Ecuador.
 115. Standardization MSP, Health Surveillance MSP
 116. South Hospital MSP, DIPLASEDE MSP
 117. HIV AIDS Program MSP
 118. Ministry for Economic and Social Coordination.
 119. World Food Program WFP
 120. UNICEF
 121. International University San Francisco de Quito
 122. Association of Faculties of Health AFEME
 123. Central University of Ecuador
 124. National Council of Women CONAMU
 125. Equinoctial Technological University
 126. Catholic University of Guayaquil
 127. Guayaquil State University
 128. Obstetrics College of the State University
 129. Mariana de Jesus Maternity
 130. Guayaquil Hospital
 131. Municipal Social Development Office
 132. Cantonal Council for Childhood and Adolescents
13. **GAMBIA**
 133. National Nutrition Agency (NaNA)
 134. Department of State for Health and Social Welfare
 - a. Reproductive and Child Health Unit
 - b. Regional Health Team
 - c. Prevention of Parent To Child Transmission
 - d. Integrated Management of Neonatal and Childhood Illness Unit
 135. Gambia Food and Nutrition Association (GAFNA)
 136. Gambia Family Planning Association (GFPA)
 137. Christian Children's Fund (CCF)
 138. UNICEF
 139. WHO
 140. Gambia College School of Nursing & Midwifery
 141. Labour Commission
 142. National AIDS Secretariat (NAS)
 143. Association of Health Journalists (AOHJ)
 144. Gambia Radio and Television Services (GRTS)
 145. Department of Community Development (DCD)
 146. Gambia Bureau of Statistics
14. **GHANA**
 147. The Ministry of Women and Children's Affairs (MOWAC)
 148. Ghana Infant Nutrition Action Network (GINAN)
 149. The Ghana Health Service (GHS)
 150. The Ghana Broadcasting Corporation (GBC)
 151. The Nurses and Midwives Council

152. The Ghana Medical School
 153. The Rural Health Training School.
- 15. INDIA**
154. Indian Council of Medical Research (ICMR)
 155. National AIDS Control Organisation (NACO)
 156. National Health Systems Resource Centre (NHSRC)
 157. Breastfeeding Promotion Network of India (BPNI)
 158. Federation of Obstetric & Gynecological Societies of India (FOGSI)
 159. Indian Academy of Pediatrics (IAP)
 160. Indian Association of Preventive and Social Medicine (IAPSM)
 161. International Baby Food Action Network (IBFAN), Asia
 162. Jan Swasthya Abhiyan (JSA)
 163. Mobile Creches
 164. Office of Commissioners to the Supreme Court (on Right to Food, CWP196/2001).
 165. Public Health Resource Network (PHRN)
 166. Trained Nurses' Association of India (TNAI)
- 16. INDONESIA**
167. Indonesian Ministry of Health.
 168. Asosiasi Ibu Menyusui Indonesia (AIMI)- Indonesian Breastfeeding Mothers Association.
 169. SELASI Sentra Laktasi Indonesia Indonesian Breastfeeding Center.
 170. Perinasia Indonesian Perinatology Association.
- 17. KOREA**
171. The Academy of Breastfeeding Medicine Korea
 172. The Korean association of Pediatric Practitioners
 173. The Korean Society of Obstetrics and Gynecology
 174. The Korean Society of Neonatology
 175. Consumers Korea
- 18. MALAWI**
176. Office of the President and Cabinet, the Department of Nutrition, HIV and AIDS
 177. Ministry of Health (Nutrition Unit)
 178. Health Information Management System
 179. Kamuzu Central Hospital
- 19. MALDIVES**
180. Ministry of Health & Family
 181. Centre for Community Health & Disease Control (CCHDC)
 182. Maldives Food & Drug Authority
- 20. MEXICO**
183. LAC MAT Mexico
 184. IBFAN Mexico
 185. LLL Mexico
- 21. MONGOLIA**
186. Ministry of Health (Child health, Nutrition, maternal health, MIS)
 187. Public Health Institute
 188. WHO, Mongolia
 189. Maternal and Child Health Research Center
 190. Mongolian Paediatric Association
 191. Mongolian Midwifery Association
 192. Health Science University of Mongolia (Dept. of Pediatrics, Dept. of Family Medicine)
 193. Ministry of social welfare and labour (ILO project)
 194. Child and adolescent support center, NGO
- 22. MOZAMBIQUE**
195. Ministry of Health
 196. Department of Nutrition
 197. Health Department for Women and Child
 198. Lawyer Advisor's Cabinet
- 23. NEPAL**
199. Nutrition Section, Child Health Division, Government of Nepal
 200. Nepal Breastfeeding Promotion Forum (NEBPROF)
 201. Nepal Paediatric Society (NEPAS)
 202. Perinatal Society of Nepal (PESON)
 203. Department of Child Health, IOM
 204. Maharajganj Nursing Campus, IOM
 205. TU Teaching Hospital
 206. Kanti Children's Hospital
 207. Bhabisya Nepal
 208. Terre des Homes
 209. Democracy for Election Alliance
 210. Stupa College of Nursing
 211. Mother and Infant Research Activity (MIRA)
- 24. NICARAGUA**
212. Ministry of Health
 213. Integral Attention of Nicaraguan Children Program - AIN
 214. Integral Attention of Women Program AIN
 215. Community Program of Health and Nutrition - PROCOSAN
 216. National Program of Micronutrients
 217. National Program of Breastfeeding
 218. Ministry of Agriculture MAG-FOR
 219. Attention for Vulnerable Groups Program
 220. WFP Nicaragua
 221. National Program for Eradication of Infant Chronic Malnutrition 2008-2015
 222. Politecn University - UPOLI
 223. National Breastfeeding Commission CONALAMA
 224. Breastfeeding Counselors Network
 225. Infant Community Kitchens Friends of Mothers and Children CICO
226. Ministry of the Family
 227. National system for the Prevention, Mitigation and Attention of Disasters
 228. Information System of the Government of National Unity - SIGRUN
- 25. PAKISTAN**
229. Ministry of Health
 230. Ministry of Law, Justices and Human right
 231. Ministry of Planning
 232. The National Nutrition Program
 233. The MNCH program
 234. The National Program for Family Planning and Primary Health Care
 235. Provincial Health departments of all four provinces.
 236. Pakistan Paediatric Association
 237. Public Health Specialist
 238. USAID
 239. PAIMAN
 240. UNICEF
 241. WHO
 242. Save the children US
 243. Save the children UK
- 26. PERU**
244. Ministry of Health
 245. Ministry of Education
 246. Ministry of Work and Promotion of Employment
 247. Ministry of Women
 248. Center for Social Studies and Publication CESIP
 249. IBFAN Peru
 250. Multisectorial Commission for the Promotion, Protection and Support of Breastfeeding
 251. Institute for the Defense of the Competence and Protection of Intellectual Property (INDECOP)
 252. IBCLC Consultants
- 27. PHILIPPINES**
253. Department of Health (DOH)
 254. UNICEF
 255. WHO
 256. ARUGAAN
 257. Trade Union Congress of the Philippines (TUCP) Women's Desk
- 28. SRI LANKA**
258. Ministry of Health & Nutrition
 259. Ministry of Health, Siyambalanduwa
 260. WHO
 261. UNICEF
 262. Census & Statistics
 263. Sarvodaya Women's Movement
- 29. TAIWAN**
264. Chinese Women Consumers Association (CWCA)
 265. Chinese Dietetic Society (Taiwan)
 266. Taiwan Academy of Breastfeeding.
- 30. UGANDA**
267. Ministry of Health
 268. World Food Programme
 269. Save the Children in Uganda
 270. IBFAN Uganda
- 31. URUGUAY**
271. Ministry of Labor and Social Security.
 272. National Directorate of Employment.
 273. Uruguayan Network to Support Nutrition and Infant Development RUANDI.
 274. International Baby Food Action Network IBFAN Uruguay.
 275. Social Security Bank.
 276. Master in Nutrition UCUDAL.
 277. Committee on Nutrition of the Pediatrics Uruguayan Society and Pediatrics Deputy Prof.
 278. MYSU- Women and Health in Uruguay.
 279. MSP - Food Department.
 280. UNICEF's Communication Area.
 281. UNDP Development Project School of Nutrition and Dietetics.
 282. Uruguayan Network of Milk Banks
 283. Breastfeeding Committee Pediatrics Uruguayan Society.
 284. Montevideo Municipality.
 285. Gender Department PIT-CNT.
 286. Primary Care Network ASSE.
- 32. VIETNAM**
287. Health Mother and Child Department, MoH
 288. National Obstetric Hospital
 289. National Institute of Nutrition
 290. National Paediatrics Hospital
 291. Communication and Health Education department
 292. UNICEF Vietnam
 293. LIGHT
 294. CEPHAD
- 33. ZAMBIA**
295. Ministry of Health
 296. National Food and Nutrition Commission
 297. Natural Resources Development College

Methods to Derive Colour Coding/Rating

Each indicator of WBTi has its specific significance. As mentioned earlier there are 10 indicators related to policies and programmes, and five that deal with infant feeding practices.

The indicators that deal with policies and programmes have each a subset of criteria or questions that go into finer details of the achievements or gaps, to indicate how a country is performing in a particular area. Each question has a possible score of 0-3 and the indicator has a maximum score of 10. Achievement is measured on a scale of 10. In this assessment several methods are used such as reading and analysis of policy document or personal interviews.

Five indicators dealing with infant and young child feeding practices reveal how effectively a country has implemented its policies and programmes. For these indicators, countries have to use secondary numerical data on each indicator from a random household survey that is national in scope. **The WBTi process does not undertake primary household surveys.**

The maximum score for indicators dealing with programmes and policies is 100, and for those dealing with feeding practices is 50, giving an overall total of 150.

The level of achievement on each indicator is rated on a scale to provide a colour-rating and grading i.e. 'Red' or 'Grade D', Yellow or 'Grade C', Blue or 'Grade B' and Green or 'Grade A'.

In the case of 10 policy and programme indicators, the WBTi ratings are given as Grade A for the best achievement and Grade D for the least achievement; the tool uses 30%, 30-60%, and 60-90% or above 90% to provide colour rating from Red, to yellow, to Blue to Green in ascending order. Each subset question has been assigned a particular 'score'. Achievement of each indicator is a total of these scores and is given after the assessment has been completed with consensus.

In the case of the 5 indicators of IYCF practices, the method of the cut-off points for each level of achievement was adapted from the WHO tool, where they were selected systematically, based on an analysis of past achievements on these indicators in developing countries. In the WHO tool, the ratings were developed based on an analysis of percentages achieved by countries on the various indicators. The results from each country were rated from the lowest to the highest, using the Excel software programme. The results were then divided into five parts. The first two-fifths of the scores were used to determine the rating for "poor", the second two-fifths for "fair" and the last one-fifth for "good". The rating "very good" was reserved to indicate practices that were close to 'optimal' for example 90-100% attainment of exclusive breastfeeding for 0-6 months. Each practice indicator is assigned a 'score' as per IBFAN Asia's guidelines.

IBFAN Asia's Guidelines for Scoring, Colour-Rating, Grading

Part 1: IYCF Policies and Programmes

Here is the guideline for scoring/colour coding. Each indicator has a maximum score of 10.

Score	Colour	Grading
0-3	RED	D
4-6	YELLOW	C
7-9	BLUE	B
9.1-10	GREEN	A

Part 1: Total

Total score of infant and young child feeding policies and programmes are calculated out of 100.

Score	Colour	Grading
0-30	RED	D
31-60	YELLOW	C
61-90	BLUE	B
91-100	GREEN	A

Part 2: IYCF Practices

In the case of indicators on IYCF practices, key to rating is used from WHO's 'Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes'. Scoring, color-rating and grading are provided according to IBFAN Asia's guidelines for WBTi. Each indicator is scored out of maximum of 10.

IYCF Practices	WHO's Infant and Young Child Feeding: A tool for assessing national practices, policies and programme	IBFAN Asia's Guidelines for scoring and rating for WBTi		
		Score	Colour	Grading
Initiation of Breastfeeding (Within 1 hour)	0-29%	3	RED	D
	30-49%	6	YELLOW	C
	50-89%	9	BLUE	B
	90-100%	10	GREEN	A
Exclusive Breastfeeding for the First Six Months	0-11%	3	RED	D
	12-49%	6	YELLOW	C
	50-89%	9	BLUE	B
	90-100%	10	GREEN	A
Media Duration of Breastfeeding	0-17 months	3	RED	D
	18-20 months	6	YELLOW	C
	21-22 months	9	BLUE	B
	23-24 months	10	GREEN	A
Bottle-feeding (<6 months)	30-100%	3	RED	D
	5-29%	6	YELLOW	C
	3-4%	9	BLUE	B
	0-2%	10	GREEN	A
Complementary Feeding (6-9 months)	0-59%	3	RED	D
	60-79%	6	YELLOW	C
	80-94%	9	BLUE	B
	95-100%	10	GREEN	A

Part 2: Total

Total score of infant and young child feeding practices are calculated out of 50.

Score	Colour	Grading
0-15	RED	D
16-30	YELLOW	C
31-45	BLUE	B
46-50	GREEN	A

Total Score of Part 1 and Part 2

Total score of infant and young child feeding practices, policies and programmes are calculated out of 150. Countries are then graded as:

Score	Colour	Grading
0-45	RED	D
46-90	YELLOW	C
91-135	BLUE	B
136-150	GREEN	A



Photo Credit: Nupur Bidla

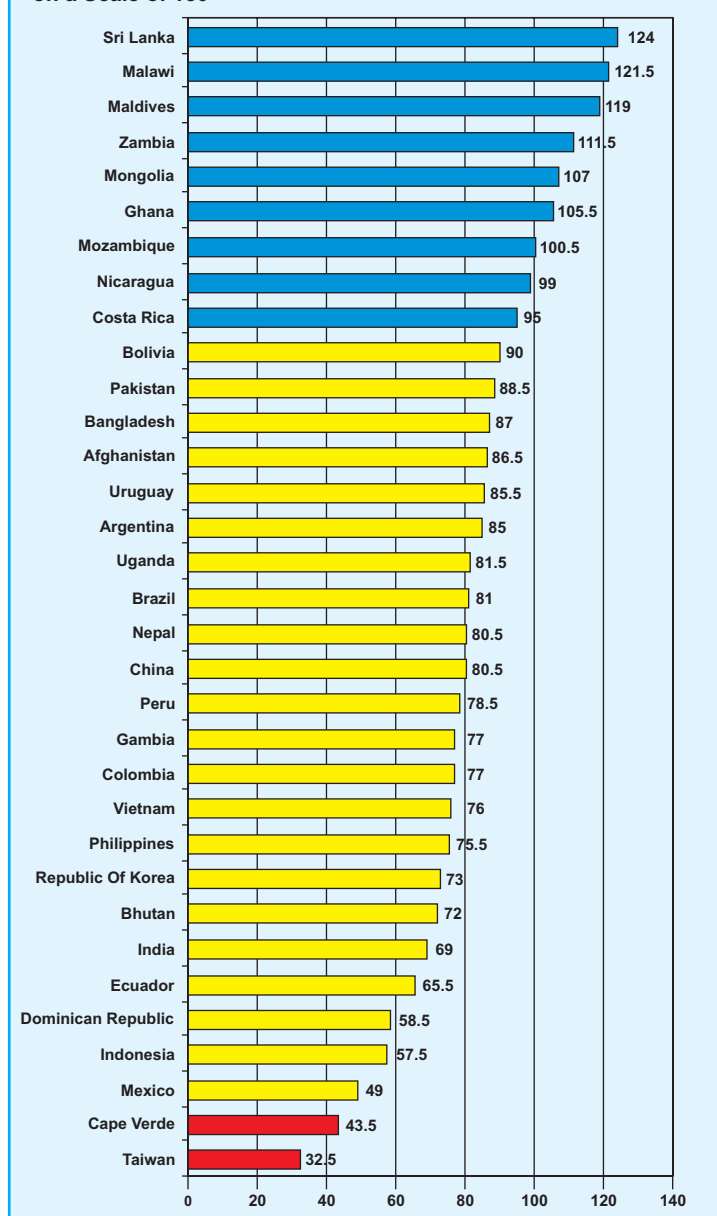
Where Countries Stand?

This section presents findings of the national WBTi assessments in 33 Countries. Part-1 gives the status of policies and programmes and Part-2 the status of the resultant infant and young child feeding practices.

This is based on the WBTi assessment conducted during 2008-09. Fig.2 gives an overview of where these countries stand on a scale of 150. It also shows the colour coding of each country; there are nine countries in blue, 22 in yellow and two in red.

It is evident from Fig. 2 that none of the 33 countries that have completed the assessment are in the green level; none have so far managed to implement the *Global Strategy* in full. The average score for the 33 countries is 82.8 out of a possible 150, that is, in the yellow level. Sri Lanka, with a score of 124, is on the top, but it is still in the blue level, which means that there is scope for improvement. The other countries in the blue level include Malawi, Maldives, Zambia, Mongolia, Ghana, Mozambique, Nicaragua and Costa Rica.

Fig. 2: The State of Breastfeeding in 33 Countries measured on a Scale of 150



The majority of the countries are in the yellow level. Bolivia, Pakistan, Bangladesh, Afghanistan, Uruguay, Argentina, Uganda, Brazil, and Nepal, People's Republic of China, Peru, Gambia, Colombia, Vietnam, Philippines, Republic of Korea, Bhutan, India, Ecuador, Dominican Republic, Indonesia and Mexico.

The countries in the red level are Cape Verde and Taiwan, with the latter assessed as having the lowest score at 32.5.

These findings give countries an opportunity to move to the next colour level, if not to jump to green directly if optimal conditions have been achieved.

Part 1: IYCF Policies and Programmes

Infant and young child feeding practices are key to reduction of malnutrition and mortality of children under 5 years of age. UNICEF's report, *Tracking Progress on Child and Maternal Nutrition: A survival and development priority* clearly states: "There is a critical window of opportunity to prevent undernutrition, while a mother is pregnant and during a child's first two years of life when proven nutrition interventions offer children the best chance to survive and reach optimal growth and development. Marked reductions in child undernutrition can be achieved through improvements in early and exclusive breastfeeding, and good-quality complementary feeding for infants and young children...."

The *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* (1990)¹⁵ set an international agenda with ambitious targets for action. The *Innocenti Declaration on Infant and Young Child Feeding*¹⁶ called on all governments for action in many areas including "....Establish sustainable systems for monitoring infant and young child feeding patterns and trends and use this information for advocacy and programming."

Recognising the importance of infant and young child feeding in preventing infant and young child malnutrition and mortality, the World Health Assembly (WHA) and the UNICEF Executive Board adopted the *Global Strategy for Feeding of Infants and Young Children* in the year 2002. Since then, there have been several calls for urgent action by all Members States to develop, implement, monitor and evaluate a comprehensive policy and a plan of action on infant and young child feeding to achieve a reduction in child malnutrition and mortality.

In May 2005, the World Health Assembly adopted resolution WHA 58.32 that called upon member states to assure resources for plans of action for improving infant and young child feeding practices whilst avoiding any conflicts of interests in the child health programmes.

In May 2010, the World Health Assembly adopted a resolution 63.23 on Infant and Young Child Nutrition, which called upon Member States ".....to scale up interventions to improve infant and young child nutrition in an integrated manner with the protection, promotion and support of breastfeeding and timely, safe and appropriate complementary feeding as core interventions...";

Scaling up interventions that lead to a rise in optimal infant and young child feeding practices is feasible if the political choices are made correctly. Over the past 5 to 10 years, for example, 16 countries, some of which faced serious development challenges



Photo Credit: WABA

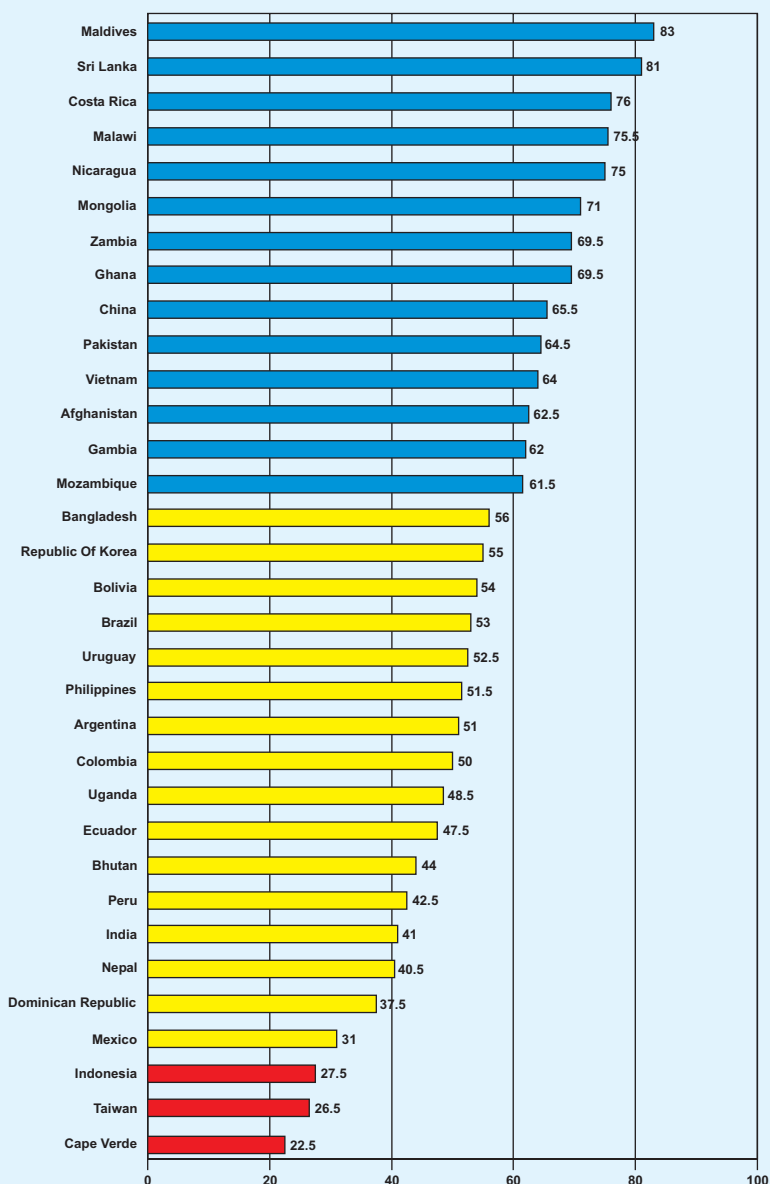
Scaling up interventions that lead to a rise in optimal infant and young child feeding practices is feasible if the political choices are made correctly.

and often emergency situations as well, recorded gains of 20 percentage points or more in exclusive breastfeeding rates.¹ The implementation of large-scale programmes in these countries was based on national policies and often guided by the *Global Strategy*. Actions have included the adoption and implementation of national legislation on the *International Code of Marketing of Breastmilk Substitutes* and subsequent *World Health Assembly Resolutions*, as well as maternity protection for working women, skilled support to women to initiate timely breastfeeding, skilled counselling and 'mother support' for exclusive breastfeeding. Situation analysis, political commitment, capacity building and community outreach are among the factors that are essential to scaling up optimal infant and young child feeding practices.

Fig. 3 gives the colour coding and total scores for the WBTi indicators related to IYCF policies and programmes, measured on a scale of 100.

The average score of the 33 countries is 54.9, putting it in the yellow level. Maldives has the highest score at 83 and Cape Verde the lowest of 22.5 out of a possible total of 100 for the 10 indicators.

Fig. 3: The State of Policies and Programmes on IYCF in 33 countries (Measured on a Scale of 100)



The majority of countries 16 are in the yellow level; 14 countries are in the blue level, and three Cape Verde, Taiwan and Indonesia are in the red level. No country has yet scored enough to enter the green level.

Indicators related to IYCF Policies and Programmes. The following 10 indicators make up of part of this assessment:

1. National Policy, Programme and Coordination
2. Baby Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding)
3. Implementation of the International Code
4. Maternity Protection
5. Health and Nutrition Care Systems
6. Mother Support and Community Outreach - Community-based support for the pregnant and breastfeeding mother
7. Information Support
8. Infant Feeding and HIV
9. Infant Feeding During Emergencies
10. Monitoring and Evaluation

In the following section findings from each indicator are presented using the finer details in the questionnaire. Each indicator is described with specific background information, questions used for assessment, respective scores for each subset and finally where the 33 countries stand.

1. National Policy, Programme and Coordination

The first operational target of the *Innocenti Declaration* 1990 called upon governments to appoint a national coordinator of breastfeeding with appropriate powers and authority, and establish a national committee composed of multi-sectoral representatives from government departments, non-governmental organizations, and health personnel involved in the matter. Operational target 5 of the *Global Strategy on Infant and Young Child Feeding* requires that governments develop, implement, monitor and evaluate a comprehensive policy on infant and young child feeding, in the context of national policies and programmes for nutrition, child and reproductive health, and poverty reduction.

The *Indicator on National Policy, Programme and Coordination* addresses this particular need of having a national infant and young child feeding/breastfeeding policy, which is well implemented for the protection, promotion, and support of optimal infant and young child feeding, and a government plan to support the policy. Besides looking at whether there is a mechanism for coordination, the subset of questions provides information on whether the policy has an attached plan and a budgetary allocation for putting the plan into action, as well as the status of its implementation.

Subset for the indicator and scoring

Table 3 gives the subset of questions for assessment and scoring of the indicator. The eight criteria 1.1 to 1.8 have scores ranging from 0.5 to 2 and the total score is calculated by adding the scores for the eight criteria.

Findings

Table 4 gives the details of scoring on each of the sub set of indicators for all the 33 countries, providing extensive information on where the gaps are.

Fig. 4 provides mapping based on colour coding and a graph of 33 countries.

Table 3: Subset Questionnaire for the Indicator and Scoring for each Criteria

No.	Criteria	Scoring
1.1	A national infant and young child feeding/breastfeeding policy has been officially adopted/approved by the government	2
1.2	The policy promotes exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	2
1.3	A national plan of action has been developed with the policy	2
1.4	The plan is adequately funded	1
1.5	There is a National Breastfeeding/IYCF Committee	1
1.6	The National Breastfeeding/Infant and Young Child Feeding Committee meets and reviews on a regular basis	1
1.7	The National Breastfeeding/ Infant and Young Child Feeding Committee links with all other sectors like health, nutrition, information etc., effectively	0.5
1.8	National Breastfeeding Committee is headed by a coordinator with clear terms of reference	0.5
Total Score		10

Table 4: Country Scores for Each Criteria

Country	Total score of indicator out of 10	Indicators							
		1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Afghanistan	10	2	2	2	1	1	1	0.5	0.5
Argentina	4	2	2	0	0	0	0	0	0
Bangladesh	6	2	2	2	0	0	0	0	0
Bhutan	7	2	2	2	0	1	0	0	0
Bolivia	10	2	2	2	1	1	1	0.5	0.5
Brazil	9	2	2	2	0	1	1	0.5	0.5
Cape Verde	0	0	0	0	0	0	0	0	0
China	10	2	2	2	1	1	1	0.5	0.5
Colombia	5.5	0	2	2	0	1	0	0.5	0
Costa Rica	10	2	2	2	1	1	1	0.5	0.5
Dominican Republic	3	0	0	0	0	1	1	0.5	0.5
Ecuador	5	2	2	0	0	1	0	0	0
Gambia	6	2	2	2	0	0	0	0	0
Ghana	9	2	2	2	0	1	1	0.5	0.5
India	2	0	0	0	0	1	0	0.5	0.5
Indonesia	6	2	2	2	0	0	0	0	0
Korea	5	2	0	2	1	0	0	0	0
Malawi	7.5	2	2	2	0	1	0	0	0.5
Maldives	9	2	2	2	1	1	0	0.5	0.5
Mexico	2	2	0	0	0	0	0	0	0
Mongolia	6.5	0	2	2	0	1	1	0.5	0
Mozambique	5	0	2	0	0	1	1	0.5	0.5
Nepal	5.5	2	2	0	0	1	0	0	0.5
Nicaragua	9	2	2	2	1	1	0	0.5	0.5
Pakistan	8	2	2	2	0	1	0	0.5	0.5
Peru	5	2	0	0	0	1	1	0.5	0.5
Philippines	8	2	2	2	0	1	0	0.5	0.5
Sri Lanka	10	2	2	2	1	1	1	0.5	0.5
Taiwan	0	0	0	0	0	0	0	0	0
Uganda	5	2	2	0	0	0	0	0.5	0.5
Uruguay	6.5	2	2	0	0	1	1	0	0.5
Vietnam	8	2	2	2	1	0	1	0	0
Zambia	9	2	2	2	0	1	1	0.5	0.5

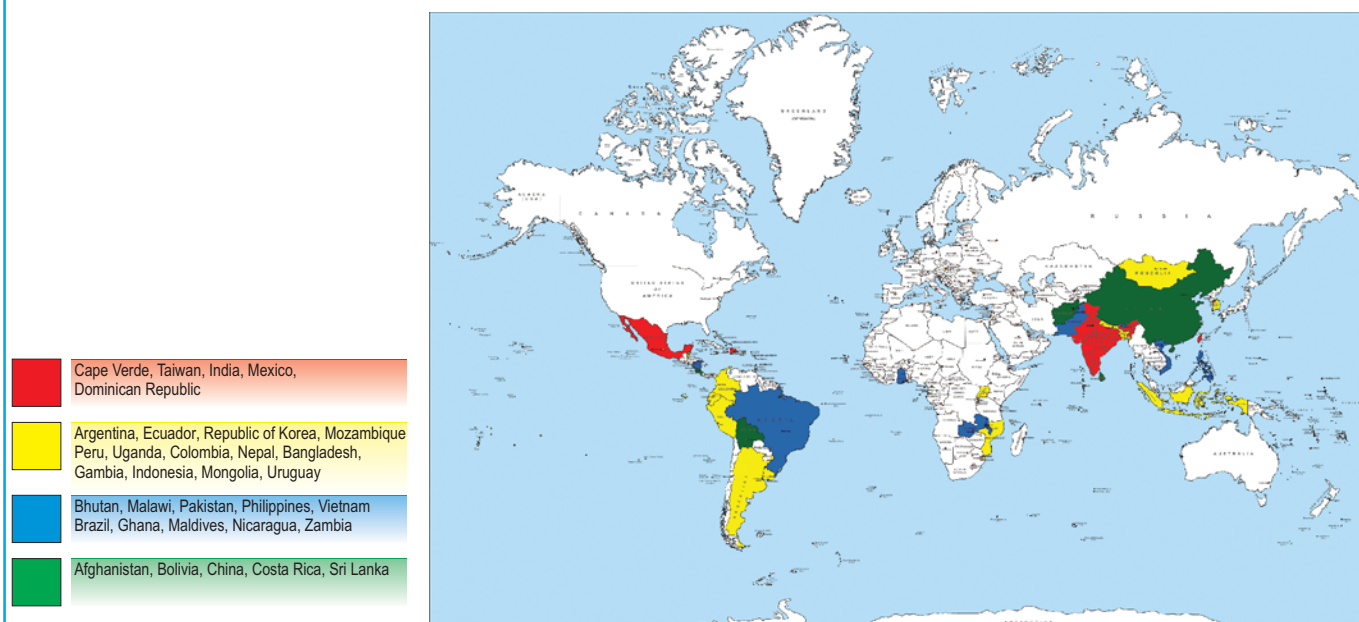
The average score for this indicator is 6.41, with Afghanistan, Bolivia, China, Costa Rica and Sri Lanka scoring a full 10 points each and entering the green level, and Cape Verde and Taiwan scoring zero each in the red level. There are 13 countries in the blue and 10 in the yellow level. India, Mexico and Dominican Republic are also in the red level.

A look at the scoring for the sub set of questions for the indicator clearly spells the need for strengthening policies plans of action and implementation of optimal breastfeeding practices. Criterion 1.1 indicates that six of the 33 countries do not have a written national policy on infant and young child feeding; these are Cape Verde, Columbia, Dominican Republic, India, Mozambique and Taiwan. While the India report reveals that there is a national guideline on infant and young child feeding, this has not been adopted as national policy. The scores for criterion 1.3 show that of those who have a policy, eight countries Argentina, Bhutan, Ecuador, Mexico, Nepal, Peru, Uganda and Uruguay - do not have a national plan of action. Where it does, it is not always funded; only nine countries have set aside a budget for it: Afghanistan, Bolivia, China, Costa Rica, Korea, Maldives, Nicaragua, Sri Lanka and Vietnam. Criteria 1.5 and 1.6 show that National Breastfeeding Committees exist in 23 countries, but meets regularly only in 14 of them.

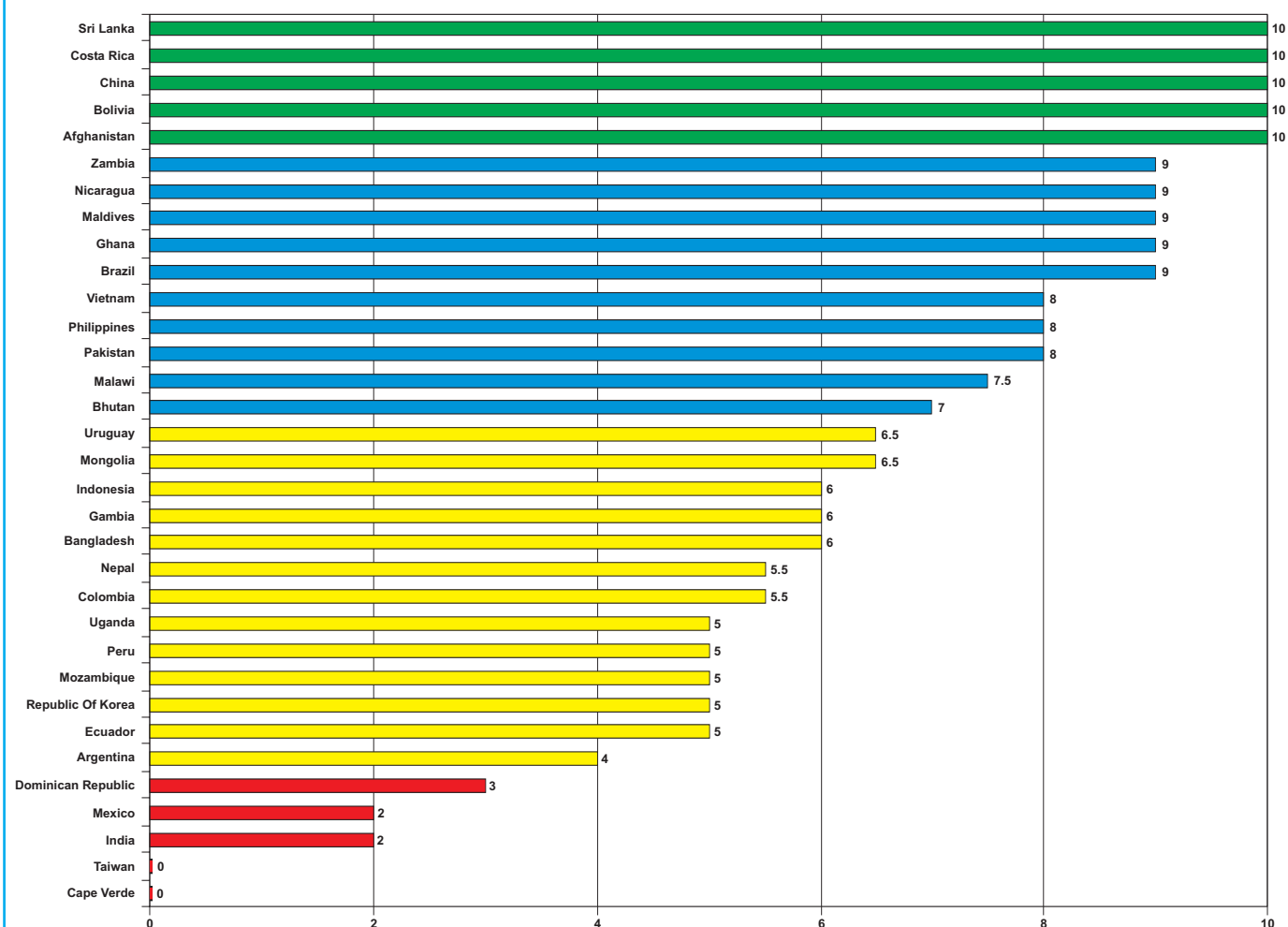
These findings point out specific gaps in the policy environment and its implementation, which need to be addressed in action plans. If most countries do not reflect action plans in their budgets it is a serious gap that must be bridged through improved understanding of programme managers.

Fig. 4: National Policy, Programme and Coordination

Colour Coding of Countries for Indicator on National Policy, Programme and Coordination



The State of National Policy, Programme and Coordination in 33 countries on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

2. Baby Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding)



Photo Credit: BPNI

UNICEF and WHO launched BFHI in 1991, to ensure that all maternity services in hospitals and nursing homes are made breastfeeding friendly and support for breastfeeding becomes a central point of their programme as a standard for care. To qualify for being designated as 'baby friendly', a facility needed to implement all "The Ten Steps to Successful Breastfeeding". This included training of all staff working in the maternity and child care sections to provide skilled support for early initiation and exclusive breastfeeding; in addition the facility could not accept free or low-cost breastmilk substitutes, feeding bottles or teats. The 10th step of BFHI also included establishment of community outreach support systems for breastfeeding mothers.

One of the operational targets of the *Innocenti Declaration* of 1990 was that by 1995, all governments would have ensured that every facility providing maternity services fully practiced all ten steps to successful breastfeeding.

The indicator to assess BFHI addresses the need for implementing breastfeeding friendly policies both in hospitals and outside hospitals. The subset of questions includes both

quantitative and qualitative assessment.

Table 5: Subset Questionnaire for the Indicator and Scoring for Each Criteria

Table 5A: Quantitative: Percentage of BFHI hospitals

Criteria 2.1	Score
0	0
0.1-7%	1
8-49%	2
50-89%	3
90-100%	4
Maximum Score	4

Table 5B: Qualitative: to find out skilled training inputs and sustainability of BFHI

This subset looks at the percentage of BFHI designated hospitals that have been certified after a minimum recommended training of 18 hours for all its staff working in maternity services.

Criteria 2.2	Score
0	0
0.1-25%	1
26-50%	1.5
51-75%	2.5
75% and more	3.5
Maximum Score	3.5

Table 5C: To find out the quality of BFHI program implementation, through questions addressing planning, monitoring, assessment, and capacity etc.

No.	Criteria	Score
2.3	BFHI programme relies on training of health workers	0.5
2.4	A standard monitoring system is in place	0.5
2.5	An assessment system relies on interviews of mothers	0.5
2.6	Reassessment systems have been incorporated in national plans	0.5
2.7	There is a time-bound program to increase the number of BFHI institutions in the country	0.5
	Maximum Score	2.5

Maximum Score of Indicator: Total of 2.1, 2.2 and 2.3

10

Subset for the Indicator and Scoring

The subset of questions addressing both the quantity and quality of BFHI is divided into three parts, as shown in Tables 5A, 5B and 5C. Table 5A is quantitative and the maximum score possible is 4. Tables 5B and 5C are qualitative, with the latter having a further five criteria. The maximum scores for 5B and 5C are 3.5 and 2.5 respectively. The total of the three scores gives the score for the indicator. While this indicator deals mostly with practices in the hospitals, other indicators address the outreach and mother support issues.

Findings

Fig. 5 provides a mapping based on colour coding and a graph of the score of this indicator on a scale of 10.

Table 6: Scores for sub set for Indicator on BFHI

Country	Total score out of 10	Indicators						
		2.1	2.2	2.3	2.4	2.5	2.6	2.7
Afghanistan	3.5	2	1	0.5	0	0	0	0
Argentina	6.5	1	3.5	0.5	0.5	0.5	0.5	0
Bangladesh	8.0	3	3.5	0.5	0	0.5	0	0.5
Bhutan	4.0	1	1	0.5	0	0.5	0.5	0.5
Bolivia	4.0	1	1	0.5	0	0.5	0.5	0.5
Brazil	2.5	1	0	0.5	0.5	0.5	0	0
Cape Verde	5.0	2	1	0.5	0.5	0.5	0.5	0
China	9	4	3.5	0.5	0.5	0	0	0.5
Colombia	5.5	0	3.5	0.5	0.5	0.5	0	0.5
Costa Rica	7.5	2	3.5	0.5	0.5	0.5	0.5	0
Dominican Republic	6.5	1	3.5	0.5	0	0.5	0.5	0.5
Ecuador	6.5	3	2.5	0.5	0	0.5	0	0
Gambia	2.5	0	0	0.5	0.5	0.5	0.5	0.5
Ghana	7	2	2.5	0.5	0.5	0.5	0.5	0.5
India	4	2	1.5	0	0	0.5	0	0
Indonesia	0	0	0	0	0	0	0	0
Korea	4.5	2	1.5	0.5	0.5	0	0	0
Malawi	7	1	3.5	0.5	0.5	0.5	0.5	0.5
Maldives	7.5	2	3.5	0.5	0.5	0.5	0.5	0
Mexico	5	3	1	0.5	0.5	0	0	0
Mongolia	7	3	2.5	0.5	0.5	0.5	0	0
Mozambique	0	0	0	0	0	0	0	0
Nepal	2.5	1	1	0	0	0.5	0	0
Nicaragua	8.5	3	3.5	0.5	0.5	0.5	0.5	0
Pakistan	4	2	0	0.5	0.5	0.5	0	0.5
Philippines	10	4	3.5	0.5	0.5	0.5	0.5	0.5
Peru	6	1	3.5	0.5	0	0	0.5	0.5
Sri Lanka	8	2	3.5	0.5	0.5	0.5	0.5	0.5
Taiwan	3	2	0	0.5	0	0.5	0	0
Uganda	2.5	1	1	0.5	0	0	0	0
Uruguay	7.5	2	3.5	0.5	0.5	0.5	0.5	0
Vietnam	3	1	1.5	0.5	0	0	0	0
Zambia	4.5	1	1	0.5	0.5	0.5	0.5	0.5

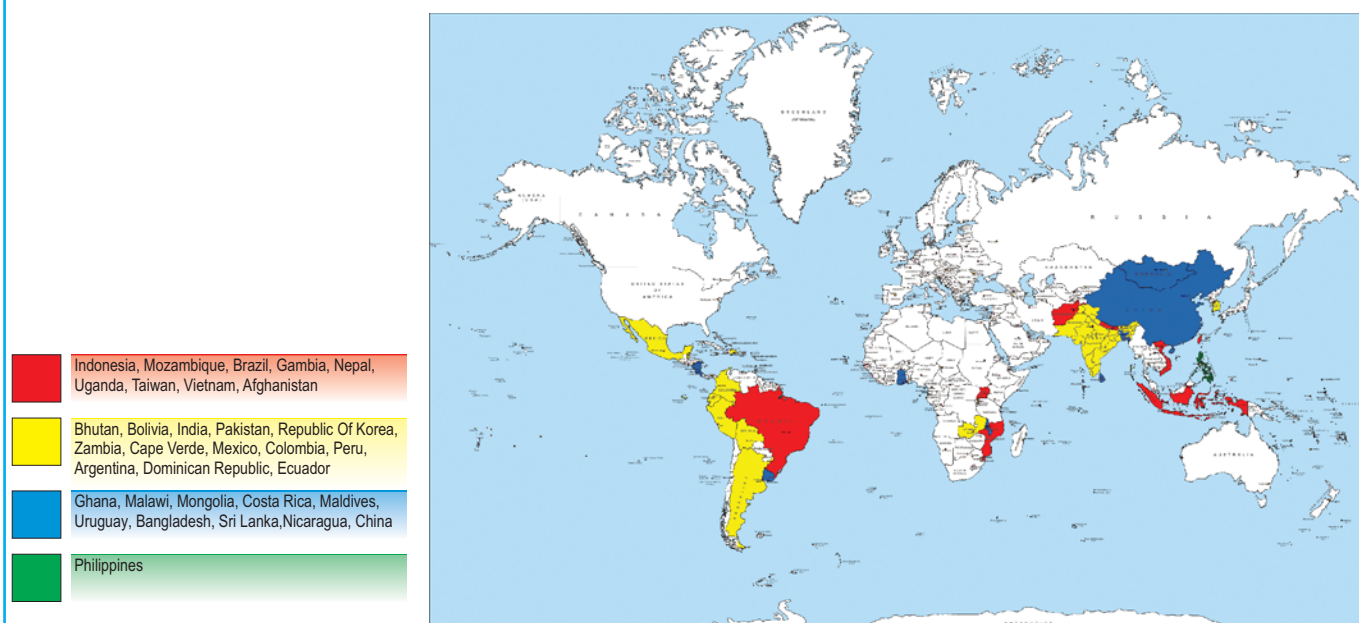
Average score for this indicator is 5.23, with only Philippines getting a full score of 10 and being in the green level. Nine countries are in the red level Afghanistan, Vietnam, Taiwan, Uganda, Nepal, Gambia, Brazil, Mozambique and Indonesia, with the last two countries scoring a zero each. There are 13 countries in the yellow level and 10 in the blue level.

Table 6 gives the scores the countries received for the indicator and its subsets.

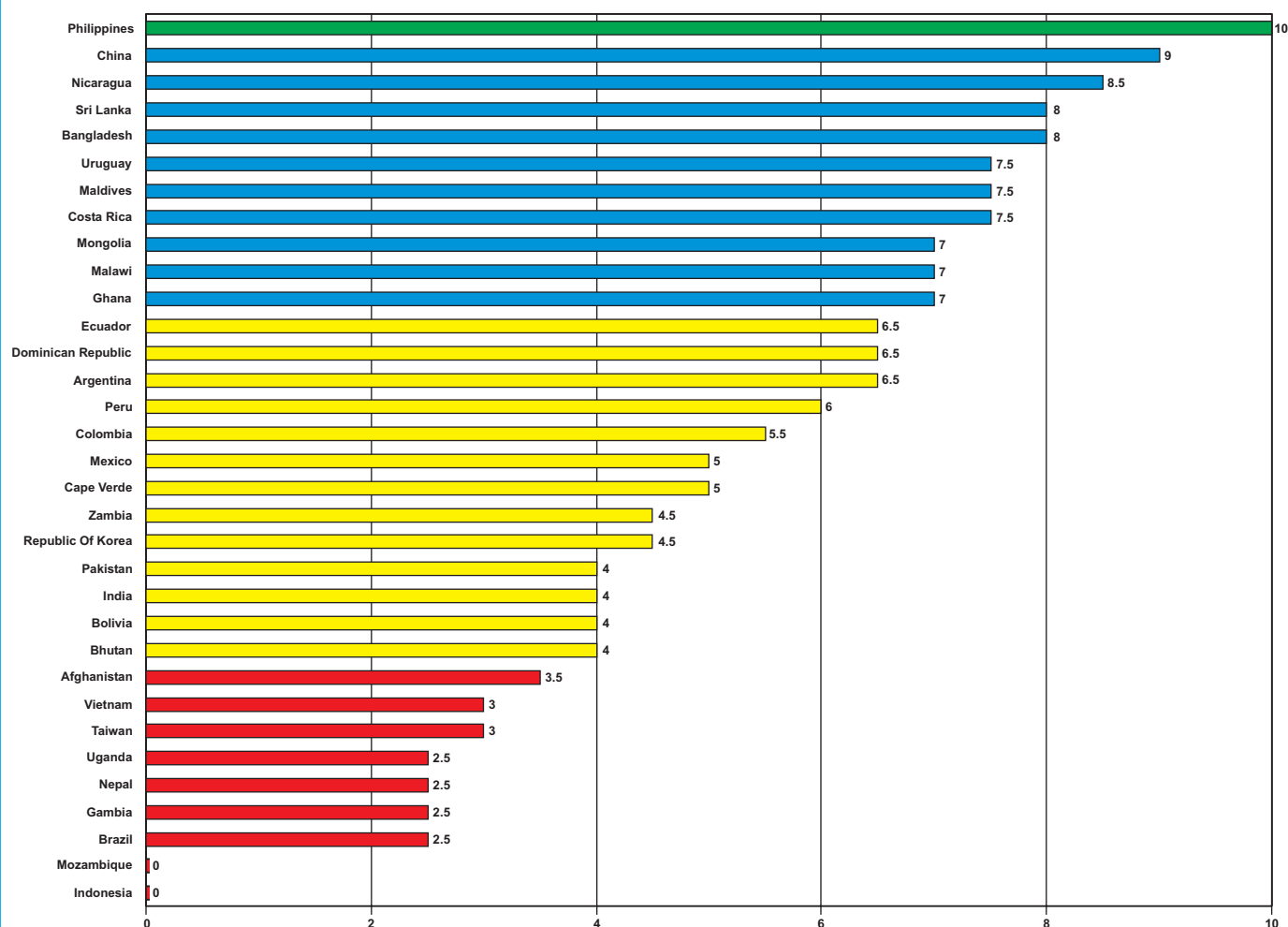
The table 6 shows that the Baby Friendly Hospital Initiative has yet to become fully integrated into the health system in almost all the countries. For instance, an examination of criteria 2.1 reveals that Colombia, Gambia, Indonesia and Mozambique do have not any accredited Baby Friendly hospitals and maternity homes. Again, many countries do not have a system of monitoring, and several more have not incorporated reassessment of BFHI status in their national plans of action. In fact, most of the countries do not have a time-bound programme to increase the number of BFHI institutions in their country. However, it should be noted that Afghanistan and Bhutan have made significant progress since they last conducted a WBTi assessment in 2005, when the BFHI had not yet been initiated there.

**Fig. 5: Baby Friendly Hospital Initiative
(Ten steps to successful breastfeeding)**

Colour Coding of Countries for Indicator on BFHI



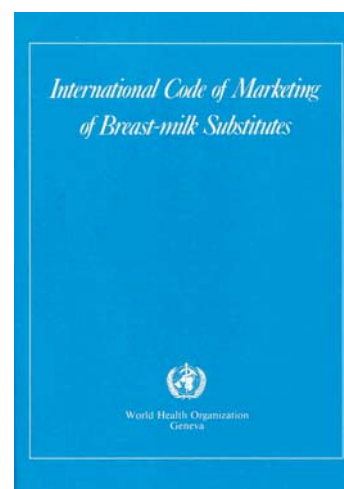
The State of BFHI in 33 Countries, on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

3. Implementation of the International Code of Marketing of Breastmilk Substitutes

The *International Code of Marketing of Breastmilk Substitutes* (referred to as the Code) was developed as the result of increasing concern in the 1960s and 70s over the general decline in breastfeeding, especially in the context of aggressive promotion of breastmilk substitutes by manufacturers. The Code, which went through four drafts, was adopted by the 34th World Health Assembly in May 1981, with 118 votes in favour to 1 against and 3 abstentions. The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. Subsequent *World Health Assembly Resolutions* have strengthened and added to the Code. Both the *Innocenti Declaration* and the *Global Strategy on Infant and Young Children*, stress on the need for countries to restrain the manufacturers of infant formula from aggressively marketing and promoting their products by adopting the Code. The incidences of contamination of infant formula with highly dangerous disease causing organisms such as *Salmonella* and *E.sakazakii*, and contaminants as happened with melamine in the Sanlu disaster are on the increase.



This indicator attempts to find out if the *International Code of Marketing of Breastmilk Substitutes* and subsequent WHA resolutions are in effect and implemented, and whether any further new action has been taken to give effect to the provisions of the Code.

Subset for the indicator and scoring

Table 7 shows ten criteria that form the subset questions used to assess and score the achievement of implementation of the Code. A country can only score one option of the 10 questions. The scores range from zero to 10.

Findings

Fig. 6 provides mapping based on colour coding and a graph of the score of this indicator on a scale of 10.

This indicator has received the highest average score 7.57, with nine countries Afghanistan, Bangladesh, Brazil, Costa Rica, Dominican Republic, Gambia, Ghana, Malawi and Mongolia being in the green level with a full score of 10 each. Bhutan and Indonesia are in the red level, with the former scoring zero for this indicator. Three countries are in the yellow level Uruguay, China and Taiwan; and the rest are in the blue level.

An examination of the criteria for scoring for the Indicator shows that there is much scope for countries to improve protection, promotion and support of breastfeeding through adopting and implementing the International Code. While countries such as Brazil that have received a full score of 10 for criterion 3.10 are implementing it in full, Indonesia, Philippines and Ecuador have only adopted a few articles of the Code as law, though Indonesia is waiting for approval for adopting it as law. In Nepal, the Code is a voluntary measure, in Taiwan, and China, only some articles of the Code are accepted as a voluntary measure. Although the law for breastfeeding promotion, support and protection incorporates a few of the articles of the Code, there are still some legal vacuums which hinder their full application.

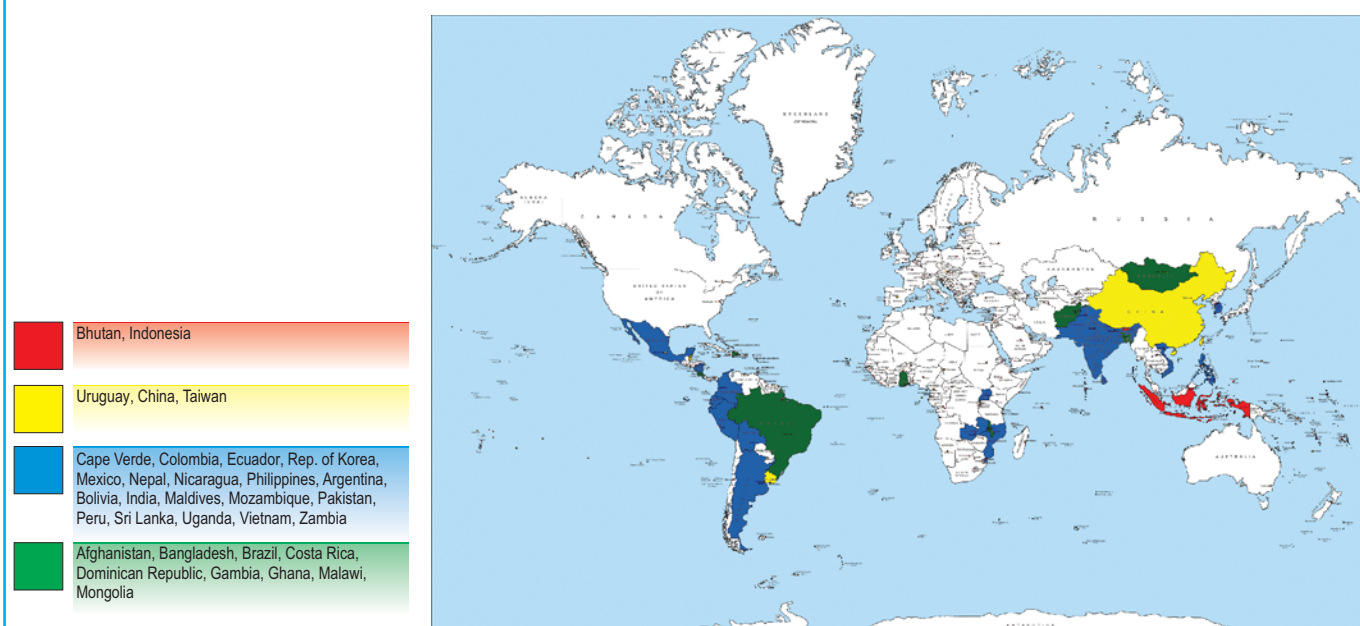
As indicated in their reports even countries with good scores need to work on effective implementation and monitoring, as merely having a law is not enough.

Table 7: Subset Question for the Indicator and Scoring for each Criteria

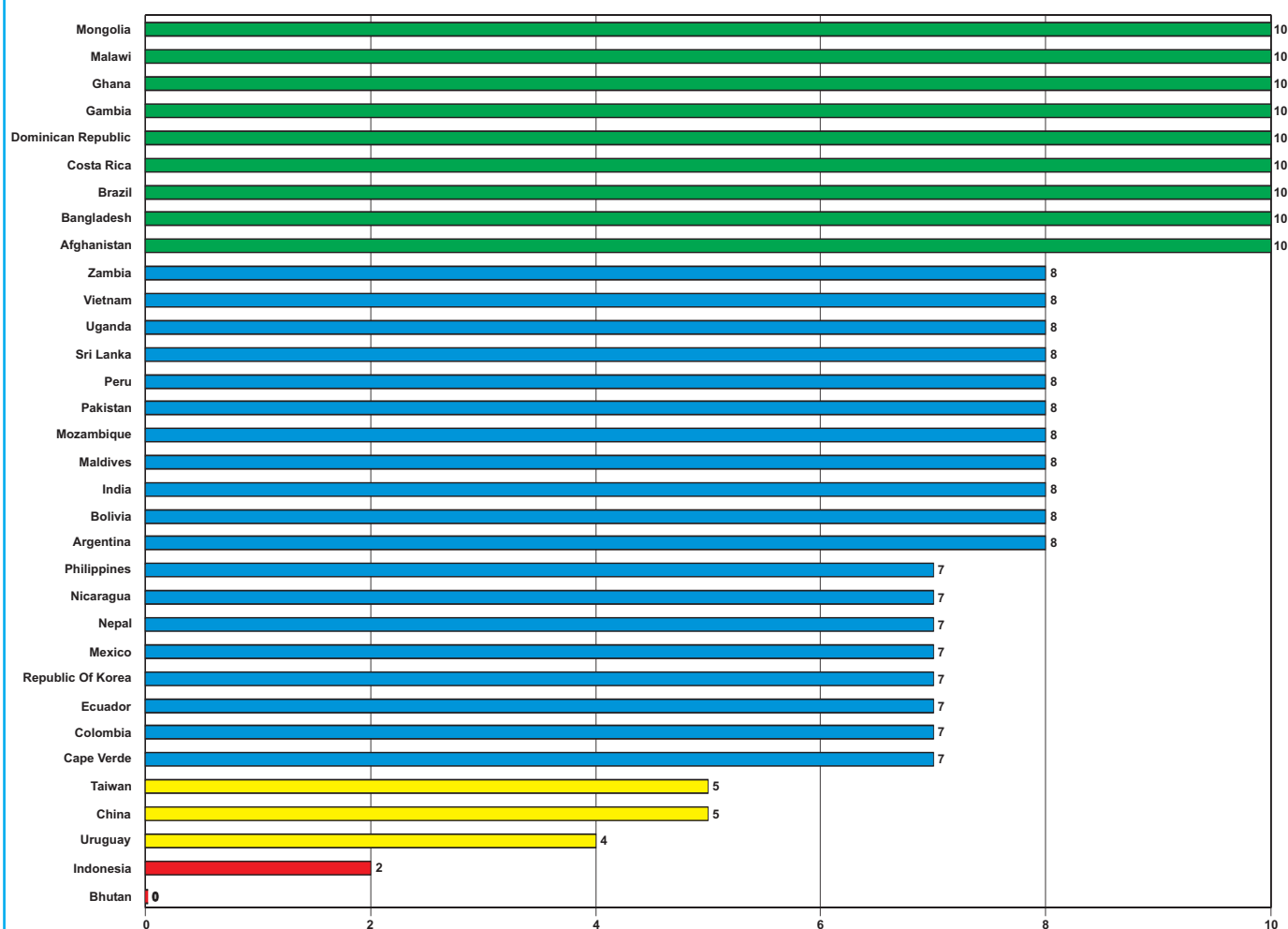
No.	Criteria	Scoring
3.1	No action taken	0
3.2	The best approach is being studied	1
3.3	National breastfeeding policy incorporating the Code in full or in part but not legally binding and therefore unenforceable	2
3.4	National measures (to take into account measures other than law), awaiting final approval	3
3.5	Administrative directive/circular implementing the Code in full or in part in health facilities with administrative sanctions	4
3.6	Some articles of the Code as a voluntary measure	5
3.7	Code as a voluntary measure	6
3.8	Some articles of the Code as law	7
3.9	All articles of the Code as law	8
3.10	All articles of the Code as law, monitored and enforced	10
Total Score		10

Fig. 6: Implementation of the International Code

Colour Coding of Countries for Indicator on Implementation of the International Code



The State of Implementation of the International Code in 33 Countries on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

4. Maternity Protection

Given that the presence of a woman is essential to breastfeeding, maternity protection for the woman is essential to achieve optimal breastfeeding as it helps her combine her reproductive and productive work. Recognising the contribution of women, the International Labour Organization (ILO) developed maternity protection through its various conventions. Several nations have also enacted maternity protection legislation. The ILO Convention C183 and recommendation R191 cover seven key elements of maternity protection: scope, leave, benefits, health protection, job protection and non-discrimination, breastfeeding breaks and breastfeeding facilities. While these elements are broad enough to cover women in all sectors of the economy, in several countries, they have been considered narrowly, thus only for providing such protection to women working in the organised sector.

This indicator examines whether there is enough structural and legal support for women to practice exclusive breastfeeding: whether there is legislation related to maternity protection and whether there are other measures (policies, regulations, practices) that meet or go beyond the ILO standards for protecting and supporting breastfeeding mothers, including those working mothers in the informal sector.

Subset for the Indicator and scoring

Table 8 gives the 12 criteria for assessing the indicator, and scores range from 0.5 to 2.

Findings

Fig. 7 provides mapping based on colour coding and a graph of the score of this indicator on a scale of 10.

Maternity Protection gets the second lowest score of all



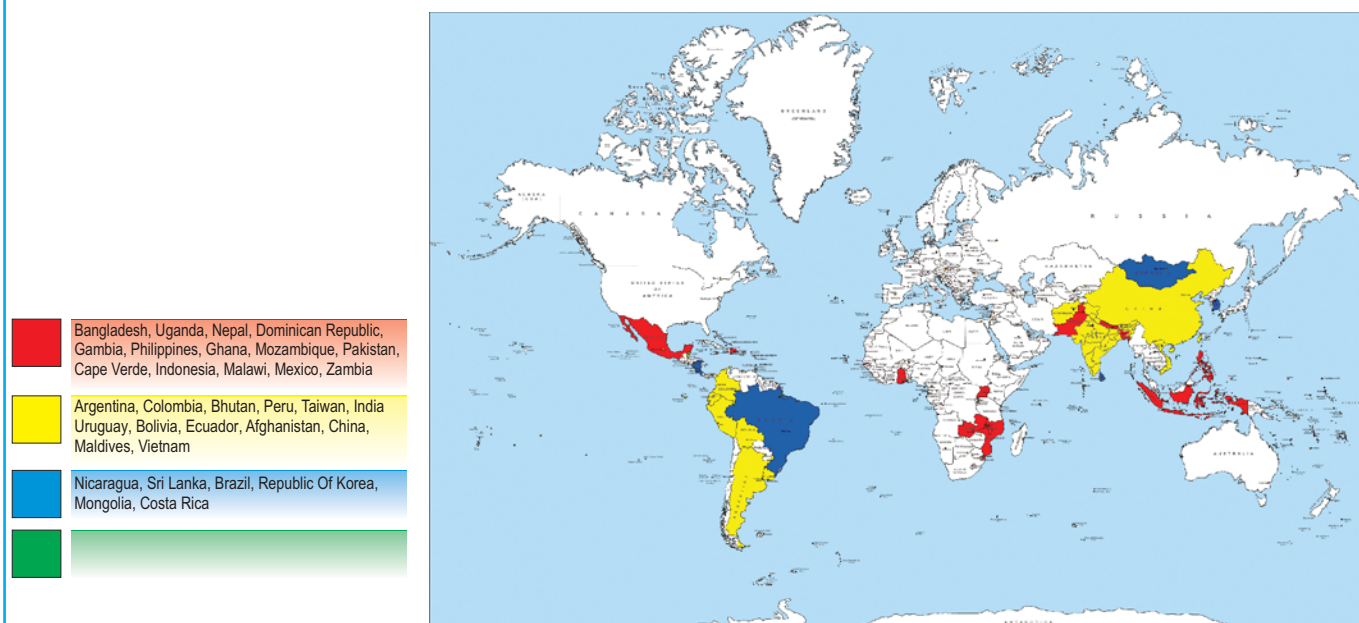
Photo Credit: WABA

Table 8: Subset Questionnaire for the Indicator and Scoring for each Criteria

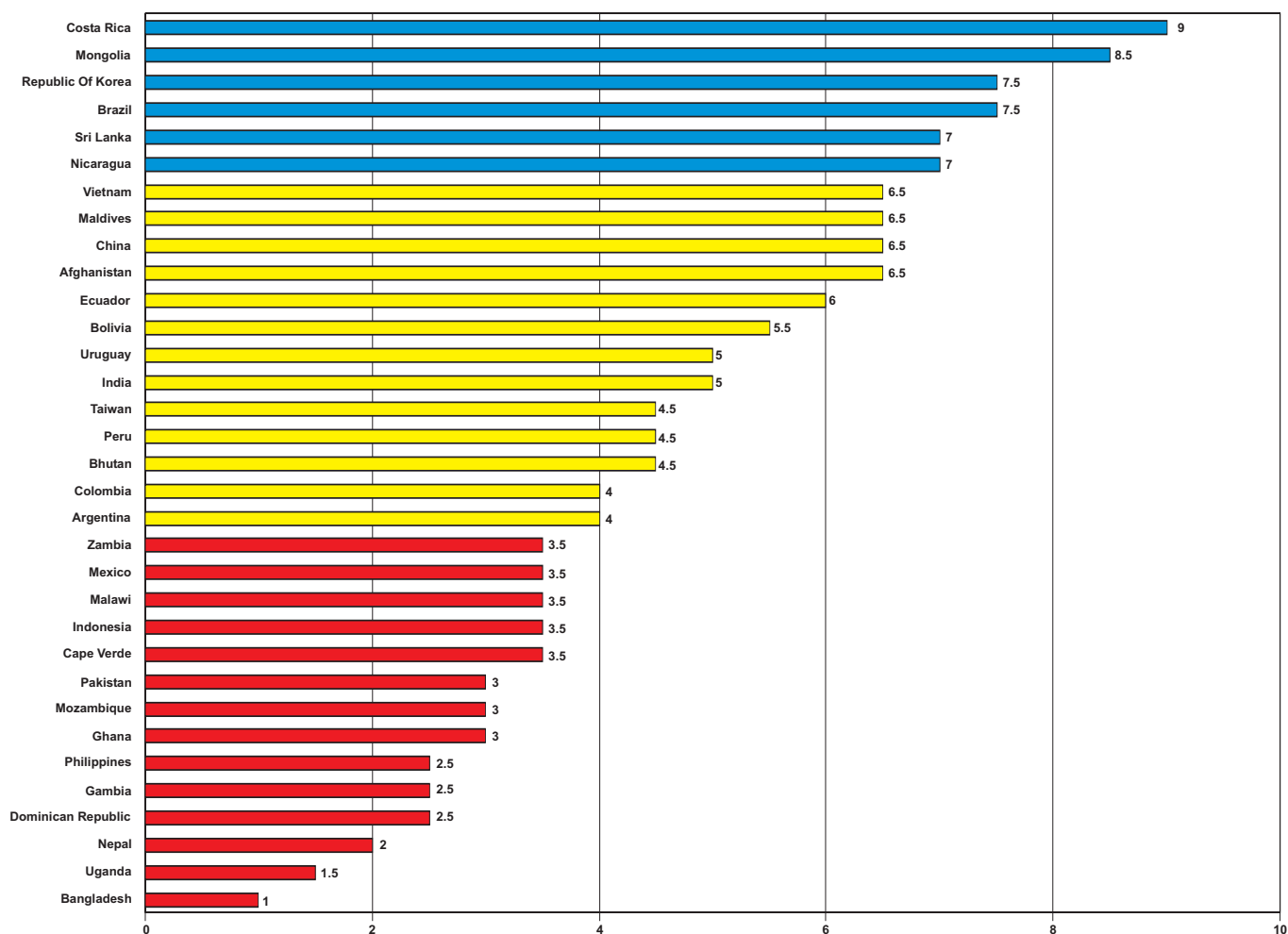
No.	Criteria	Scoring
4.1	Women covered by the national legislation are allowed the following weeks of paid maternity leave	
	a. Any leave less than 14 weeks	0.5
	b. 14 to 17 weeks	1
	c. 18 to 25 weeks	1.5
	d. 26 weeks or more	2
4.2	Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily.	1
	a. Unpaid break	0.5
	b. Paid break	1
4.3	Legislation obliges private sector employers of women in the country to give at least 14 weeks paid maternity leave and paid nursing breaks.	1
4.4	There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector.	2
4.5	Women in informal/unorganized and agriculture sector are:	1
	a. accorded some protective measures	0.5
	b. accorded the same protection as women working in the formal sector	1
4.6	a. Information about maternity protection laws, regulations, or policies is made available to workers	0.5
	b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.'	0.5
4.7	Paternity leave is granted in public sector for at least 3 days.	0.5
4.8	Paternity leave is granted in the private sector for at least 3 days.	0.5
4.9	There is legislation providing health protection for pregnant and breastfeeding workers and the legislation provides that they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	0.5
4.10	There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	0.5
4.11	ILO MPC No 183 has been ratified, or the country has a national law equal to or stronger than C183.	0.5
4.12	The ILO MPC No 183 has been enacted, or the country has enacted provisions equal to or stronger than C183.	0.5
Total Score		10

Fig. 7: Maternity Protection

Colour Coding of Countries for Indicator on Maternity Protection



The State of Maternity Protection in 33 Countries, on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

indicators. With an average score of 4.67, it just manages to move into the yellow level. Not a single country is in the green level, and only six countries – Nicaragua, Sri Lanka, Brazil, Republic of Korea, Mongolia and Costa Rica – are in the blue level. Costa Rica gets the highest score of 9, while Bangladesh gets the lowest score of 1. Thirteen countries are in the yellow level, while the rest are in the red level.

Table 9 gives the score for each criteria for all 33 countries.

The scores for this indicator demonstrate that each of the assessed countries has a lot to do to support women to successfully breastfeed. This is clearly evident when 14 countries are in red – and 13 in yellow... For instance, for criteria 4.1 on legislation on maternity leave, 19 countries provide less than 14 weeks; Mongolia, Sri Lanka and Nicaragua are the only three countries to provide more than 26 weeks of leave, while Bolivia provides 18 to 24 weeks. Criteria 4.5 shows that only five countries offer women in the informal or unorganised sector the same level of protection as those offered in the formal sector – Afghanistan, Costa Rica, Maldives, Mongolia and Zambia, and seven countries offer some measure of protection. Most countries offer at least one paid nursing break during work hours as indicated by the scores received for criteria 4.2. However, criterion 4.4 reveals that of these, the legislations of Bhutan, Cape Verde, Colombia, Ghana, Malawi, Maldives, Mexico, Mongolia, Mozambique, Sri Lanka, Taiwan, Uruguay and Vietnam do not provide for worksite childcare facilities to accommodate breastfeeding and/or complementary feeding. Paternity leave of three days is offered by 18 countries.

Table 9: Country Scores for each Criteria

Table of Country Scores for each Indicator															
Country	Total score of Indicator (out of 10)	Subset Scores													
		4.1	4.2	4.3	4.4	4.5	4.6a	4.6b	4.7	4.8	4.9	4.10	4.11	4.12	
Afghanistan	6.5	0.5	1	0	1	1	0.5	0.5	0.5	0	0.5	0.5	0	0.5	
Argentina	4	0.5	1	0	1	0	0.5	0	0	0	0.5	0.5	0	0	
Bangladesh	1	1	0	0	0	0	0	0	0	0	0	0	0	0	
Bhutan	4.5	0.5	1	1	0	0	0.5	0	0.5	0	0.5	0	0.5	0	
Bolivia	5.5	1.5	1	1	1	0	0	0	0	0	0.5	0.5	0	0	
Brazil	7.5	1	1	1	1	0	0.5	0	0.5	0.5	0.5	0.5	0.5	0.5	
Cape Verde	3.5	0.5	1	0	0	0.5	0	0.5	0	0	0	0.5	0.5	0	
China	6.5	0.5	1	1	1	0.5	0.5	0.5	0	0	0.5	0.5	0.5	0	
Colombia	4	0.5	1	0	0	0.5	0	0	0.5	0.5	0.5	0.5	0	0	
Costa Rica	9	1	1	1	1	1	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	
Dominican Republic	2.5	0.5	0	0	1	0	0	0	0	0	0.5	0.5	0	0	
Ecuador	6	0.5	1	1	1	0	0.5	0	0.5	0.5	0	0	0.5	0.5	
Gambia	2.5	0.5	0	0	0	0	0.5	0.5	0	0	0	0.5	0.5	0	
Ghana	3	0.5	1	0	0	0	0.5	0	0	0	0.5	0.5	0	0	
India	5	0.5	1	0	1	0.5	0.5	0	0.5	0	0.5	0.5	0	0	
Indonesia	3.5	0.5	1	0	1	0	0.5	0	0	0	0	0.5	0	0	
Korea	7.5	0.5	1	1	1	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	
Malawi	3.5	1	0.5	1	0	0	0	0	0	0	0	0	0.5	0.5	
Maldives	6.5	1	1	1	0	1	0.5	0	0.5	0.5	0.5	0.5	0	0	
Mexico	3.5	0.5	1	0	0	0	0	0	0	0	0.5	0.5	0.5	0.5	
Mongolia	8.5	2	1	1	0	1	0.5	0	0.5	0.5	0.5	0.5	0.5	0.5	
Mozambique	3	0.5	1	0	0	0	0.5	0	0	0	0.5	0.5	0	0	
Nepal	2	0.5	0	0	1	0	0	0	0.5	0	0	0	0	0	
Nicaragua	7	2	1	1	1	0	0.5	0	0	0	0.5	0.5	0.5	0	
Pakistan	3	0.5	0	1	0	0	0.5	0.5	0	0	0.5	0	0	0	
Philippines	2.5	0.5	0	0	0	0	0.5	0.5	0.5	0.5	0	0	0	0	
Peru	4.5	0.5	1	0	1	0	0	0	0.5	0.5	0.5	0.5	0	0	
Sri Lanka	7	2	1	0	0	0.5	0.5	0.5	0.5	0	0.5	0.5	0.5	0.5	
Taiwan	4.5	0.5	1	0	0	0.5	0.5	0	0.5	0.5	0.5	0.5	0	0	
Uganda	1.5	0.5	0	0	0	0	0	0	0.5	0.5	0	0	0	0	
Uruguay	5	0.5	1	0	0	0	0.5	0	0.5	0.5	0.5	0.5	0.5	0.5	
Vietnam	6.5	1	1	1	0	0.5	0.5	0.5	0	0	0.5	0.5	0.5	0.5	
Zambia	3.5	0.5	0	0	0	1	0.5	0.5	0.5	0	0	0.5	0	0	

5. Health and Nutrition Care Systems (in support of breastfeeding & IYCF)



Photo Credit: WABA

Breastfeeding and infant and young child feeding practices need to be integrated in both health and nutrition care systems so that women are supported through these services to feed their infants properly and optimally. Starting from pregnancy when women should be informed about the need to properly breastfeed, especially timely initiation and exclusive breastfeeding, women need support to carry this out during the period of lactation; they also need support and guidance regarding the time of introduction of complementary foods, their adequacy and appropriateness. Thus it is imperative that both health and nutrition service providers at all levels have infant and young child feeding built into their curricula, including how to counsel women and communities, feeding during illnesses, and also elements of the International Code or national legislation. Countries need to develop standards and guidelines regarding mother-friendly childbirth procedures so that women can initiate breastfeeding within the first hour of birth and this being considered like a continuum, the fourth stage of labour.

This indicator examines whether health care providers undergo skills training and whether their pre-service education curriculum supports optimal infant and young child feeding. It also provides information on whether these services support women to breastfeed at birth. Whether health workers responsibilities to Code are in place or not is answered as well.

Subset for the Indicator and scoring

Table 10 gives the criteria for assessing the Indicator and scores range from 0.5 to 2.

Table 10: Subset Questionnaire for the Indicator and Scoring for each Criteria

No.	Criteria	Score		
		Adequate	Inadequate	No reference
5.1	A review of health provider schools and pre-service education programmes in the country [*] indicates that infant and young child feeding curricula or session plans are adequate/inadequate	2	1	0
5.2	Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care.	2	1	0
5.3	There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers. [#]	2	1	0
5.4	Health workers are trained with responsibility towards Code implementation as a key input.	1	0.5	0
5.5	Infant feeding-related content and skills are integrated, as appropriate, into training programmes focusing on relevant topics (diarrhoeal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, etc.)	1	0.5	0
5.6	These in-service training programmes are being provided throughout the country. [^]	1	0.5	0
5.7	Child health policies provide for mothers and babies to stay together when one of them is sick	1	0.5	0
Total Score		-----/10		

^{*} Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. Which departments within various schools are responsible for teaching various topics may also vary. The assessment team should decide which schools and departments are most essential to include in the review, with guidance from educational experts on infant and young child feeding, as necessary.

[#] The types of health providers that should receive training may vary from country to country, but should include providers that care for mothers and children in fields such as medicine, nursing, midwifery, nutrition and public health.

[^] Training programmes can be considered to be provided "throughout the country" if there is at least one training programme in each region or province or similar jurisdiction.

Findings

Fig. 8 provides mapping based on colour coding and a graph of the score of this indicator on a scale of 10.

Though a score of 6.17 places the average for this indicator in the yellow level, three countries – Colombia, Maldives and Mozambique – are in the green level, with the last country scoring full 10. Cape Verde is the only country in the red level, with a score of zero. Mongolia, Vietnam, Argentina, Zambia, Malawi, Sri Lanka, Ghana, Republic of Korea and Nicaragua are in the blue level, and the rest of the countries are in the yellow level.

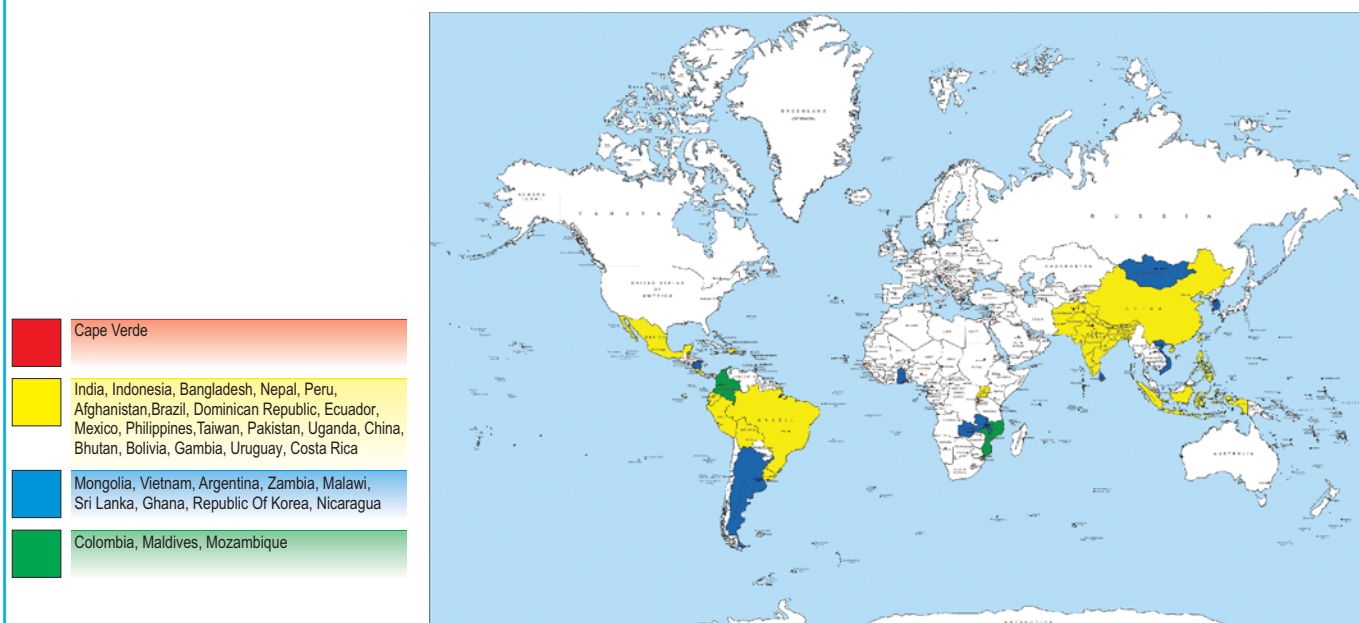
Table 11 gives the individual country score for the indicator as well as its subset of questions.

The table reveals that national health and nutrition systems in the assessed countries have not integrated or built capacity to protect and support optimal breastfeeding practices. An analysis of the first three subsets of the indicator shows that curriculum and policy support are not 'adequate' in most countries. Scores for criterion 5.4 show that there is some information given to health and nutrition workers about the International Code, but this is not enough. Similarly if we look at criteria 5.5 to 5.7, the maximum score of '1' reflecting 'Adequate' is hard to find.

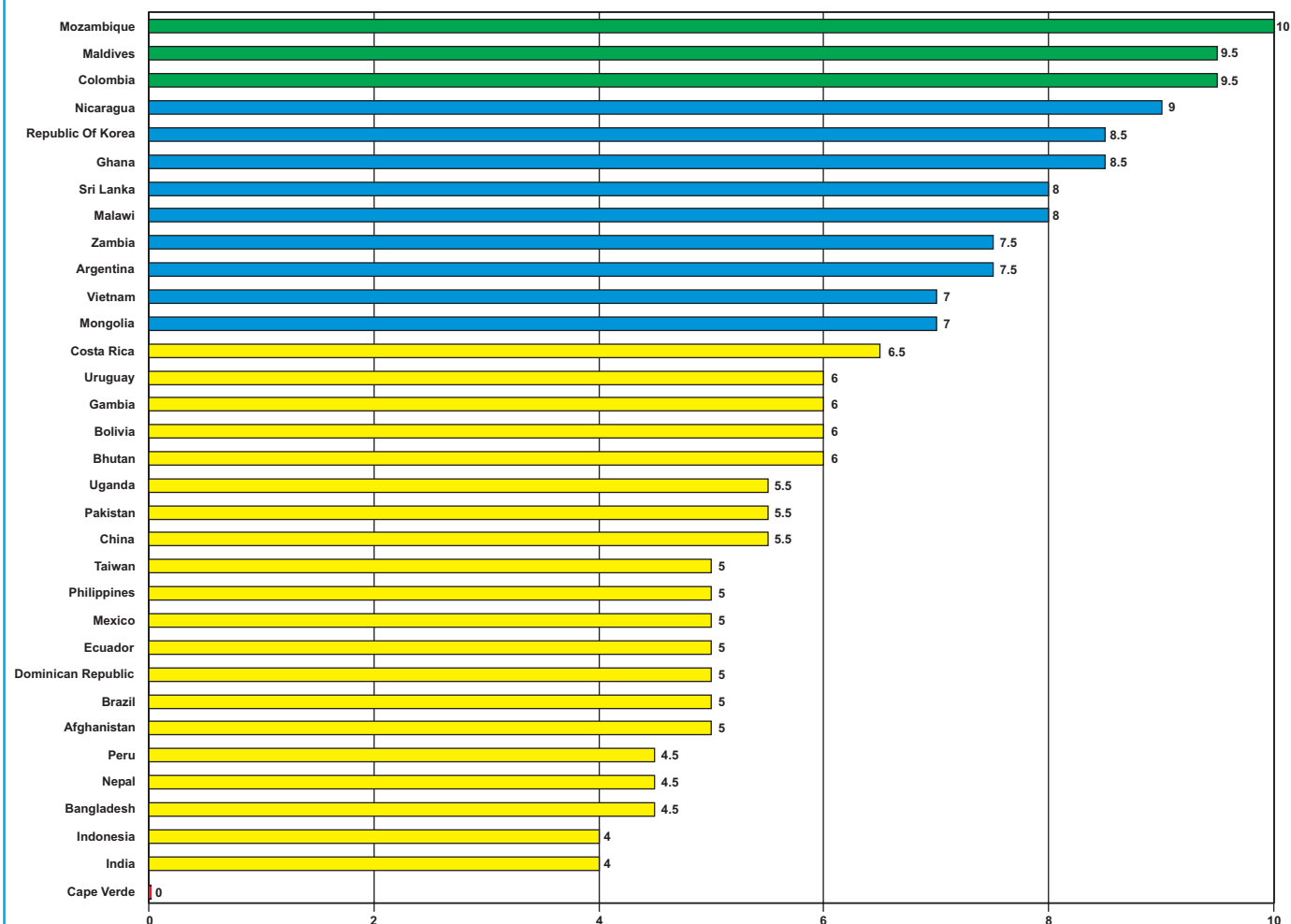
Country	Total score of indicator (out of 10)	Subset Scores						
		5.1	5.2	5.3	5.4	5.5	5.6	5.7
Afghanistan	5	1	1	1	0.5	0.5	0	1
Argentina	7.5	1	2	2	0.5	1	1	0
Bangladesh	4.5	1	1	1	0.5	0.5	0.5	0
Bhutan	6	1	0	2	0	1	1	1
Bolivia	6	1	1	2	0.5	0.5	1	0
Brazil	5	0	1	1	0.5	1	0.5	1
Cape Verde	0	0	0	0	0	0	0	0
China	5.5	1	1	1	0.5	1	0.5	0.5
Colombia	9.5	2	2	2	1	1	1	0.5
Costa Rica	6.5	0	2	2	0.5	0.5	0.5	1
Dominican Republic	5	1	1	1	0.5	1	0.5	0
Ecuador	5	1	1	1	0	1	0.5	0.5
Gambia	6	1	0	2	1	1	1	0
Ghana	8.5	2	1	2	0.5	1	1	1
India	4	1	1	1	0	0.5	0.5	0
Indonesia	4	1	1	1	0	0.5	0.5	0
Republic of Korea	8.5	2	1	2	1	0.5	1	1
Malawi	8	1	1	2	1	1	1	1
Maldives	9.5	2	2	2	0.5	1	1	1
Mexico	5	1	1	1	0.5	0.5	0.5	0.5
Mongolia	7	1	1	2	0	1	1	1
Mozambique	10	2	2	2	1	1	1	1
Nepal	4.5	1	1	1	0	0.5	0.5	0.5
Nicaragua	9	2	2	1	1	1	1	1
Pakistan	5.5	1	1	1	0.5	1	0.5	0.5
Philippines	5	1	1	1	0.5	0.5	0.5	0.5
Peru	4.5	1	1	1	0	1	0.5	0
Sri Lanka	8	1	2	2	0.5	0.5	1	1
Taiwan	5	1	1	1	0.5	0.5	0.5	0.5
Uganda	5.5	1	1	1	0.5	1	0.5	0.5
Uruguay	6	1	2	1	0.5	0.5	0.5	0.5
Vietnam	7	1	1	2	0.5	1	0.5	1
Zambia	7.5	1	2	1	1	1	0.5	1

Fig. 8: Health and Nutrition Care Systems

Colour Coding of Countries for Indicator on Health and Nutrition Care Systems



The State of Health and Nutrition Care Systems in 33 Countries, on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

6. Mother Support and Community Outreach - Community-based Support for the Pregnant and Breastfeeding Mother

All women need outreach and support in the community to succeed in practising optimal breastfeeding. Outreach activities include the easy availability within the community of skilled counselling by trained personnel, home visits and other such services that enable women to feed their infants and young children in the best possible manner. This is particularly true for success in exclusive breastfeeding and the timely introduction of adequate and appropriate complementary foods. This is also important in areas where many mothers deliver at home. Women requiring such services include those who have delivered in hospitals and have returned to the community. Community outreach needs to involve the entire community, especially all members of the family including the father, the grandmother and grandfather, as well as other influential figures who influence infant and young child feeding practices. Mother Support groups are especially useful in extending support to women. This is a critical extension to BFHI work.



Photo Credit: BFCHI Lalitpur Project

The indicator examines if there are mother support and community outreach systems in place to protect, promote and support optimal infant and young child feeding in the country or not.

Subset for the Indicator and scoring

Table 12 gives the five criteria for scoring this indicator. The scores for each criteria range from zero to two. The maximum a country can score is 10.

Findings

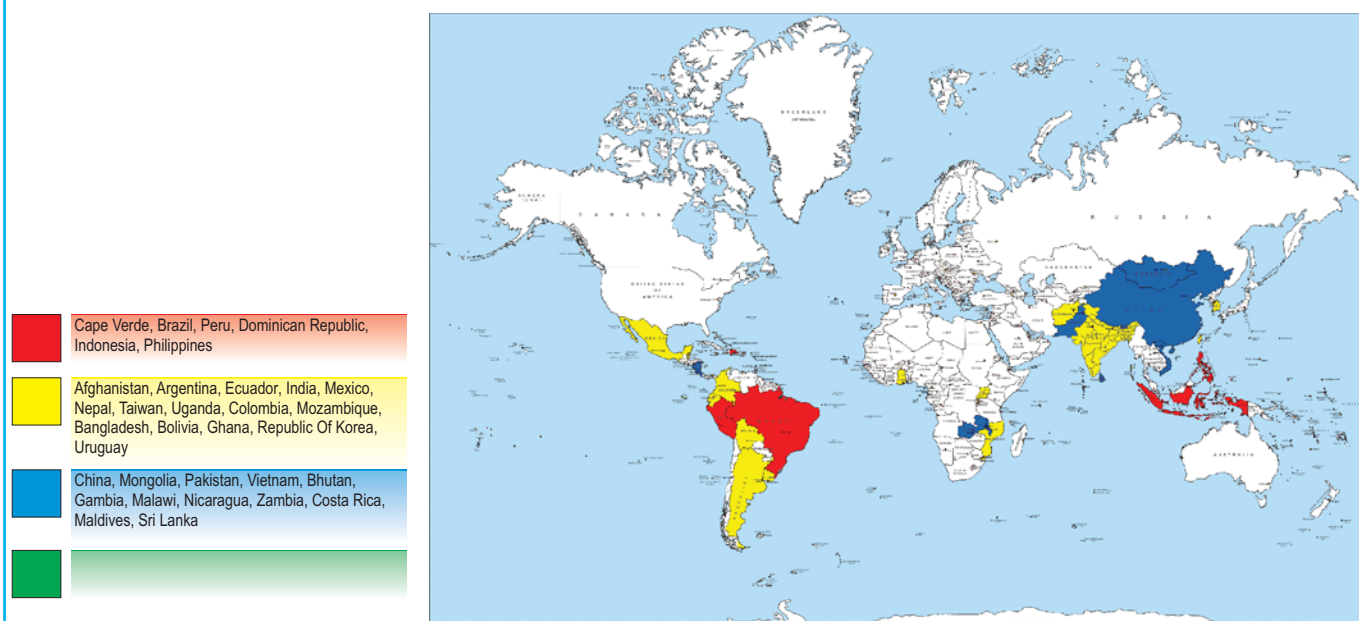
Fig. 9 provides a mapping based on colour coding and a graph of the score of this indicator on a scale of 10.

Table 12: Subset Questionnaire for the Indicator and Scoring for each Criteria

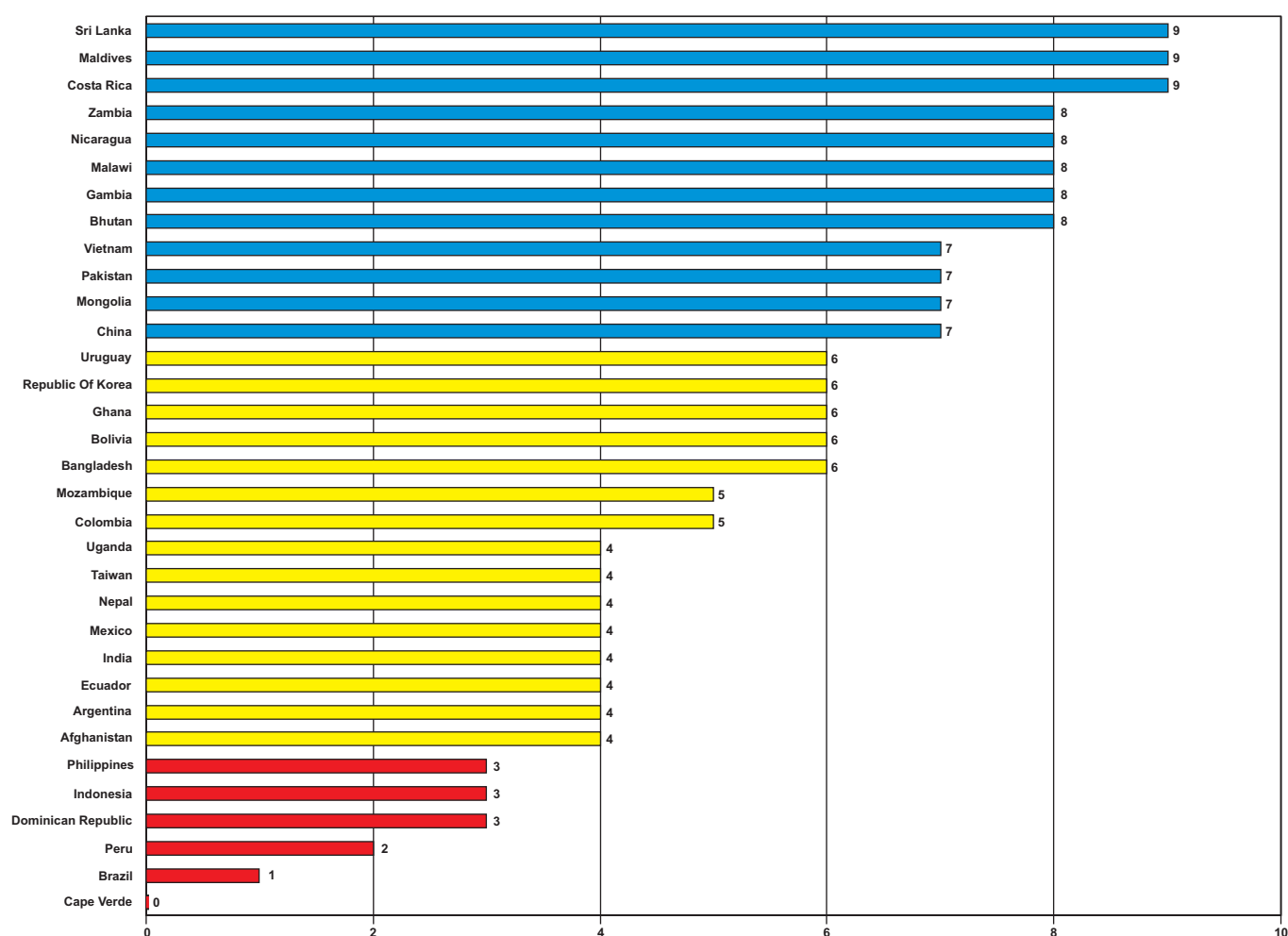
No.	Criteria	Score		
		Yes	To some degree	No
6.1	All pregnant women have access to community-based support systems and services on infant and young child feeding.	2	1	0
6.2	All women have access to support for infant and young child feeding after birth.	2	1	0
6.3	Infant and young child feeding support services have national coverage.	2	1	0
6.4	Community-based support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development strategy (inter-sectoral and intra-sectoral).	2	1	0
6.5	Community-based volunteers and health workers possess correct information and are trained in counselling and listening skills for infant and young child feeding.	2	1	0
Total Score		-----/10		

**Fig. 9: Mother Support and Community Outreach -
Community-based Support for the pregnant and breastfeeding mother**

Colour Coding of Countries for Indicator on Mother Support and Community Outreach



The State of Mother Support and Community Outreach in 33 Countries, on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

The average score for the indicator is 5.42. While no country is in the green level, Sri Lanka, Maldives and Costa Rica have scored 9 points each out of a possible ten, and are ahead of the other nine countries in the blue level. Cape Verde has the lowest score of zero for this indicator, and is in the red level, together with Philippines, Indonesia, Dominican Republic, Peru and Brazil. The remaining countries are in the yellow level.

Table 13 shows scores of the subset of indicators in all 33 countries.

If we examine the criteria 6.2 and 6.4 in the table 13, we find that while in most countries pregnant women and women who have just given birth have some access to community based support systems on infant and young child feeding, most countries have not incorporated such support in their development strategies. The scores for the last criterion indicate that in only six countries Ecuador, Malawi, Mozambique, Nicaragua, Pakistan and Sri Lanka are the community workers adequately trained in both information and counselling skills. No such training is given in Cape Verde, Indonesia and Mexico.

Table 13: Country Scores for Each Criteria

Country	Total score of Indicator (out of 10)	Subset Scores				
		6.1	6.2	6.3	6.4	6.5
Afghanistan	4	1	1	1	0	1
Argentina	4	1	1	1	0	1
Bangladesh	6	1	1	1	2	1
Bhutan	8	1	2	2	2	1
Bolivia	6	1	1	1	2	1
Brazil	1	0	0	0	0	1
Cape Verde	0	0	0	0	0	0
China	7	2	2	1	1	1
Colombia	5	1	1	1	1	1
Costa Rica	9	2	2	2	2	1
Dominican Republic	3	0	0	1	1	1
Ecuador	4	1	1	1	0	1
Gambia	8	1	1	2	2	2
Ghana	6	1	1	2	1	1
India	4	1	1	1	0	1
Indonesia	3	1	1	1	0	0
Republic of Korea	6	1	1	2	1	1
Malawi	8	1	1	2	2	2
Maldives	9	2	2	2	2	1
Mexico	4	1	1	0	2	0
Mongolia	7	1	2	2	1	1
Mozambique	5	1	1	0	1	2
Nepal	4	1	1	1	0	1
Nicaragua	8	1	2	1	2	2
Pakistan	7	1	1	1	2	2
Philippines	3	1	1	1	0	0
Peru	2	0	1	0	0	1
Sri Lanka	9	1	2	2	2	2
Taiwan	4	1	1	0	1	1
Uganda	4	0	1	1	1	1
Uruguay	6	1	1	1	2	1
Vietnam	7	2	1	1	2	1
Zambia	8	1	2	2	2	1

7. Information Support

Another key to successful breastfeeding is Information, Education and Communication (IEC) strategies aimed at behaviour change and the accuracy of such a communication. This is particularly true in regions where culture and tradition play extremely significant roles in modulating infant feeding practices. Thus appropriate, adequate and effective IEC strategy needs to become the vital factor in promoting breastfeeding. IEC strategies are comprehensive when they use a wide variety of media and channels to convey concise, consistent, appropriate, action-oriented messages to targeted audiences at national, facility, community and family levels. IEC approaches include the use of electronic (TV, radio, video), print (posters, counselling cards, flip charts, manuals, newspapers, magazines), interpersonal (counselling, group education, support groups) and community activities to communicate important information and motivational material to mothers, families and the community. In this indicator we try to find out if the information made available or not, and if so, is it comprehensive and accurate.

Subset of this Indicator and scoring

Table 14 gives the five criteria for assessing how a country performs on this indicator. The scores range from zero to two for each criterion; the maximum total score for the indicator is 10.

Findings

Fig. 10 provides a mapping based on colour coding and a graph of the score of this indicator on a scale of 10.

The average score received for the Indicator is 6.42, with three countries Sri Lanka, Malawi and Gambia getting full scores and reaching the green level. Mexico has the lowest score of 1, and is, together with Taiwan, Dominican Republic, Peru and Indonesia, in the red level. The majority of the countries are in the blue level, and Uganda, PR China, Uruguay, Philippines, Nepal, India, Ecuador, Bhutan, Bangladesh and Bolivia are in the yellow level.

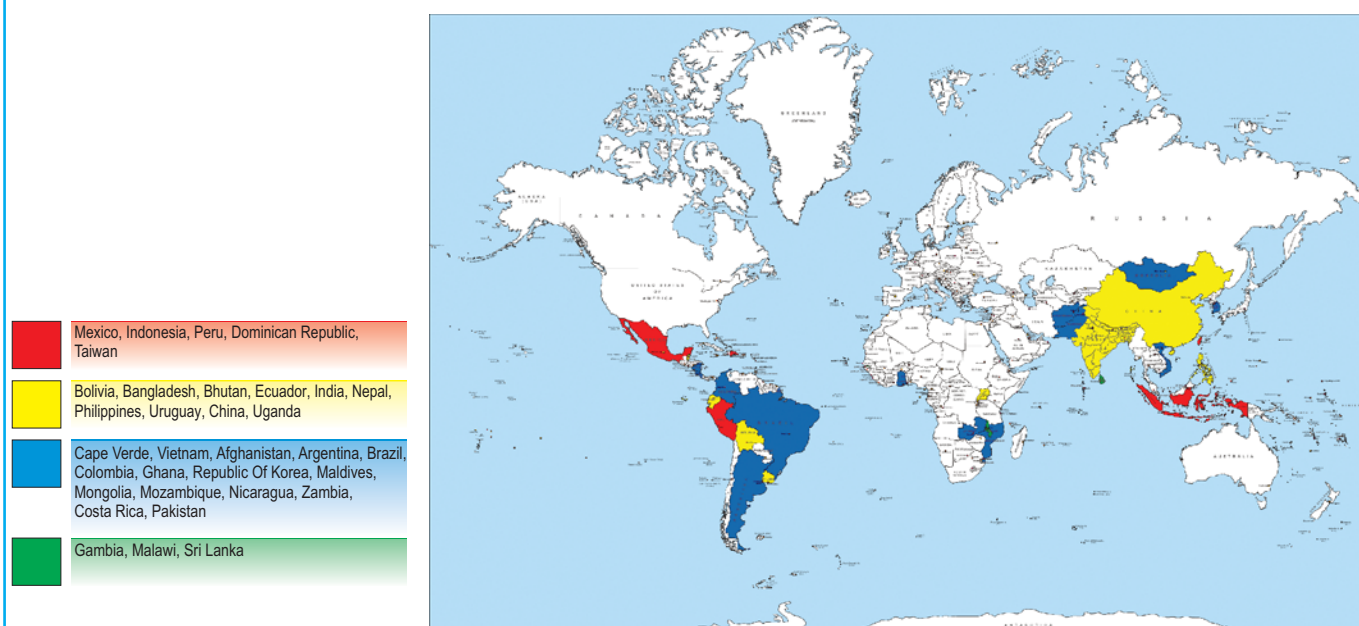
Table 14: Subset Questionnaire for the Indicator and Scoring for each Criteria

No.	Criteria	Score		
		Yes	To some degree	No
7.1	There is a comprehensive national IEC strategy for improving infant and young child feeding.	2	1	0
7.2	IEC programmes (e.g. World Breastfeeding Week) that include infant and young child feeding are being actively implemented at local levels	2	1	0
7.3	Individual counselling and group education services related to infant and young child feeding are available within the health/nutrition care system or through community outreach.	2	1	0
7.4	The content of IEC messages is technically correct, sound, based on national or international guidelines.	2	1	0
7.5	A national IEC campaign or programme ¹ using electronic and print media and activities has channelled messages on infant and young child feeding to targeted audiences in the last 12 months.	2	1	0
Total Score		10		

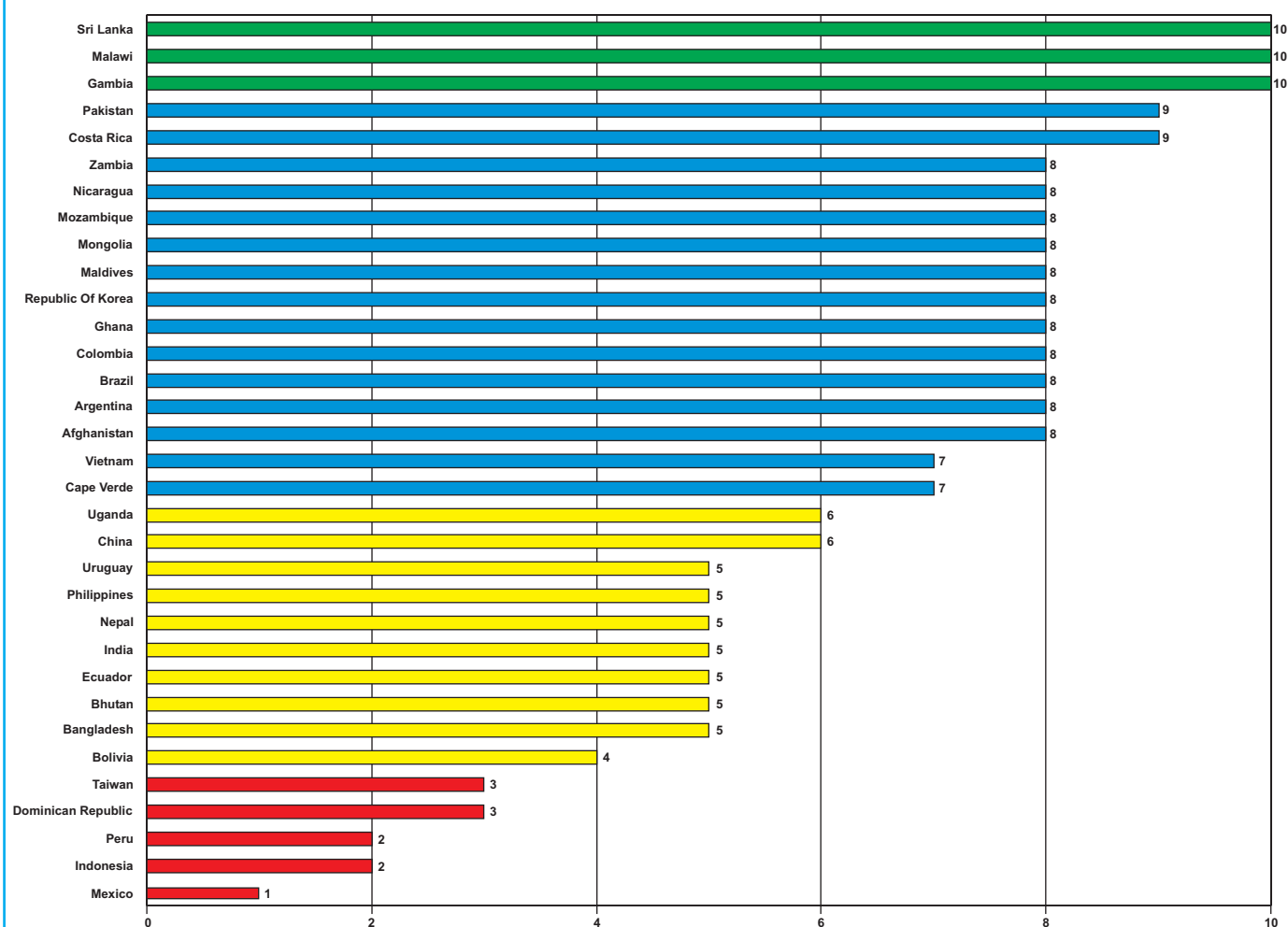
¹ An IEC campaign or programme is considered "national" if its messages can be received by the target audience in all major geographic or political units in the country (e.g., regions or districts).

Fig. 10: Information Support

Colour Coding of Countries for Indicator on Information Support



The State of Information Support in 33 Countries, on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

Table 15 gives the detailed scoring for the indicator for each country.

Table 15 shows that while all the assessed countries are engaging in some IEC activity with regard to infant and young child feeding, only nine countries - Afghanistan, Argentina, Costa Rica, Malawi, Maldives, Mozambique, Nicaragua, Sri Lanka and Vietnam - have a national IEC policy for this in place. However, all countries except Indonesia, Mexico, Peru, Sri Lanka and Uganda have had a national IEC campaign or programme using electronic and print media and activities and have channelled messages on infant and young child feeding to targeted audiences in the last 12 months. Again, all countries except Mexico and Indonesia have had IEC programmes during the World Breastfeeding Week. The technical content of the IEC programmes has generally been sound, based on national and international guidelines.

Table 15: Country Scores for each Criteria

Country	Total score of Indicator out of 10	Subset Scores				
		7.1	7.2	7.3	7.4	7.5
Afghanistan	8	2	2	1	2	1
Argentina	8	2	2	1	2	1
Bangladesh	5	0	1	1	2	1
Bhutan	5	1	1	1	1	1
Bolivia	4	1	1	0	1	1
Brazil	8	1	2	1	2	2
Cape Verde	7	1	1	1	2	2
China	6	1	1	2	1	1
Colombia	8	0	2	2	2	2
Costa Rica	9	2	2	2	2	1
Dominican Republic	3	0	1	0	1	1
Ecuador	5	1	1	0	2	1
Gambia	10	2	2	2	2	2
Ghana	8	1	1	2	2	2
India	5	0	1	1	2	1
Indonesia	2	0	0	0	2	0
Republic of Korea	8	1	2	1	2	2
Malawi	10	2	2	2	2	2
Maldives	8	2	2	1	2	1
Mexico	1	1	0	0	0	0
Mongolia	8	1	2	1	2	2
Mozambique	8	2	2	0	2	2
Nepal	5	1	1	1	1	1
Nicaragua	8	2	2	1	2	1
Pakistan	9	1	2	2	2	2
Philippines	5	1	1	1	1	1
Peru	2	0	1	0	1	0
Sri Lanka	10	2	2	2	2	2
Taiwan	3	0	1	1	1	0
Uganda	6	1	1	1	2	1
Uruguay	5	0	2	1	2	0
Vietnam	7	2	1	1	2	1
Zambia	8	1	2	2	1	2

8. Infant Feeding and HIV

The *Global Strategy* for IYCF highlights the importance of correct policy and programme work in this area for achieving the targets. The UN Framework for priority action on infant feeding and HIV activities accords the highest priority to the development of a comprehensive national infant and young child policy that includes HIV and infant feeding. Updated guidelines of the WHO are based on the research evidence establishing that antiretroviral (ARV) interventions to either the HIV-infected mother or HIV-exposed infant can significantly reduce the risk of postnatal transmission of HIV through breastfeeding. The WHO guidelines further suggest how to strengthen the infant and young child feeding component in the national HIV and child health programmes.¹⁷

The listing also includes implementation and enforcement of the International Code and subsequent WHA resolutions, intensification of efforts to protect, promote and support appropriate infant and young child feeding while recognising HIV as an exceptionally difficult circumstance, providing adequate support to HIV positive women to make informed choices and carry them out successfully, and support research on HIV and infant feeding.

The indicator explores what kind of support is made available for women, who are HIV positive and want to continue breastfeeding, or breastfeeding is recommended based on the AFASS criteria or artificial feeding is to be given to the baby because of certain criteria. We try and find out if policies and programmes are in place to ensure that HIV positive

Table 16: Subset Questionnaire for the Indicator and Scoring for each Criteria

No.	Criteria	Score		
		Adequate	Inadequate	No reference
8.1	The country has a comprehensive policy on infant and young child feeding that includes infant feeding and HIV	2	1	0
8.2	The infant feeding and HIV policy gives effect to the International Code/ National Legislation.	1	0.5	0
8.3	Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	1	0.5	0
8.4	Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	1	0.5	0
8.5	Infant feeding counselling in line with current international recommendations and locally appropriate is provided to HIV positive mothers.	1	0.5	0
8.6	Mothers are supported in making their infant feeding decisions with further counselling and follow-up to make implementation of these decisions as safe as possible.	1	0.5	0
8.7	Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	1	0.5	0
8.8	On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	1	0.5	0
8.9	The Baby-friendly Hospital Initiative incorporates provision of guidance to hospital administrators and staff in settings with high HIV prevalence on how to assess the needs and provide support for HIV positive mothers.	1	0.5	0
Total Score		-----/10		

Table 17: country for Each Indicators

Country	Total score of Indicator (out of 10)	Subset Scores								
		8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9
Afghanistan	3.5	1	0	0.5	0.5	0.5	0.5	0.5	0	0
Argentina	2	0	0	0	0.5	0	0	1	0.5	0
Bangladesh	4.5	2	1	0	0.5	0.5	0.5	0	0	0
Bhutan	7.5	1	0	1	1	1	1	1	1	0.5
Bolivia	1.5	0	0	0	0.5	0.5	0.5	0	0	0
Brazil	5	1	1	1	1	0	0	0	0	1
Cape Verde	0	0	0	0	0	0	0	0	0	0
China	5.5	2	0.5	0.5	0.5	0.5	0.5	0	1	0
Colombia	3.5	0	0	0.5	1	0.5	0	0.5	0	1
Costa Rica	4	1	1	0	0	1	0	1	0	0
Dominican Republic	2.5	1	1	0	0.5	0	0	0	0	0
Ecuador	3	1	0.5	0.5	0.5	0.5	0	0	0	0
Gambia	9	2	1	1	0.5	1	1	1	0.5	1
Ghana	8	2	1	0.5	1	1	1	1	0	0.5
India	2	0	0	0.5	0.5	0	0.5	0	0.5	0
Indonesia	0	0	0	0	0	0	0	0	0	0
Korea	5.5	1	0.5	0.5	1	1	0.5	0.5	0.5	0
Malawi	8.5	2	1	1	0.5	1	0.5	1	0.5	1
Maldives	5.5	2	1	0.5	1	0	0	0	1	0
Mexico	3.5	1	0	0	1	0.5	0.5	0	0	0.5
Mongolia	7	2	0.5	0.5	1	1	0.5	0.5	0.5	0.5
Mozambique	6.5	1	1	1	1	1	0.5	1	0	0
Nepal	4	1	1	0.5	0.5	0.5	0.5	0	0	0
Nicaragua	5.5	2	0.5	0.5	1	0	0.5	0.5	0.5	0
Pakistan	7	1	0.5	1	0.5	1	1	1	1	0
Philippines	2	1	0.5	0.5	0	0	0	0	0	0
Peru	3.5	2	0	0	0.5	0.5	0.5	0	0	0
Sri Lanka	5	1	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Taiwan	0	0	0	0	0	0	0	0	0	0
Uganda	8	2	1	0.5	1	1	0.5	1	0.5	0.5
Uruguay	6.5	2	1	0.5	1	0.5	0.5	0	1	0
Vietnam	5.5	2	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Zambia	9	2	1	1	1	1	0.5	1	0.5	1

mothers are informed about the risks and benefits of different infant feeding options and supported in carrying out their infant feeding decisions.

Subset for the Indicator and scoring

Table 16 shows the subset of indicator on Infant Feeding and HIV and the maximum score that one can achieve. There are nine criteria for measuring national achievement for this indicator.

Findings

Fig. 11 provides mapping based on colour coding and a

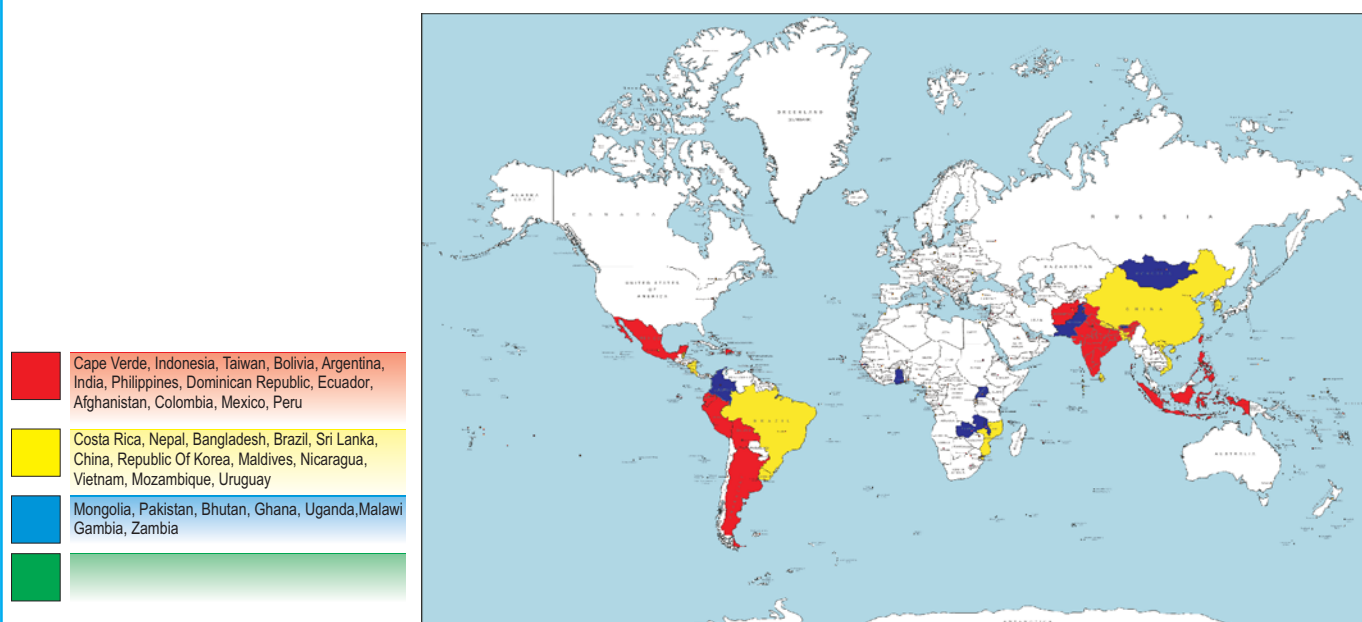
graph of the score of this indicator on a scale of 10.

The average score of the 33 countries for this indicator is 4.67. The scores range from 9 for Zambia and Gambia to zero for Taiwan, Indonesia and Cape Verde. Eight countries are in the blue level, 12 in the yellow level and 13 are in the red level. No country has, as yet, reached the green level. It should be noted that except for Cape Verde, African countries in general have more adequate programmes for integrating infant feeding issues in HIV/AIDS than those in Asia or Latin America, the exceptions being Bhutan and Mongolia. Table 17 provides the scores of each country and sub set of indicators.

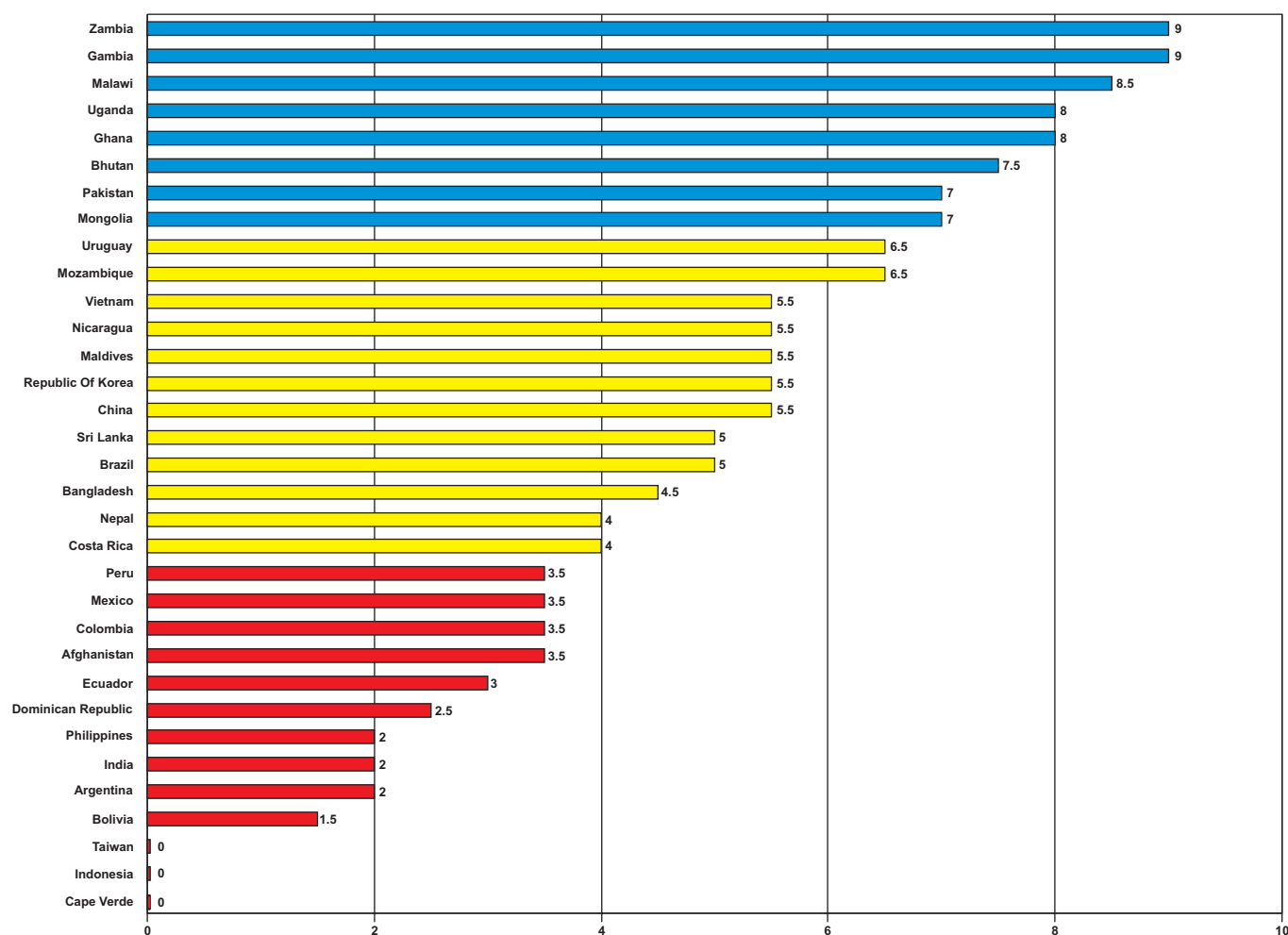
Out of 33 countries, only 12 have included infant feeding and HIV in their infant and young child feeding policy, while 13 have included it to some degree. Those who have adequately included Infant Feeding HIV in their national policies include all African countries except Cape Verde which has no policy & some Asian countries - Bangladesh, China, and Maldives, Mongolia and Vietnam, and three countries from Latin America Nicaragua, Uruguay and Peru. The policy gives effect to the International Code in 13 countries, and to some extent in another eight countries. Of the countries that have adequately integrated infant feeding in HIV in their policy, adequate training is given only in Gambia, Malawi, Mozambique, Uganda, Uruguay and Zambia. Seven countries Argentina, Bolivia, Cape Verde, Colombia, India, Indonesia and Taiwan have not integrated infant feeding and HIV in their national policies.

Fig. 11: Infant Feeding and HIV

Colour Coding of Countries for Indicator on Infant Feeding and HIV



The State of Infant Feeding and HIV in 33 Countries, on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

9. Infant Feeding during Emergencies



Photo Credit: IBFAN Southeast Asia



Photo Credit: IBFAN LAC

Natural disasters and emergencies like earthquakes, floods, typhoons and tsunami pose a real challenge for Governments, aid agencies, NGOs and community. Providing adequate and appropriate nutrition to the affected people including infants and children acquires top priority in such situations. Infants and young children are among the most vulnerable groups in emergencies both manmade and natural. Interruption of breastfeeding and inappropriate complementary feeding increase the risks of illness, malnutrition, and mortality.

Malnutrition increases dramatically, and kills most rapidly, in emergencies. Most children do not die due to conflicts or natural disasters themselves, but rather to resulting food shortages, lack of safe water, inadequate health care, and poor sanitation and hygiene.¹⁸ Child survival is a key issue in disasters and need for specific response including adequate strategies to maintain optimal infant and young child feeding (IYCF) is paramount.

The risks of artificial feeding were exposed in Botswana in 2005/06 where replacement feeding with infant formula was offered to all HIV-infected mothers as part of a national programme to prevent transmission of HIV from mother to child (PMTCT). Flooding led to contaminated water supplies, a huge rise in diarrhoea and malnutrition in young children. National under five mortality increased by at least 18% over 1 year. Non-breastfed infants were 50 times more likely to need hospital treatment than breastfed infants, and much more likely to die. Use of infant formula 'spilled over' to 15% of HIV-uninfected women, exposing their infants to unnecessary risk.¹⁹

In emergency and relief situations the responsibility for protecting, promoting and supporting optimal infant and young child feeding practices and minimizing harmful practices should be shared by the emergency-affected host country and responding agencies, especially in view of the fact that formula and packaged food dominate donations.

Optimal feeding of infants and young children during emergencies requires that national authorities (or equivalent) responsible for emergency preparedness and response and designated staff in national and nutrition programmes should be adequately prepared for ensuring optimal feeding practices in emergencies, including providing traumatized mothers with the support and counselling they may require.

This indicator examines whether countries have in place appropriate policies and programmes to ensure that mothers, infants and children will be provided adequate protection and support for appropriate feeding during emergencies?

Subset for the Indicator and scoring

Table 18 gives the subset of questions for Indicator on Infant Feeding during Emergencies. There are five criteria, each with a score ranging from zero to two.

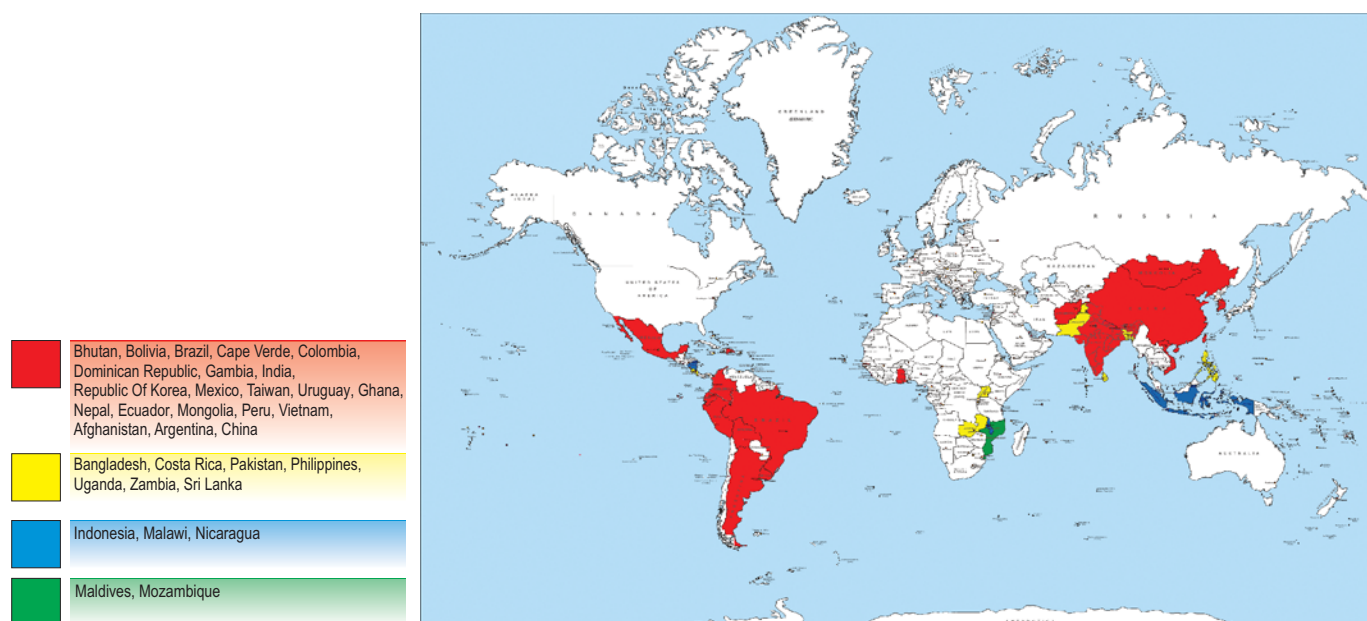
Findings

Fig. 12 provides mapping based on colour coding and a graph of the score of this indicator on a scale of 10.

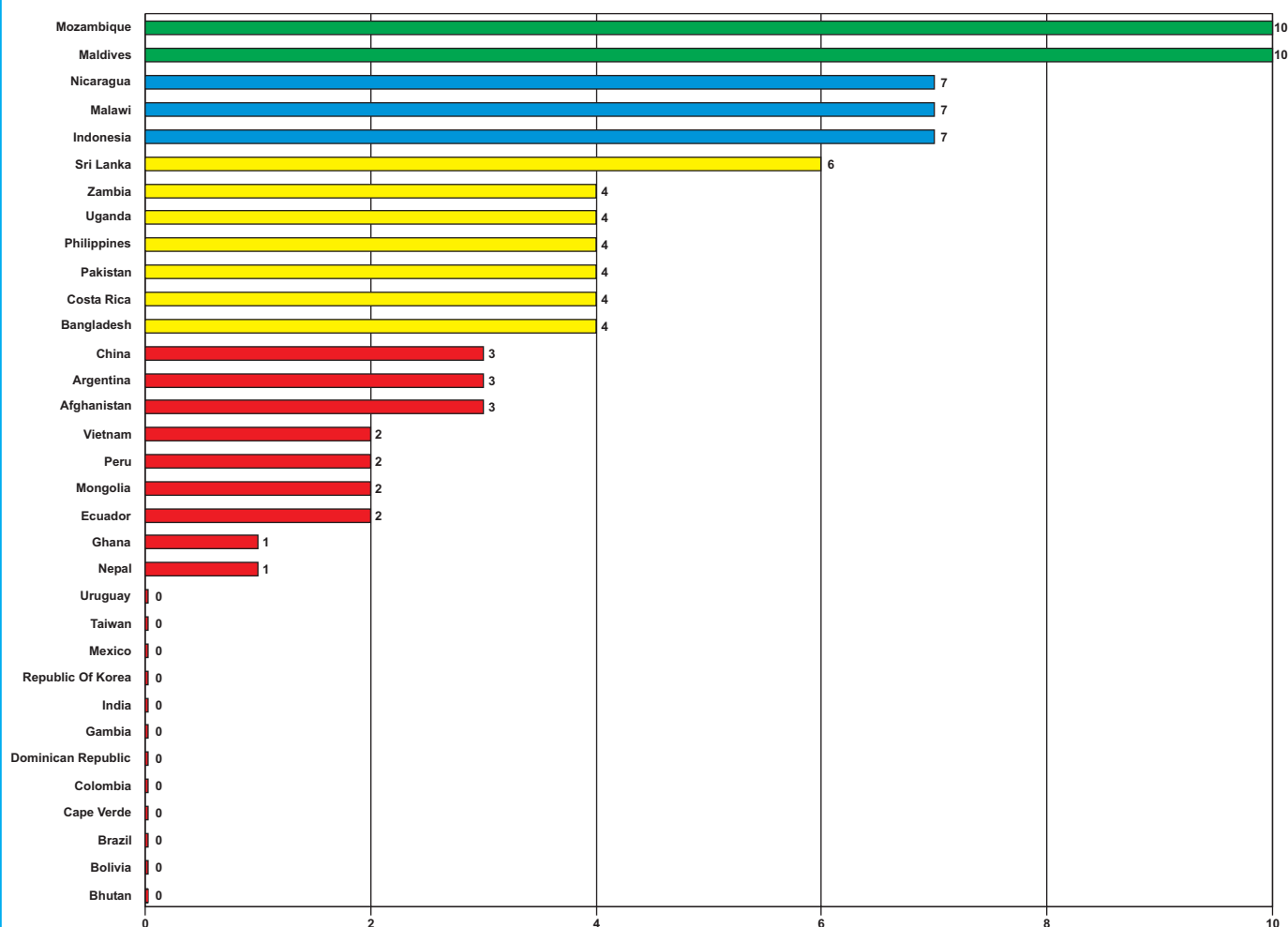
The Fig. 12 reveals that infant feeding during emergencies is not yet a priority in most countries. This indicator has received the lowest average score of 2.73. Only two countries - Mozambique and Maldives - have prioritised it, getting the full score of 10 and reaching the

Fig. 12: Infant Feeding During Emergencies

Colour Coding of Countries for Indicator on Infant Feeding During Emergencies



The State of Infant Feeding During Emergencies in 33 Countries, on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

Table 18: Subset Questionnaire for the Indicator and Scoring for each Criteria

No.	Criteria	Score		
		Yes	To some degree	No
9.1	The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies	2	1	0
9.2	Person(s) tasked with responsibility for national coordination with the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed	2	1	0
9.3	An emergency preparedness plan to undertake activities to ensure exclusive breastfeeding and appropriate complementary feeding and to minimize the risk of artificial feeding has been developed	2	1	0
9.4	Resources identified for implementation of the plan during emergencies	2	1	0
9.5	Appropriate teaching material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.	2	1	0
Total Score		-----/10		

green level. The majority 21 countries - are in the red level, with 12 countries scoring zero-

Uruguay, Taiwan, Mexico, Republic of Korea, India, Gambia, Dominican Republic, Colombia, Cape Verde, Brazil, Bolivia and Bhutan. Three countries-Nicaragua, Malawi and Indonesia are in the blue level, and the rest are in the yellow level.

Table 19 gives the scores that each country gave itself during assessment.

Countries are generally ill-equipped to handle infant feeding in emergencies as is evident from the above table. Only eight countries-Bangladesh, Indonesia, Malawi, Maldives, Mozambique, Uganda, Vietnam and Zambia - have a comprehensive infant and young child feeding policy that includes infant feeding in emergencies. Often these, only Maldives and Mozambique have a comprehensive emergency preparedness plan that includes plans to support exclusive breastfeeding and appropriate complementary feeding, and to minimize the risk of artificial foods replacing breastfeeding and locally available complementary foods. Maldives, Mozambique, Malawi and Nicaragua have identified the resources needed to implement the plan, while eight other countries have partially identified them. China, Costa Rica, Indonesia, Maldives, Mozambique, Sri Lanka and Uganda have appointed persons to coordinate national and international donor agencies and rescue agencies such as the military on infant and young child feeding.

Table 19: Country Scores for Each Criteria

Country	Total score of Indicator (out of 10)	Indicators				
		9.1	9.2	9.3	9.4	9.5
Afghanistan	3	1	0	1	1	0
Argentina	3	1	0	1	0	1
Bangladesh	4	2	0	1	1	0
Bhutan	0	0	0	0	0	0
Bolivia	0	0	0	0	0	0
Brazil	0	0	0	0	0	0
Cape Verde	0	0	0	0	0	0
China	3	0	2	0	0	1
Colombia	0	0	0	0	0	0
Costa Rica	4	0	2	0	1	1
Dominican Republic	0	0	0	0	0	0
Ecuador	2	0	1	0	0	1
Gambia	0	0	0	0	0	0
Ghana	1	1	0	0	0	0
India	0	0	0	0	0	0
Indonesia	7	2	2	1	1	1
Republic of Korea	0	0	0	0	0	0
Malawi	7	2	1	1	2	1
Maldives	10	2	2	2	2	2
Mexico	0	0	0	0	0	0
Mongolia	2	0	0	1	1	0
Mozambique	10	2	2	2	2	2
Nepal	1	1	0	0	0	0
Nicaragua	7	1	2	1	2	1
Pakistan	4	1	1	1	0	1
Philippines	4	1	1	1	1	0
Peru	2	0	1	0	1	0
Sri Lanka	6	1	2	1	1	1
Taiwan	0	0	0	0	0	0
Uganda	4	2	2	0	0	0
Uruguay	0	0	0	0	0	0
Vietnam	2	2	0	0	0	0
Zambia	4	2	1	1	0	0

10. Monitoring and Evaluation

A regular system of monitoring and evaluation is important for knowing the status of infant and young child feeding in the country. Such monitoring and evaluation also highlights the areas where special attention is required. Therefore monitoring and evaluation (M & E) components should be built into all major infant and young child feeding programme activities and collection of data concerning feeding practices integrated into national nutritional surveillance and health monitoring systems or surveys. Monitoring or management information system data should be collected systematically and considered by programme managers as part of the management and planning process. When appropriate, both baseline and follow-up data should be collected to measure outcomes. Use of internationally agreed-upon indicators and data collection strategies should be considered, in an effort to increase availability of comparable data. It is important that strategies be devised to help insure that key decision-makers receive important evaluation results and are encouraged to use them.

This Indicator looks at whether countries have a system to routinely collect monitoring and evaluation data, and whether such data is used to improve infant and young child feeding practices.

Subset for the Indicator and scoring

Table 20 gives the five criteria for assessing countries on the indicator, with each criterion getting a score ranging from zero to two. The maximum total score for the indicator is 10.

Findings

Fig. 13 provides mapping based on colour coding and a graph of the score of this indicator on a scale of 10.

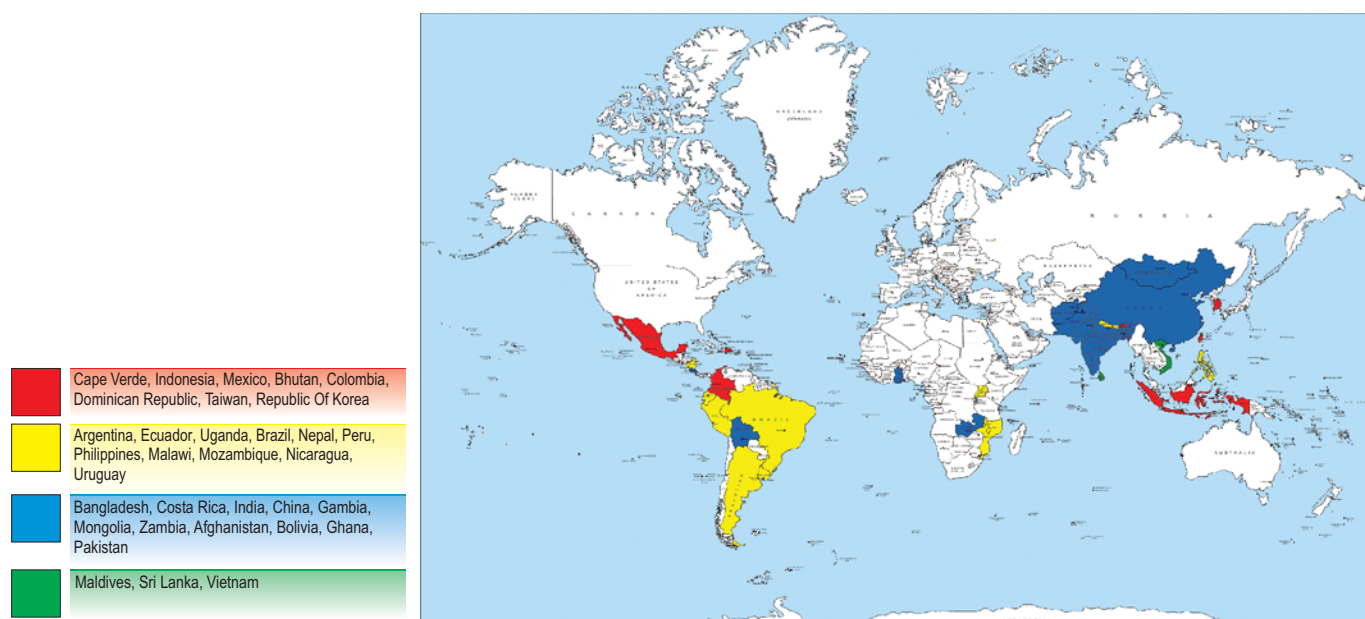
The average score for this indicator is 5.64. Three countries Vietnam, Sri Lanka and Maldives, are in the green level with the highest score of 10. Mexico, Indonesia and Cape Verde are in the red level with scores of zero each. Republic of Korea, Taiwan, Dominican Republic, Colombia and Bhutan are also in the red level. The remaining countries are equally divided between the blue and the yellow level.

Table 20: Subset Questionnaire for the Indicator and Scoring for each Criteria

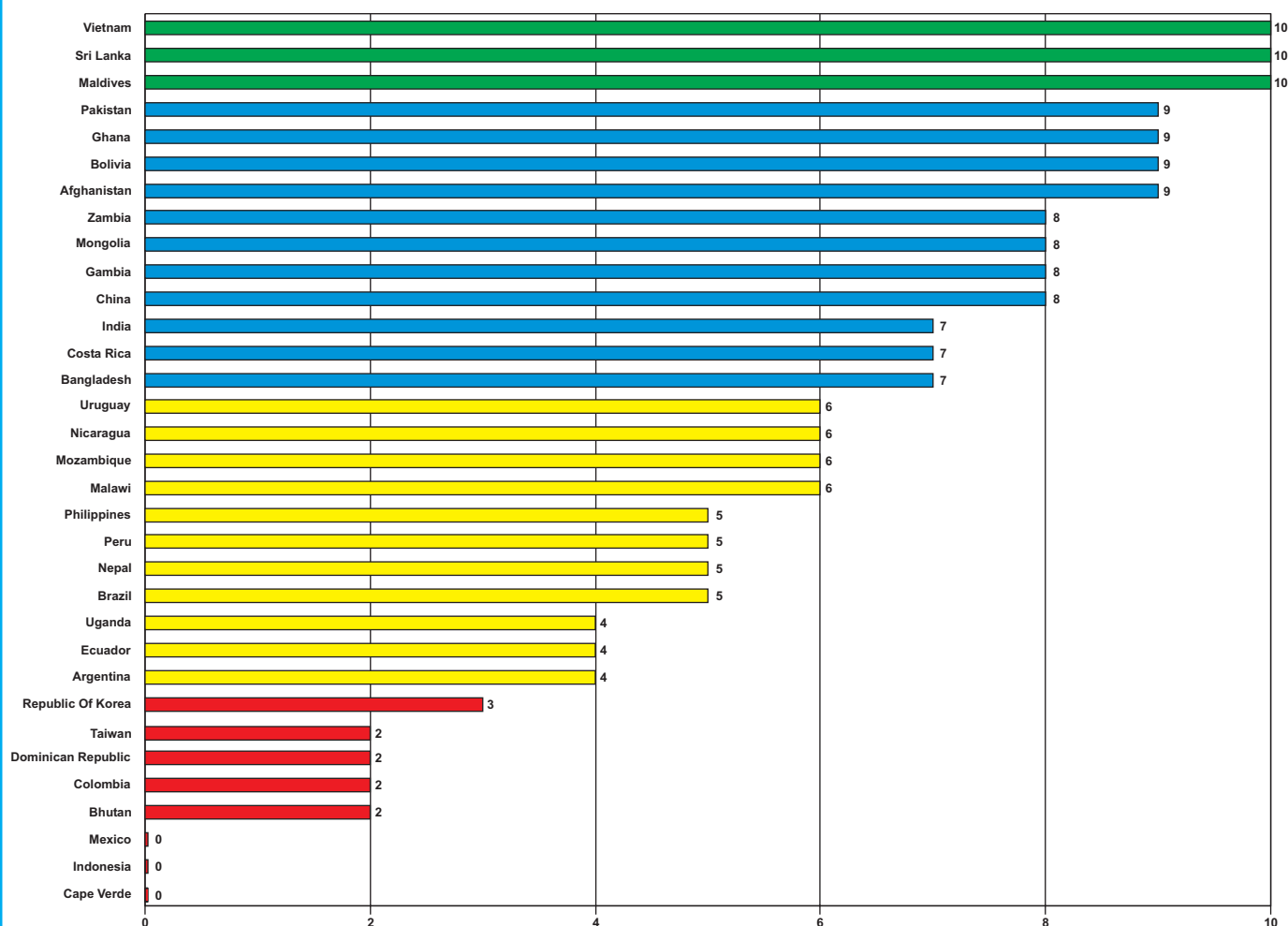
No.	Criteria	Score		
		Yes	To some degree	No
10.1	Monitoring and evaluation components are built into major infant and young child feeding programme activities.	2	1	0
10.2	Monitoring or Management Information System (MIS) data are considered by programme managers in the integrated management process.	2	1	0
10.3	Baseline and follow-up data are collected to measure outcomes for major infant and young child feeding programme activities.	2	1	0
10.4	Evaluation results related to major infant and young child feeding programme activities are reported to key decision-makers	2	1	0
10.5	Monitoring of key infant and young child feeding practices is built into a broader nutritional surveillance and/or health monitoring system or periodic national health surveys.	2	1	0
Total Score		-----/10		

Fig. 13: Monitoring and Evaluation

Colour Coding of Countries for Indicator on Monitoring and Evaluation



The State of Monitoring and Evaluation in 33 Countries, on a Scale of Ten (10)



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

Table 21 gives the details of the score each country received for the indicator.

Monitoring and evaluation is fully built into the major programme activities related to infant and young child feeding in ten countries Afghanistan, Bolivia, China, Gambia, Maldives, Pakistan, Sri Lanka, Uruguay, Vietnam and Zambia. However, in many countries, evaluation results are communicated to key policy makers. Monitoring of infant feeding practices is built into the national surveillance system of 12 countries.

Table 21: Country Scores for Each Criteria

Country	Total score of Indicators (out of 10)	Subset Scores				
		10.1	10.2	10.3	10.4	10..5
Afghanistan	9	2	1	2	2	2
Argentina	4	1	1	0	1	1
Bangladesh	7	1	1	1	2	2
Bhutan	2	1	0	1	0	0
Bolivia	9	2	2	1	2	2
Brazil	5	1	1	1	1	1
Cape Verde	0	0	0	0	0	0
China	8	2	2	1	2	1
Colombia	2	0	0	0	0	2
Costa Rica	7	1	1	1	2	2
Dominican Republic	2	1	0	0	0	1
Ecuador	4	1	0	1	1	1
Gambia	8	2	1	2	2	1
Ghana	9	1	2	2	2	2
India	7	1	1	2	2	1
Indonesia	0	0	0	0	0	0
Korea	3	1	0	1	1	0
Malawi	6	1	2	1	1	1
Maldives	10	2	2	2	2	2
Mexico	0	0	0	0	0	0
Mongolia	8	1	1	2	2	2
Mozambique	6	0	2	1	2	1
Nepal	5	1	1	1	1	1
Nicaragua	6	1	2	1	1	1
Pakistan	9	2	2	2	1	2
Philippines	5	1	1	1	1	1
Peru	5	1	1	0	1	2
Sri Lanka	10	2	2	2	2	2
Taiwan	2	1	0	0	1	0
Uganda	4	0	1	1	1	1
Uruguay	6	2	2	1	1	0
Vietnam	10	2	2	2	2	2
Zambia	8	2	2	1	2	1

Part 2: IYCF Practices

Optimal infant and young child feeding practices include initiation of breastfeeding within one hour of birth, exclusive breastfeeding for the first six months of life and addition of appropriate and adequate family foods for complementary feeding after six months, together with continued breastfeeding for two years or beyond.

This section provides information on optimal infant and young child feeding practices, which exist as a result of policy and programmes. **These findings are derived from collection of secondary data through the country led process of the WBTi assessment. The assessment guidelines ask for data, which is national in scope and should be referenced.**

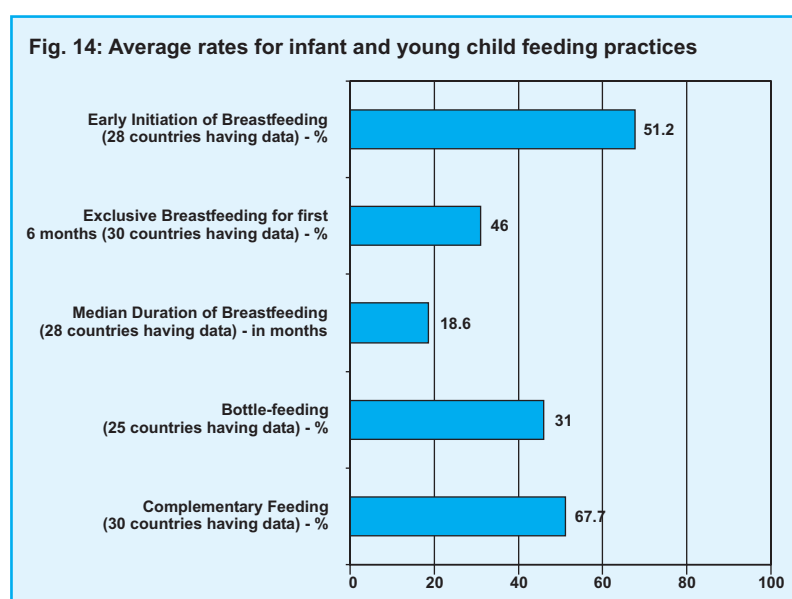
These practices can also be viewed in the context of the state of child health and nutrition in those 33 countries given in the background section. On examining the situation we find that, except in Zambia, Mozambique and Ghana, a high proportion of the deaths of children under five in the countries occur in the first year of life. Several of these countries have extremely high rates of neonatal mortality compared to under 5 mortality and infant mortality. This clearly reflects the need in these countries to improve rates of timely initiation of breastfeeding and exclusive breastfeeding for the first six months of life.

The WBTi assessment pointed out that some countries had not collected data on infant and young child feeding practices. For instance, four countries-Costa Rica, Korea, Taiwan and Vietnam-have no data on initiation of breastfeeding within one hour; Bhutan and Vietnam have no data on exclusive breastfeeding; Colombia, Gambia, Korea and Taiwan have no data on median duration of breastfeeding; eight countries - Afghanistan, Cape Verde, China, Ecuador, Gambia, Mexico, Nicaragua and Taiwan - have no data on bottle-feeding rates; Cape Verde and Taiwan have no data on complementary feeding. Fig. 14 gives the average rates of five infant and young child feeding practices in the participating countries, where data was available.

Fig. 14 makes it evident that infant and young child feeding practices in the assessed countries are nowhere near optimal, contributing to the high global rates of infant mortality and childhood malnutrition. While the average rate for initiation of breastfeeding within an hour of birth is just above 50 per cent, and that of exclusive breastfeeding a little below 50 percent, the median duration of breastfeeding is at a low of 18.5 months.

Complementary foods are introduced by the 6th to 9th month for only 67.7 per cent of infants. Some countries do not even have national data on all the parameters for assessing the state of infant nutrition.

In the description of these five indicators on feeding practices, we are using actual rates in the findings section. Colour coding and scoring used is based on the IBFAN Asia's guidelines.



1. Timely initiation of breastfeeding within one hour of birth

Optimally, the baby should start to breastfeed before any routine procedure (such as bathing, weighing, umbilical cord care, administration of eye medications) is performed. Early breastfeeding and skin to skin contact helps better temperature control of the newborn baby, enhances bonding between the mother and the baby, and also increases the chances of establishing exclusive breastfeeding early and its success. Evidence from a large community study has established early initiation as a major intervention to prevent neonatal mortality.



Photo Credit: Arun Gupta

Many women across the world, deliver their babies at home, particularly in the developing countries and more so in rural areas. Breastfeeding is started late in many of these settings due to cultural and other beliefs and practices. According to the new guidelines in Baby Friendly Hospital Initiative (BFHI) "Step" 4 of the *Ten Steps to Successful Breastfeeding*, the baby should be placed "skin-to-skin" with the mother in the first half an hour following delivery and offered the breast within the first hour in all normal deliveries. If the mother has had a caesarean section the baby should be offered breast when mother is able to respond and it happens within few hours of the general anaesthesia also. Mothers who have undergone caesarean sections need extra help with breastfeeding otherwise they initiate breastfeeding much later.

Question to be answered and criteria for scoring

Question: Percentage of babies breastfed within one hour of birth

Key: 0-29% scores as 3/Red; 30-49% as 6/Yellow; 50-89% scores as 9/Blue; 90-100% scores as 10/Green.

Findings

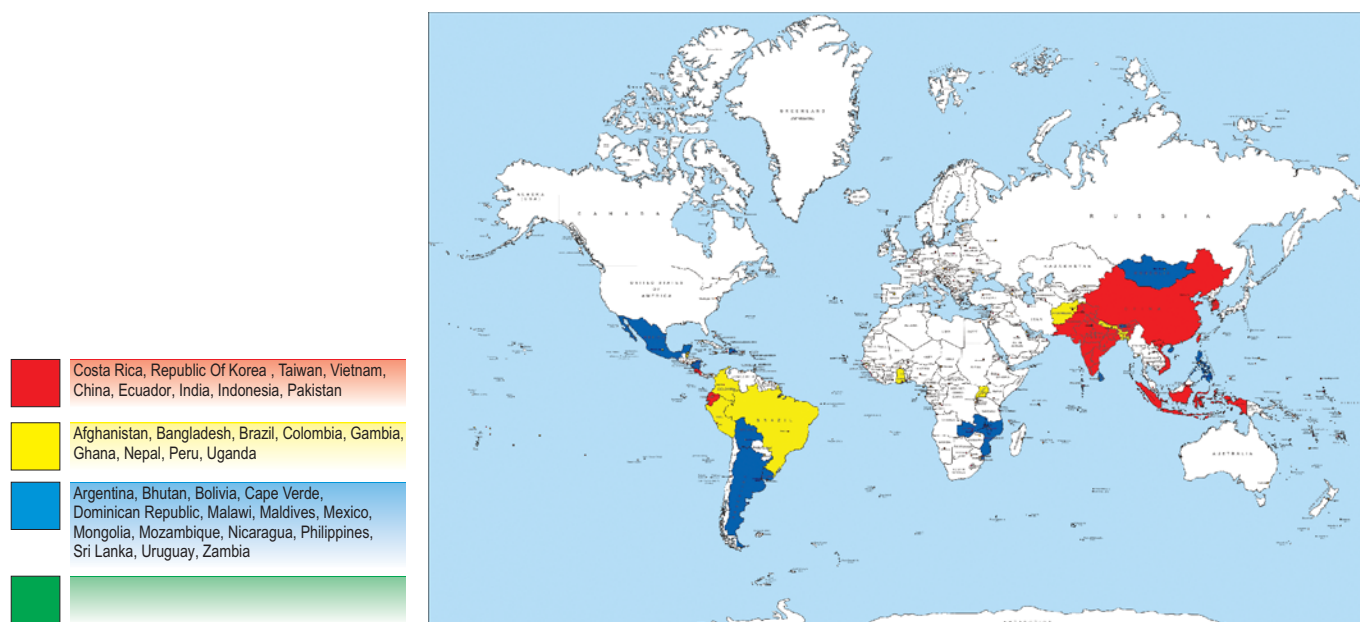
No data on rate for initiation of breastfeeding within an hour of birth was available for four countries - Vietnam, Taiwan, Korea and Costa Rica; the average rate for the remaining 29 countries is 51.3 per cent. The rates for individual countries show wide variation, ranging from a mere 3.7 per cent in Indonesia to 81 per cent in Bhutan.

The blue level has the highest number of countries - Bhutan, Argentina, Maldives, Sri Lanka, Mongolia, Cape Verde, Mozambique, Dominican Republic, Bolivia, Uruguay, Malawi, Mexico, Philippines, Nicaragua and Zambia. Nine countries are in the yellow level - Colombia, Gambia, Peru, Ghana, Brazil, Bangladesh, Uganda, Afghanistan and Nepal; while five are in the red level Pakistan, Ecuador, India, PR China and Indonesia. No country has reached the green level yet.

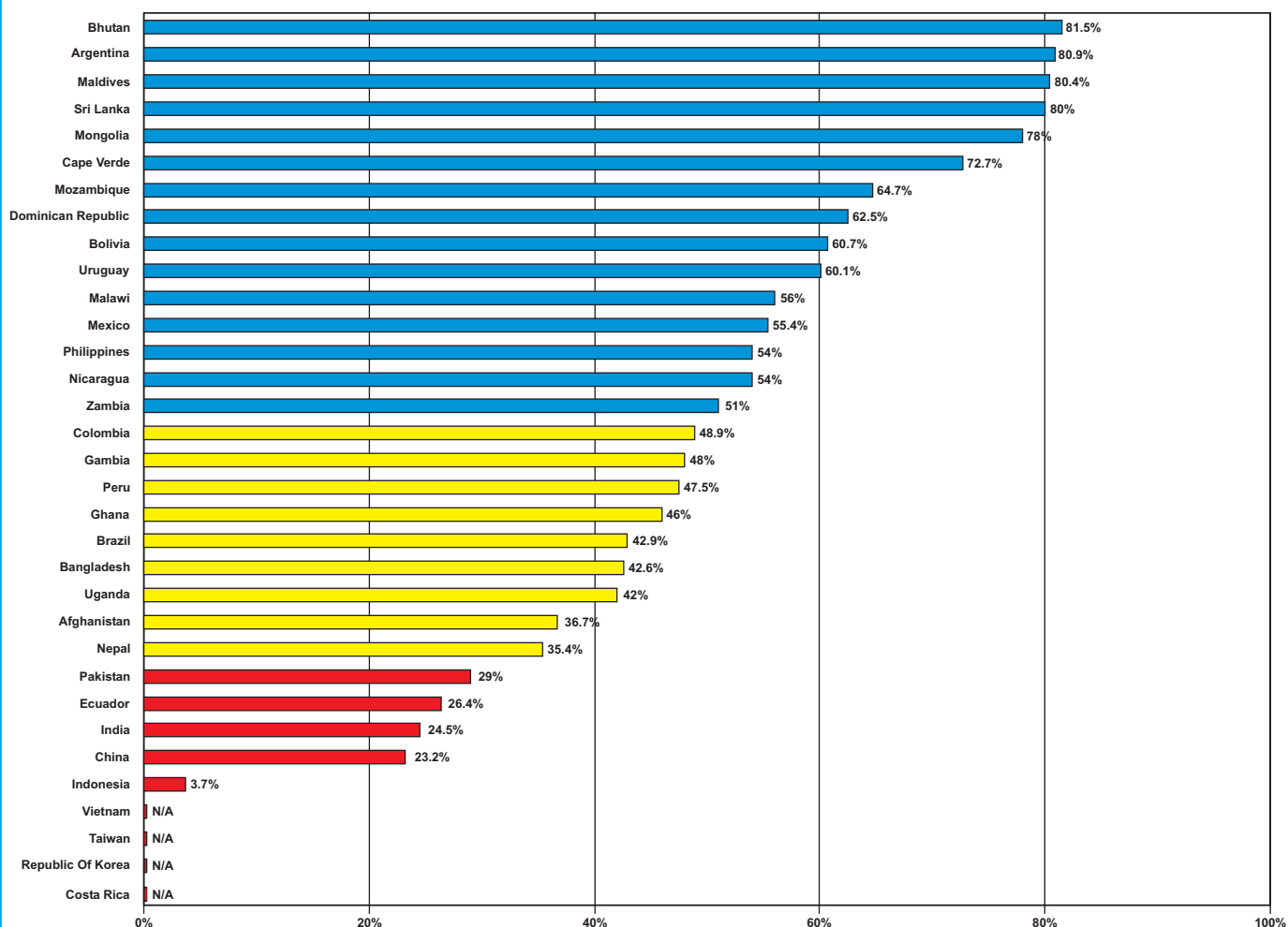
Fig. 15 gives each country's colour coding and score for this indicator, measured on a scale of ten.

Fig. 15: Early Initiation of Breastfeeding

Colour Coding of Countries for Indicator on Early Initiation of Breastfeeding



Percentage of Initiation of Breastfeeding within One Hour in 33 Countries



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

2. Exclusive Breastfeeding

Exclusive breastfeeding for the first six months is very crucial for survival, growth and development of infant and young children. It lowers the risk of illness, particularly from diarrhoeal diseases. It also prolongs lactation amenorrhoea in mothers who breastfeed frequently. WHO commissioned a systematic review of the published scientific literature about the optimum duration of exclusive breastfeeding and in March 2001, the findings were submitted for technical review and scrutiny during an Expert Consultation. This Expert Consultation recommended a change to “exclusive breastfeeding for six months from earlier recommendation of 4 to 6 months. The World Health Assembly (WHA) in May 2001 formally adopted this recommendation through a Resolution 54.2 /2001 that the period of exclusive breastfeeding is for the first six months. The World Health Assembly in 2002 approved another resolution 55.25 that adopted the *Global Strategy for Infant and Young Child Feeding*. Later the UNICEF Executive Board also adopted this resolution and the *Global Strategy for Infant and Young Child Feeding* in September 2002, bringing a unique consensus on this health recommendation. Further, in areas with high HIV prevalence there is evidence that exclusive breastfeeding is more protective than “mixed feeding” for risks of HIV transmission through breastmilk and overall HIV free child survival; on this basis WHO has revised its recommendations. New analysis published in Lancet series on Maternal and Child Undernutrition, 2008, clearly pointed out the role of exclusive breastfeeding during first six months for infant survival and development.



Photo Credit: UNICEF Egypt

Question to be answered and criteria for scoring

Question: Percentage of babies 0<6 months of age exclusively breastfed in the last 24 hours?

Key: 0-11% scores as 3/Red; 12-49% as 6/Yellow; 50-89% scores as 9/Blue; 90-100% scores as 10/Green.

Findings

Figure 16 gives the percentage of babies between birth and six months who have been exclusively breastfed for each country, and the colour coding.

The above figure shows that most children in the countries assessed are not exclusively breastfed for the first six months of life; the average of the 31 countries that have data is just 46 per cent. The percentage of infants who are exclusively breastfed ranges from a low 5.5 per cent in Mexico to 83 per cent in Afghanistan. Bhutan and Vietnam have no national level data available on exclusive breastfeeding rates.

The rates of true exclusive breastfeeding may actually be even lower than reported, as the surveys include infants who are less than six months old; some of these babies may be weaned off breastmilk before they reach six months. Looking at exclusive breastfeeding at six months gives a more accurate picture, which could be very low. This can be explained from the report of India, one can see the fall of exclusive breastfeeding from 69% at 2 month to 27.6% at six months. (Fig. 17)

Seventeen countries are in the blue level for this indicator, while 13 are in the yellow level and three in the red Costa Rica, Dominican Republic and Mexico. There is no country in green yet.

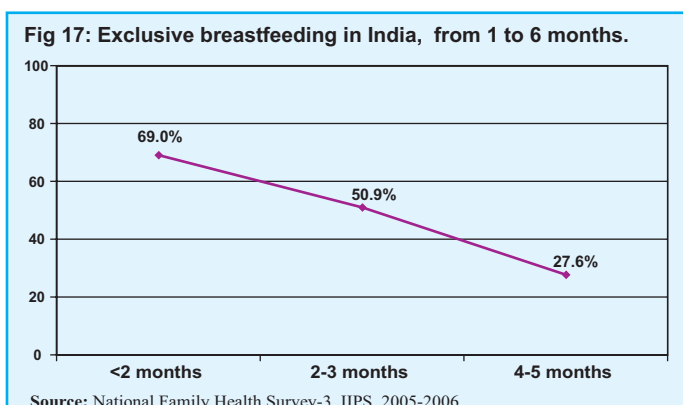
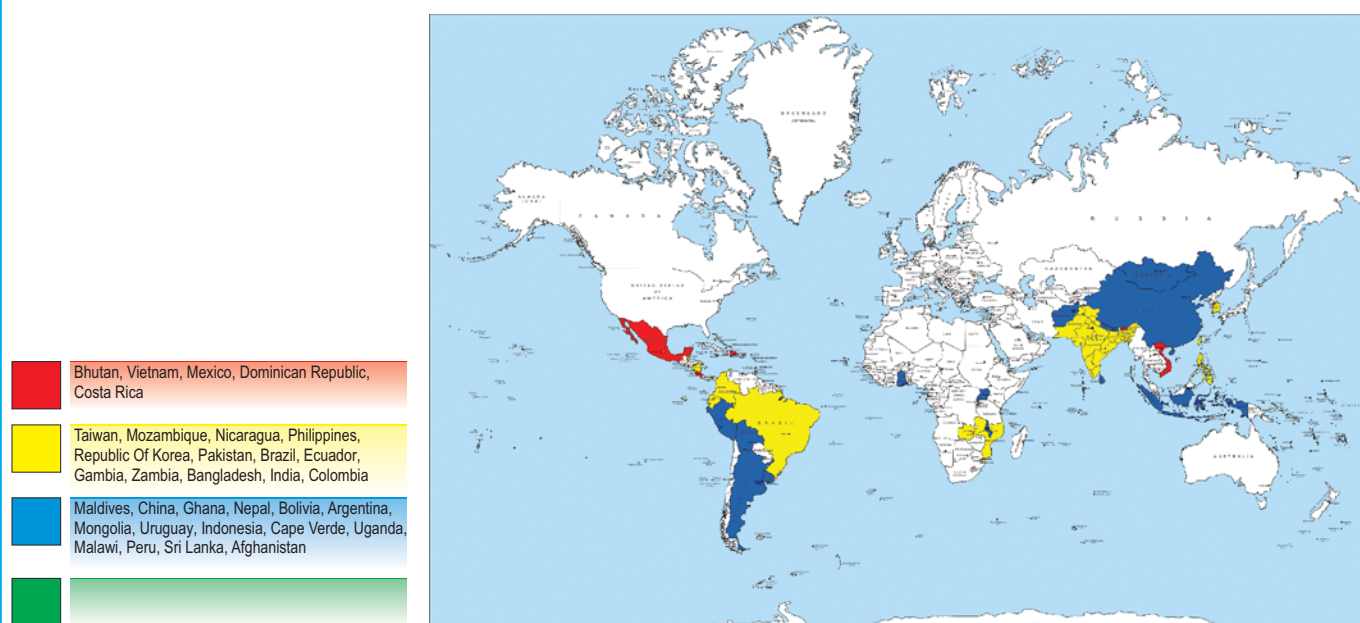
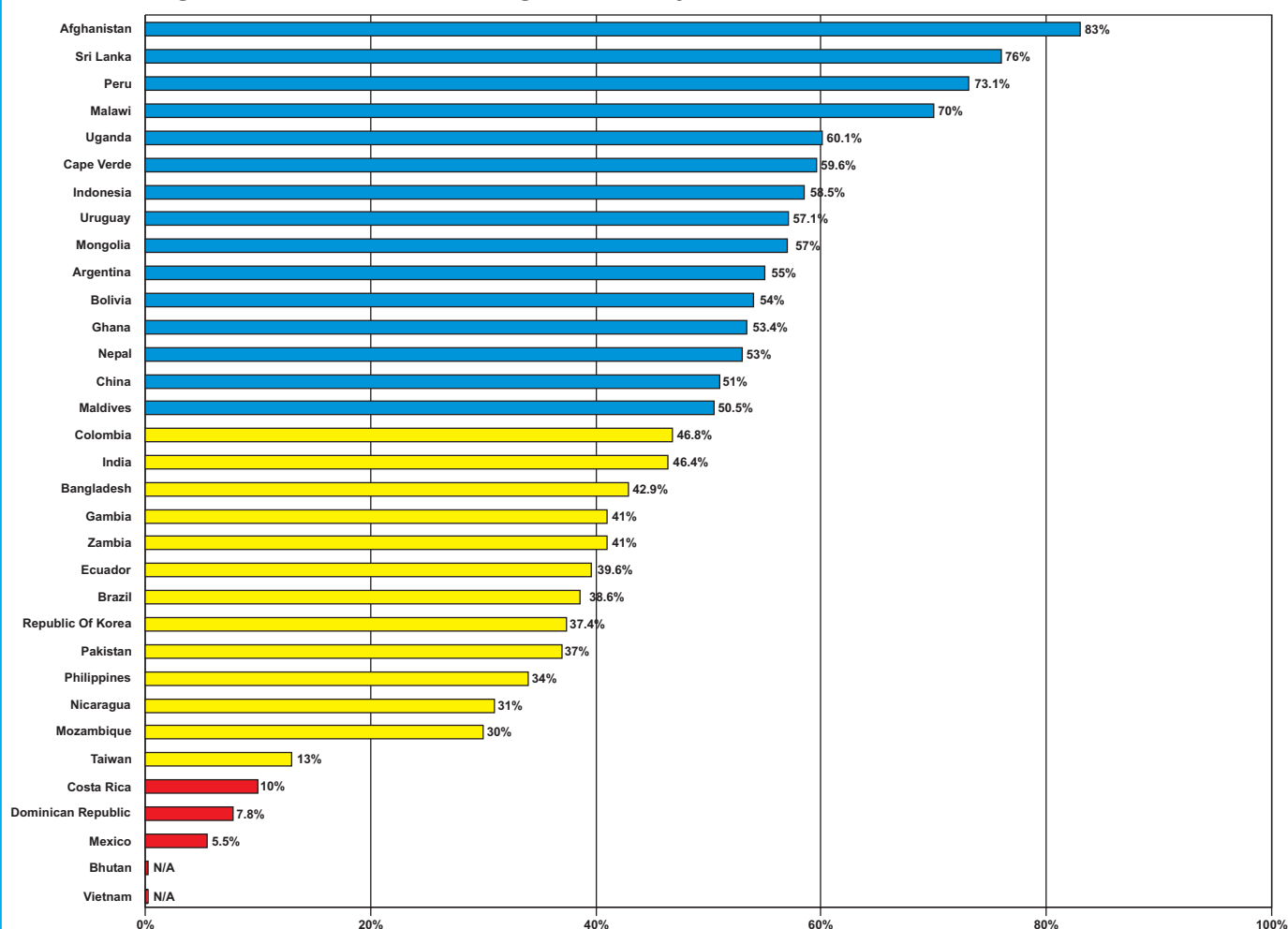


Fig. 16: Exclusive breastfeeding for the first six months

Colour Coding of Countries for Indicator on Exclusive Breastfeeding



Percentage of Infants 0-6 months of Age Exclusively Breastfed in the last 24 hours in 33 Countries



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

3. Median duration of breastfeeding

The “*Innocenti Declaration*” and the *Global Strategy* recommends that babies continue to be breastfed for two years of age or beyond along with adequate and appropriate complementary foods starting after six months of age. Breastmilk continues to be an important source of nutrition and fluids and immunological protection for the infant and the young child. The continued closeness between mother and child provided by breastfeeding helps in optimal development of the infant and young child.

Question to be answered and criteria for scoring

Question: Babies are breastfed for a median duration of how many months?

Key: 0-17 months scores as 3/Red; 18-20 as 6/Yellow; 21-22 scores as 9/Blue; 23-24 or beyond scores as 10/Green.

Findings

The average median duration of breastfeeding for 29 countries with national data available is 18.6 months, which falls in the yellow level. The duration ranges from 7.1 months in Dominican Republic to 33 months in Sri Lanka, which, together with Bangladesh, Nepal, India, Malawi and Bhutan, falls in the green level. Indonesia, Ghana, Mozambique, Zambia and Mongolia fall in the blue level. Six countries Uganda, Peru, Bolivia, Pakistan, Nicaragua and Afghanistan follow in the yellow level. The rest of the countries, except for Taiwan, Korea, Gambia and PR China, where no national level data is available, fall in the red level. There are six countries in the highest green level .

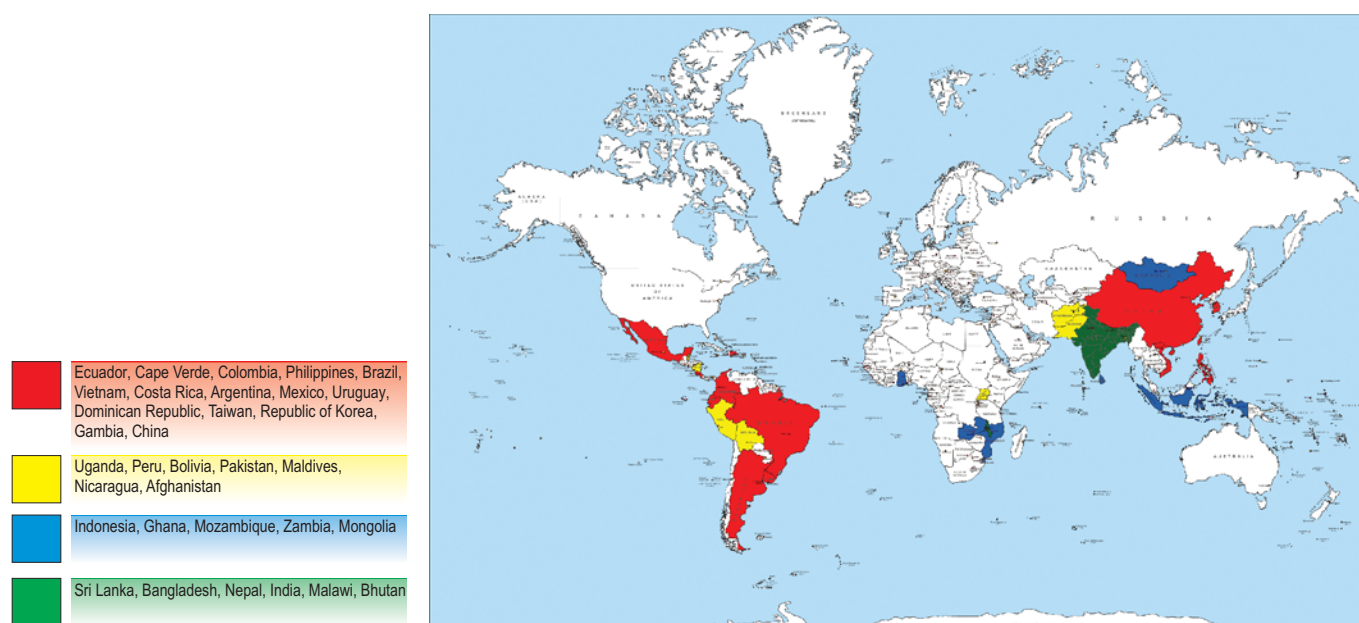
Figure 18 gives the colour coding for each country along with the median duration of breastfeeding.



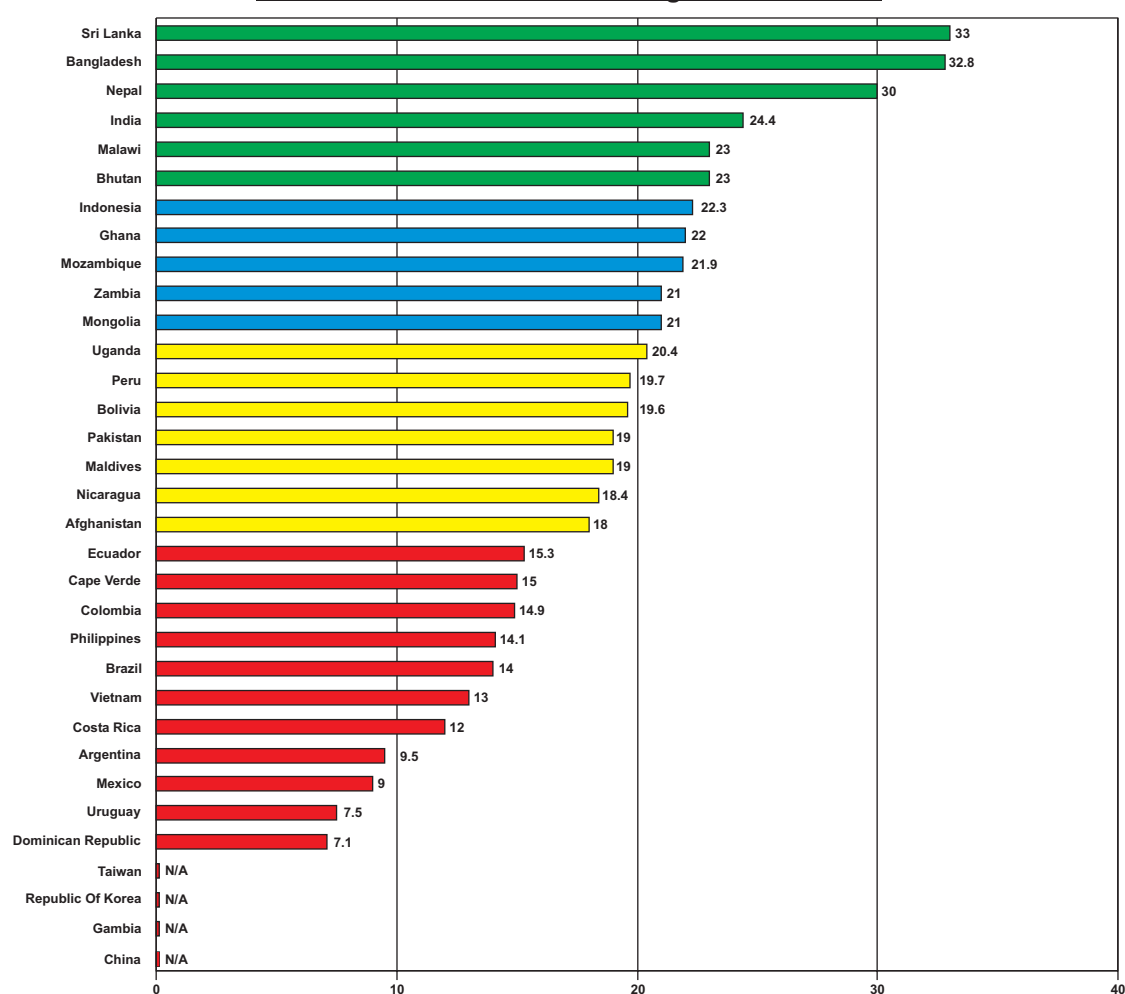
Photo Credit: WABA

Fig. 18: Median duration of breastfeeding

Colour Coding of Countries for Indicator on Median Duration of Breastfeeding



Median Duration of Breastfeeding in 33 Countries



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

4. Bottle-feeding

Babies should be breastfed exclusively for first six months of age and they need not be given any other fluids, fresh or tinned milk formulas as this would replace breastmilk and cause them more harm. Similarly after six months babies should ideally receive mother's milk plus solid complementary foods. If a baby cannot be fed the breastmilk from its mother's breast, it should be fed with a cup. (If unable to swallow, breastmilk can be provided by means of an infant feeding tube.) After six months of age, any liquids given should be fed by cup, rather than by bottle. Feeding bottles with artificial nipples and pacifiers (teats or dummies) may cause 'nipple confusion' and infants' refusal of the breast after their use. Feeding bottles are more difficult to keep clean than cups and the ingestion of pathogens can lead to illness and even death. Pacifiers also can easily become contaminated and cause illness.

Question to be answered and criteria for scoring

Question: What percentage of breastfed babies less than 6 months old receives other foods or drinks from bottles?

Key: 30-100% scores as 3/Red; 5-29% as 6/Yellow; 3-4% scores as 9/Blue; 0-2% scores as 10/Green.

Findings

The figure 19 makes it clear that the use of bottles for feeding babies continues unabated. The 25-country average percentage of bottle-fed babies is 31 per cent, There is no national level data available in eight countries - Afghanistan, Cape Verde, PR China, Ecuador, Gambia, Mexico, Nicaragua and Taiwan. Costa Rica has a high 90 per cent of babies who are bottle-fed, and Malawi a low 3.4 per cent.

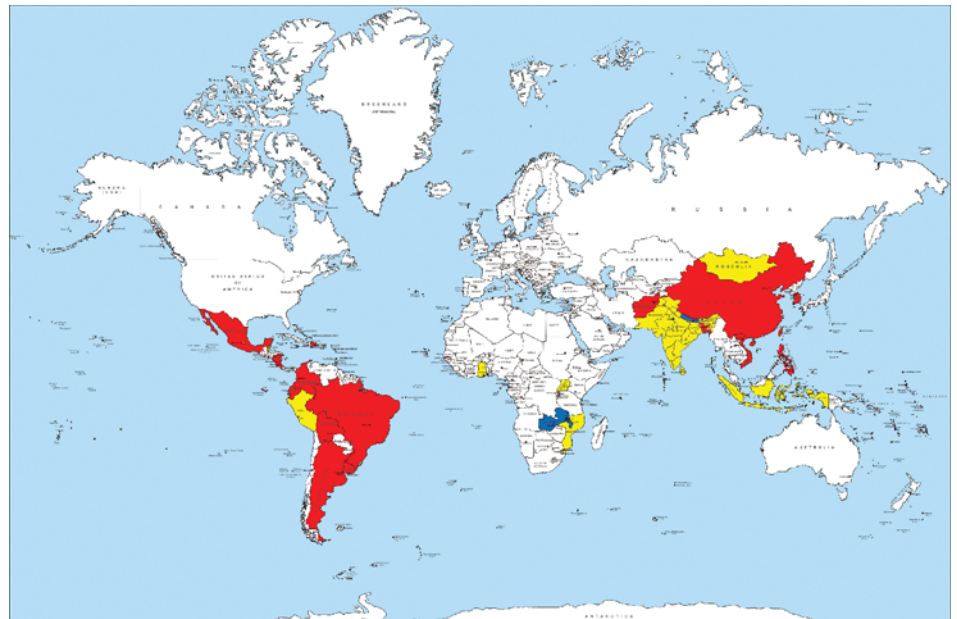
Only three countries - Malawi, Zambia and Nepal- fall in the blue level, and 11 countries in the yellow level. The remainder, except for those who do not have data, fall in the red level. There is no African country in this level, showing that African countries in general prefer not to use the bottle to feed babies.

Figure 19 gives details of how many babies are bottle-fed in the assessed countries as well as their colour coding.

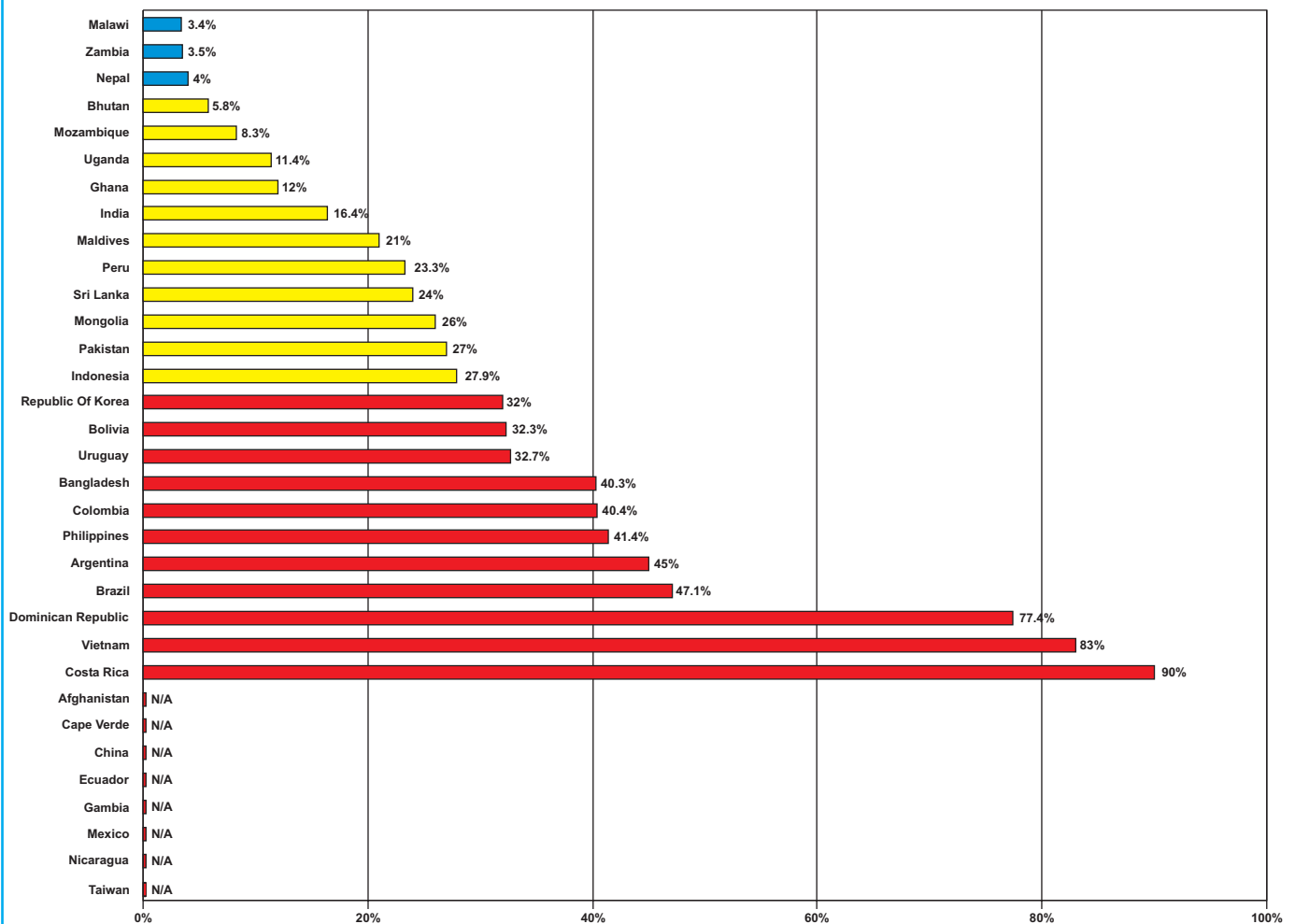


Fig. 19: Bottle-feeding

Colour Coding of Countries for Indicator on Bottle-feeding



Percentage of Infants who are Bottle-fed in 33 countries



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

5. Complementary Feeding

As babies grow continuously, they need additional nutrition along with continued breastfeeding after they are 6 months of age. Complementary feeding should begin with locally available indigenous foods as they are affordable and sustainable. Infants should be offered soft or mashed foods in small quantities 3-5 times a day. Complementary feeding should gradually increase in amount density and frequency as the baby grows. Breastfeeding, on demand should continue for 2 years or beyond. Complementary feeding is also important from the care point of view; the caregiver should continuously interact with the baby, providing the stimulation essential for all-round growth. In addition, the caregiver should ensure hygiene so that the infant is safe from infectious diseases.

Question to be answered and criteria for scoring

Question: Percentage of breastfed babies receiving complementary foods at 6-9 months of age?

Key: 0-59% scores as 3/Red; 60-79% as 6/Yellow; 80-94% scores as 9/Blue; 95-100% scores as 10/Green.

Findings

On an average, 67 per cent of breastfed infants in the assessed countries receive some kind of complementary foods between 6 and 9 months of age, putting the average for this indicator in the yellow level. As seen in Fig. 20, Argentina has the highest percentage of infants between these ages receiving complementary foods - 99.1 per cent, putting it in the green level. Other countries in the green level are Brazil and Costa Rica. Bhutan, with 21 per cent, is the last. Figures are unavailable for Cape Verde and Taiwan.

There are 12 countries in the red level, forming the majority of the assessed countries; six in the yellow level and nine in the blue level.

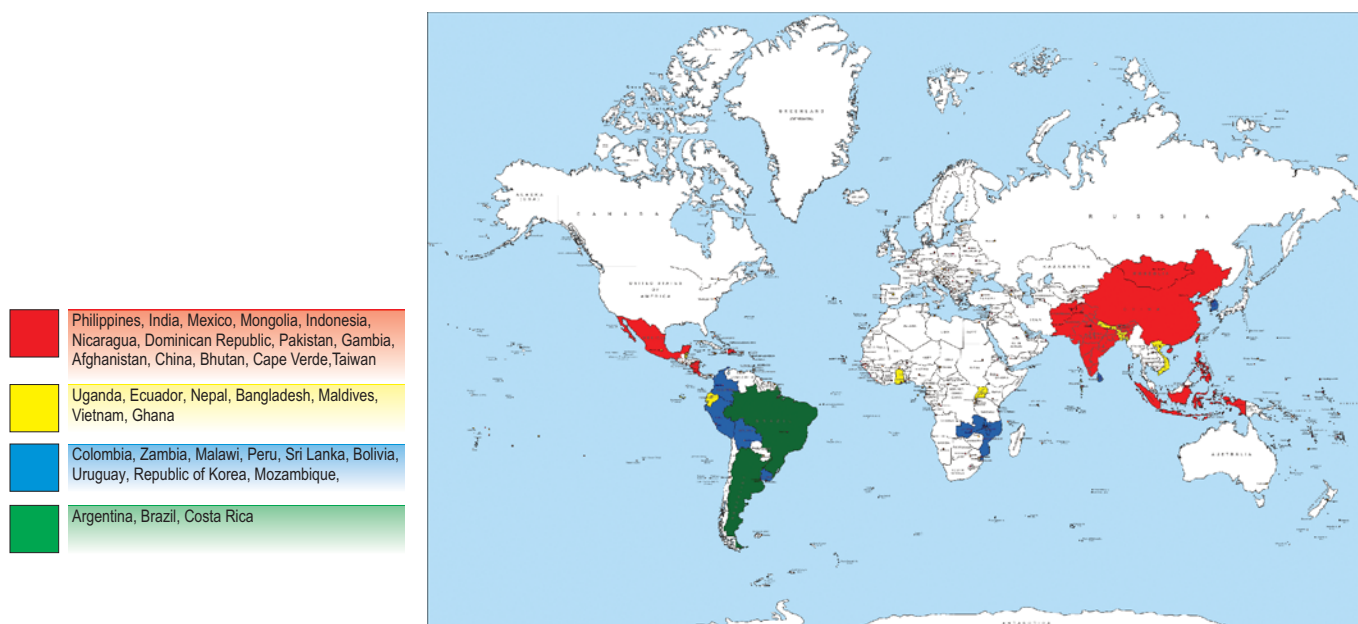
Figure 20 gives the colour coding for each country for this indicator as well as the percentage of breastfed babies between 6 and 9 months of age receiving complementary foods.



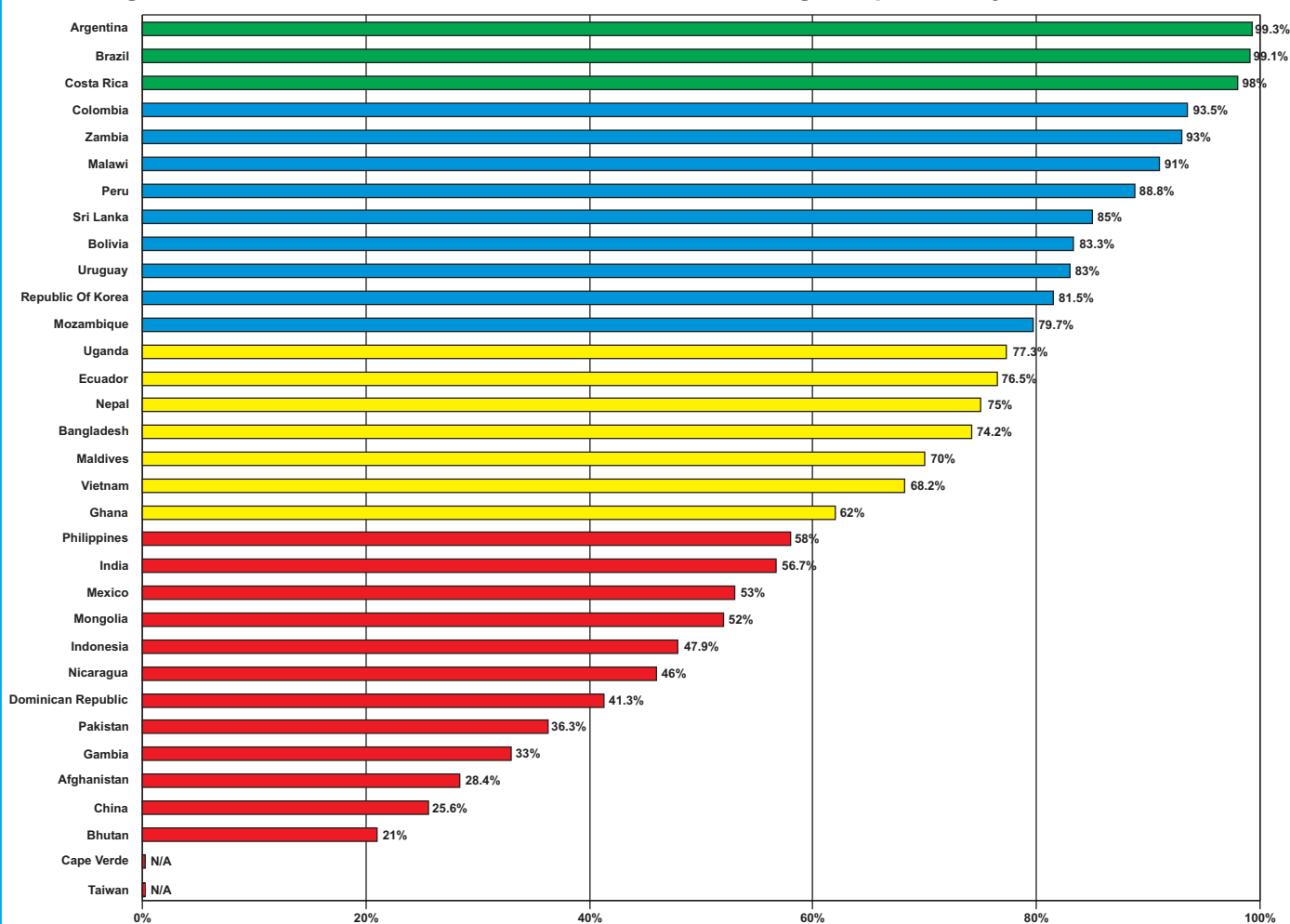
Photo Credit: IBFAN Southeast Asia

Fig. 20: Complementary Feeding

Colour Coding of Countries for Indicator on Complementary Feeding



Percentage of Breastfed Infants Between 6 and 9 months Receiving Complementary Foods in 33 Countries



Note: Details of each country's sources of information can be found in the country's report at <http://www.worldbreastfeedingtrends.org>

Analysis and the Way Forward

This section provides analysis of the reports of all 33 countries given their findings and observations as well as recommendations they have made in their individual report and provide a way forward. As there are overlaps in recommendations, further sections of this analysis do not necessarily match each programme/policy indicator, but reflect overall understanding of all areas of action required to effectively implement the *Global Strategy for Infant and Young Child Feeding*.

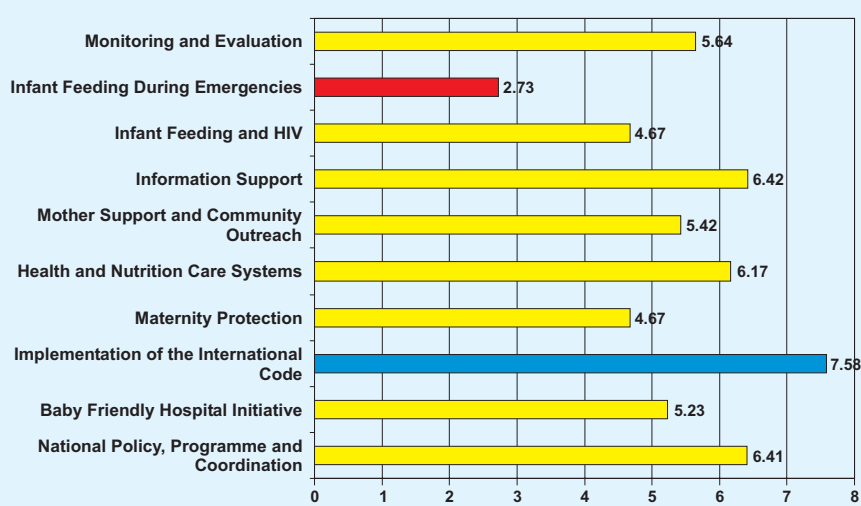
The *Global Strategy* and the *Innocenti Declaration* have outlined the directions nations need to move in, in order to reduce malnutrition and mortality amongst infants and young children. The WBTi assessment of the 10 steps of the *Global Strategy* show that the world still has a long way to go to achieve universal optimal infant and young child feeding practices. Fig. 21 gives the average scores for each of the indicators, on a scale of ten (10) for all the 33 countries. These indicators determine the level of implementation of policy and programmes to achieve optimal feeding practices.

The Fig. 21 clearly indicates that achieving optimal rates of breastfeeding has not yet been a priority for any of the nations assessed, in spite of the overwhelming evidence of its role in achieving MDGs 1 and 4. Not a single indicator has reached the green level; there is only one indicator for which the average is in the blue level. Infant and young child nutrition has not been successfully integrated into health and nutrition systems across the countries. The Baby Friendly Hospital Initiative (BFHI) was launched with much enthusiasm; however, this enthusiasm has not been maintained in spite of evidence that it works.

Support to women to carry out optimal feeding practices through maternity protection receives an abysmally low average of 4.67, higher only to preparedness for infant and young child feeding in disasters and emergencies, which receives an average score of 2.73. This is also reflected in the low average score of 4.67 received for infant feeding in HIV, even though HIV/AIDS has reached epidemic proportions in several of the countries. Supporting women adequately is the underlying issue in all three areas of action. In the context of maternity protection, it can mean adequate paid leave, financial and/or nutritional assistance, skilled counselling, accessible and adequate childcare facilities, etc. In the case of HIV feeding it includes women's health care, counselling, support to women to carry out effectively their choice of feeding method. Women in disaster situations in particular need access to skilled counselling, help in care and rehabilitation of the family and its various members, access to privacy, emotional support, protection from dumped baby milks and baby foods, and so on.

While the implementation of the International Code has received the highest average score of 7.58, the evidence of violations by baby food manufacturers across the world applying new strategies to reach out to parents, shows that it is not being implemented effectively. There is also much scope for improvement in areas of women's access to information and services including skilled counselling at

Fig. 21: Average score for Indicators on Policy, Programme and Coordination on a scale of Ten (10)



all levels of the health system, integration of infant and young child feeding practices in pre-service and in-service curricula at all levels, monitoring and evaluation of programmes as well as using the data thus obtained to inform policy and programming.

This chapter examines some of the areas that need immediate action from national and international governance systems.

1. Policy Action for Prioritising early nutrition

The *Lancet Series on Maternal and Child Undernutrition* spells out the urgent need for creating and implementing effective plans for improving nutritional status of women and children, and especially of infants, if the world is serious about meeting MDG goals of reducing under 5 mortality and morbidity and maternal mortality.

The 2010 World Health Assembly resolution 63.23 also recognized the fact that “inappropriate feeding practices and their consequences are major obstacles to attaining sustainable socioeconomic development and poverty reduction;” and that “the improvement of exclusive breastfeeding practices, adequate and timely complementary feeding, along with continued breastfeeding for up to two years or beyond, could save annually the lives of 1.5 million children under five years of age;” Similarly the MDG Report² 2010 notes that “...Halving the prevalence of underweight children by 2015 (from a 1990 baseline) will require accelerated and concerted action to scale up interventions that effectively combat undernutrition. A number of simple and cost-effective interventions at key stages in a child's life could go a long way in reducing undernutrition, such as breastfeeding within one hour of birth, exclusive breastfeeding for the first six months of life, adequate complementary feeding and micronutrient supplementation between six and 24 months of age...” (Emphasis Added)

The 33-country assessment shows the low status of breastfeeding - both early initiation as well as exclusive breastfeeding, which reflect the kind of inadequate nutrition inputs the world's children, receive during first year of their life. The low rates clearly highlight the need for putting in place policies that ensure support to women at birth, at home, in the community and the workplace. The health system needs to create effective outreach programmes so that every woman needing help, support, or skilled counselling can access it.

In a review, Bryce et al list seven key challenges for effective action at the national level²⁰:

- Getting nutrition on to the list of priorities and keeping it there
- Doing the right things
- Not doing the wrong things
- Acting at scale
- Reaching those in need
- Data-based decision making for nutrition
- Building strategic and operational capacity.

Victora et al make a strong case for investment in maternal and infant undernutrition as being the most effective intervention for improvement of adult health and human capital.²¹ Bhutta et al have termed early and exclusive breastfeeding and timely introduction of complementary foods as “core” interventions having the highest capacity to effect change in malnutrition.²²

The WBTi assessment shows that countries have recognised the need for action on these core interventions. For instance, the reports of Costa Rica and China clearly state the need to take action on early initiation of breastfeeding; China has also felt the need to take steps to prevent too early introduction of complementary foods. The concept of exclusive breastfeeding for the first six months has been recognised well and some ad hoc actions have also been taken e.g. enhancing the maternity leave to six months for some women.

If breastfeeding rates have to be scaled up, it is essential that political choices are made for this by setting up National Breastfeeding Committees, developing National Plans of Action and allocating adequate budgets for its effective implementation. Having an effective mechanism to coordinate the implementation of the plan is crucial. Dominican Republic has recommended to legislate a national breastfeeding policy to allow necessary mechanisms to be put in place and have guaranteed funds for the National Breastfeeding Commission. Taiwan and Korea have recognised the need to have a Breastfeeding Committee that meets regularly and develop at National Plan of Action. China, which scores 10 on national policy, has, in the detailed report acknowledged the need to set up a Breastfeeding Committee with intersectoral representation, Bangladesh feels the need for having specific terms of reference for the Committee, while Maldives recommends that the Committee must be effective. For Afghanistan, creating a strategic plan, gaining capacity for implementing it and carrying out regular nutritional surveillance are priorities. Bhutan, which has only recently developed its policy, feels the need for improved coordination. Bolivia has identified an immediate action - to update the terms of reference and operations manual for the coordination of the Breastfeeding Committee for meeting the goal of Zero Malnutrition.

The importance of bridging the gap created by lack of or inadequate funding for IYCF is pointed out by Bryce et al, who state that national plans must specify actions and be accompanied by timelines and budgets.²³ Concerns have been expressed globally about early infant nutrition (breastfeeding and complementary feeding) not been funded adequately as against the attraction towards other interventions.²⁴ Renowned scientist on child survival, CG Victora has argued clearly in favour of increased investments in breastfeeding and complementary feeding and noted that nutrition has received little international funding, especially when compared with large investments for the control of other diseases. He has also alerted the global community to the fact that “the limited funding for combating undernutrition is dominated by programmes for food aid and micronutrient supplementation. While such programmes have a role in some circumstances, there is urgent need for strengthening investments for community-based approaches to early life nutrition...” most notably promoting exclusive breastfeeding, the effect of which on child survival and nutritional status has been well established.

These findings support that view and call for enhanced international funding towards early infant nutrition. The lack of funding for protecting, promoting and supporting breastfeeding and appropriate complementary feeding has emerged as a serious gap in the WBT*i* assessment of several countries including all countries from Latin America and Africa that participated in the assessment. In fact, Brazil, which boasts a broad policy, institutionalized at federal, state and municipal levels, with a challenge to guarantee young children's right to adequate feeding and breastfeeding, recognizes the need for increased resources owing to the large size of the country. Vietnam, Mongolia, Korea, and Nepal have also specifically highlighted the lack of sufficient financial resources. The shortage of funds as well as trained human resources is felt in all the ten areas of action. In fact, Ghana recommends that stakeholders' capacity to fundraise be enhanced.

A striking fact that emerges from the WBT*i* analysis of the indicator on Policy, Programme and Coordination, is that having policies and programmes alone does not guarantee optimal breastfeeding practices. Enhancing optimal breastfeeding practices thus goes beyond policy and coordination; it must be mainstreamed into all programmes including health, welfare, labour, and so on. Optimal infant and young child feeding practices, counselling skills, as well as skills for effective implementation of outreach programmes must be integrated into pre-service and in-service training of health and nutrition personnel at all levels. All participating countries have recommended skilled training in IYCF for health workers. It is important that all indicators are implemented comprehensively and diverse forms of support to women are provided in order to achieve some gains in breastfeeding practices.

While ad hoc actions are being taken, the recent 6-country report on the programme review by the UNICEF (http://www.unicef.org/nutrition/files/IYCF_Booklet_April_2010_Web.pdf) has led to the recommendation “..Develop and implement a comprehensive IYCF strategy for implementation at scaleThe Global Strategy for IYCF lays out a comprehensive framework, yet the tendency is to focus on one or two of the components. Piecemeal approaches and ad hoc activities leave major barriers to improved practices unaddressed and fail to reach critical populations.”

African countries have suggested that other ministries including agriculture, welfare, etc. incorporate infant and young child feeding in their policies and programmes. Ecuador recommends that research be carried out by scientific institutions on IYCF.

Equally vital is the monitoring of the implementation of policies and programmes that both directly and indirectly affect optimal breastfeeding practices. The results of such exercise must inform both policy makers as well as those who are implementing the policy through programmes. Taiwan for instance recognises that the gap caused by lack of a monitoring and evaluation system needs to be filled by setting up such a system. Several countries have recommended that monitoring of infant and young child indicators be made consistent, that baseline data be collected and that nutrition surveillance for these indicators be conducted more frequently, at least once every two years. Bangladesh, in addition, recommends that the staff doing monitoring require special training.

IEC plays a vital role in prioritising nutrition of infants and young children in all segments of the population. IEC aimed at parents is particularly important for removing taboos that result in inappropriate feeding practices. Zambia recommends that all IEC material should be screened by a coordinating body specially set up for this purpose, so that the messages are consistent. Costa Rica and some other Latin American countries recommend a close look at cultural beliefs and practices that can encourage optimal IYCF so that IEC messages can be routed to the community in a way that is more acceptable to them.

2. Resurrecting the Baby Friendly Hospital Initiative as the Baby Friendly Community Initiative

The undeniable benefits of breastfeeding for both women and children generated the “common sense” approach to protecting it. The Baby Friendly Hospital Initiative.²⁵ 10 steps include:

- Have a written breastfeeding policy that is routinely communicated to all health care staff.
- Train all health care staff in skills necessary to implement this policy.
- Inform all pregnant women about the benefits and management of breastfeeding.
- Help mothers initiate breastfeeding within one half-hour of birth.
- Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants.
- Give newborn infants no food or drink other than breastmilk, unless medically indicated.
- Practice rooming in - that is, allow mothers and infants to remain together 24 hours a day.
- Encourage breastfeeding on demand.
- Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

A meta analysis conducted in the 1990s showed that all the 10 steps - particularly rooming in, skilled counselling by trained personnel and non-availability of formula in hospitals - acted in synergy to enhance breastfeeding.²⁶ Further studies such as the Brazilian study²⁷ and the PROBIT Trial in Belarus²⁸ showed that full implementation of BFHI led to significant improvement in rates of exclusive breastfeeding. Another study on the cost-effectiveness of

BFHI in terms of health care savings associated with lower incidence of diarrhoea and respiratory illnesses showed a saving of US\$ 2-19 per DALY (Disability-adjusted life years) at 1992 rates.²⁹ A study by Bartick and Reinhold says that the US could save 13 million dollars if 90 per cent of women would exclusively breastfeed their infants for the first six months. The costing also includes direct costs of health care and parent's time missed from work. The study however does not include the cost of formula, which would have raised it higher.³⁰

A very recent study from Toronto, Canada, has also shown clearly that health policy and programme interventions can enhance exclusive breastfeeding for the first six months, as women who received education on breastfeeding during pregnancy were more likely to exclusive breastfeeding at two weeks and six months.³¹

The clearest evidence of an efficiently functioning universalized baby friendly hospital initiative is firstly a high rate of early initiation of breastfeeding. However, Philippines, with a total score of 10, has a timely initiation rate of just 54 per cent. That means Philippines requires ongoing support and monitoring to enhance this practice to near universal.

In comparison, the rates of timely initiation of breastfeeding are high in Bhutan, Argentina, Maldives, Sri Lanka and Mongolia, with rates of 81 per cent, 81 per cent, 80 per cent, 80 per cent and 78 per cent respectively. Home delivery is still the norm in Bhutan, which means that there is an effort to make the entire health service as well as communities baby-friendly, rather than restricting the initiative to merely health facilities. This is also borne out by the rates on exclusive breastfeeding, which is the second most important indicator of the efficiency of BFHI counselling services.

All the countries that have participated in the WBT*i* assessment feel the need to revive BFHI by integrating it in the health system and establishing a community linkage. Bolivia has identified the lack of an adequate monitoring system for BFHI and the need for training all health personnel, in both hospitals and outreach programmes in the Code and the Breastfeeding law. The recommendations include improving training of staff as well as of assessors and conducting regular evaluations, and specifically in Taiwan, to have administrative directives to strictly implement the International Code in BFHI hospitals and health care institutions. Ecuador recommends that the government should make a commitment to re-launch BFHI for both public and private hospitals, recertify those that were initially certified as baby friendly, and set up a monitoring and evaluation system to oversee the advancement of the Initiative within the health services, carrying out corrective measures wherever necessary, including preparing IEC material and making resources available. Pakistan in particular has recommended that funding for BFHI, which was stopped, needs to be revived.

The scores for Indicator on Baby Friendly Hospital Initiative reveal that without regular monitoring and reassessment, BFHI status of health facilities cannot achieve much in terms of optimal breastfeeding. There is clear evidence that if all women have to be reached, the concept "baby friendly" needs to be extended to the community at large.

The Brazilian study highlighted the vital role played by Step 10 - community facilitation of breastfeeding. Community based skilled counselling by trained personnel was further validated by several studies from across the world^{32,33,34,35,36,37,38,39}. However, it is not uncommon to see that training is ignored and under valued. Whether the programme relies on training inputs is another important issue for sustaining it. Skilled training is essential for both providing technical support to women how to hold the baby, the right latching, and so on, as well as to remove any doubts she may have about her ability to breastfeed successfully.

Step 10 - community outreach - remains the most neglected so far and needs to come to the forefront of any BFHI implementation. The theme of the World Breastfeeding Week, 2010,

focuses on this issue and is likely to generate much needed public debate and discussion.⁴⁰

Skill training is an essential component of BFHI, and is specially important for community outreach. The assessment has shown this to be a major gap in almost all the countries. Pre-service and in-service training in infant and young child feeding of all health personnel, training in counselling skills especially of those health workers who interact with mothers, are specific gaps recognised by the countries. The common recommendation is that skill training for infant and young child feeding and training in counselling methods need to be an integral part of pre-service and in-service training of health personnel as well as non-health programme personnel of all levels, and not just for BFHI.

3. Effectively implementing the International Code and subsequent resolutions of the WHA

The *International Code for Marketing of Breastmilk Substitutes* and subsequent WHA resolutions to protect breastfeeding have been ratified by almost all the countries of the world, including the 33 countries that have carried out the WBTi assessment. However, as the assessment shows, there are still several actions that need to be taken if the Code has to effectively protect and promote optimal breastfeeding practices. For instance, though Costa Rica has scored 10 for both the indicator as well as the subset on monitoring national legislation, only 10 per cent of infants are exclusively breastfed till six months of age, and 90 per cent are bottle-fed. Bottle-feeding rates are also high in Bangladesh (40 per cent), Brazil (47 per cent), and Colombia (40 per cent); all these countries have the highest score of 10 for this indicator. Vietnam, with a total indicator score of 8.0, has a bottle-feeding rate of 83 per cent. While figures on bottle-feeding rates are not available for several African countries that score 10 for the indicator, exclusive breastfeeding rates in Gambia is 41 per cent, in Ghana 53 per cent and in Mozambique 30 per cent.

The WBTi assessment shows that several countries have yet to adopt the Code in full, or even in part. Some countries, such as Indonesia, have passed decrees, Pakistan has issued regulations. In Uruguay, only a few provisions in the Code are currently in force within the National Food Science Regulation (Decree 315/94). The Decree does not include bottles, teats and other items used in artificial feeding, or the subsequent WHA Resolutions which complement the Code. Korea recognises the need to legislate all aspects of the Code, and not just some. In Bolivia, regulations for the Breastfeeding Promotion Law have not been approved, which prevents its enforcement. In Mexico, the phrase “when the mother is unable to produce milk” in the current regulations is a subjective definition joined with misleading/incomplete information regarding milk production and flow, opens the gate for advertising of breastmilk substitutes and infant foods.

Once the Code has been adopted, either in full or in part, or even as a voluntary measure, or has been converted into national legislation, it is imperative that it is effectively monitored and implemented. However almost all the countries recognise that both implementation and monitoring is weak; Afghanistan specifically notes that capacity for monitoring and implementation of the Code needs to be built through special training. A comparison of India's scores for this indicator, based on the current assessment and on the previous one in 2005 shows that while the country may have one of the strongest legislation in the world on restricting the marketing activities of baby food manufacturers, there is little being done to monitor its implementation and its violations. As a result the promotion and marketing of infant formula and other baby milks and foods continue relentlessly. The recommendations of Mexico include a call to civil society organisations to monitor Code violations and bring it to the notice of the government.

There has been ample evidence to show that companies continue to violate the Code or national legislations and undermine breastfeeding.⁴¹ Recent exposure of Code violation in Vietnam by a journalist shows clever methods used by baby food companies to increase their sales.⁴² The report of the International Code Documentation Centre (ICDC) on

violations show that in Vietnam, where all the articles of the Code have been legislated nationally, companies like Mead Johnson have misleading labels on their products, which allow the misconception that their products are equivalent to breastmilk. Advertisements are being carried by professional journals while Article 11 (3) of the Indonesian Ministerial Decree 273/MENKES/SK/IV/1997 stipulates that advertising in professional journals should only be allowed with the consent of the Ministry of Health; no such consent is apparent in the advertisements.⁴³

ICDC reports that the global baby food market will be worth between US\$37.6 billion to US\$42.7 billion in sales by 2014. In the Asia-Pacific region, which accounts for 31 per cent of global sales, this upsurge is expected mainly in China and Vietnam where fast growing economies have resulted in hectic lifestyles, increased purchasing power and a growing infatuation with Western packaged and processed baby food.⁴⁴

How companies continue to violate the code is shown in the pictures quite clearly.

In India, the national legislation clearly prohibits advertising of infant milks and infant foods for children up to the age of two years. Yet Nestle, which commands 85 per cent of the INR 1,500 crore (about US\$ 350 million) market in infant foods and nutrition⁴⁵ continues to use health professionals to have a higher profit margin relative to its other products such as instant noodles. In its Director's Report in the Annual Report of the year ending 2007, Nestle informed of its intention to continue expanding the baby milk and baby food market, including for infants, and yet claim to comply with the law, which prohibits promotion of baby foods for children up to two years of age.



Photo Credit: Breaking the Law 2007, ICDC, Penena

The scores for the Indicator on Implementation of the International Code reveal the urgent need to adopt the entire Code and the subsequent WHA resolutions related to marketing of breastmilk substitutes and baby foods, as well as to strengthen national legislation, where it exists, particularly with respect to enforcing it. In addition, the unrestricted and aggressive promotion of complementary foods, catch up milks and other such products displaces both continued breastfeeding and the use of family foods for infants and young children. Often, in a bid to increase sales, the manufacturers resort to misleading or irrelevant health claims, which project their products as better than breastmilk or diversity based family foods. All countries should make a clear provision of banning promotion of all baby foods meant for children under two years of age. This also holds true for complementary feeding, where paediatric and nutrition experts are agreed that family foods make the best complementary foods.

One learning emerging from the evidence on BFHI can also be applied to the implementation of the International Code. The Code is a tool to protect, promote and support breastfeeding. While its full and effective implementation will protect breastfeeding there is a need to demand that all the other action areas of the *Global Strategy* are also implemented effectively for supporting women.

The World Health Assembly resolution 63.23 of 2010, calls upon all nations to enact suitable regulations to end all kinds of 'inappropriate' promotions of baby foods for infants and young children. It also calls upon the baby food manufacturers to abide by the International Code of Marketing of Breast- milk Substitutes and subsequent relevant World Health Assembly resolutions.

4. Making Maternity Protection Universal

The international instruments obligate states to take appropriate measures to ensure the realization of the human right to adequate food for infants and everyone else within their jurisdiction. The infant's right is thus primarily based on the mother being able to actualize her rights to successfully breastfeed her infant. She has the right to be fully informed, the right to adequate nutrition and health care, and the right to support if she is working outside the home to enable her to provide optimal breastfeeding to her baby. In an analysis of breastfeeding in the human rights perspective, Engesveen concluded that building mothers' capacity to perform is essential, as is action to enhance capacity of the state to create an enabling environment for breastfeeding women.⁴⁶

CRC Commitment

Convention on the Rights of the Child (CRC): The Convention on the Rights of the Child adopted by United Nations in 1990 is a legal obligation of the Member States to protect mothers and families to support breastfeeding practices. Article 24 (paragraph 2a) of the CRC states that State Parties shall "take appropriate measures to diminish infant and child mortality." This article also says that State parties shall take appropriate measures.... "To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition (and) the advantages of breastfeeding...."

The WBTi assessment shows that maternity protection is not an intervention, which has received good support. This may be because countries are struggling and facing major challenges in resource mobilisation for ratifying the ILO Convention. This is in spite of the fact that in order to exclusively breastfeed the infant on demand, the mother and infant have to remain in close proximity for the first six months of life. This indicator has received the second lowest average score among the various indicators. Almost all the countries have recommended legislating maternity protection, especially for the private sector, and better implementation and monitoring of this indicator; Mongolia has also recommended improved implementation of mother-friendly birth procedures.

While women working in the formal sector do receive some limited form of protection, women working in the informal and agricultural sectors and those who are self-employed, face the most severe challenges in feeding their infants optimally. There is little support for such women in most Latin American and African countries. India offers a vivid example of how these women get left out of policy and programmes, as well as legislation.

Women working for the Central Government and some state governments are given six months paid maternity leave. However, the national maternity legislation itself provides for 12 weeks leave for those employed by the private sector. Women working in the unorganised sector including agricultural labourers and self-employed women are yet not entitled legally to maternity leave. In this context, India, Sri Lanka and Nepal have recommended that there be an umbrella legislation on maternity benefits that covers all women.

The ILO Convention 183 recommends that government ensure that women get “a period of maternity leave of not less than 14 weeks”. ILO Recommendation 191 - Maternity Protection Recommendation, 2000 - states, “Members should endeavour to extend the period of maternity leave... to at least 18 weeks”. Neither the Convention requirement nor the recommendation are adequate for working women to carry out exclusive breastfeeding, which necessitates that the infant be fed on demand. Given that maternity leave in most of the assessed countries is generally 14 weeks or less, providing just one paid nursing break in a working day does not allow the woman to practise exclusive breastfeeding adequately. African countries in particular have recommended ratification of C183 and extension of maternity leave to cover the period of exclusive breastfeeding, as has Costa Rica.

A few countries offer some form of limited protection to women in the unorganised sector. These often take the form of cash transfers, limited nutritional supplementation, crèches and day care centres. For example, in Uruguay, there are no legal rules in place to enforce the setting up of nurseries or breastfeeding spaces, whatever is available has been the result of collective bargaining. In China, some local regulations are also being updated to cover the informal and agricultural sector. However, with growing industrialization and urbanization, child care facilities such as a nursing room at the work place are disappearing.

Women require several forms of support if gains have to be made in optimal breastfeeding rates. Any strategy to provide support to women for practicing optimal infant and young child feeding needs to include a basic service and support package for pregnant and lactating women, called a Minimum Essential Programme (MEP) of services. This should ensure that all women have access to accurate information on optimal feeding practices, and skilled counselling and practical support at birth and later; and maternity benefits, which include leave for the first six months for women who are formally employed, and some financial support for lactating mothers who are poor. It would be ideal if all women could be financially compensated for devoting six months to exclusive breastfeeding. However, this may not be possible, or may not be needed in different situations and nations need to choose and prioritize. While some elements of the package could be provided for all women, other components like cash benefits and nutrition support could be provided only to women of low socioeconomic status.⁴⁷

In addition, MEP should include provisions like adequately managed safe child care facilities at the work site, and safe and easy means of transportation so that the woman can take her infant with her to the workplace.

The WBT*i* assessment highlights the fact that support to women for breastfeeding has to come from several areas, and that governance structures dealing with welfare, labour, health, nutrition, social service, transportation, and so on have to integrate protection, promotion and support of breastfeeding in their policies and programmes. This is not happening, as the assessment reveals, either at national or at international levels. For example, though adequate evidence exists of the importance of exclusive breastfeeding for the first six months of life, ILO recommendation on maternity leave continues to be for a lesser period; the recommendation also does not take into account the total inadequacy of one or two paid nursing breaks, when infants below six months need to be fed on demand.

5. Integrating Infant Feeding in policies and programmes related to control of HIV/AIDS

The risk of HIV transmission through breastfeeding presents policy makers, infant feeding counsellors and mothers with a difficult dilemma. They must balance the risk of death due to artificial feeding with the risk of HIV transmission through breastfeeding. Apart from increased mortality associated with not breastfeeding⁴⁸, other socio-economic factors complicating the issue are the risk of stigmatisation (if not breastfeeding signals the mother's HIV status), the financial costs of replacement feeding, causing a spill over effect and the risk of becoming pregnant again. Evidence has shown that mixed feeding results in a much higher risk for infants than exclusive breastfeeding. Mixed feeding not only leads to increased transmission of HIV via breastmilk⁴⁹, it also leads to increased morbidity and mortality due to common childhood illnesses.⁵⁰

Policies and programmes to meet this challenge should provide access to voluntary and confidential counselling and testing (VCCT) and, for HIV-positive mothers, counselling on infant feeding options. Safeguards should be in place to protect, promote and support breastfeeding in the rest of the population.

Currently, none of the Latin American countries participating in the assessment have a specific national policy on Infant Feeding in HIV, except for Uruguay, where HIV positive women are prevented from breastfeeding; they are offered no choice and receive no counselling. The policy in Bhutan too is for all babies of HIV positive women to receive artificial feeding. Countries like India and China, where the adult population living with HIV is 0.3 per cent and 0.1 per cent respectively, have large real numbers of people afflicted with HIV. While China has comprehensive policy, the implementation is not effective; India does not have a comprehensive policy on infant feeding in HIV.

Table 2 on infant feeding and HIV indicates that having a policy on infant feeding and HIV can pay good dividends. For instance, Malawi, where 11.9 per cent of the population between those ages of 15 and 49 has HIV, the rates of exclusive breastfeeding is 70 per cent. The Under 5 Mortality Rate has also come down significantly from 209 in 1990 to 111 in 2007 and this includes deaths due to HIV.⁵¹ While it is not possible at present to attribute this reduction to a well thought out and well implemented infant feeding and HIV policy, the need for having a policy in place becomes clear when we compare it with the Under 5 Mortality Rate in Mozambique a decline from 201 in 1990 to 168 in 2007. An estimated 12.5 per cent of the adult population in Mozambique is living with HIV.⁵² In spite of having policies and programmes on HIV and Infant Feeding, several African countries feel that these are inadequate in terms of training, implementation of the International Code, and more particularly, male participation. Another gap that is specially mentioned by them is the lack of data on how many children actually develop HIV through breastfeeding, and the outcomes of PMTCT programmes, as well as lack of adequate attention to the food and nutritional security of infants with HIV.

During last few years, researchers are focussing the role of antiretroviral drugs in curtailing transmission of HIV from mother to child. This has led to a revision of the global guideline on HIV and infant feeding. The WHO's guidelines on infant feeding and HIV (2010) has recognized the important impact of the recent evidence on the effects of ARVs during the breastfeeding period. Broadly, the guidelines say that where Anti retroviral drugs (ARVs) are available, mothers known to be HIV-infected are now recommended to breastfeed until 12 months of age.¹⁷ More recently, a study from Botswana on antiretroviral regimens in pregnancy and breastfeeding has concluded that all regimens of highly active antiretroviral therapy (HAART) from pregnancy through 6 months post partum resulted in high rates of virologic suppression, with an overall rate of mother-to-child transmission of 1.1%. In view of ongoing research on the subject and ever evolving global guidelines, national guidelines should periodically harmonize with them.

6. Integrating Infant and Young Child Feeding into Disaster Preparedness and Management Plans

Asian, African and Latin American countries have commonly experienced emergency situations – natural disaster like tsunami, earthquakes, floods, famines, etc. In addition, Sri Lanka and several African countries are facing a problem of displaced people due to conflict, living in refugee camps.

Women, especially lactating women, are extremely vulnerable to stress, and this affects their ability to breastfeed successfully, especially if there is no space. Formula and baby food manufacturers look at this as an opportunity to advertise their products as “in kind” donations. A record kept by the Department of Social Welfare and Development (DSWD), Philippines, in April 2007 for the victims of Typhoon Reming showed many such donations, including those by NGOs and government agencies, included infant formula and assorted powdered milk. Forty per cent of all that arrived in the first three days was mostly from foreign sources and was not monitored. The evaluation highlighted the need for guidelines and clear-cut strategies for managing the flood of donations post-disaster.

The WBTi assessment revealed that half the assessed countries had no policy related to infant and young child feeding during emergencies and disasters and that almost all the countries have not allocated any resources for this.

While it is not possible currently to establish the extent to which failure to support women in optimal breastfeeding practices during emergencies results in suboptimal infant feeding practices, emergencies that do not take into account infant and young child feeding can have long-term effects on national breastfeeding rates in particular. Supporting breastfeeding during emergencies is particularly important as women bear the brunt of the responsibility for caring for the families during and after emergencies, and this may interfere with infant feeding. The provision of formula as donation adds to the risk of giving up exclusive breastfeeding in infants under six months; in addition, it creates a potential market for industrially produced foods, including complementary foods, displacing both breastfeeding and home cooked foods.

Though some progress have been made internationally to develop guidelines for infant feeding in emergencies⁵³, there is a need to translate them into practice at national level. Some underlying reasons behind failure to implementing the policies could be the weak institutionalisation of policies, the massive quantities of unsolicited donations of infant-feeding products, the absence of monitoring systems, and the inadequate co-ordination mechanisms.⁵⁴

Supporting women to practise optimal feeding during emergencies calls for strengthening the training of health workers and disaster management personnel especially in counselling skills, techniques for relactation, trauma management, and so on. As members of the local community are the first to provide help, training of a special cadre of volunteers, mostly women, within the community in providing skilled support to women to continue breastfeeding in times of emergency is important..

The One Asia Breastfeeding Partners Forum 6, held in Colombo in November 2009, focused on infant and young child feeding in disasters and emergencies. The “Colombo Declaration on Infant and Young Child Feeding”, developed and unanimously adopted at the Forum by representatives of 17 countries, calls upon countries to give priority to developing and implementing policies related to infant and young child feeding in such situations.⁵⁵

Recommendations

The value of WBTi is that countries are able to dissect where bottle-necks are in as far as their low performing interventions. There is a need for national discussion on those specifics in order to understand poor performance as well as to understand the role of various players in the process of bridging those gaps. This will enable governments to specify where they need support and what type of support.

As the WBTi picks up more momentum, other countries begin using the tool as a lens and thus increase its value further for stimulating national actions towards strengthening policies and programmes around breastfeeding and infant and young child feeding. Hopefully, it will energise reassessments, countries are expected to get seriously involved in making breastfeeding and infant and young child feeding a mainstream component in their child health/nutrition programmes to be able to address malnutrition in infancy and beyond more effectively. The *Global Strategy for Infant and Young Child Feeding*, it seems, will be implemented both in letter and spirit. The built-in encouragement in the WBTi to keep track of one's own progress, look at the finer details, makes possible a focus on key areas of action. Opportunities will be many to undertake this work. The Countdown to 2015 report recommends on a priority 8 interventions in the post natal period out of total 20 interventions for maternal, newborn and child health. The WBTi goes on to track at least 3 of the Countdown to 2015, postnatal interventions. Not only that, it adds value to the tracking process by assessing policy and programme support to reach universal coverage of the interventions.

The Countdown Report 2015 also notes that policy support to IYCF is weak, as 22 out of 68 enacted *International Code of Marketing of Breast-milk Substitutes* and 1 out of 68 provides maternity protection in accordance with ILO Convention 183. The WBTi brings information on several other policy and programmes required to fulfill a multi-sectoral support to women as their right. Only this support could enable women to fulfill the rights of their babies for breastfeeding, nutrition, development and survival.

Bryce et al, in their paper in the *Lancet Series on Maternal and Child Undernutrition* point out “national leaders need trustworthy reports on coverage and nutritional effect for both direct nutrition actions and broader intersectoral efforts. National efforts to address nutrition have been hampered in the past by initiatives that address one part of the pathway from planning to effect without ensuring appropriate attention to other aspects.... National efforts must be devoted to the entire policy continuum, including agenda setting and commitment building, choice and design of actions, quality of implementation, adjustment of actions based on monitoring and assessment, and human and institutional capacity building.”

The WBTi provides an ideal tool, incorporating as it does, assessment of both processes as well as outcomes, for nations to create a continuum of policy to cover all factors that impact infant and young child feeding, and select and prioritise actions to adequately protect, promote and support it. In addition, the assessment provides a benchmark for each country to judge the impact or effectiveness of its future actions, and institute mid-course corrections where needed. These benchmarks and subsequent assessments can also inform the global community, international organizations such as WHO and UNICEF, as well as provide key information to the countdown process to meeting the MDGs, especially MDG 1 and MDG4.

Victora has already pointed out the need for prioritizing nutrition through allocation of national and international financial resources to infant and young child feeding. Bryce et al

have highlighted the ineffectiveness of national and international initiatives that address just one issue related to nutrition e.g. growth monitoring without having nutritional counselling and other such measures in place. The recent 6-country programme review on IYCF calls for comprehensive action.⁵⁶

Resources are key to effective strategising and prioritising; the WBTi helps to identify areas that need special strengthening, and thus allocate finances for it. As can be seen from the section on Impact, this has already happened in some countries, especially at the national level.

In this section, we provide a set of general recommendations for the donors, global community, UN and other international organizations. Specific recommendations on policy and programmes are directed to national governments. If taken up comprehensively, it could rapidly achieve high coverage of interventions.

Global Recommendations

1. Primarily, the UN and donors should commit financial resources and **invest on 'early nutrition'** in a substantial way in order to universalize key interventions related to breastfeeding and complementary feeding. These include implementation of the Code of Marketing of Breastmilk Substitutes, coordination, reaching out to all women with counselling, and maternity protection.
2. Secondly, donors can support action in countries by prioritising those that are most in need, identified using the WBTi's ranking as well as commit to areas of action that need most support.
3. Programme managers with all international, regional or national organizations dealing with women and children have to understand the nature of support needed for women to be successful in carrying out their nurturing role. This support includes 'skilled breastfeeding counselling and support' in health sector, maternity entitlements such as leave or cash benefits, crèches and breastfeeding rooms at work places. The key element of action is that this should be directed to all women.
4. WBTi assessments need to be included as a key input for global monitoring processes on child health and nutrition in order to enhance participation of countries identified by the Countdown to 2015 report. In this respect, 18 of the 33 countries in this report are a part of countdown process. See the ranking in the Table-A.

Specific recommendations for national governments

Countries participating in the current assessment have developed several recommendations in each area of action to improve their breastfeeding rates. Several of these recommendations are common to almost all countries. These relate to both policy and strengthening of specific programme areas. (For details of recommendations for each country, see national reports at <http://www.worldbreastfeedingtrends.org>). The common recommendations that emerged from the analysis were as follows:

Policy Action for Prioritising Nutrition

1. Mainstream infant and young child nutrition in all areas of governance, through the creation of a comprehensive written policy that includes all the ten areas of action highlighted in the *Global Strategy for Infant and Young Child Feeding*.
2. Set up a Breastfeeding /IYCF Committee with representation from sectors such as health, nutrition, welfare, labour, and legal affairs. This body can also screen all IEC materials for consistency.
3. Create a coordination mechanism for planning and supervising the implementation of the policy in an integrated manner at all levels, from policy making to service delivery at the grassroots level.
4. Invest in breastfeeding interventions; create a budget line with adequate resources for effective implementation of all the ten areas of action; and increase human resources in all areas for effective action.

5. Set a timeline for achieving results.
6. Ensure that all health and nutrition personnel at all levels have the necessary skills to provide counselling and correct information to support women to breastfeed. Integrate quality training on infant and young child feeding in pre-service and in-service training.
7. Monitor key breastfeeding and complementary feeding indicators regularly and use the results to make policy and programmes more effective. Monitor exclusive breastfeeding rates at six months for a truer picture of the situation, rather than from 0-6 months.

For Maternity Protection and Support to Women

1. Enact legislation to provide all women with adequate paid maternity leave/ financial compensation to carry out exclusive breastfeeding of their infants from birth to six months.
2. Provide adequate number of paid nursing breaks during the period of exclusive breastfeeding, when the infant needs to be fed on demand.
3. Ensure that all women have access to health and nutrition care during pregnancy and lactation.
4. Ensure that all women have access to correct information and skilled nutrition counselling services during pregnancy and lactation, with a special focus on supporting women on key infant nutrition practices.
5. Ensure that all women have access to safe childcare facilities managed by trained personnel at the workplace and in the community.
6. Find innovative methods for compensation of maternity entitlements for women.

For Providing Universal Access to Women for Accurate Information and Skilled Counseling on IYCF

1. Create a corps of health and nutrition workers trained in skilled counseling at the level of the health facility and in the community to provide support to women on IYCF
2. Provide adequate and consistent funding for the programme.
3. Integrate infant and young child feeding in the training of administrators and other government personnel to mainstream nutrition in the whole establishment.
4. Resurrect the BFHI by encouraging hospitals to adopt the 10 Steps to Baby Friendly Hospital Initiative and a strong community component.
5. Conduct regular monitoring of the status of BFHI hospitals.
6. Ensure that all staff that interacts with women admitted in hospital is adequately trained to protect and promote breastfeeding, and have the skills to provide support to the woman to initiate breastfeeding within one hour of birth.
7. Integrate BFHI into the health system and link it to outreach programmes and mother support in the community.

For Effective Implementation of the International Code of Marketing of Breastmilk Substitutes.

1. Adopt the International Code through the creation of National legislation with rules and regulations that are justiciable.
2. Strictly enforce the International Code/National legislation.
3. Provide funds for the implementation of the International Code/National legislation.
4. Strengthen the International Code/National legislation to ensure the inclusion of ending all promotions of baby foods for children up to 2 years.
5. Create effective mechanisms to address violations.
6. Train government personnel on the implementation of the International Code/National legislation and on mechanisms addressing violations to enable them to take proper action.
7. Create public awareness on the International Code/National legislation and redressal mechanisms for violations.

For Infant Feeding in the context of HIV

1. Integrate infant feeding in HIV in national infant and young child feeding policies and plans of action.
2. Conduct operations research to determine the number of babies that get HIV through breastfeeding.
3. Put systems in place to monitor and determine the outcomes of prevention of mother to child transmission (PMTCT).
4. Harmonize national guidelines on HIV and Infant feeding with the current global recommendations.

For Infant Feeding During Emergencies

1. Integrate infant feeding during emergencies in the national policy on infant and young child feeding.
2. Incorporate infant and young child feeding in national disaster management policies and plans.
3. Train relief workers in infant and young child feeding, especially in providing skilled counselling to mothers, and in establishing relactation.
4. Strictly enforce the International Code to protect, promote and support breastfeeding during emergencies.

Influencing Nations to Act- The Impact of WBTi

All countries are at a different level of implementation of the *Global Strategy for Infant and Young Child Feeding*, which was launched exactly 10 years ago at the World Health Assembly and all nations provided a unique consensus to adopt it.

The impact of any action is always due to collective effort, and the World Breastfeeding Trends Initiative (WBTi) represents that collective effort on breastfeeding or infant and young child feeding. Ever since it was launched in south Asia in 2005, and other parts of the world in 2008, it has already shown signs of its success. Much of the success story is seen in south Asia, where the countries did a repeat assessment and documented the change. At many places governments and other key players were involved in the process of assessment and building a consensus around existing gaps and in developing recommendations; the collective effort has either effected change where it has happened or has accelerated it.

The WBTi process has been accepted, findings have been recognized and action plans developed with funds allocated at some places. The South Asia case study provides the best examples. In the years from 2005 to 2008, south Asian groups had been meeting in an annual event, South Asia Breastfeeding Partners Forum, where findings were presented and discussed. Positive stories were shared. In November 2009, 17 countries met in Colombo and shared their experiences about having conducted WBTi assessments. They thought that it had increased awareness among policy makers about the issue of IYCF, generated a sense of pride among the stakeholders they are participating in a global initiative, stakeholders built a work plan for themselves, and improvement in networking at national level. Some immediate successes in some countries included the following:

- Funds were made available for training in IYCF
- Inclusion of IYCF indicators in HMIS
- National plan developed for IYCF
- Legislation to protect breastfeeding developed

WBTi had an impact on thinking process of partners. According to a government officer in south Asia, “The 2005 assessment was an eye opener for us as we realised that we had no baseline data on Infant and Young Child Feeding (IYCF) practices”. Another said, “At least we can see where we are heading to and what needs to be done on each indicator”.

South Asia case study 2005-2008

The World Breastfeeding Trends Initiative (WBTi) was first launched in eight countries of south Asia; all countries conducted an assessment of their policy and programmes on IYCF. This eight-country initiative provided us the much-needed encouragement as well some key lessons to move forward.

The real value of the initiative emerged in 2008 when all eight countries conducted a repeat assessment using the same tools and compared the results with their 2005 assessments. A key finding was that the tool is indeed participatory and action oriented. All countries were able to assess the extent to which breastfeeding is effectively protected, promoted and supported in a given social and political context. Further, they all learnt some lessons for strengthening both policies and programmes related to achieve optimal breastfeeding practices.

IBFAN groups at national level coordinated the assessment process, and their own capacity in data collection and analysis was enhanced. Participation of multiple stakeholders including government representatives, health professional organization, people's

organizations, women's and children's rights groups, UN agencies and other international organisations, etc. enhanced their capacity to influence infant feeding policies.

The south Asia exercise generated a dynamic of change and improvement. Using the WBTi as a lens, each country has documented a list of gaps informing them where they stand on the *Global Strategy*. The various stakeholders working together as a group generated the recommendations. Now they are using it as a basis for their advocacy. WBTi helps not just in identifying gaps, also in knowing what action needs to be taken to bridge them. The comparative score card in Figure 22 shows this. For a detailed indicator-wise comparison interested readers are referred to the report on the website. <http://www.worldbreastfeedingtrends.org/report/southasia-report-2005-2008.pdf>

Afghanistan and Bhutan stand out in the comparative scorecards of 2005 and 2008, showing the potential in WBTi. Both countries were ranked lowest in 2005, and initiated immediate actions. In both countries IYCF issues have attracted priority attention, with baseline data being generated, national policies being developed, action being taken on legislating the International Code and providing information support. In Afghanistan, the International Code is now a regulation under Ministry of Public Health (MoPH). The actions taken in both countries resulted in Afghanistan moving up from a score of 29.5/150 in 2005 to 86/150 in 2008, and Bhutan from 31.5/150 to 72/150 in the same period. Figure 23 compares the colour coding the South Asian countries received in 2005 and in 2008.

The above figure shows that both countries have also improved their colour rating from red to yellow. The detailed rating for Afghanistan makes it evident that, besides starting to implement the International Code, the country has taken several other actions to protect, promote and support breastfeeding; in five out of ten indicators on policy and programmes their ranking has moved from Red to the next or even greater level of achievement.

Bhutan invited the IBFAN Asia to help develop their national policy on breastfeeding along with a plan of action. The country has moved out of red in three out of six indicators related to policy and programmes. Bhutan is a new democracy, and its parliamentarians and high-level policy are involved and taking deep interest in improving breastfeeding practices.

Maldives has moved to the next level in five indicators of policy and programmes, and jumped from 88 to 116 in total score. The Government is working towards bridging the gaps. In few indicators where they did not have data earlier, now it exists.

Most other countries have also shown some progress; a few have some shown little progress and some have even declined. For example, Bangladesh has shown significant improvements in the sectors of national policy and planning, where the score has risen from 2.5 in 2005 to 9 in 2008; and in monitoring and evaluation where the score has risen from 6 to 10 respectively but it has shown an overall marginal decline in other indicators, and no change in many.

In India, there has not been much change. This is because India has failed to capitalize upon the early

Fig. 22: Comparison of WBTi Score of 2005 and 2008 in South Asia

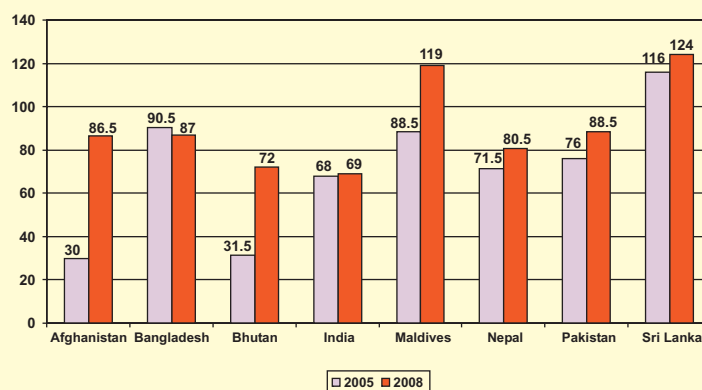
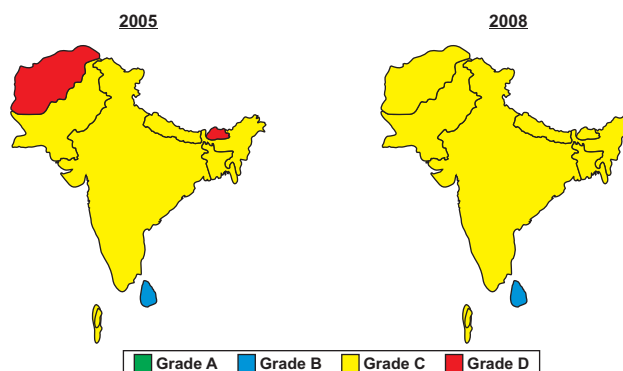


Fig. 23: Colour Coding of South Asian countries in 2005 and 2008



promise of the IYCF guidelines by non-conversion into policy, non-translation into budgets and specific programmes and poor implementation on the whole. Not only that, the pressure to create a national level coordination mechanism that is functional has been largely unsuccessful. Similarly, the country's ranking on the indicator relating to baby friendly hospitals, has declined. Early gains have been completely forgotten. On the other hand the WBTi assessment provided civil society with a tool for successful advocacy, which has resulted in increased maternity leave for the women in the Central Government, and pilot projects for financial maternity benefits to women in the unorganized sector. However, lack of action on the other indicators has resulted in deterioration of the rates for complementary feeding; more babies are using the bottle. India progresses to next level in only two out of ten indicators. This also provides specific information to step up advocacy for future.

In Sri Lanka, national policy has been strengthened, with the score moving up from 5.5 in 2005 to 9 in 2008; similarly, monitoring and evaluation norms have been strengthened, with the score moving up from 5 to 10. Sri Lanka moved to next level in five indicators, scored a total of 124 in the 2008 assessment, and remains at the top of the table not only in South Asia but also among all the 33 countries reported here.

Pakistan has moved from 76 to 86.5 in the total scoring, improving its score and ranking in three indicators. The government has notified the breastfeeding rules and regulations. They have developed communication and training materials on IYCF.

Nepal has moved from 71.5 to 80.5, and made it to the next level in five indicators. The Government has developed a National Nutrition Policy and Strategy, and is involved in carrying out training of different level of health professionals on IYCF.

What Country Coordinators Say

Here are some excerpts from the comments by the country coordinators on the impact of WBTi. It helps to know the immediate impact and envisage what long terms impact would become evident in years to come.

Linking WBTi with CRC

Elaine Petitot Cote*

Since 1997, IBFAN has taken part in the monitoring process of the Committee on the Rights of the Child by sending alternative or shadow reports to the Committee on issues related to infant and young child feeding. Over the years our systematic reporting has been fruitful as the Committee now discusses these issues during each State party review and in its Concluding observations makes recommendations on these issues in 9 cases out of 10. The Committee members insist on the importance of sending shadow reports containing both detailed and reliable information. They have often encouraged us to pursue our work in this way.

It is sometimes difficult for IBFAN groups to prepare alternative reports and since 2008 we have used to great advantage the information compiled in a number of WBTi reports. When possible we have also sent two complementary documents to the CRC members, the IBFAN report and the corresponding WBTi country report. Committee members have been impressed by the WBTi documents and shown interest in the project itself.

Reports and report cards from Bangladesh, Bhutan, Mongolia, Pakistan have been used in the past. We will be sending the Nicaragua report for session 55 in September 2010.

**Human Rights Programme Officer, GIFA*

Bhutan

"....reviewed the IYCF policy and came up with a draft IYCF policy and strategy; also now the programme has an operational plan for the IYCF... there are a series of BFHI trainings going on for the health workers working closely with the mothers and children..."

Mongolia

"The selection criteria for BFHI was updated after WBTi and certification of BFHI was included into hospital accreditation system. (Before it was assessed separately requiring additional fund from UNICEF). In 2009, WHO /UNICEF IYCF counselling manual was translated into Mongolian and two training has been conducted on that."

Indonesia

"On October 2009, Government of the Republic of Indonesia enacted law no. 36 of 2009 regarding Health which amends the old health law no. 23/1992. In this new health law there are three articles related to breastfeeding: article 128, 129 and article 200..."

Pakistan

"Approval of breastfeeding rules and regulation. When we

presented our report in front of policy makers, civil societies, INGOs and local NGOs, development partners, academicians and media, it was an eye opener for them. We also presented the comparison between Pakistan and other countries. All (stakeholders acted) together and forced the Ministry of Health to approve the breastfeeding rules and regulations, which was a long standing issue. So this is one of the greatest achievements of WBTi report.”

Argentina

“In Argentina we have helped a group of writers at the national congress for (developing) a draft of a new law regarding the International Code....’

Nepal

“Government of Nepal has published national guidelines on IYCF and is conducting training for various level of health professional on IYCF”

Zambia

“a) BFHI Assessment tools (in readiness to start assessing health facilities), b) code of marketing of breast milk substitute manual (to train enforcers and provide guidelines for enforcement), and c) IYCF Community package (for training the community in IYCF). In addition, between 2008 and now about 39 trainers and over 600 health workers have been trainees. Zambia is trying to retrain assessors and thereafter start carrying out assessment of health facilities.”

Sudan[#]

“In Sudan we held many meetings with FMOH, reaching a consensus on a strategy and action plan for filling gaps of information needed to fill the form. As well three committees will be assigned this May to work on the Code, maternity leave and other protection measures, and the national sectoral committee for IYCF promotion. The objective is to reactivate efforts on these three issues to achieve tangible desired results. Now a IYCF KAP survey sponsored by UNICEF will be conducted (which will) include all indicators missed in the last HHS national survey of 2006; the missed indicators were identified when we discussed the WBTi process...”

China

China provides information on lot of specific activities, in a nutshell..

“After May 2008, much contribution were put on infant feeding improvement in the earthquake areas”

- Infant Feeding in Emergencies: Code Monitoring and Survey on infant feeding in Emergency in Sichuan earthquake area, 2008 Nov., MoH, UNICEF
- Breastfeeding and Infant and Young Child Feeding Promotion in Earthquake area in Sichuan, Gansu and Shaanxi Provinces, 2008 Oct to 2009 May, MoH, UNICEF and CIDA

About WBTi in Africa

Thulani Maphosa*

While a lot has been done to design Monitoring and Evaluation System globally for the implementation of nutrition programmes, it has remained in the form of databases that countries have in most instances failed to effectively utilize. Monitoring and Evaluation (M and E) make an insight on the implementation plan that countries intend to do and have a system in place on how to monitor the implementation of the plan in terms of impact and programme effectiveness. Clearly it has remained a challenge to fully utilize the information that we gather on regular basis to inform country programming.

Having been involved in the training of about 10 countries in the Sub-Saharan it is clear that World Breastfeeding Trends Initiative (WBTi) is very critical in identifying gaps and key recommendations for programming of Infant and Young Child Feeding (IYCF). WBTi has also shown to be the answer for effective identification of implemented projects versus immediate outcomes evaluation. Countries have been doing regular surveys as well as the Routine M and E but this has not been translated to progress evaluation through sharing and discussing the way forward. WBTi has brought a different dimension for these countries as it has made it easy to identify gaps, key recommendations and provide an opportunity for a cluster of stakeholders to share and identify areas of focus with regards to the findings of the secondary data evaluation exercise. It has improved collaboration and coordination of the efforts in implementing IYCF programmes with focused prioritized activities and targets. It has also provided a platform to sensitize policy makers and this might greatly improve funding for IYCF projects.

WBTi has shown to provide effective utilization of secondary data, providing platform to share and agree on priority areas of action and as well as to keep check on the progress that countries are making towards the implementation of the *Global Strategy*. Clearly there seem to be no much progress that has been made in implementing the Global Strategy but the WBTi will bring a different dimension altogether. It seems simple and countries can easily adopt them with a small budget allocation and policy makers are bound to get regular updates on progress made in implementing the Global Strategy. What countries wish for is further support to ensure that this programme remains a success and sustainable.

**Chief Programme Officer, IBFAN Africa*

[#]. Sudan is in the process of carrying out the assessment. The process of the assessment itself has led to positive results, even before its completion.

- Breastfeeding promotion and complementary feeding education in temporary shelters, 2009 Feb to 2009 May, MoH, WHO and CIDA
- Promote exclusive breastfeeding in 6 months through Communication-for-Behavioural-Impact (COMBI), 2010 Jan to 2010 May, MoH UNICEF
- WHO 2008-2010 joint program to protect, promote and support breastfeeding Adoption and Pilot of the renewed Baby Friendly Hospital assessment tools, 2008 Mar to 2008 Jun
- Training course on BFHI update for Health staff in selected hospitals, 2008 Jun to 2008 Oct
- Pilot of baby friendly communities in Huairou district in Beijing 2008 Nov to 2009 Nov, MoH Work Plan
- National BFHI Forum and BFHI update training, 2009 Oct
- Revision of the Regulations on Marketing of Breastmilk Substitutes, 2005 Aug to present

Brazil

“Brazil is a very large country and it is difficult change policies or programme implementation in a short time, especially at national level. IBFAN-Brasil, will officially present the WBTi report at the next breastfeeding national meeting IX ENAM, which will be held from 8th to 12th July. (<http://www.enam2010.com.br>)”

The Invaluable tool for the Nations : WBTi

*Marta Trejos**

WBTi can become a powerful instrument for social and health development in the hands of national main actors in infant and young child rights, nutrition and development. IBFAN groups; governmental authorities and various ministries such as Health, Social Development, Women, Family and Infancy, Education and others; civil society activists as women, human rights, environment, social justice, community development and many more; academic and research universities and professional institutions; UN agencies and international co-operation, and a wide variety of national coalitions have been part of the WBTi national processes of assessing, evaluating and proposing changes in relation to the themes connected to the Global Strategy and Millennium Development Goals.

WBTi is a tool for action: trying to picture the national situation, finding main data and many times assessing that the country does not have the correct or actualized indicators or mechanisms in place; analyzing programs in place and their actual practices with people that participated in their design and that are daily involved in their development; building bridges between policy makers and implementing bodies; questioning and looking for main gaps; and what is really powerful, facilitating discussion and propositions for action and change.

WBTi creates a participatory process that not only involves people but also creates a platform that can be appropriated by the national people involved to own the process itself. It assesses, monitors, proposes, questions, audit, watches, demands, controls and in no way substitutes the work the State has to do, but accompanies it, hopefully in mutual collaboration.

WBTi can also become an 'Observatory of Public Policies' based on the defense of basic rights that might be in danger in a particular aspect or country, or that need to be promoted and respected in the form of public policies. National experience will develop and will permit to learn from each other, in our region and worldwide.

Meanwhile, WBTi is supporting the national development and strengthening of IBFAN groups and partners, the building of national capacities to assess reality and offering a joint platform worldwide to share, coordinate and collaborate based on national experiences.

**Regional Coordinator, IBFAN LAC*

Gambia

“The National Nutrition Agency of The Gambia has recently validated a new Nutrition Policy that was developed after the WBTi exercise. The Policy used the WBTi report and its recommendations to include issues of Nutrition in emergency and other issues that were not adequately captured in the previous policy. A Women's bill has also recently been enacted and the WBTi Report was used to advocate for incorporation of issues of maternity protection in the bill. These show that the WBTi report has been of significant importance to The Gambia”.

Uganda

“National Policy Guidelines on IYCF: During the finalization of the IYCF policy guidelines development, the information generated from the WBTi was used. These guidelines were disseminated to the districts where they were expected to identify strengths, weaknesses; opportunities and threats (SWOT) in the IYCF programme at that level. The WBTi report was used as a very good resource material during this activity. Participants then developed district specific 5-year strategic plans based on the SWOT. The Government and development partners and are expected to support these district plans in the next five years.

BFHI/CODE: The findings as reported in the WBTi report have been used to advocate for support for Infant and Young Child Feeding at the National and District levels and UNICEF has approved a 1-year project to cost about USD 100,000 to support the CODE and BFHI related

activities in 34 out of 100 districts in the Country. The funds have been given to IBFAN Uganda to support the project. Furthermore, Centers for Disease Control (CDC) through PEPFAR support has given the Ministry of Health a total of USD 20,000 to conduct BFHI assessment to all the facilities implementing Mother to Child Transmission of HIV/AIDS interventions in the Country. The Code of marketing of Infant Foods has since been reviewed in Uganda. In the course of the review and update of the Regulations on the Marketing of Infant Foods (CODE) the gaps identified during the WBTi assessment have been taken care of.

Hence, the WBTi report influenced policies and practices at the National and local levels.”

Vietnam

“... we are preparing for the policy about 6-month-full paid leave for breastfeeding mother in order to support mother in exclusive breastfeeding”.

HongKongSAR:

“As from 1st April 2010 public hospitals in Hong Kong SAR discontinued free supplies of infant formula”.

Philippines:

The WBTi process was helpful in enacting the new Philippine law on Expanded Breastfeeding Promotion Act that was passed early this year 2010 that enable working women to breastfeed at workplaces. It boosts cooperative efforts amongst NGOs, government agencies and legislators in effecting IYCF implementation.

Lessons Learnt

The World Breastfeeding Trends Initiative (WBTi) has given us a lot to learn from countries involved in the process. It has shown that objectives of WBTi can be met, provided the focus remains on national level action, engaging with governments and others, and doing that in a continuous manner. Some lessons learnt include:

Accomplishing National Assessments

It required concerted efforts on the part of IBFAN to explain the whole idea of the initiative to the regional and national stakeholders to initiate the action. The first step for involvement was the regional training for the country coordinators. However, out of 51 who were trained in first batch in 2008, 33 countries have successfully completed the process, while others are at various stages of completion, some even yet to kick-start.

Later on some 22 more countries got involved in the year 2009 making the total number of countries taking part to 73. The pace of initiating and completing the assessment work has not been consistent.

Lessons have to be learnt from 8 countries of south Asia who did similar action in 2005 and now took part in a repeat assessment in 2008, therefore they could study the trends, and impact of WBTi was more or less visible during the second assessment.

According to the experience of some of the country coordinators who shared their assessment findings during the One Asia Breastfeeding Partner's Forum-6 at Colombo in November 2009, bringing together national stakeholders, having necessary meetings to prepare the assessment draft and sensitization of policy makers remained a challenge. Other challenging issues during the process of national assessment were lack of national data for particular indicators, outdated/old data for a particular indicator, paucity of funds to undertake the process, resistance among various agencies to disclose the data and conflicting data from different sources. These problems were tackled by regular meetings with partners and other relevant government organizations and explaining the concerned people about the process and its' relevance to national action on IYCF programmes.

There were some positive experiences during the process of country assessment such as the opportunity for the stakeholders to come together and assess the strengths and gaps in the programmes and policies on IYCF and come out with recommendations to bridge the gaps. In some countries, action has already started based on the assessment findings. The whole process gave a sense of pride among the national stakeholders that they are participating in a global initiative.

Visualisation of the performance of different indicators generated a keen interest among national partners and their resolve to periodically monitor their programmes in order to have full information of breastfeeding policies and programmes in the next 2 to 3 years.

WBTi serves as an important medium for sharing experiences and learning from each other by countries. At a glance one can see which country is showing high scores, which helps in networking specifically to strengthen programmes.

Overall, the lesson learnt is that it is feasible and possible to build a network of partners at national level, provided they have the right guidance on what to do and how, and achieve some consensus around infant feeding issues. However, it requires understanding, patience, committed resources, establishing partnerships, and time.

Improving the Process

The WBTi is a dynamic process, which allows it to learn from the experience gathered during the national assessment, coordination at IBFAN Asia office and while preparing, disseminating and utilising the report. Some inputs gathered during the whole process include:

- The national teams need to be communicated in advance about the process and relevant training material needs to be shared with them before the regional training.
- The national assessment teams require consistent and ongoing technical support from IBFAN Asia/ other regional offices to carry out the assessment and to utilize the process for subsequent advocacy; for example, some countries asked for a formal letter from the IBFAN office to the national assessment coordinator and the government officials.
- The process respects the consensus assessment findings agreed up on by the national assessment groups and also accept the supporting evidence provided by the group for its findings. However, the process and its scrutiny may be made more robust to ward off any inconsistencies.

Involving Countries More Seriously

IBFAN Africa, South Asia and IBFAN LAC have already shown that the way forward by effectively engaging with the national groups. The IBFAN Africa coordinator shared that training one country at a time in the country made it much more meaningful than bringing one or two representatives to a regional training. LAC region has also shown positive energy in moving national groups. South Asia showed how the regional network meetings could become a platform for sharing WBTi reports and other action around it. The WBTi assessment process provides an opportunity for greater networking among the stakeholders from different countries and may be utilized to strengthen the breastfeeding movement as evident from the fruitful participation of WBTi national coordinators from Asian countries in the One Asia Breastfeeding Partner's Forum-6 at Colombo.

Making the Tool More Effective and Keeping it Updated with Newer Developments

The indicators used in the assessment tool need continuous scrutiny and strengthening in view of emergence of relevant scientific facts. One such example could be inclusion of subset questions about provision of antiretroviral drugs to pregnant and lactating women and infants as prescribed in the revised WHO guidelines on HIV and infant feeding -2010. BFHI may need to be updated. Feedback from the regions call for change in how indicators should be weighted, in order to give more weight to implementation of a policy than the policy itself.

Keeping it Consistent with other Sources of Information

Most of the feedback we have received is about data on IYCF practices being different from another reports. We have noted that people look at numeric data and ignore the value of the WBTi in generating national actions to find and bridge gaps. We have been able to explain it more and more to make people understand. The report may fill in this gap. It made us to compare the findings of other reports, and most notably the latest Countdown to 2015 report, which reports coverage interventions on 3 of the 5 IYCF practice indicators. Most of the time we find that there is a difference in the year of reporting, or use of national data /MICS or DHS data which makes this difference. WBTi has encouraged the use of any such data, which is national in scope. Level of implementation of the *Global Strategy* as provided by the WBTi tool may seem to differ from the scores or findings on policy/programmes that other agencies may have given them in several areas of action. It could be due to different methodology and timing of the assessment. WBTi is complementary to those findings and does not necessarily compete with them as a database. It is a unique source of information about all the policies and programmes that result in infant feeding practices, informing countries where they stand today.

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About IBFAN and gBICS

About IBFAN

The International Baby Food Action Network, IBFAN, consists of public interest groups working around the world to reduce infant and young child morbidity and mortality. IBFAN aims to improve the health and well-being of babies and young children, their mothers and their families through the protection, promotion and support of breastfeeding and optimal infant feeding practices. IBFAN works for universal and full implementation of the International Code and Resolutions.

About gBICS

The global Breastfeeding Initiative for Child Survival is a worldwide civil society-driven initiative aiming to accelerate progress in attaining the health-related Millennium Development Goals (MDGs) by 2015, especially Goal 4, reduction of child mortality, by scaling up early, exclusive and continued breastfeeding. The Goal of the gBICS Programme is to ensure that breastfeeding protection, promotion and support be further recognised as a key intervention to reduce child mortality and improve children's health. The Purpose of the gBICS Programme is to contribute to reduction in child malnutrition and improvement in infant and young child survival, health and development through improved infant feeding practices.

The gBICS is a joint Programme with the two largest networks of breastfeeding advocates: the International Baby Food Action Network, IBFAN and the World Alliance for Breastfeeding Action, WABA. Before taking action, the gBICS conducts an important evaluation to establish a participatory process to assess the situation of breastfeeding in a country and establish priorities using the World Breastfeeding Trends Initiative (WBTi). The WBTi uses innovative web-based technology as well as the participatory involvement of key actors to press for effective policies and programmes at national level.

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**Breastfeeding Promotion Network of India (BPNI)/
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BP-33, PITAMPURA, DELHI-110034, INDIA

Phone: +91-11-27343608, 42683059 Tel/Fax: +91-11-27343606

Email: info@ibfanasia.org, Website: www.ibfanasia.org



The International Baby Food Action Network (IBFAN) is the 1998 Right Livelihood Award Recipient. It consists of more than 200 public interest groups working around the world to save lives of infants and young children by working together to bring lasting changes in infant feeding practices at all levels. IBFAN aims to promote the health and well being of infants and young children and their mothers through protection, promotion and support of optimal infant and young child feeding practices. IBFAN works for the universal and full implementation of 'International Code of Marketing of Breastmilk Substitutes' and subsequent relevant World Health Assembly (WHA) resolutions.