2012

The World Breastfeeding Trends Initiative (WBT*i*)

ARE OUR BABIES FALLING THROUGH THE GAPS?

The State of Policies and Programme Implementation of the Global Strategy for Infant and Young Child Feeding in 51 Countries

BPNI

IBFAN

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Are our babies falling through the gaps?

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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
WBT*i*	World Breastfeeding Trends Initiative
WHO	World Health Organization

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Foreword

Measurement is critical to assess the degree of implementation of policies and programs to protect, promote and support breastfeeding, as well as to assess trends through time. Limited knowledge about the scale and distribution of inadequate breastfeeding policies and programs has hampered action to correct the problems identified and advocate for the resources needed. To date a methodology that systematically analyzes the implementation of policies and practices to foster improved breastfeeding has not existed. The World Breastfeeding Trends Initiative (WBT*i*) addresses this gap by providing a systematic method to evaluate the implementation of the World Health Organization (WHO)/UNICEF Global of Infant and Young Child Feeding.

Adopted by the World Health Assembly and the UNICEF Executive Board in 2002, the Global Strategy for Infant and Young Child Feeding recognized that *"Malnutrition has been responsible directly or indirectly, for 60% of the 10.9 million deaths annually among children under five. Well over two-thirds of these deaths, which are often associated with inappropriate feeding practices, occur during the first year of life. No more than 35% of infants worldwide are exclusively breastfed for the first four months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate or unsafe. Malnourished children who survive are more often sick and suffer life-long consequences of impaired development. Because poor feeding practices are a major threat to social and economic development, they are among the most serious obstacles to attain and maintain health that face this age group."*

To address these problems, the *Global Strategy* set forth nine operational targets related to both breastfeeding and complementary feeding. To assess progress in the implementation of the *Global Strategy*, the World Health Organization developed a tool for assessing national practices, policies and programs in support of infant and young child feeding. Inspired by this tool, the International Baby Food Action Network (IBFAN) of Asia developed the WBT*i* to track, assess and monitor infant and young child feeding practices, policies and programs worldwide in support of breastfeeding and complementary feeding. To provide a measure of the key factors associated with breastfeeding and complementary feeding practices, the WBT*i* focuses on a set of 15 indicators; five related to feeding practices and 10 related to policies and programs.

WBT*i* provides simple, valid, and reliable indicators essential to track progress of the implementation of policies and programs in favor of breastfeeding. It also provides an easy to interpret color coded

presentation style to clearly communicate results to policy makers and other interested parties. Importantly, WBT*i* results predict improved breastfeeding practices. An analysis of 23 countries that have reported WBTi results and that have measures of exclusive breastfeeding during the last 15 to 20 years shows a significant association between WBTi score and increases in exclusive breastfeeding.

WBT*i* measures the degree to which conditions are present that provide mothers with supportive conditions at birth to initiate breastfeeding within the first hour of birth, and an optimal environment thereafter, to practice exclusive breastfeeding for the first six months and to continue breastfeeding for two years or more. Results generated through its application can be used for advocacy to strengthen efforts of the United Nations, Ministries of Health, non-government organization and all stakeholders who work to improve the breastfeeding environment globally. They can also be used to identify weaknesses and strengths in breastfeeding policies and programs so that weaknesses can be corrected and strengths celebrated. An old adage states that "we do what we measure". By providing a systematic quantifiably tool for measuring implementation of policies and programs in favor of breastfeeding, WBT*i* is an essential element for global efforts to protect, promote and support breastfeeding protection.

Dr. Chessa Lutter
Senior Advisor, Food and Nutrition
Pan American Health Organization/World Health Organization

Preface

International Baby Food Action Network (IBFAN) is a global network of peoples' groups in more than 160 countries and it uses its voice to make the voices of mothers and children heard by the policy-makers, multinational companies, employers and the medical profession. IBFAN works globally, regionally and at national level for advocacy on breastfeeding and infant and young child feeding issues countering the commercial lobby. In 2007, when IBFAN discussed strategic directions, one of the major work that emerged was monitoring and evaluation of programmes worldwide. This was seen in light of the right- based approach to food and nutrition security and IBFAN believed that policy framework of the *Global Strategy* must move to national level and be implemented in its entirety.

WBT*i* is expected to document the gaps in implementation of the Global Strategy, and develop easy to understand tools for policy makers. Another key objective was to make available information on policy and programmes universally accessible. With the belief that such information would prepare a country to take action to bridge the gaps in policy and programmes, WBT*i* built in development of report cards, ranking, colour coding, and an element of advocacy to make use of these to call for change. It was also a part of the process that WBT*i* countries would indulge in study of trends over a period of time repeating assessments and documenting change, thus developing a dynamic process of assessment, analysis and action and these tools become an integral part of the processes used by countries while working on infant and young child feeding issues.

The WBT*i* was launched in 2004 in South Asia and first report of action was published in 2008 for 8 countries that highlighted the gaps in policy and programmes. The report was successfully used for advocacy for change in few countries and this success led us to introduce the initiative to other parts of the world in 2008 and 2009. By 2010, 33 countries completed this work and a report was published and at the same time South Asia countries began doing re-assessments to study trends. In 2012 a review paper was published in 'Health Policy and Planning' based on data of 40 countries. *(See http://heapol.oxfordjournals.org/content/early/2012/07/01/heapol.czs061.full.pdf?keytype=ref&ijkey=z6Ds8powSSzsdYZ)*

By middle of 2012, WBT*i* was introduced in 82 countries and 51 completed the work by October and shared their national reports, which are accessible on the WBT*i* portal *http://www.worldbreastfeedingtrends.org/countrylinks.php*

The tool has shown the potential for moving the policy from paper to practice as we hear from country after country taking action to set in place some kind of mechanisms or direct action on IYCF programmes. I hope more countries will join in over next five years and those who have already joined would produce trend reports by then. The journey from policy to practice is an important one. While IBFAN's regional offices in Africa, Latin America, Arab world, Oceania, Southeast Asia, and East Asia have made use of the tool with quite impressive results, this is an idea whose time has come !

Dr Arun Gupta.
Regional Coordinator, IBFAN Asia

Contents

Executive Summary

Every year close to 136 million babies are born all over the world. Of them as many as 92 million are not able to experience the WHO's recommended optimal feeding practices: Beginning breastfeeding within one hour, Being exclusively breastfed for the first six months, and Timely and appropriate complementary feeding with continued breastfeeding after 6 months, up to 2 years. This is in spite of the well-known benefits of optimal feeding for a child's health, development and survival, as well as its advantages in long-term health in adulthood and prevention of non-communicable diseases (NCDs).

> ***"…I think WBTi is a real break through in our ability to measure inputs to improve IYCF"***
> *Chessa Lutter. Regional Advisor Pan American Health Organization*

In order to increase the rates of optimal feeding practices, the WHO and UNICEF developed the Global Strategy for Infant and Young Child Feeding, which provides a framework for action to scale up breastfeeding and infant and young child feeding interventions. They also developed a tool to monitor these inputs.

Based on these tools, the Breastfeeding Promotion Network of India/ International Baby Food Action Network (IBFAN), Asia, developed the World Breastfeeding Trends Initiative (WBT*i*), which measures inputs and generates national action. WBTi analyses the situation, documents gaps, builds consensus and recommendations, and stimulates governments to take some action to bridge the gaps. The W.H.O. has recognised the value of this action tool and the W.H.O. has recently launched The Global database on the Implementation of Nutrition Action (GINA) *https://extranet.who.int/nutrition/gina/* is an interactive platform for sharing standardized information on nutrition policies and actions, i.e. what are the commitments made and who is doing what, where, when, why and how (including lessons learnt) . It includes WBT*i* in list of partners and data sources..

The WBT*i* includes assessment, action, and advocacy. It is an innovative web tool giving universal access to this information, and leads to colour coding and objective scoring to make it easily understandable for the policy makers. It is the central strategy of the global Breastfeeding Initiative for Child Survival (gBICS), jointly launched by the International Baby Food Action Network (IBFAN) and the World Alliance for Breastfeeding Action (WABA) in 2008.

The WBT*i* was earlier launched in 2004-05 in South Asia, and its success led to its introduction in other regions of Asia, Africa, the Arab world and Latin America in 2008, and in Oceania in 2010.

Introduced in 82 countries, it has led to documentation in 51 countries, which is the basis

Box 1: The WBT*i*

The WBT*i* includes assessment, action, and advocacy. The is an innovative web tool giving universal access to this information, and leads to colour coding and objective scoring to make it easily understandable for the policy makers. It is the central strategy of the global Breastfeeding Initiative for Child Survival (gBICS), jointly launched by the International Baby Food Action Network (IBFAN) and World Alliance for Breastfeeding Action (WABA) in 2008. The WBT*i* was earlier launched in 2004/05 in South Asia and its success led to introduction to other regions of Asia, Africa, Afrique, Arab world and Latin American in 2008, and Oceania in 2010. Introduced in 82 countries it has led to documentation in 51 countries, which is the basis of this report. IBFAN led this process nationally that brought together concerned groups like governments, professional bodies, international organizations and civil society to accomplish this work. Detailed national reports can be downloaded at http://www.worldbreastfeedingtrends.org/countrylinks.php.

of this report. IBFAN has led this process nationally and brought together concerned groups like governments, professional bodies, international organizations and civil society to accomplish this work. (Detailed national reports can be downloaded at *http://www.worldbreastfeedingtrends.org/countrylinks.php*)

The WBT*i* report, **"ARE OUR BABIES FALLING THROUGH THE GAPS? The State of Policies and Programme Implementation of the Global Strategy for Infant and Young Child Feeding in 51 Countries"** documents the gaps in policy and programmes in 10 areas of action (See box on indicators below). Although the report lays bare the gaps, it also shows the action that has been generated as a result of advocacy. This report is from 51 countries where 83 million children are born each year - almost 2/3rd of the children born in the world.

Box 2: Indicators of WBT*i*

MEASURING PROGRESS

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

HIGH FIVE

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)

KEEPING SCORE

Where the countries stand on implementing the *Global Strategy?*

The WBT*i* helps to track and rank countries. The WBT*i* tool helps score each indicator on a scale of 10 and provides a colour code - red, yellow, blue and green in ascending order of performance - to reflect achievement on each indicator. Thus, the maximum score for policy and programmes is 100, and 50 for IYCF practices. Scoring done by the WBT*i* is based on IBFAN Asia's guidelines and the WHO tool provides the key to this.

Table 1 gives the details of various countries' scores and ranks for indicators 1-10 covering the policy and programmes. Going by the ranking on this, 21 countries are coded blue, 27 yellow, and 3 red, with their total scores out of 100 ranging from 22.5 for Cape Verde to 85 for Sri Lanka.

The 5 countries that scored the highest are Sri Lanka, Maldives, Kenya, Malawi, and Nicaragua. The 5 countries that scored the least are Cape Verde, Taiwan, Indonesia, Mexico, and Egypt.

Table 1: Ranking of WBTi 51 countries in 2008-2012*

Country	Total score for Indicators 1-10 (Out of 100)	Rank[a]
Sri Lanka	85	1st
Maldives	83	2nd
Kenya	77	3rd
Malawi	75.5	4th
Nicaragua	75	5th
Costa Rica	71	6th
Mongolia	71	6th
Bangladesh	70.5	7th
Venezuela	70.5	7th
Ghana	69.5	8th
Zambia	69.5	8th
Zimbabwe	67.5	9th
China	65.5	10th
Pakistan	64.5	11th
Vietnam	64	12th
Afghanistan	62	13th
Gambia	62	13th
Jordan	62	13th
Mozambique	61.5	14th
Dominican Republic	61	15th
Lesotho	61	15th
Swaziland	59	16th
Elsalvador	58.5	17th
Kuwait	58	18th
Fiji	55	19th
Republic Of Korea	55	19th
Thailand	54.5	20th
Bolivia	54	21st
Saudi Arabia	54	21st
Bhutan	53	22nd
Brazil	53	22nd
Kiribati	53	22nd
Lebanon	52.5	23rd
Uruguay	52.5	23rd
Cameroon	51.5	24th
Philippines	51.5	24th
Argentina	51	25th
Colombia	50	26th
Uganda	48.5	27th
Ecuador	47.5	28th
Sao Tome And Principe	46.5	29th
Guatemala	45.5	30th
Botswana	44.5	31st
India	43	32nd
Peru	42.5	33rd
Nepal	40.5	34th
Egypt	40	35th
Mexico	31	36th
Indonesia	27.5	37th
Taiwan	26.5	38th
Cape Verde	22.5	39th

** In the case of countries, which have conducted assessments more than once, we have taken the results of the latest assessment for our calculations.*
[a] Countries with the same scores have the same rank

None of the 51 countries have succeeded yet in fully implementing the Global Strategy for universalising optimal IYCF practices. **Several gaps remain in policy and programme implementation with respect to the health and nutrition of children under 2 years.**

THE AVERAGE, IS AVERAGE

Average rates for the five Infant and Young Child Feeding (IYCF) practices in the 51 countries

Indicators 11-15 look at IYCF practices i.e. timely initiation of breastfeeding, exclusive breastfeeding for the first six months, median duration of breastfeeding, bottle -feeding and the introduction of complementary foods after the age of 6 months. Table 2 shows the average practice in the countries where data is available.

These rates of IYCF practices are close to the global rates given in *UNICEF's State of the World's Children 2012*, according to which the global rate of timely initiation of breastfeeding is 43%, of exclusive breastfeeding is 37%, and that of introduction of timely introduction of complementary feeding is 60%.

Going by the numbers in 51 countries, where nearly 83 million children are born, only about 43 million begin breastfeeding within an hour, 34 million practice exclusive breastfeeding for the first six months, 55 million get timely complementary feeding, and as many as 26 million are hooked on to bottle-feeding.

It is important to note that the majority of infants born are not exclusively breastfed during first six months. These are about 92 million mother -baby dyads who have to practice artificial feeding in the form of infant formula or other milk products, and bottle feeding, which are detrimental to their health causing more obesity, a higher risk of diarrhoea and other infections, and a higher risk of NCDs also.

Table 2: Average rates for the 5 IYCF Practices in 51 countries

IYCF Practices (Indicators 11-15)	Average
Initiation of breastfeeding within 1 hour in percentage (average of 47 countries)	52.9%
Exclusive breastfeeding for the first six months in percentage (average of 50 countries)	41.4%
Median duration of breastfeeding in months (average of 46 countries)	18.1 months
Bottle feeding (<6 months) in percentage (average of 42 countries)	31.3%
Complementary feeding (6-9 months) in percentage (average of 49 countries)	67%

In order to accelerate achievement of the Millennium Development Goal 4 to reduce child mortality by 2/3rd by 2015, it is critical that breastfeeding and IYCF interventions are scaled up in all countries, especially the resource poor ones.

GLARING GAPS

The key findings in the 10 areas of policy and programmes

Fig.1 shows the average score for each indicator out of 10 along with colour coding. Most indicators are in yellow, except for Implementation of the International Code, which is in blue, and Infant Feeding during Emergencies, which is in red. The averages score ranges from 2.56 for Infant Feeding during Emergencies to 7.21 for Implementation of the International Code.

The gaps are extremely significant and are found in almost all the countries and on all indicators from 1 to 10. The following are the key gaps we noted:

- Lack of budgets for implementing policy and programmes
- Lack of inter-sectoral coordination, which leads to ad-hoc actions.
- Inadequate attention in health facilities, like on BFHI
- Weak implementation of the International Code
- Women in the unorganized and informal sector are neglected on maternity protection
- Health workers are inadequately trained in implementation of the International Code
- Community outreach of support to women to practice optimal IYCF is highly inadequate
- Women lack full information support on IYCF
- HIV and Infant Feeding is not integrated in IYCF policies and programmes.
- Infant Feeding during Emergencies in their Disaster policies or programmes are almost non-existent.
- Weak monitoring and evaluation.

A LONG WAY TO GO

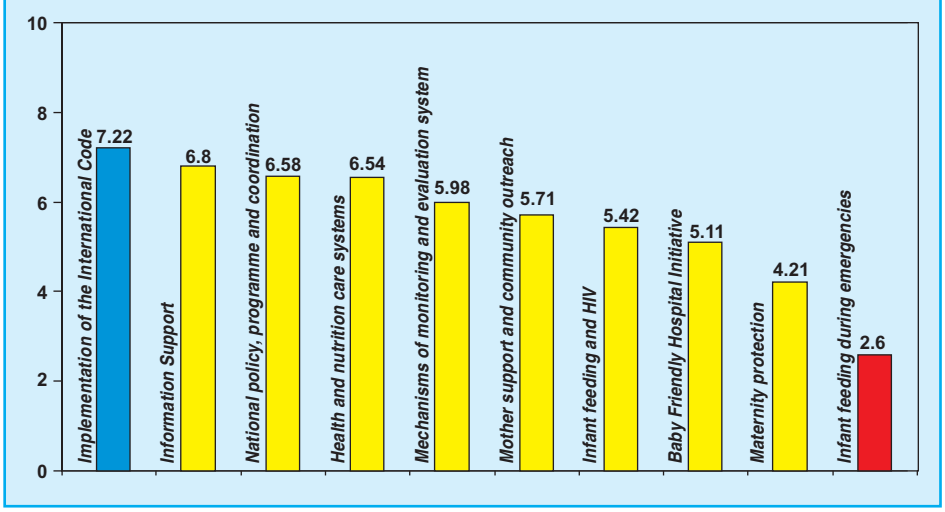
An analysis of the situation

Both UNICEF and WHO have repeatedly made a call to nations to have a comprehensive policy, a comprehensive action plan, a cross-cutting strategy for action, and adequate budgets for implementing large-scale, multi-level action in all areas identified by the Global Strategy if optimal IYCF practices have to be universalised.

While many countries have faced natural disasters of large scale in the past like tsunami, earthquakes, hurricanes or nuclear disasters that led to unprecedented displacement of populations, support for optimal infant feeding during emergency situations is found to be deficient in most countries. Unfortunately the response that comes in such situations is more in the form of donation of formulas rather than creating breastfeeding support groups.

Detailed analysis shows that even though there is huge scientific evidence to

Fig. 1: Average scores for indicators 1-10



scale up interventions to increase breastfeeding rates, investment of both human and financial resources is not commensurate with the need.

Therefore a focus on policy and a legislative framework to align with the needs is required to achieve high breastfeeding rates. For example, Indicator 1 reveals that the mechanism of coordination is weak, which results in ad hoc actions rather than the implementation of a comprehensive strategy at scale. It indicates that women need more support at both the level of the facility and the community to carry out optimal breastfeeding practices. This is borne out by the low average scores for Indicators related to Health and Nutrition Systems (6.46 out of 10), Mother Support and Community Outreach (5.68 out of 10) and Maternity Protection (4.56 out of 10).

As Indicator 1 on National Policy, Programme and Coordination shows, while over three quarters of the countries have a policy, just about a quarter of them have a budget to implement it. At the same time, while countries may appear to have high scores for some indicators, very serious gaps remain in the area of implementation.

This is especially true of Indicator 3 on the Implementation of the International Code of marketing of breast milk substitutes, which means enforcement of the Code or national legislation to control marketing and promotion of infant formula and baby foods. It has received the highest average score and is the only one in blue. The subsets reveal that the Code has been legislated in only about half the countries fully in 17 countries, and partially in 10 countries; it has been implemented in only 10 of them.

Some of these gaps can be addressed through strengthening existing laws, and setting up committees free from conflict of interest. Almost all the countries have recommended legislating maternity protection.

This analysis shows that in order to scale up interventions to improve the IYCF practices indicators, far more work need to be done.

WBT*i* WORKS

The Impact: The national action that WBT*i* has generated

The reports point out the immediate benefits of the WBT*i* - bringing people together to discuss and analyse as well as building consensus. The process of ranking and colour coding makes it easy to understand the state of policy and programmes, and brings high-level attention to the issues.

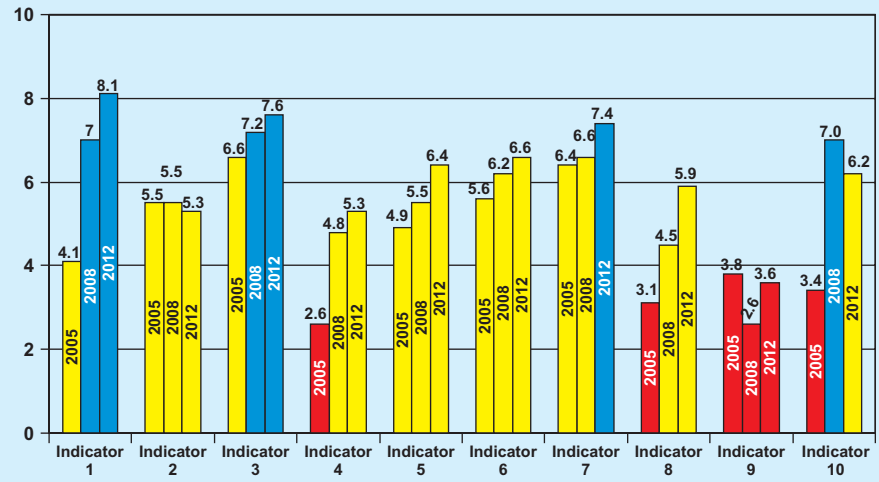
The WBT*i* has led to a study of trends of WBT*i* since five South Asian countries have done their 3rd assessment since 2004-05 and two countries in the LAC region have completed their 2nd assessment since 2008-09.

Many countries in Africa and Asia are in the process of conducting trend analysis with their 2nd assessment. This shows that the interest is growing to find the gaps and bridge them.

The WBT*i*'s impact on national action can be viewed from two angles. One is the rise in scores over a period of time in countries that did the reassessments, and the other is to look at the action taken at a national level to bridge the gaps.

1. The average scores for all indicators for the five South Asian countries that have completed their third assessment Afghanistan, Bangladesh, Bhutan, India and Sri Lanka - is shown in Fig. 2. The figure reveals that the score for many indicators - Indicator 1 (National Policies, Programmes and Coordination), Indicator 3 (Implementing the International Code), Indicator 4 (Maternity Protection) and Indicator 8 (Infant feeding and HIV) - the rise has been steady, from one assessment to the next. There is a decrease in the score of the indicator on BFHI that could be attributed to the difficulty these countries face in raising funds for reactivating BFHI or a lack of priority given to the intervention. The score

Fig. 2: Average Scores for indicators 1-10 for 5 South Asian Countries 2005-2012



for indicator 9 (Infant Feeding during Emergencies) continues to be in the red, showing that many countries have not yet begun to realize its value.

- Costa Rica and Dominican Republic have also moved up to a higher level.

2. The action taken by many countries, according to the national and regional coordinators, was a direct result of using WBT*i* assessment findings effectively for advocacy. For example,

- On the subject of National Policy Coordination or Funding, in Asia, Afghanistan, Bhutan, Bangladesh, China, and Thailand took action. Similarly, Gambia, Kenya, and Uganda did so in Africa; and Costa Rica, Dominican Republic, Colombia, El Salvador, Uruguay, and Guatemala took action in the LAC region.
- On Maternity Protection, many different types of actions emerged, ranging from putting up a Bill to increase maternity protection in Lebanon, Gambia, and Uruguay; to the launching of new schemes for women in the unorganised sector in India; the provision of increased maternity leave in Vietnam, China and Bangladesh; allowing mothers to work from home in Bhutan; extending or improving workplace facilities in Colombia, Peru, Philippines and Ecuador; and initiating several activities in support of women in Brazil, Dominican Republic, and El Salvador.
- On Support in Health Care Facilities, Bangladesh, Mongolia, China, Zambia, Dominican Republic, Guatemala and Lebanon, took action to strengthen the basic work on BFHI in the form of training of workers and development of standards.
- Many countries took action on strengthening implementation of the International Code of Marketing of Breast Milk Substitutes (Code) or its provisions. The actions included developing new drafts, inclusion of recent World Health Assembly provisions into the regulations, preparing drafts for approval, deepening protection levels, integration with other legislations, and setting up mechanisms for implementation. Some countries raised funds to implement, while a few others trained their staff.

WHAT NEXT?

The way forward and recommendations

The WBT*i* is an idea whose time has come! Several countries have successfully used the tool with impressive results. A recent study by Lutter and Morrow has shown that it is possible to increase breastfeeding rates provided countries work on policy and programmes.

There is also evidence being generated that specific interventions, particularly skilled counseling and maternity protection, do lead to enhanced breastfeeding rates. The following recommendations have mostly emerged from the national reports as well as the analysis of the situation.

General recommendations for countries

1. Countries that have begun the WBT*i* process need to organise their coordination and funding immediately and adequately, in order to quickly scale up interventions to increase breastfeeding rates. They should also plan for re-assessments after 3-5 years to study the trends and review action to be taken, and aim to reach the next level of performance.
2. Those who have not yet started using the WBT*i* could begin using this tool.

Specific recommendations to countries

- Develop a comprehensive, cross-sectoral, multi-level IYCF policy with a plan of action and a timeline. Budget the policy action and raise resources for its implementation. Appoint a coordinating body, with representation from all sectors involved, to oversee its comprehensive implementation.
- Rejuvenate BFHI with a timeline to cover all hospitals. Ensure that adequate human and financial resources are available for this action.
- Legislate the International Code and all relevant subsequent WHA resolutions and stringently implement it. Raise public awareness on the Code/national legislation and train Code Monitors to take note of violations for further action.
- Extend maternity leave for all women to six months to enable exclusive breastfeeding. Extend maternity protection to women working in the informal/unorganised sector and raise adequate resources for this.
- Integrate IYCF, including the International Code, Infant Feeding in HIV and Infant Feeding during Emergencies, in pre-service and in-service training of health and nutrition workers, at all levels of the health and nutrition system.
- Build community outreach into the IYCF policy. Make communities baby friendly by ensuring the provision of easy access to skilled counselling and child-care services.
- Develop a specific communication strategy for IYCF.
- Integrate HIV and infant feeding into the IYCF policy, IYCF training for all levels of health providers and IYCF communication strategy.
- Integrate infant feeding during emergencies into the IYCF policy, and disaster management planning including breastfeeding support services, as a part of the supply chain.
- Include IYCF practice indicators in national surveys and monitor them annually, or at least every two years. Use this data to inform policy.

Specific recommendations to the global community

- Build implementation of the Global Strategy for Infant and Young Child Feeding as a key priority in the future agenda of child health and survival.
- Create budget lines for implementing the Global strategy commensurate with the need.
- Dedicate specific budget lines to address breastfeeding and IYCF interventions under child health or nutrition programming.
- Global community should focus on policy advocacy for legislation on the International Code of Marketing of Breastmilk Substitutes (Code) and subsequent World Health Assembly resolutions , keeping it clear of conflicts of interests.
- In order to increase exclusive breastfeeding for the first six months, encourage the use of the WBT*i* tool to initiate action under the UN Secretary General's Global Strategy for Women's and Children's Health, or the WHO's Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition
- Donors could choose to help increase breastfeeding rates by supporting specific countries with low WBT*i* scores or those LDC countries where resources are constrained.
- Donors could also choose to support specific indicators with low scores in many countries e.g. International Code of Marketing of Breastmilk Substitutes(Code), infant feeding policy during emergencies, or maternity protection.

Background

World over about 136 million babies are born every year, only 48 million - are able to practice exclusive breastfeeding; and 92 million are NOT. There is thus a need to reach all families of the world on minute-to-minute basis.

According to UNICEF's *State of the Worlds Children 2012*, 7.61 million children die every year before they reach their fifth birthday; of these less than 1% are in industrialized countries. Of the total number of children under five, 16% are moderately severe underweight, 9% are severely underweight; 10% have moderate and severe wasting, while 27% are moderately and severely stunted. The report further informs that only 43% of the children born are initiated into breastfeeding early, only 37% are exclusively breastfed for 6 months, only 60% get adequate and appropriate complementary foods at 6-8 months, and just 55% continue to be breastfed for at least two years. Table 3 gives the region-wise figures for breastfeeding practices.

In 2011, the World Health Assembly resolution on Infant and Young Child Nutrition (WHA 63.23) highlighted 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." However, in spite of the overwhelming evidence on the cost-effectiveness of optimal breastfeeding practices on reduction of child mortality, morbidity and malnutrition, as well as its economic value to both the family and the nation, breastfeeding rates are low almost all over the world.

IYCF practices need to be viewed in the context of the state of child health and nutrition in the 51 countries conducting the assessment (Table 4).

Table 3: Optimal IYCF practice rates by region

Region	% of children (20062010*) who are:		
	Exclusively breastfed (<6 months)	Introduced to solid, semi-solid or soft foods (6-8 months)	Breastfed at age 2 (20-23 months)
Africa	34	68	44
Sub-Saharan Africa	33	69	46
Eastern and Southern Africa	49	81	54
West and Central Africa	24	63	42
Middle East and North Africa	34	57	31
Asia	38	55	69
South Asia	45	56	76
East Asia and Pacific	29	54	44
Latin America and Caribbean	42	71	33
CEE/CIS	30	55	22
Industrialized countries	-	-	-
Developing countries	37	60	56
Least developed countries	42	68	61
World	37	60	55

Source: UNICEF. *State of the World's Children 2012*

On examining the situation we find that, except in the African region, a very 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 WBT*i* assessment pointed out that some countries had not collected data on infant and young child feeding practices. For instance, four

Table 4: Status of Under-5 Mortality and Malnutrition in WBT*i* Assessment Countries*

Countries	Under-5 mortality* (2010)	Infant Mortality (2010)	Neonatal Mortality (2010)	% of underfives (2006-2010*) suffering from:			
				Underweight		Wasting	Stunting
				Moderate and Severe	Severe	Moderate and Severe	Severe
Afghanistan	149	103	45	33	12	9	59
Argentina	14	12	7	2	0	1	8
Bangladesh	48	38	27	41	12	17	43
Bhutan	56	44	26	13	3	6	34
Bolivia (Plurinational State of)	54	42	23	4	1	1	27
Botswana	48	36	19	11	4	7	31
Brazil	19	17	12	2	-	2	7
Cameroon	136	84	34	16	5	7	36
Cape Verde	36	29	14	-	-	-	-
China	18	16	11	4	-	3	10
Colombia	19	17	12	3	1	1	13
Costa Rica	10	9	6	1	-	1	6
Dominican Republic	27	22	15	7	2	3	18
Ecuador	20	18	10	6	-	-	-
Egypt	22	19	9	6	1	7	29
El Salvador	16	14	6	6	1	1	19
Fiji	17	15	8	-	-	-	-
Gambia	98	57	31	18	4	10	24
Ghana	74	50	28	14	3	9	28
Guatemala	32	25	15	13	-	1	48
India	63	48	32	43	16	20	48
Indonesia	35	27	17	18	5	14	37
Jordan	22	18	13	2	0	2	8
Kenya	85	55	28	16	4	7	35
Kiribati	49	39	19	-	-	-	-
Kuwait	11	10	6	-	-	-	-
Lebanon	22	19	12	-	-	-	-
Lesotho	85	65	35	13	2	4	39
Malawi	92	58	27	13	3	4	47
Maldives	15	14	9	17	3	11	19
Mexico	17	14	7	3	-	2	16
Mongolia	32	26	12	5	1	3	27
Mozambique	135	92	39	18	5	4	44
Nepal	50	41	28	39	11	13	49
Nicaragua	27	23	12	6	1	1	22
Pakistan	87	70	41	31	13	14	42
Peru	19	15	9	4	1	1	24
Philippines	29	23	14	22	-	7	32
Republic of Korea	5	4	2	-	-	-	-
Sao Tome and Principe	80	53	25	13	3	11	29
Saudi Arabia	18	15	10	-	-	-	-
Sri Lanka	17	14	10	21	4	15	17
Swaziland	78	55	21	6	1	1	31
Thailand	13	11	8	7	1	5	16
Uganda	99	63	26	16	4	6	38
Uruguay	11	9	6	5	2	2	15
Venezuela	18	16	10	4	-	5	16
Viet Nam	23	19	12	20	-	10	31
Zambia	111	69	30	15	3	5	45
Zimbabwe	80	51	27	10	2	3	32

Source: UNICEF. *State of the World's Children 2012*

**Data for Taiwan is not included in this table*
a. deaths per 1000 live births

countries - Korea, Taiwan, Venezuela and Vietnam - have no data on initiation of breastfeeding within one hour; with the last also having no data on exclusive breastfeeding rates; China, Gambia, Korea, Taiwan and Thailand have no data on median duration of breastfeeding; Bostwana, Cape Verde, China, Ecuador, Fiji, Gambia, Mexico, Nicaragua and Taiwan have no data on bottle-feeding rates; Cape Verde and Taiwan have no data on timely and appropriate complementary feeding after six months along with continued breastfeeding.

Role of Optimal Infant and Young Child Feeding Practices

Major killers of infants include neonatal infections, diarrhea and pneumonia. World Health Organization (WHO) estimates that 53 percent of pneumonia and 55 percent of diarrhea deaths are attributable to poor feeding practices during the first six months of life. Initiation of breastfeeding within an hour of birth is known to reduce infection specific neonatal mortality, and this impact is independent of the effect of exclusive breastfeeding during the first month of life. Sub-optimal breastfeeding is estimated to be responsible for 1.4 million child deaths and 43.5 million Disability Adjusted Life Years (DALYs), with non-exclusive breastfeeding during 0-6 months accounting for 77 percent (1.06 million) of the deaths and 85 percent of the DALYs. There is a growing body of evidence on the role of infant and young child feeding practices, especially exclusive breastfeeding, in mitigating both forms of malnutrition including in adulthood. Breastfeeding in particular has been linked to reduce risk of developing high blood pressure, serum cholesterol and Type II diabetes during adulthood. The WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non Communicable Diseases (NCDs) calls for the promotion of and support to exclusive breastfeeding for the first six months of life and to promote programmes to ensure optimal feeding for all infants and young children. However, improving breastfeeding practices and enhancing breastfeeding rates has been largely neglected in international health and development initiatives.

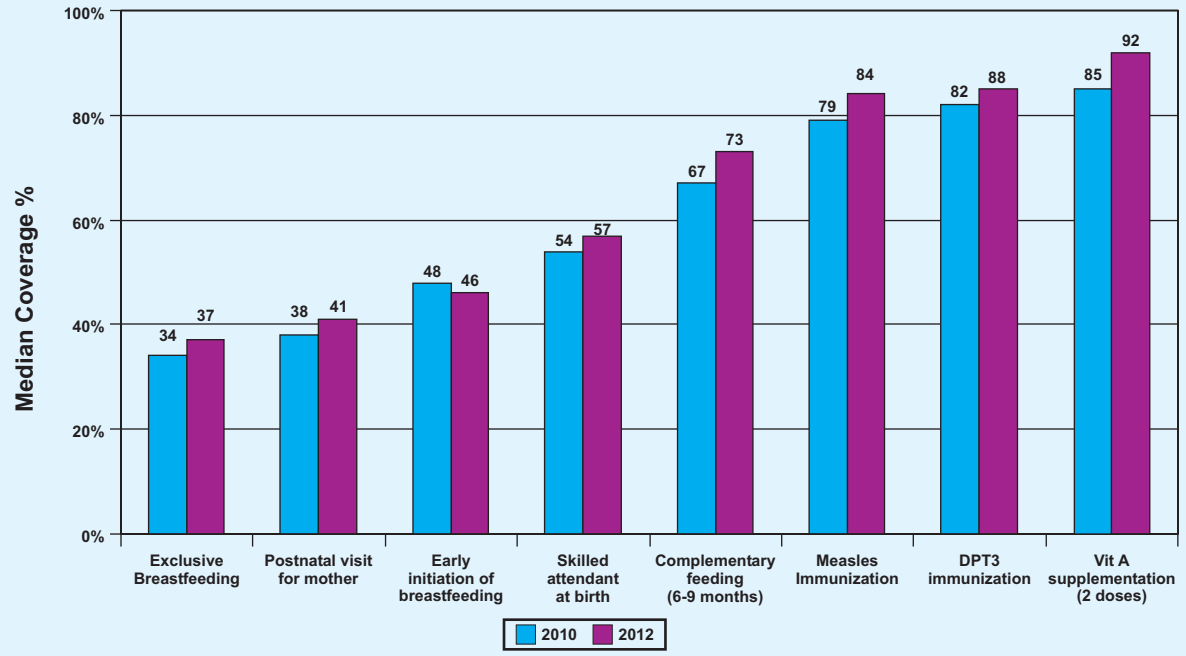
Global commitments

The Countdown to 2015, Maternal, Newborn Child Survival, Report 2012 monitors core interventions to improve maternal, newborn and child survival. Fig. 3 compares the coverage of 8 'postnatal interventions' relating to infant feeding and care, and shows that lowest attention is being paid to early and exclusive breastfeeding indicators among others. This is so important to take note, for the health and nutrition of children Under-2. Reaching coverage of 80% requires scaling up action on breastfeeding and IYCF interventions. For this to happen the report of 51 countries provides opportunity for specific action.

A decade ago in 2001, the World Health Assembly adopted a resolution The *Global Strategy for Infant and Young Child Feeding* - to give effect to the policy for infant and young child feeding, calling for action in essential 10 areas to promote optimal infant and young child feeding practices; UNICEF later endorsed this. The state of implementation of this strategy is the subject of this 51 Country Report. A recent study by Lutter and Morrow, yet to be published, has linked the improved implementation of the *Global Strategy for Infant and Young Child Feeding* with increased rates of breastfeeding.

The **MDG Report 2010** noted: "…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

Fig. 3: Coverage of postnatal interventions Countdown Report 2010



micronutrient supplementation between six and 24 months of age…"

Recognizing that a special push is needed to enhance optimal IYCF practices, the UN Secretary General's *Global Strategy for Women's and Children's Health* set a target: "….in 2015 alone, 21.9 million more infants would be exclusively breastfed for first six months …".

In May 2012, WHO's Member States further reinforced the *Global Strategy* by endorsing a *comprehensive implementation plan for maternal, infant and young child nutrition*, where emphasis is placed on early and exclusive breastfeeding for its substantial benefits in reducing child mortality and morbidity.

In June 2012, the *Child Survival Call to Action - Committing to Child Survival: A Promise Renewed* challenged the world to reduce child mortality to below 20 child deaths or fewer per 1,000 live births in every country by 2035.

The World Breastfeeding Trends Initiative (WBT*i*) 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 (WBT*i*), to assess infant feeding policy and programmes at country level.

Endnotes:

1. UNICEF. State of the World's Children 2010
2. Lauer JA, Betrán AP, Barros AJD and Onís MD. Deaths and years of life lost due to suboptimal breastfeeding among children in the developing world: a global ecological risk assessment. Public Health Nutrition 2006 Sept;9: 673-685.
3. Edmond KM, Zandoh C, Quigley MA, Amenga-Etego S, Owusu-Agyei S, Kirkwood BR. Delayed breastfeeding initiation increases risk of neonatal mortality. Pediatrics 2006;117: e380-e386.
4. Black RE, Allen LH, Bhutta ZA et al. Maternal and child undernutrition: global and regional exposures and health consequences. The Lancet 2008;371:243-260.
5. Horta BL et al. Evidence on the long-term effects of breastfeeding. Systematic reviews and meta-analysis. World Health Organization 2007
6. WHO. 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. Geneva: World Health Organization, 2008
7. Lutter C, Morrow AL. 2012. Protection, Promotion and Support and Global Trends in Breastfeeding. Advances in Nutrition. (in press)

Keeping Score

Where the countries stand on implementing the *Global Strategy?*

This section presents ranking charts of the 51 countries based on their performance on policy and programmes as well as a combined score of all 15 indicators. This is based on assessment conducted during 2008-12. As some countries have done the assessment more than once, we have taken the latest findings for both policies and practices for this report.

Fig. 4 gives colour coding and total scores, an overview of where these countries stand on implementing the 10 areas of policy and programmes, and score on a scale of 100. There are 16 countries in blue, 33 in yellow and 2 in red; no country has yet managed to be in the green zone. Sri Lanka has the highest score at 85 and Cape Verde the lowest at 22.5.

The majority of countries 27- are in the yellow level; 3 countries are in the blue level, and five countries - Cape Verde, Taiwan, , and Indonesia are in the red level. No country has yet scored enough to enter the green level.

Fig. 5 provides the total score and colour coding with all the 15 indictaors including IYCF practices and thus their score is out of 150. Sri Lanka, with a score of 129, is at the top, but it is still in the blue level. The other countries in the blue level include Malawi, Maldives, Zambia, Kenya, Costa Rica, Bangladesh, Mozambique, Mongolia, Ghana, Zimbabwe, Kiribati, Afghanistan, Lesotho, Nicaragua, and Bhutan. The majority of the countries are in the yellow level: Egypt, Venezuela, Botswana, Jordan, Fiji, Swaziland, Pakistan, Uruguay, Argentina, Philippines, Sao Tome & Principe, Cape Verde, Dominican Republic, Nepal, Uganda, Vietnam, Brazil, China, Colombia, Thailand, Gambia, Saudi Arabia, India, Lebanon, Kuwait, El Salvador, Guatemala, Peru, Indonesia, Ecuador, Bolivia, Korea, and Mexico. Cape Verde and Taiwan are in the red level, with scores of 43.5 and 32.5 respectively.

These rankings provide countries an opportunity to move to the next level, if not to green level directly by taking required action.

Fig. 4: The State of Breastfeeding in 51 Countries (Policy and Programmes)

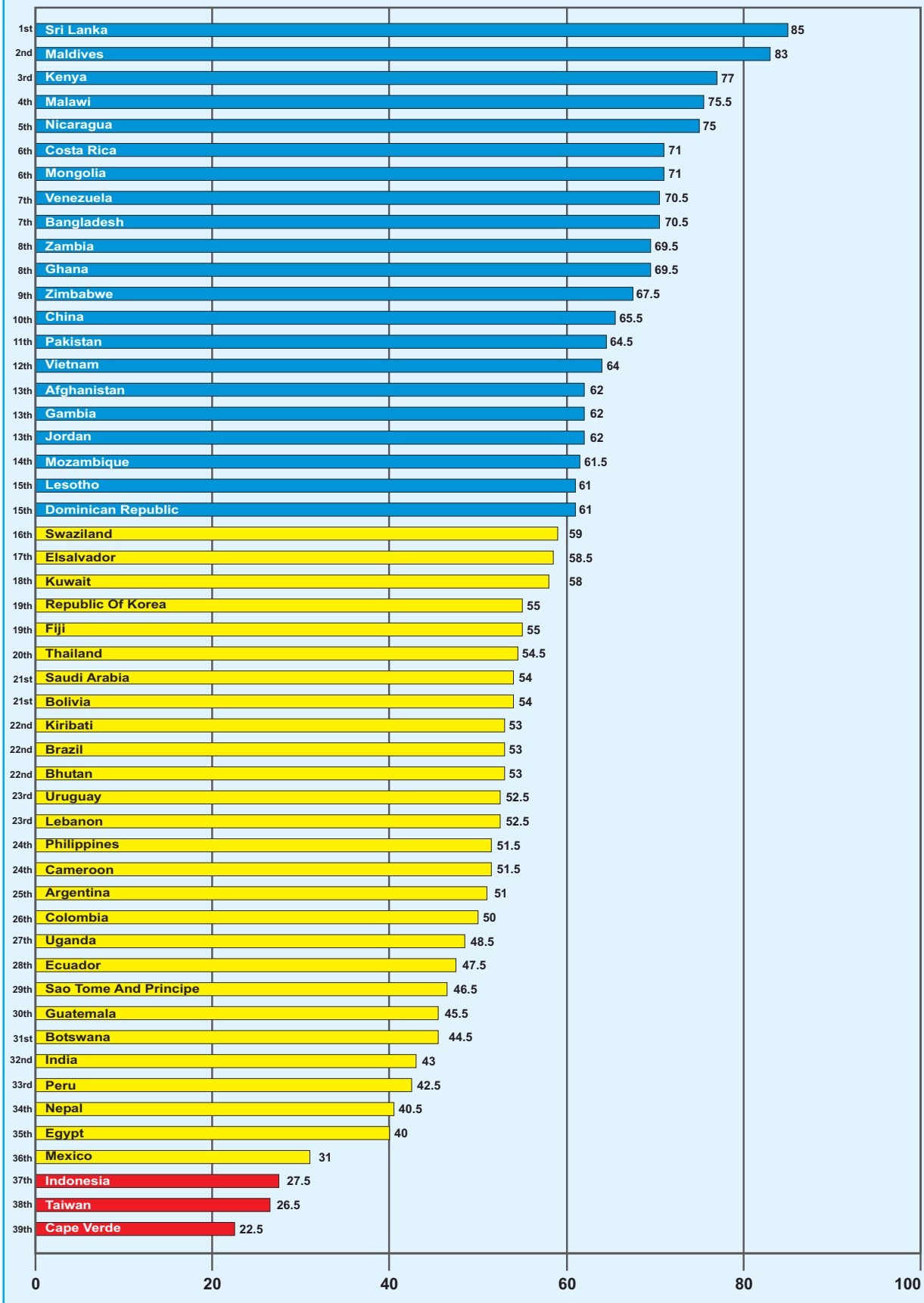
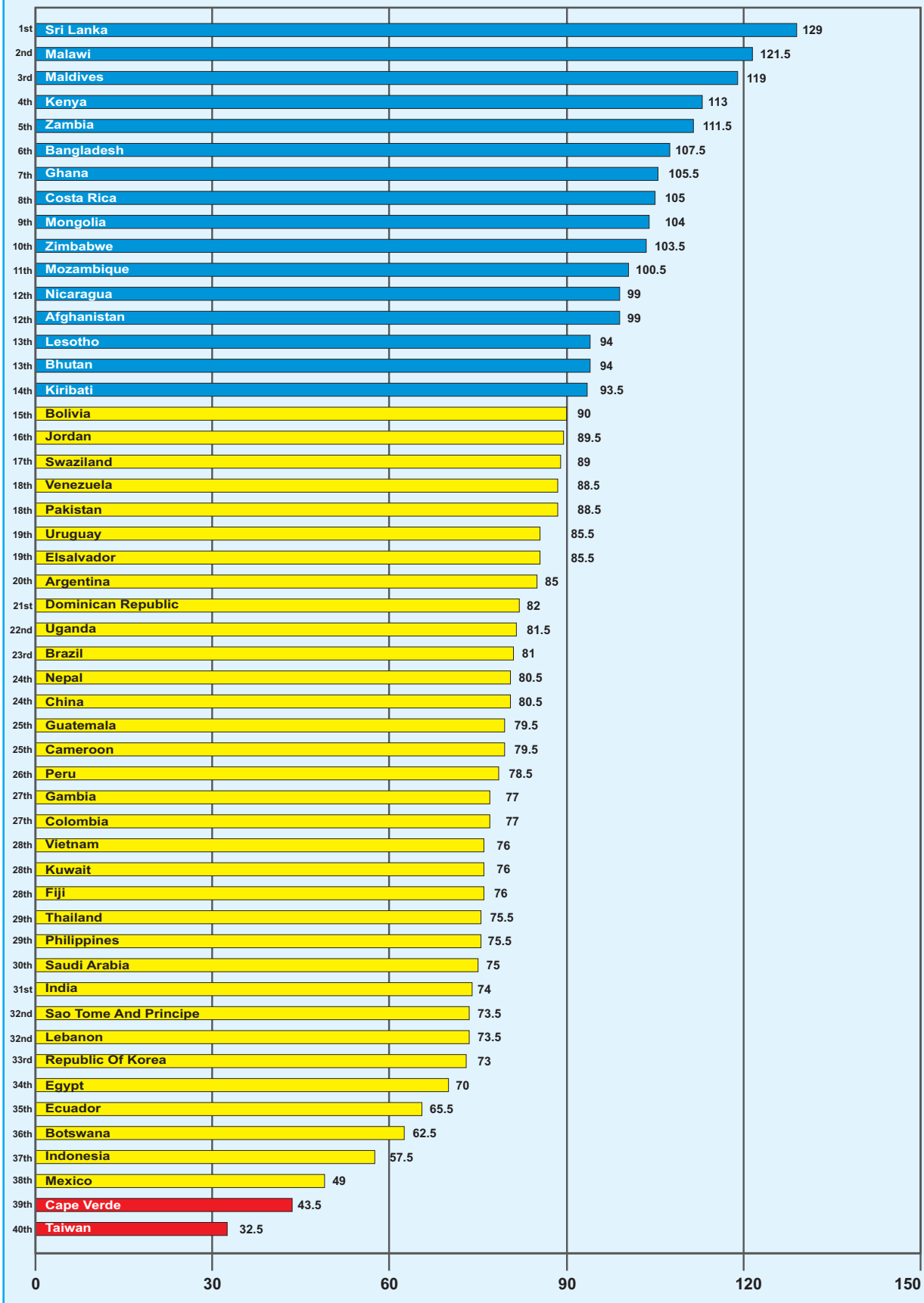


Fig. 5: The State of Breastfeeding in 51 Countries measured on a scale of 150



Glaring Gaps

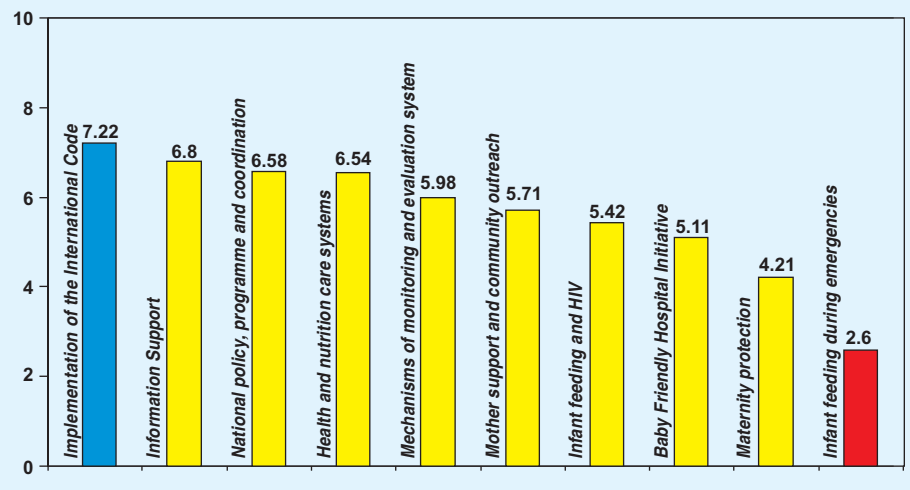
The key findings in the 10 areas of policy and programmes

Fig.6 shows the average score for each indicator out of 10 along with colour coding. Most indicators are in yellow, except for Implementation of the International Code, which is in blue, and Infant Feeding during Emergencies, which is in red. The averages score ranges from 2.56 for Infant Feeding during Emergencies to 7.21 for Implementation of the International Code.

The gaps are extremely significant and are found in almost all the countries and on all indicators from 1 to 10. The following are the key gaps we noted:

- Lack of budgets for implementing policy and programmes
- Lack of inter-sectoral coordination, which leads to ad-hoc actions.
- Inadequate attention in health facilities, like on BFHI
- Weak implementation of the International Code
- Women in the unorganized and informal sector are neglected on maternity protection
- Health workers are inadequately trained in implementation of the International Code
- Community outreach of support to women to practice optimal IYCF is highly inadequate
- Women lack full information support on IYCF
- HIV and Infant Feeding is not integrated in IYCF policies and programmes.
- Infant Feeding during Emergencies in their Disaster policies or programmes are almost non-existent.
- Weak monitoring and evaluation.

Fig. 6: Average scores for indicators 1-10



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

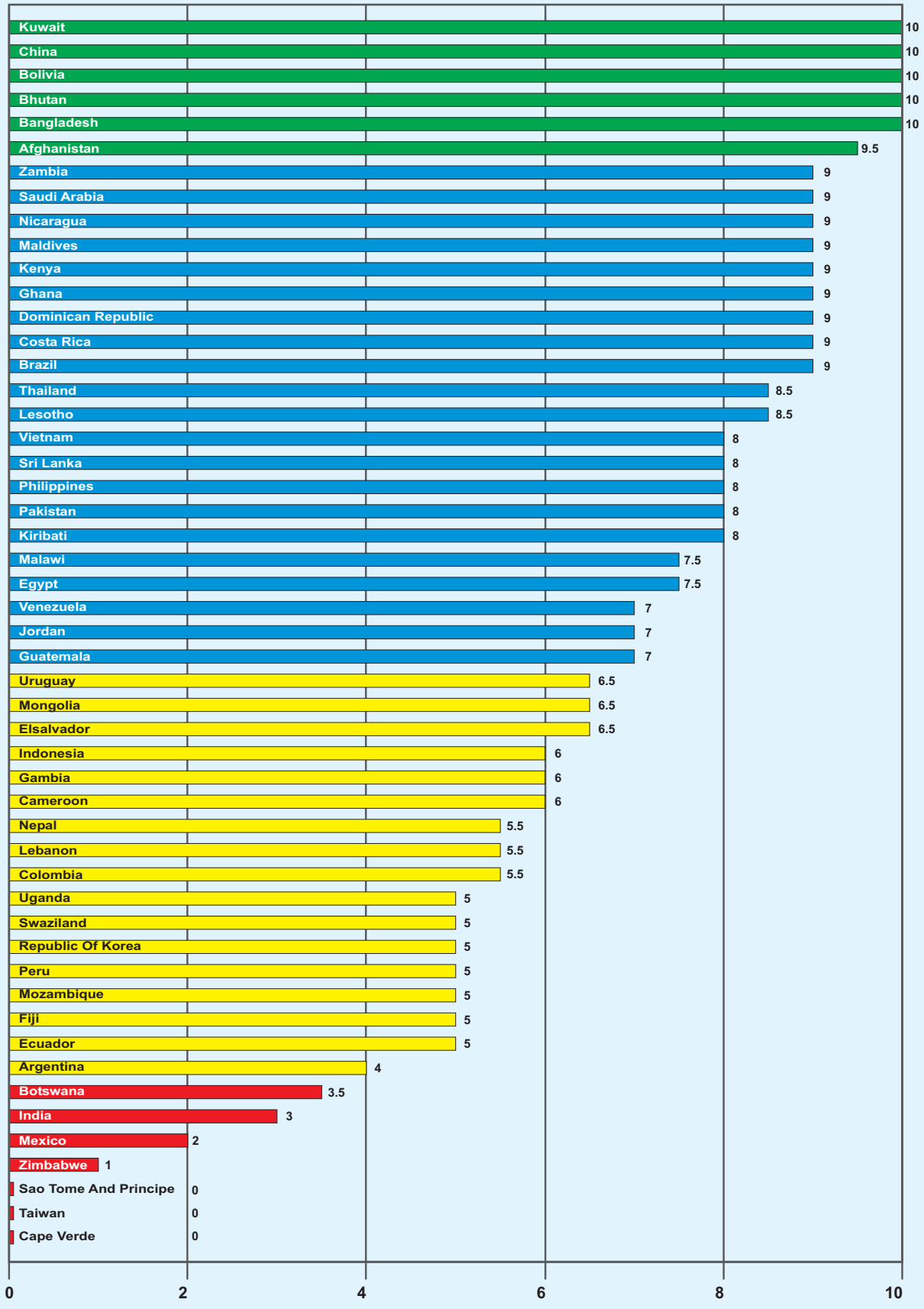
Table 6 gives the subset of questions for assessment and scoring of the indicator. The eight criteria 1.1 to 1.8 have scores ranging from 0.5 to 2 and the total score is calculated by adding the scores for the eight criteria.

Fig. 7 provides a graph of 51 countries based on colour coding on a scale of 10.

Table 6: 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 developed with the policy	2
1.4	The plan is adequately funded	1
1.5	There is a National Breastfeeding 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	Breastfeeding Committee is headed by a coordinator with clear terms of reference	0.5
	Total Score	**10**

Fig. 7: The State of National Policy, Programme and Coordination in 51 Countries on a Scale of Ten (10)



The average score for this indicator is 6.58, with Bangladesh, Bhutan, Bolivia, China, and Kuwait scoring a full 10 points each. They are in the green level together with Afghanistan, with a score of 9.5. The red level has seven countries, with Cape Verde, Sao Tome & Principe and Taiwan scoring zero each. There are 21 countries in the blue level, and 17 in the yellow level.


Photo Credit: IBFAN Uganda

Detailed Findings

Table 7 gives the details of scoring on each of the sub set of indicators for all the 51 countries, providing extensive information on where the gaps are.

A look at the scoring for the sub set of questions for the indicator (see above table) clearly spells the need for strengthening policies plans of action and implementation of optimal breastfeeding practices. Criterion 1.1 indicates that nine of the 51 countries do not have a written national policy on infant and young child feeding; these are Botswana, Cape Verde, Columbia, India, Mongolia, Mozambique, Sao Tome & Principe, Taiwan and Zimbabwe. The scores for criterion 1.3 show that of those who have a policy, Argentina, Ecuador, El Salvador, Guatemala, Lebanon, Mexico, Nepal, Peru, Uganda, Uruguay , Sri Lanka and Venezuela - do not have a national plan of action. Only 14 countries have set aside a budget for implementing IYCF policies: Afghanistan, Bangladesh, Bhutan, Bolivia, China, Fiji, Jordan, Korea, Kuwait, Maldives, Nicaragua, Sri Lanka, Thailand and Vietnam. Criteria 1.5 and 1.6 show that while 38 countries have National Breastfeeding Committees, but this body meets regularly only in 23 of them.

It is evident from the assessment that there is a vital need for countries to develop policies, translate them into action plans with adequate budgets and coordinate action through a specific body such as the National Breastfeeding/IYCF committee in order to enhance optimal IYCF rates.

Key Finding

Weak coordination and lack of well defined or dedicated budgets for action on breastfeeding and infant and young child feeding is a major gap, and makes it an opportunity to accelerate action to scale up interventions in this area.

Only 14 countries out of 51 - Afghanistan, Bangladesh, Bhutan, Bolivia, China, Fiji, Jordan, Korea, Kuwait, Maldives, Nicaragua, Sri Lanka, Thailand and Vietnam - have a budget for implementing IYCF policies.

Key Recommendation

Develop a comprehensive, cross-sectoral, multi-level IYCF policy with a plan of action and a timeline. Budget the policy and raise resources for its implementation. Appoint a coordinating body with representation from all involved sectors to oversee its comprehensive implementation.

Table 7: Country Scores for Each Criteria on National Policy, Programme and Coordination

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	9.5	2	2	2	1	1	1	0.5	0
Argentina	4	2	2	0	0	0	0	0	0
Bangladesh	10	2	2	2	1	1	1	0.5	0.5
Bhutan	10	2	2	2	1	1	1	0.5	0.5
Bolivia	10	2	2	2	1	1	1	0.5	0.5
Botswana	3.5	0	2	0	0	1	0	0	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
Cameroon	6	2	2	2	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	9	2	2	2	0	1	1	0.5	0.5
Dominican Republic	9	2	2	2	0	1	1	0.5	0.5
Ecuador	5	2	2	0	0	1	0	0	0
El Salvador	6.5	2	2	0	0	1	1	0.5	0
Egypt	7.5	2	2	2	0	1	0	0	0.5
Fiji	5	2	0	2	1	0	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
Guatemala	7	2	2	0	0	1	1	0.5	0.5
India	3	0	0	0	0	1	1	0.5	0.5
Indonesia	6	2	2	2	0	0	0	0	0
Jordon	7	2	2	2	1	0	0	0	0
Kenya	9	2	2	2	0	1	1	0.5	0.5
Kiribati	8	2	2	2	0	1	0	0.5	0.5
Korea	5	2	0	2	1	0	0	0	0
Kuwait	10	2	2	2	1	1	1	0.5	0.5
Lebanon	5.5	2	2	0	0	1	0	0	0.5
Lesotho	8.5	2	2	2	0	1	1	0	0.5
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
Saudi Arabia	9	2	2	2		1	1	0.5	0.5
Sao Tome & Pincipe	0	0	0	0	0	0	0	0	0
Sri Lanka	8	2	2	0	1	1	1	0.5	0.5
Swaziland	5	2	2	0	0	1	0	0	0
Taiwan	0	0	0	0	0	0	0	0	0
Thailand	8.5	2	2	2	1	1	0	0.5	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
Venezuela	7	2	2	0	0	1	1	0.5	0.5
Vietnam	8	2	2	2	1	0	1	0	0
Zambia	9	2	2	2	0	1	1	0.5	0.5
Zimbabwe	1	0	0	0	0	1	0	0	0

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

UNICEF and WHO launched BFHI in 1991, with the aim of centering support for breastfeeding in all activities in hospitals and health facilities. To qualify for being designated as 'baby friendly', a facility needs to implement all "The Ten Steps to Successful Breastfeeding" - training of all staff working in the maternity and child care sections to provide skilled support for early initiation and exclusive breastfeeding and strict implementation of the International Code of Marketing of Breastmilk substitutes, whereby the facility cannot accept free or low-cost breastmilk substitutes, feeding bottles or teats. The 10th step of BFHI also includes 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.

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 8A, 8B and 8C. Table 8A is quantitative and the maximum score possible is 4. Tables 8B and 8C are qualitative, with the latter having a further five criteria. The maximum scores for 8B and 8C 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

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

Table 8A: 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 8B: 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% or more	3.5
Maximum Score	**3.5**

Table 8C: To find out the quality of BFHI program implementation, though 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**

Findings

Fig. 8 provides a graph of 51 countries based on colour coding on a scale of 10.

Average score for this indicator is 5, with only 1 countries in the green level - Philippines getting a full score of 10. 17 countries are in the red level with five getting a score of zero Sao Tome & Principe, Mozambique, Indonesia, Egypt and Cameroon. There are 16 countries in the yellow level and 17 in the blue level.

Table 9 gives the scores the countries received for the indicator and its subsets.

BFHI is a particularly important initiative as it promotes timely initiation of breastfeeding, an intervention that can save up to 30% of neonatal deaths in developing countries, if universalized. As Table 4 shows, the Baby Friendly Hospital Initiative has not yet become fully integrated into the health system in almost all the countries, except for Fiji , China and Philippines. According to the national report, on 10 August 2009, it was announced that Fiji had become the first country in the Asia-Pacific region to have all of its 21 subdivisional hospitals designated Baby-Friendly by UNICEF. A schedule is also in place for re-assessments. The table also shows the inadequacy of training of the staff of the health facility. More than half the countries do not have a reassessment strategy, and even fewer have a time-bound strategy to increase the number of BFHI facilities.

Key Finding

Of the 51 countries, only China, Fiji and Philippines has all its government hospitals accredited as Baby Friendly. Lack of interest in this intervention is a major problem for which solutions must be found.

Key Recommendation

Health care support to breastfeeding mothers is an area that needs utmost attention. Whether it is rejuvenation of BFHI with a timeline to cover all hospitals or new ways of provision of such a support have to be found like having breastfeeding and infant and young child feeding Counselling centers managed by skilled and adequately trained workers. It would be therefore be critical to ensure that adequate human and financial resources are available for this action.

Fig. 8: The State of BFHI in 51 Countries on a Scale of Ten (10)

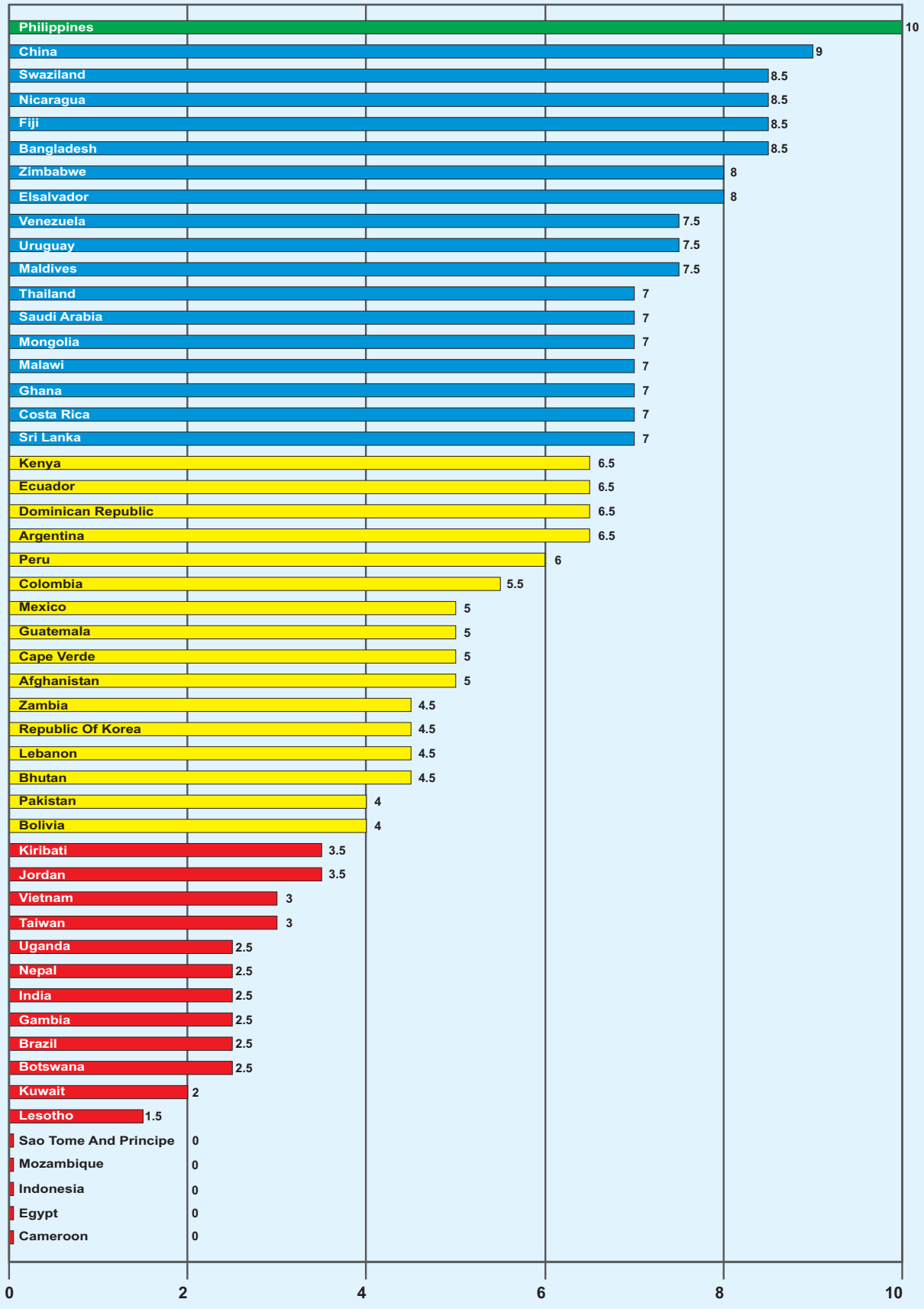


Table 9: Scores for sub set for Indicator on BFHI

Country	Total score out of 10	Indicators						
		2.1	*2.2*	*2.3*	*2.4*	*2.5*	*2.6*	*2.7*
Afghanistan	5	2	1.5	0.5	0	0.5	0	0.5
Argentina	6.5	1	3.5	0.5	0.5	0.5	0.5	0
Bangladesh	8.5	3	3.5	0.5	0	0.5	0.5	0.5
Bhutan	4.5	2	1.5	0.5	0	0	0	0.5
Botswana	2.5	0	0	0.5	0.5	0.5	0.5	0.5
Bolivia	4	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	2	1	0.5	0.5	0.5	0.5	0
Cameroon	0	0	0	0	0	0	0	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	2	3.5	0.5	0	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
El Salvador	8	3	3.5	0.5	0.5	0.5	0	0
Egypt	0	0	0	0	0	0	0	0
Fiji	8.5	4	2.5	0.5	0.5	0.5	0.5	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
Guatemala	5	2	1.5	0.5	0	0.5	0	0.5
India	2.5	2	0	0	0	0.5	0	0
Indonesia	0	0	0	0	0	0	0	0
Jordon	3.5	1	1	0.5	0.5	0.5	0	0
Kenya	6.5	1	3.5	0.5	0.5	0.5	0.5	0
Kiribati	3.5	1	1	0.5	0.5	0.5	0	0
Korea	4.5	2	1.5	0.5	0.5	0	0	0
Kuwait	2	0	0	0.5	0.5	0.5	0	0.5
Lebanon	4.5	2	1	0.5	0.5	0.5	0	0
Lesotho	1.5	0	0	0.5	0.5	0.5	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
Saudi Arabia	7	1	3.5	0.5	0.5	0.5	0.5	0.5
Sao Tome & Principe	0	0	0	0	0	0	0	0
Sri Lanka	7	3	2.5	0.5	0.5	0	0	0.5
Swaziland	8.5	3	3.5	0.5	0	0.5	0.5	0.5
Taiwan	3	2	0	0.5	0	0.5	0	0
Thailand	7	3	1.5	0.5	0.5	0.5	0.5	0.5
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
Venezuela	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
Zimbabwe	8	2	3.5	0.5	0.5	0.5	0.5	0.5

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

The increasing concern in the 60s and 70s about the aggressive marketing strategies and tactics of baby milk manufacturers, especially in the light of high rates of infant mortality in developing countries, as well as the decline of breastfeeding, led to the development of the International Code of Marketing of Breastmilk Substitutes (referred to as the Code). The Code was adopted by the 34th World Health Assembly in May 1981, with 118 votes in favour to 1 against and 3 abstentions. The Code aims 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.
One important element of this indicator which is critical is implementation and enforcement of the Code.

Subset for the indicator and scoring

Table 10 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.

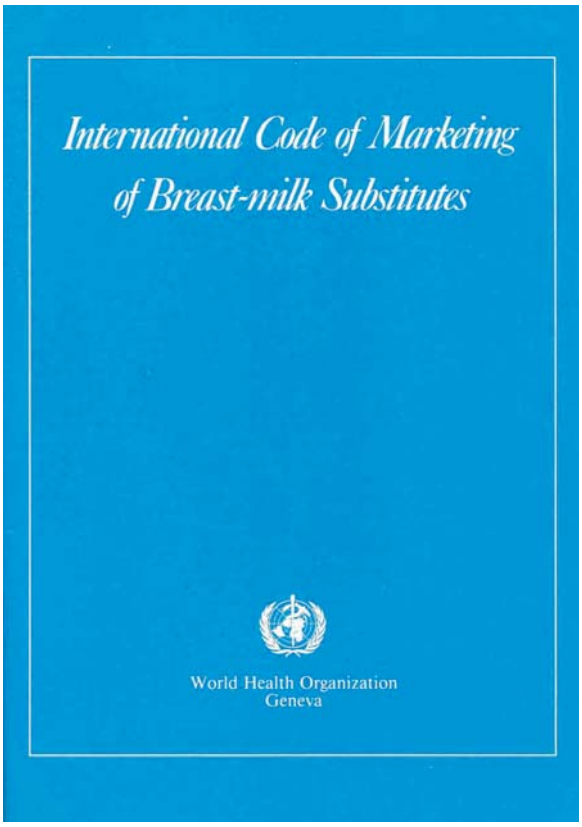
Table 10: Subset Question for the Indicator and Scoring for each Criteria

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**

Detailed Findings

Fig. 9 provides a graph of 51 countries based on colour coding on a scale of 10.

This indicator has received the highest average score 7.22, with 7 countries Brazil, , Dominican Republic, Gambia, Ghana, Malawi, Mongolia and Zimbabwe getting a full score of 10 each and being in the green level. Lesotho and Indonesia are in the red level, both with a score of 2. Eleven countries are in the yellow level - Swaziland,



Sao Tome & Principe, Kenya, Bhutan, Taiwan, Kiribati, El Salvador, China, Uruguay, Kuwait and Egypt; the rest are in the blue level. The reason for highest score could be presence of IBFAN people in these countries who pushed it hard and persistently.

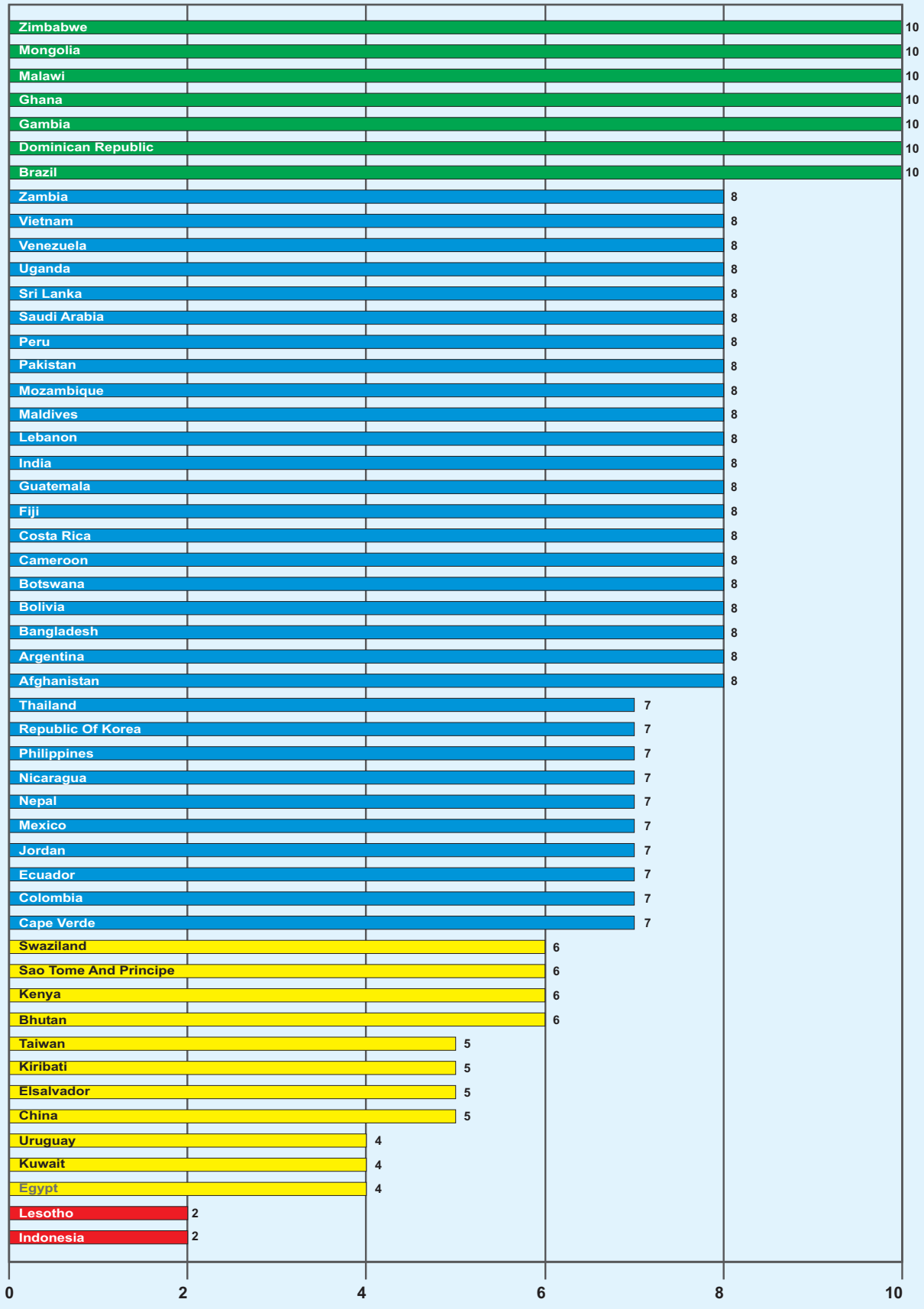
Key finding

Of 51 countries, Brazil, Dominican Republic, Gambia, Ghana, Malawi, Mongolia and Zimbabwe have legislated all articles of the International Code and are implementing it according to the scores available. It is however noted that many countries are not implementing the Code well on the ground in spite of the fact they have legislated, and manufacturers are using all possible means to bypass it and aggressively market the products.

Key Recommendation

Legislate the International Code and all relevant subsequent WHA resolutions and stringently implement it. Raise public awareness on the Code/national legislation and train code monitors to take note of violations for further action.

Fig. 9: The State of Implementation of the International Code in 51 Countries on a Scale of Ten (10)



4. Maternity Protection

Photo Credit: WABA

In order to practice IYCF, especially breastfeeding optimally, maternity protection is vital. Exclusive breastfeeding in particular requires that a woman be in close proximity to her baby, so that she can breastfeed on demand. Adequate maternity protection enables the woman to combine her productive role effectively with optimal feeding practices for her baby. Recognizing 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 providing such protection to women working in the organized 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 women working in the informal sector.

Subset for the Indicator and scoring

Table 11 gives the 12 criteria for assessing the indicator, and scores range from 0.5 to 2.

Table 11: 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 b. 14 to 17 weeks c. 18 to 25 weeks d. 26 weeks or more	 0.5 1 1.5 2
4.2	Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily. a. Unpaid break b. Paid break	 0.5 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: a. accorded some protective measures b. accorded the same protection as women working in the formal sector	 0.5 1
4.6	a. Information about maternity protection laws, regulations, or policies is made available to workers b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.'	0.5 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**

Findings

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

Maternity Protection, with the second lowest average score of 4.42 showing the relative neglect of this area of support to women . No country in the green level. Only eight countries, headed by Venezuela at 9, and including Mongolia, Costa Rica, Nicaragua, Sri Lanka, Brazil, and Republic of Korea, are in the blue level. Thailand has the lowest score of 0.5 and is in the red level with Botswana, Cape Verde, Egypt, El Salvador, Fiji, Gambia, Ghana, Guatemala, Indonesia, Kuwait, Lebanon, Lesotho, Malawi, Mexico, Mozambique, Nepal, Pakistan, Sao Tome & Principe, Philippines, Swaziland, Uganda and Zambia. Twenty one countries are in the yellow level.

The table 12 shows clearly how inadequately women are supported to breastfeed and practice optimal IYCF. There is increasing evidence that women tend to breastfeed for longer duration with longer maternity leave. However, of the 51 countries assessed, 37 provide maternity leave of less than 14 weeks; only six countries Bangladesh, Bolivia, Sri Lanka, Nicaragua, Venezuela and Mongolia provide maternity leave

of 18 weeks or more, with the last three providing at least 26 weeks, enabling women to carry out exclusive breastfeeding.

While most countries offer at least one paid nursing break during work hours as indicated by the scores received for criteria 4.2, 10 countries offer no breaks at all. 21 countries offer paternity leave of three days in public sector and 17 countries both in public sector and private sector.

Criterion 4.5 shows that only eight countries offer women in the informal or un-organised sector the same level of protection as those offered in the formal sector, while 11 offer some measure of protection; the rest of the countries offer no protection to women working in the unorganized sector. An ILO Report, Women in labour markets: Measuring progress and identifying challenges, published in March 2010, informs that between 1980 and 2008, the rate of female labour force participation increased from 50.2% to 51.7%.

However, the report adds that in the world's poorest regions, over 50% of the women work in vulnerable employment, characterized by low pay, long hours of work and informal working arrangements.

With the increasing feminization of labour, countries need to strengthen maternity protection, especially for women working in the unorganized sector, and provide support services like crèches if rates of optimal IYCF have to increase.

Key finding

Level of support to women is minimal, and only 8 countries out of 51 Afghanistan, Cameroon, Costa Rica, Kiribati, Maldives, Mongolia, Zambia and Zimbabwe - offer women in the unorganized and informal sector the same level of maternity protection as the formal sector. Not all countries or sectors provide at least 6 months of maternity leave.

Key Recommendation

Extend maternity leave to six months to enable exclusive breastfeeding. Extend maternity protection to women working in the informal/unorganized sector and raise adequate resources for this. Ensure workplaces are made baby-friendly.

Fig. 10: The State of Maternity Protection in 51 Countries on a Scale of Ten (10)

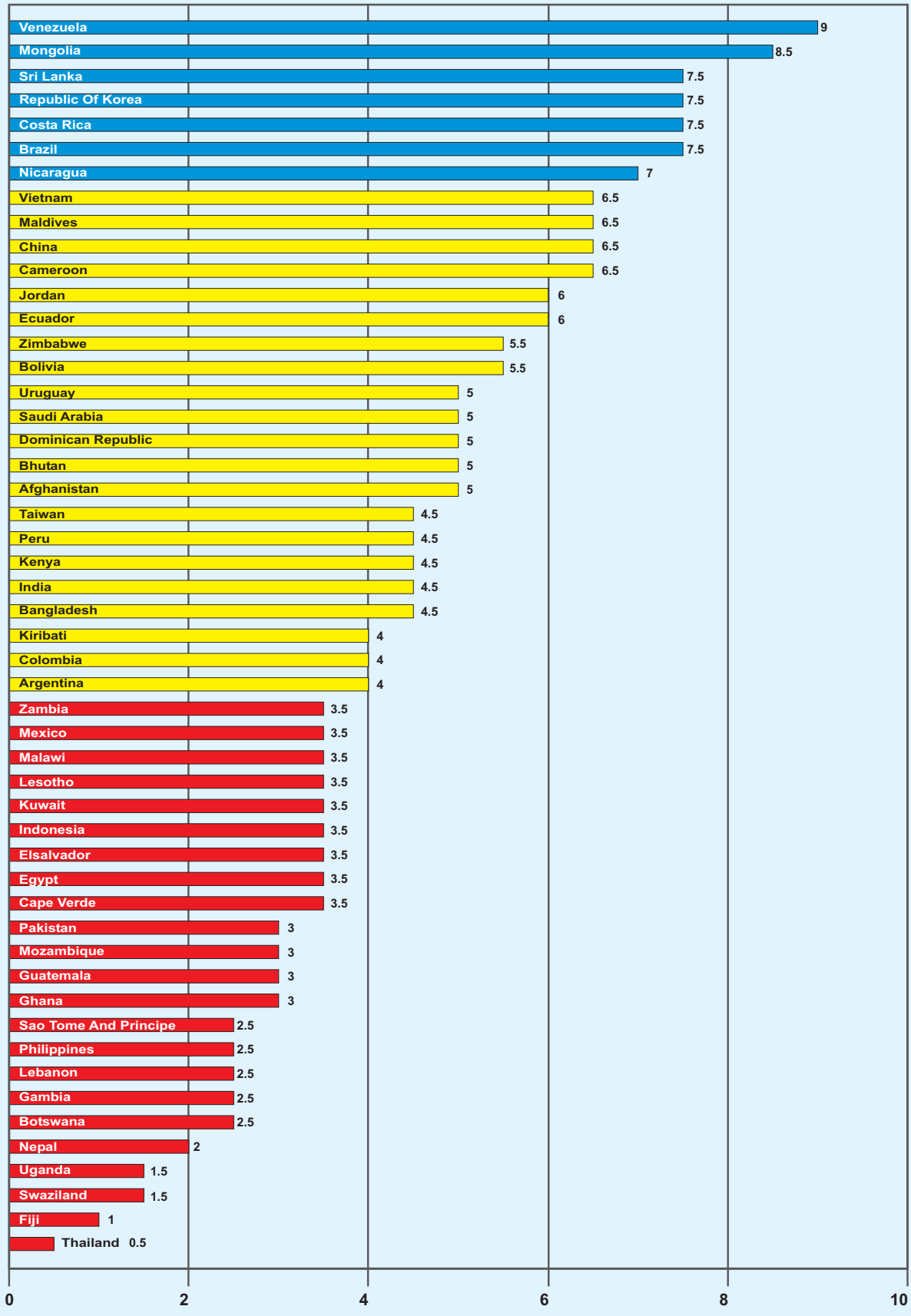


Table 12: Scores for sub set for Indicator on Maternity Protection

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	5	0.5	1	0	1	1	0.5	0.5	0	0	0	0.5	0	0
Argentina	4	0.5	1	0	1	0	0.5	0	0	0	0.5	0.5	0	0
Bangladesh	4.5	1.5	1	0	1	0	0.5	0	0	0.5	0	0	0	0
Bhutan	5	0.5	1	1	0	0	0.5	0	0.5	0.5	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
Botswana	2.5	0.5	1	0	0	0	0.5	0.5	0	0	0	0	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
Cameroon	6.5	1	1	1	0	1	0	0	0.5	0.5	0	0.5	0.5	0.5
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	7.5	1	1	1	1	1	0.5	0.5	0	0	0	0.5	0.5	0.5
Dominican Republic	5	0.5	1	1	1	0	0.5	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
El Salvador	3.5	0.5	1	0	1	0	0	0.5	0	0	0	0	0	0.5
Egypt	3.5	0.5	1	0	1	0	0	0	0.5	0.5	0	0	0	0
Fiji	1	0.5	0	0	0	0	0	0	0	0	0	0.5	0	0
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
Guatemala	3	0.5	0	0	1	0	0.5	0	0	0	0.5	0.5	0	0
India	4.5	0.5	1	0	1	0.5	0	0	0.5	0.5	0	0.5	0	0
Indonesia	3.5	0.5	1	0	1	0	0.5	0	0	0	0	0.5	0	0
Jordon	6	0.5	1	1	1	0.5	0.5	0	0	0	0.5	0.5	0.5	0
Kenya	4.5	0.5	0	0	1	0	0.5	0	0.5	0.5	0	0.5	0.5	0.5
Kiribati	4	0.5	1	0	0	1	0.5	0.5	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
Kuwait	3.5	0.5	1	0	0	0	0.5	0.5	0	0	0.5	0.5	0	0
Lebanon	2.5	0.5	0.5	0	0	0.5	0.5	0.5	0	0	0	0	0	0
Lesotho	3.5	1	1	0	0	0	0.5	0.5	0	0	0	0	0	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
Sao Tome & Principe	2.5	0.5	1	0	0	0	0.5	0	0.5	0	0	0	0	0
Saudi Arabia	5	0.5	1	0	1	0.5	0	0	0	0	0.5	0.5	0.5	0.5
Sri Lanka	7.5	1.5	1	1	1	0.5	0.5	0.5	0.5	0	0.5	0.5	0	0
Swaziland	1.5	0.5	1	0	0	0	0	0	0	0	0	0	0	0
Taiwan	4.5	0.5	1	0	0	0.5	0.5	0	0.5	0.5	0.5	0.5	0	0
Thailand	0.5	0.5	0	0	0	0	0	0	0	0	0	0	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
Venezuela	9	2	1	1	1	0.5	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
Zimbabwe	5.5	1	1	1	0	1	0.5	0.5	0	0	0	0.5	0	0

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

An important contributor to low breastfeeding and complementary feeding rates is the absence of adequate support to IYCF in the health services. Worldwide, infant and young child feeding is not fully integrated in the base training of health and nutrition providers. Successful breastfeeding in particular is dependent upon a complex set of dynamics and health and nutrition workers at almost all levels of the system often lack both the knowledge and the skills to provide effective counseling. They are also often ignorant about their responsibilities to the Code. It is therefore necessary to invest in improvement of the IYCF component in both pre-service and in-service training of these providers.

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

Findings

Fig. 11 provides colour coding and a graph of the score of this indicator on a scale of 10.

The average score for this indicator is 6.54, with four countries - Colombia, Lesotho, Maldives and Mozambique are in the green level, Mozambique scoring a full 10. Cape Verde and Thailand are in the red level, with Cape Verde getting a score of zero. Afghanistan, Argentina, Dominican

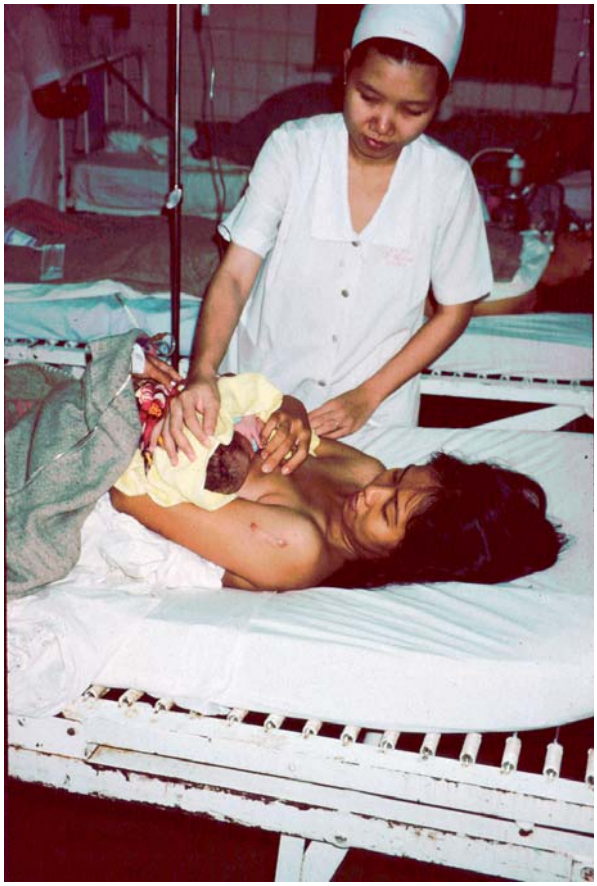


Photo Credit: WABA

Republic, El Salvador, Fiji, Ghana, Jordon, Kenya, Kiribati, Korea, Kuwait, Malawi, Mongolia, Nicaragua, Sao Tome & Principe, Sri Lanka, Swaziland, Venezuela, Vietnam, Zambia, Zimbabwe are in blue, while the rest of the countries are in the yellow level.

The table 14 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 many countries. Scores for criterion 5.4 show that most countries do not provide adequate information to health and nutrition workers about the International Code. Again, criterion 5.5 informs that while some countries

Table 13: 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.

give adequate information about HIV/AIDS and Infant Feeding to their workers, many do not.

In this criteria subjective element is there, but the local core group decides based on their best understanding of available facts. With increasing interest in the study of trends it would be possible to examine such indicators more closely and with quality.

Key finding

Very few countries have health workers are adequately trained in their role to support breastfeeding mothers as well as in implementation of the International Code.

Key Recommendation

Integrate IYCF, including the International Code, in pre-service and in-service training of health and nutrition workers at all levels of the health and nutrition system.

Fig. 11: The State of Health and Nutrition Care Systems in 51 Countries on a Scale of Ten (10)

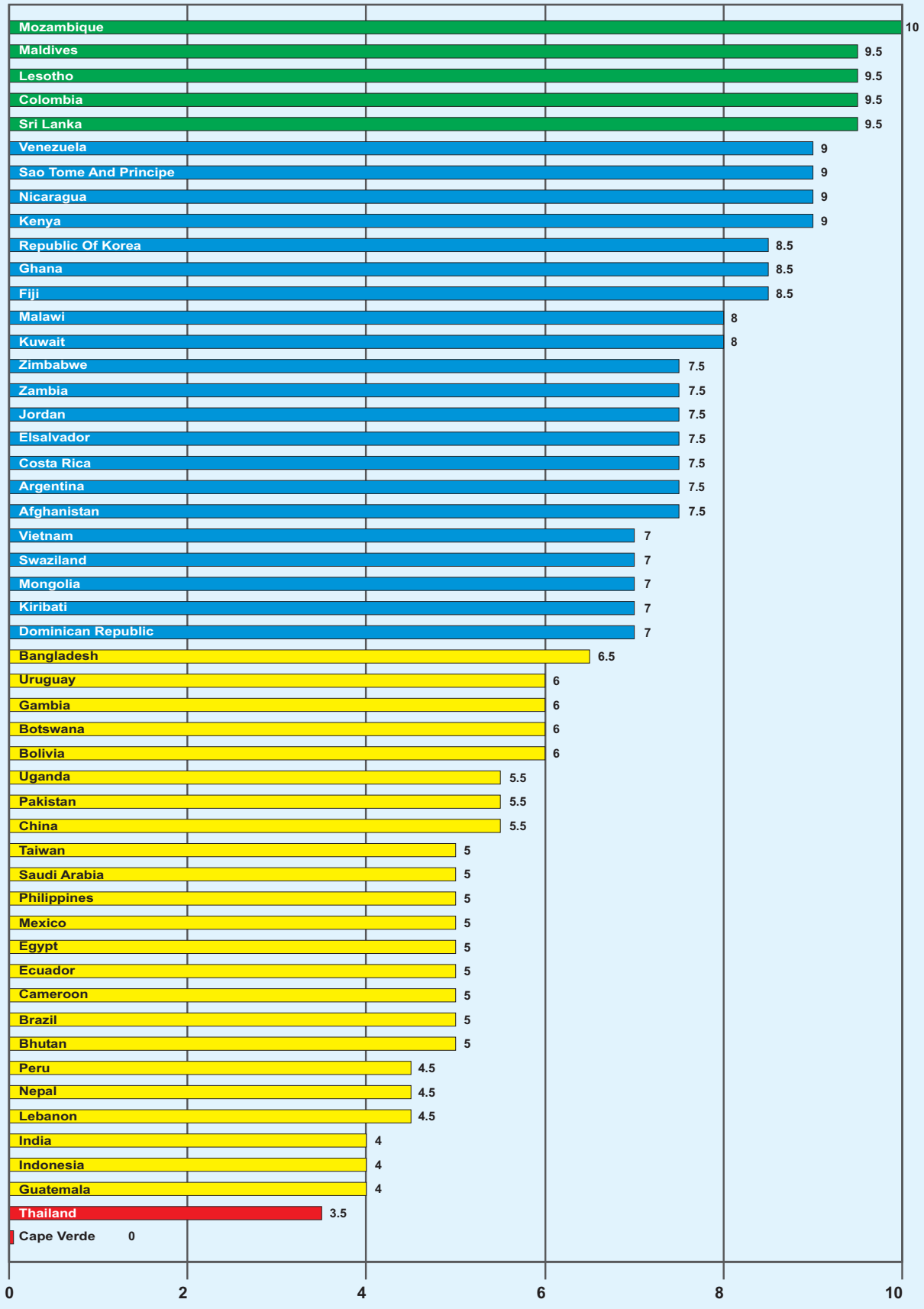


Table 14: Scores for sub set for Indicator on Health and Nutrition Care

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	7.5	0	2	2	0.5	1	1	1
Argentina	7.5	1	2	2	0.5	1	1	0
Bangladesh	6.5	2	1	1	0	1	0.5	1
Bhutan	5	1	0	2	0	0	1	1
Bolivia	6	1	1	2	0.5	0.5	1	0
Botswana	6	0	1	2	0.5	1	0.5	1
Brazil	5	0	1	1	0.5	1	0.5	1
Cape Verde	0	0	0	0	0	0	0	0
Cameroon	5	0	0	2	0.5	1	0.5	1
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	7.5	1	2	2	0.5	0.5	0.5	1
Dominican Republic	7	1	2	2	0.5	1	0.5	0
Ecuador	5	1	1	1	0	1	0.5	0.5
El Salvador	7.5	1	1	2	0.5	1	1	1
Egypt	5	0	1	2	0	1	1	0
Fiji	8.5	1	2	2	0.5	1	1	1
Gambia	6	1	0	2	1	1	1	0
Ghana	8.5	2	1	2	0.5	1	1	1
Guatemala	4	1	0	2	0	1	0	0
India	4	1	1	1	0	0.5	0.5	0
Indonesia	4	1	1	1	0	0.5	0.5	0
Jordon	7.5	1	2	2	0.5	1	0.5	0.5
Kenya	9	1	2	2	1	1	1	1
Kiribati	7	2	1	2	0	1	1	0
Korea	8.5	2	1	2	1	0.5	1	1
Kuwait	8	1	1	2	1	1	1	1
Lebanon	4.5	1	1	1	0.5	0.5	0.5	0
Lesotho	9.5	2	2	2	0.5	1	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
Sao Tome & Principe	9	2	2	2	1	0.5	1	0.5
Saudi Arabia	5	1	1	1	0.5	0.5	0.5	0.5
Sri Lanka	9.5	2	2	2	1	1	0.5	1
Swaziland	7	1	0	2	1	1	1	1
Taiwan	5	1	1	1	0.5	0.5	0.5	0.5
Thailand	3.5	1	0	1	0.5	0	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
Venezuela	9	1	2	2	1	1	1	1
Vietnam	7	1	1	2	0.5	1	0.5	1
Zambia	7.5	1	2	1	1	1	0.5	1
Zimbabwe	7.5	0	2	2	1	1	0.5	1

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

Women's feeding decisions are not taken and carried out in isolation. They are influenced by the family, in particular the decision-makers father, grandfather, grandmother, aunts, siblings, etc. and the community around them. Decisions regarding initiation of breastfeeding, giving of prelacteal feeds, exclusive breastfeeding, as well as when to start complementary foods and what is to be given, all are vulnerable to family and community pressures. Thus women require support at the community level, 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, and can take the form of Mother Support Groups, peer counselors, and so on. This is a critical extension to BFHI work.

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 15 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.

Table 15: 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**	

Findings

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

The average score for the indicator is 5.7. While no country is in the green level, 20 countries are in the blue level, with three countries - Sri Lanka and Maldives scoring 9 points each out of a possible ten. Cape Verde has the lowest score of zero for this indicator, and is in the red level, together with Philippines, Indonesia, Guatemala, Peru and Brazil. The remaining countries are in the yellow level.

A look at the table 16 informs clearly that community level support for women to practice optimal breastfeeding and IYCF practices is not adequate. In only 13 countries - Bhutan, China, Costa Rica, Egypt, Jordan, Kuwait, Lesotho, Maldives, Mongolia, Nicaragua, Sri Lanka, Swaziland, and Zambia - is adequate support available at birth, which is particularly important to establish timely initiation of breastfeeding and prevent the giving of prelacteal feeds. In only 7 countries Dominican Republic, El Salvador, Gambia, Malawi, Mozambique, Nicaragua and Pakistan are community workers given adequate training in information and counseling skills. No training is given to them in Cape Verde, Costa Rica, Egypt, Indonesia, Mexico, Philippines, and Saudi Arabia.

Making available community based support to the mother, giving her access in the community itself to right information and counseling if and when she needs it, is vital to enhancing optimal IYCF practices. It is evident that much more attention needs to be paid by countries to enhancing the counseling capacity of community workers for optimal IYCF practices.
Once again this indicator results are based on some subjective understanding.

Key Finding

Looking at the overall performance in community outreach of support to women to practice optimal IYCF is inadequate in majority of countries but is highly inadequate in Brazil, Cape Verde, Guatemala, Indonesia, Peru and Philippines.

Key Recommendation

Build community outreach into the IYCF policy. Make communities baby friendly by ensuring the provision of easy and universal access to skilled counseling and child-care services.

Fig. 12: The State of Mother Support and Community Outreach in 51 Countries on a Scale of Ten (10)

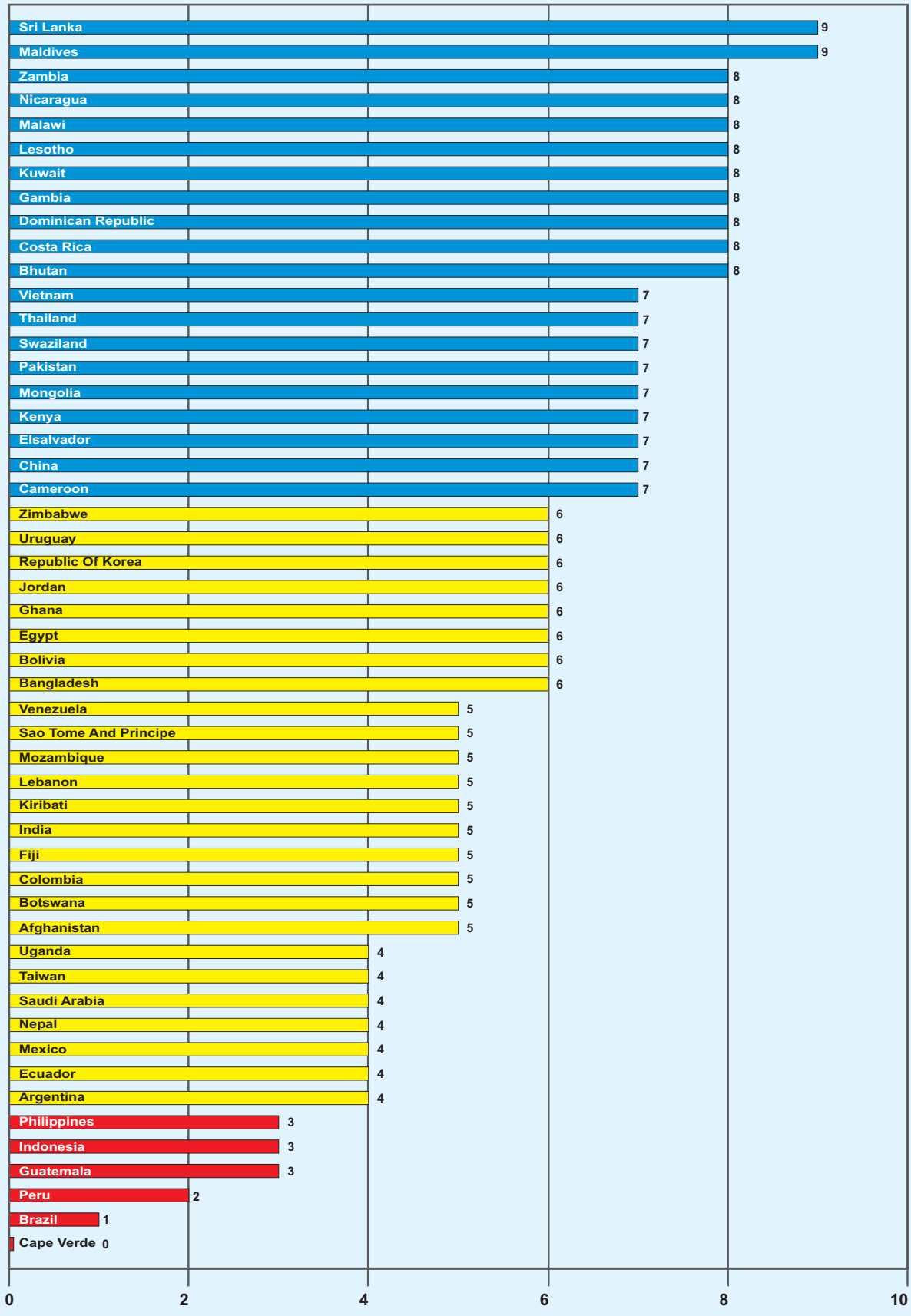


Table 16: Country scores for each criteria

Country	Total score of Indicator (out of 10)	Subset Scores				
		6.1	*6.2*	*6.3*	*6.4*	*6.5*
Afghanistan	5	1	1	1	1	1
Argentina	4	1	1	1	0	1
Bangladesh	6	2	1	2	0	1
Bhutan	8	1	2	2	2	1
Bolivia	6	1	1	1	2	1
Botswana	5	1	1	1	1	1
Brazil	1	0	0	0	0	1
Cape Verde	0	0	0	0	0	0
Cameroon	7	2	1	1	2	1
China	7	2	2	1	1	1
Colombia	5	1	1	1	1	1
Costa Rica	8	2	2	2	2	0
Dominican Republic	8	2	1	1	2	2
Ecuador	4	1	1	1	0	1
El Salvador	7	1	1	1	2	2
Egypt	6	0	2	2	2	0
Fiji	5	1	1	1	1	1
Gambia	8	1	1	2	2	2
Ghana	6	1	1	2	1	1
Guatemala	3	1	0	0	1	1
India	5	1	1	1	1	1
Indonesia	3	1	1	1	0	0
Jordon	6	1	2	1	1	1
Kenya	7	1	1	2	2	1
Kiribati	5	1	1	1	1	1
Korea	6	1	1	2	1	1
Kuwait	8	2	2	2	1	1
Lebanon	5	1	1	1	1	1
Lesotho	8	1	2	2	2	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
Sao Tome & Principe	5	1	1	1	1	1
Saudi Arabia	4	0	1	1	2	0
Sri Lanka	9	2	2	2	2	1
Swaziland	7	1	2	2	1	1
Taiwan	4	1	1	0	1	1
Thailand	7	1	1	2	2	1
Uganda	4	0	1	1	1	1
Uruguay	6	1	1	1	2	1
Venezuela	5	1	1	1	1	1
Vietnam	7	2	1	1	2	1
Zambia	8	1	2	2	2	1
Zimbabwe	6	1	1	2	1	1

7. Information Support

As for any other health and nutrition programme, Information, Education and Communication (IEC) aimed at behaviour change and the accuracy of such a communication is a key strategy for enhancing optimal breastfeeding practices. 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 becomes the vital factor in improving breastfeeding rates.. 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. This indicator examines the information made available or not, and if so, is it comprehensive and accurate.

Subset of this Indicator and scoring

Table 17 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.

Detailed Findings

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

The average score received for the Indicator is 6.8, with three countries - Kenya,, Malawi and Gambia - getting full scores and reaching the

Table 17: 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* 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**	

* 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).

green level. Mexico has the lowest score of 1, and is, together with Taiwan, Peru and Indonesia, in the red level. The majority of the countries 28 countries - are in the blue level, and 16 are in the yellow level.

The table 18 shows that only 15 of the 51 countries have a comprehensive IEC strategy for IYCF, while nine do not have any strategy; in the rest of the countries the national assessment teams found the strategy to be inadequate. The table clearly makes a point that how inadequate the information system is and all countries do communicate IYCF messages using various media, and that this generally is correct, based on national and international guidelines. However, the national assessment teams in almost all countries feel that IEC efforts need to be intensified.

Key finding

Only 3 out of 51 countries Gambia, Malawi, and Kenya offer women full information support on IYCF.

Key Recommendation

Develop a specific communication strategy for IYCF, which includes adequate and correct communication on International code, infant feeding in HIV, infant feeding in emergencies.

Fig. 13: The State of Information Support in 51 Countries on a Scale of Ten (10)

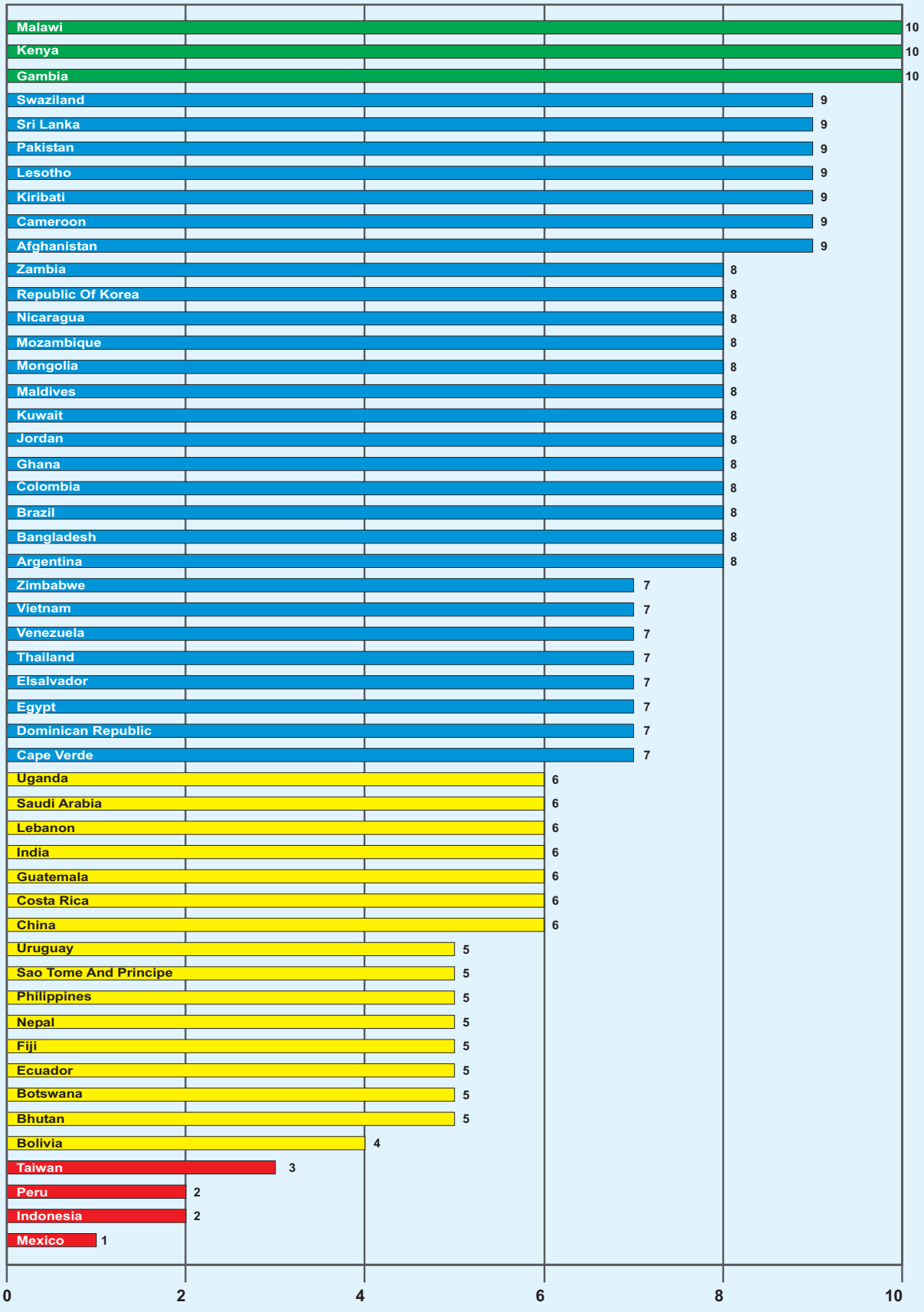


Table 18: Country scores for each criteria in Information Support

Country	Total score of Indicator (out of 10)	Subset Scores				
		7.1	*7.2*	*7.3*	*7.4*	*7.5*
Afghanistan	9	2	2	1	2	2
Argentina	8	2	2	1	2	1
Bangladesh	8	2	1	1	2	2
Bhutan	5	1	1	1	1	1
Bolivia	4	1	1	0	1	1
Botswana	5	0	1	1	2	1
Brazil	8	1	2	1	2	2
Cape Verde	7	1	1	1	2	2
Cameroon	9	1	2	2	2	2
China	6	1	1	2	1	1
Colombia	8	0	2	2	2	2
Costa Rica	6	1	2	0	2	1
Dominican Republic	7	1	2	0	2	2
Ecuador	5	1	1	0	2	1
El Salvador	7	1	2	2	1	1
Egypt	7	0	2	2	2	1
Fiji	5	1	1	1	1	1
Gambia	10	2	2	2	2	2
Ghana	8	1	1	2	2	2
Guatemala	6	2	1	1	2	0
India	6	0	1	1	2	2
Indonesia	2	0	0	0	2	0
Jordon	8	2	2	1	2	1
Kenya	10	2	2	2	2	2
Kiribati	9	2	2	1	2	2
Korea	8	1	2	1	2	2
Kuwait	8	1	2	1	2	2
Lebanon	6	1	2	1	1	1
Lesotho	9	2	2	2	2	1
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
Sao Tome & Principe	5	1	1	2	1	0
Saudi Arabia	6	1	1	1	2	1
Sri Lanka	9	2	2	2	2	1
Swaziland	9	1	2	2	2	2
Taiwan	3	0	1	1	1	0
Thailand	7	1	1	1	2	2
Uganda	6	1	1	1	2	1
Uruguay	5	0	2	1	2	0
Venezuela	7	1	2	1	2	1
Vietnam	7	2	1	1	2	1
Zambia	8	1	2	2	1	2
Zimbabwe	7	0	2	1	2	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.

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 recognizing 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 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 19 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. 14 provides colour coding and a graph of the score of this indicator on a scale of 10.

The average score of the 51 countries for this indicator is 5.42. The scores range from 10 for Sri Lanka to zero for Egypt, Saudi Arabia, Taiwan, Indonesia and Cape Verde. Twenty countries are in the blue level, 14 in the yellow level, and 16 are in the red level; in fact, amongst all indicators, this indicator has the second highest number of countries in the red level.

Table 20 gives each country's score on the subset of questions.

Twelve countries out of 51 have not included infant feeding and HIV in their IYCF policies; of the rest, 25 have included it adequately and the rest to some degree. Seven of the 10 countries with a score of 0 do not offer VCCT to pregnant women, and 16 offer it to some of the women. In countries where there is a policy, at least to some extent, the policy gives effect to the International Code in 21 countries, and to some extent in another 13 countries.

Though Indicator 10 does not have the lowest average score of all indicators, it is obvious that several countries need to do much more to prioritise action on this front to assist and support women with HIV/AIDS to make informed choices about feeding their infants. If

Table 19: 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**	

the country scores less than 5 out of 10 it simply means lot of attention is required in this area.

Key finding

Only Sri Lanka out of 51 countries has fully incorporate HIV and Infant Feeding in its IYCF policies and programmes.

Key Recommendation

Integrate HIV and infant feeding into the IYCF policy, IYCF training for all levels of health providers and IYCF communication strategy.

Fig. 14: The State of Infant Feeding and HIV in 51 Countries on a Scale of Ten (10)

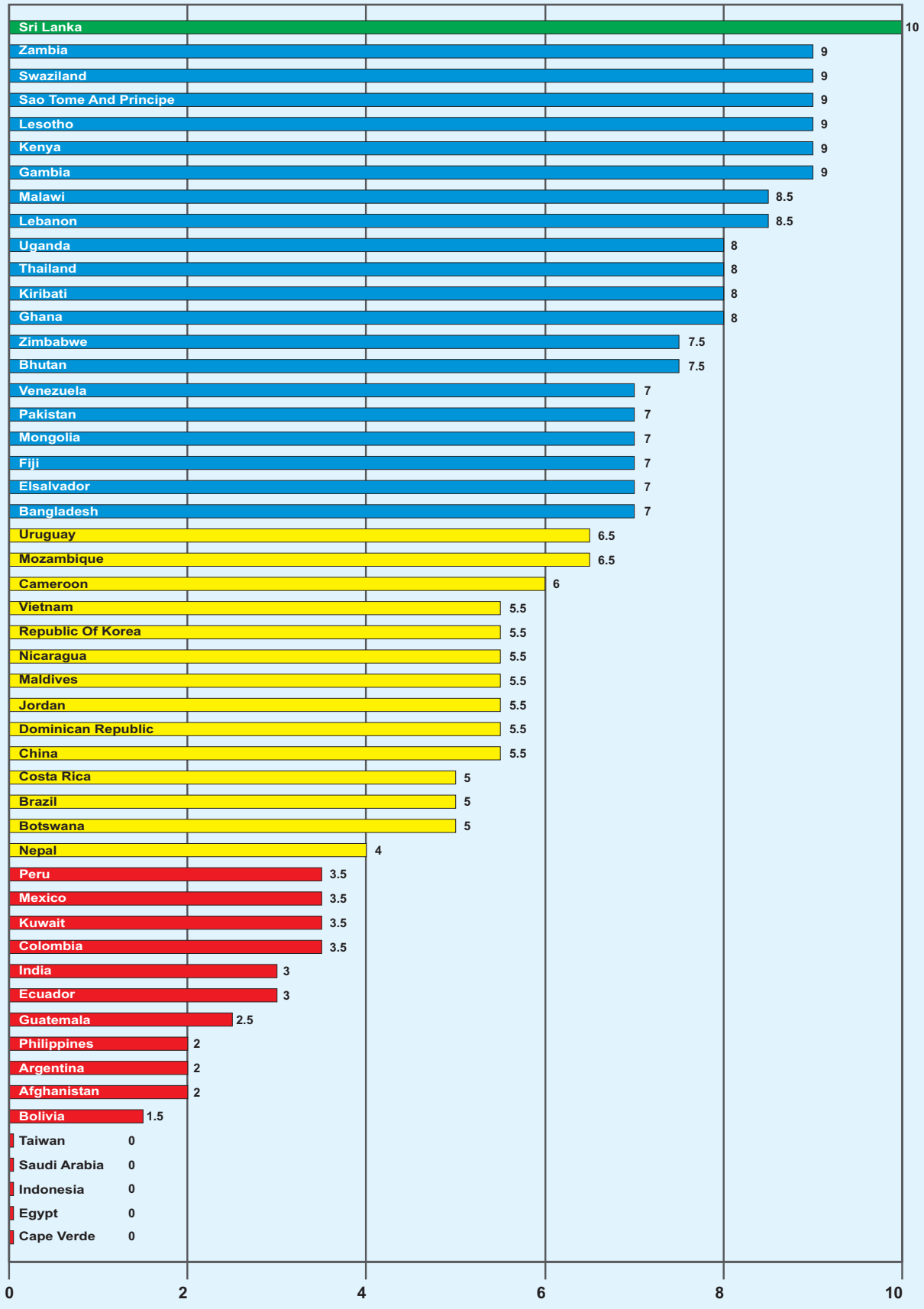


Table 20: Country scores for each criteria on Infant Feeding and HIV

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	2	0	0	0	0.5	0	0.5	0.5	0	0.5
Argentina	2	0	0	0	0.5	0	0	1	0.5	0
Bangladesh	7	2	1	1	0.5	1	1	0.5	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
Botswana	5	1	0.5	1	1	0.5	0.5	0	0	0.5
Brazil	5	1	1	1	1	0	0	0	0	1
Cape Verde	0	0	0	0	0	0	0	0	0	0
Cameroon	6	2	0.5	0.5	0.5	1	0.5	0.5	0.5	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	5	2	0	0.5	1	0.5	0	0	0	1
Dominican Republic	5.5	2	1	0	0.5	0	0	1	0	1
Ecuador	3	1	0.5	0.5	0.5	0.5	0	0	0	0
El Salvador	7	2	0.5	1	1	0.5	0.5	0	1	0.5
Egypt	0	0	0	0	0	0	0	0	0	0
Fiji	7	0	0	1	1	1	1	1	1	1
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
Guatemala	2.5	1	0.5	0	0	0.5	0	0.5	0	0
India	3	0	0	0.5	0.5	1	0.5	0	0.5	0
Indonesia	0	0	0	0	0	0	0	0	0	0
Jordon	5.5	1	0.5	0.5	1	0.5	0.5	0.5	0.5	0.5
Kenya	9	2	1	1	1	1	0.5	0.5	1	1
Kiribati	8	2	1	1	0.5	0.5	0.5	0.5	1	1
Korea	5.5	1	0.5	0.5	1	1	0.5	0.5	0.5	0
Kuwait	3.5	0	0	0.5	1	1	1	0	0	0
Lebanon	8.5	2	1	1	1	1	1	1	0.5	0
Lesotho	9	2	1	1	1	1	1	1	0.5	0.5
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
Sao Tome & Principe	9	2	1	1	1	1	1	1	1	0
Saudi Arabia	0	0	0	0	0	0	0	0	0	0
Sri Lanka	10	2	1	1	1	1	1	1	1	1
Swaziland	9	2	1	1	1	1	1	1	0	1
Taiwan	0	0	0	0	0	0	0	0	0	0
Thailand	8	2	1	1	1	1	1	0	0	1
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
Venezuela	7	2	0.5	0.5	1	1	0.5	0.5	0.5	0.5
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
Zimbabwe	7.5	1	1	1	1	0.5	0.5	1	0.5	1

9. Infant Feeding During Emergencies

Emergencies and natural disasters pose serious challenges for Governments, aid agencies, NGOs and community to provide food, water, shelter, medical aid and protection to the affected people. Infants and young children are among the most vulnerable groups in emergencies both during manmade and natural disasters. Interruption of breastfeeding and inappropriate complementary feeding increase the risks of illness, malnutrition, and mortality, especially in situations where other support services like provision of clean drinking water, sanitation facilities and medical help may be inadequate.

It seems this is a much neglected area in spite of the fact that natural disasters have been a common occurrence and demonstrate much needed support to women, In the rapid response which is required breastfeeding support services are rarely found. This is therefore a great opportunity for any country to develop a system where rapid response should include breastfeeding counsellors in the supply lines.

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. 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.

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 them 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 21 gives the subset of questions for

Table 21: 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**	

Indicator on Infant Feeding during Emergencies. There are five criteria, each with a score ranging from zero to two.

Findings

Fig. 15 provides colour coding and a graph of the score of this indicator on a scale of 10.

Table 22 reveals that infant feeding during emergencies is not yet a priority in most countries. This indicator has received the lowest average score of 2.6. Thirty three countries out of fifty-one are in the red level, with 20 countries getting a score of zero, including some where natural disasters are a frequent occurrence. Only two countries - Mozambique and Maldives - have prioritized it, getting the full score of 10 and reaching the green level. Eleven countries are in the yellow level, and the rest in blue.

Photo Credit: IBFAN Southeast Asia

Countries are generally ill-equipped to handle infant feeding in emergencies as is evident from the above table. Only eleven countries - Indonesia, Kenya, Lebanon, Malawi, Maldives, Mozambique, Sri Lanka ,Uganda, Venezuela, Vietnam and Zambia - have adequately included infant feeding in emergencies in their infant and young child feeding policy; a further 12 countries have some reference to it in their policy. Kenya, Maldives, Sri Lanka and Mozambique have specifically included support to exclusive breastfeeding and appropriate complementary feeding, and to minimize the risk of artificial foods replacing breastfeeding and locally available complementary foods in their emergency preparedness plans. Costa Rica, Maldives, Mozambique, Malawi, Nicaragua, Lesotho, Sri Lanka and Zimbabwe have identified the resources needed to implement the

plan, while eight other countries have partially identified them. China, Costa Rica, Indonesia, Kenya, Maldives, Mozambique, Nicaragua, Sri Lanka, Uganda and Zimbabwe have appointed persons to coordinate national and international donor agencies and rescue agencies such as the military on infant and young child feeding. Sixteen countries have developed training material for infant feeding in emergencies and integrated them to some extent in pre-service and in-service training of emergency workers, while Maldives and Mozambique are the only two countries to integrate it completely in such training.

Key Findings

28 out of 51 countries have neither policies or programmes to incorporate Infant Feeding during Emergencies in their Disaster Management plans. Only two countries Maldives and Mozambique have done so.

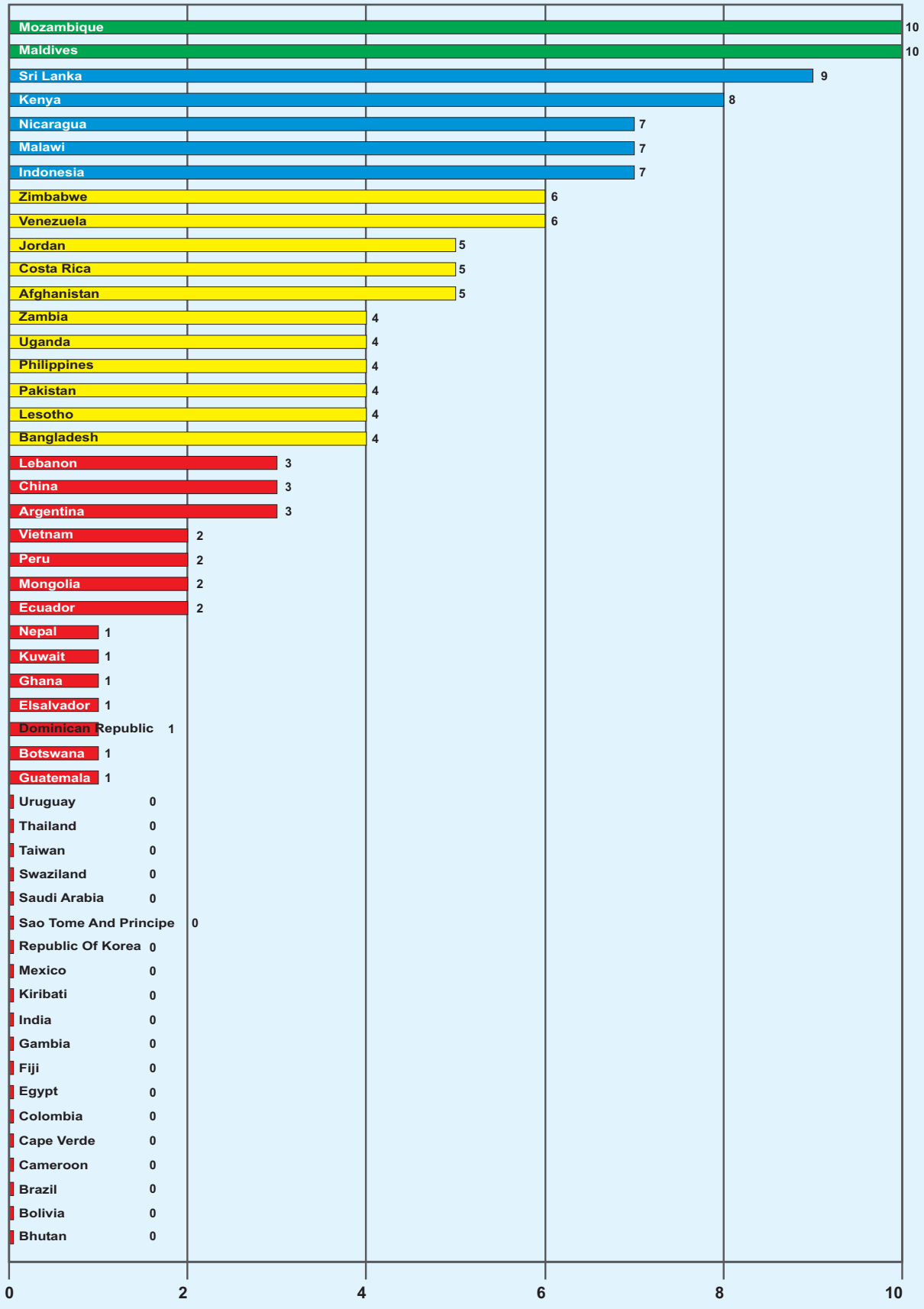
Key Recommendation

There is a need to integrate infant feeding during emergencies into the IYCF policy and Disaster Management Planning which means effectively implementing International Code on marketing of BMS and skilled breastfeeding and IYCF training for all levels of health providers and disaster management personnel.

Table 22: Country scores for each criteria

Country	Total score of Indicator (out of 10)	Subset Scores				
		9.1	*9.2*	*9.3*	*9.4*	*9.5*
Afghanistan	5	1	1	1	1	1
Argentina	3	1	0	1	0	1
Bangladesh	4	1	1	1	0	1
Bhutan	0	0	0	0	0	0
Bolivia	0	0	0	0	0	0
Botswana	1	1	0	0	0	0
Brazil	0	0	0	0	0	0
Cape Verde	0	0	0	0	0	0
Cameroon	0	0	0	0	0	0
China	3	0	2	0	0	1
Colombia	0	0	0	0	0	0
Costa Rica	5	0	2	1	2	0
Dominican Republic	1	0	1	0	0	0
Ecuador	2	0	1	0	0	1
El Salvador	1	1	0	0	0	0
Egypt	0	0	0	0	0	0
Fiji	0	0	0	0	0	0
Gambia	0	0	0	0	0	0
Ghana	1	1	0	0	0	0
Guatemala	1	0	1	0	0	0
India	0	0	0	0	0	0
Indonesia	7	2	2	1	1	1
Jordon	5	1	1	1	1	1
Kenya	8	2	2	2	1	1
Kiribati	0	0	0	0	0	0
Korea	0	0	0	0	0	0
Kuwait	1	0	0	0	0	1
Lebanon	3	2	0	0	0	1
Lesotho	4	1	1	0	2	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
Sao Tome & Principe	0	0	0	0	0	0
Saudi Arabia	0	0	0	0	0	0
Sri Lanka	9	2	2	2	2	1
Swaziland	0	0	0	0	0	0
Taiwan	0	0	0	0	0	0
Thailand	0	0	0	0	0	0
Uganda	4	2	2	0	0	0
Uruguay	0	0	0	0	0	0
Venezuela	6	2	1	1	1	1
Vietnam	2	2	0	0	0	0
Zambia	4	2	1	1	0	0
Zimbabwe	6	0	2	1	2	1

Fig. 15: The State of Infant Feeding During Emergencies in 51 Countries on a Scale of Ten (10)



10. Monitoring and Evaluation

Monitoring of policy implementation and programmes and their evaluation at regular intervals is essential to improve both the policy itself and its implementation. An equally regular monitoring of optimal IYCF practices can help to identify improvements, and together with the M&E of policy, can identify gaps as well as action that needs to be carried out to enhance IYCF practices. 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. This data should form a part of the input for programme managers and key decision makers for future planning as well as for mid-term review. 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 23 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. 16 provides colour coding and a graph of the score of this indicator on a scale of 10.

The average score for this indicator is 5.98. Five countries - Vietnam, Saudi Arabia, Sao Tome & Principe, Maldives and Kuwait - are in the green level with the highest score of 10. Eight countries Korea ,Taiwan, , Dominican Republic, Colombia,

Table 23: 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**	

Bhutan, Mexico, Indonesia and Cape Verde are in the red level, with the last three countries getting a score of zero each. Sixteen countries are in blue level, while 22 are in yellow.

Table 24 gives the details of the score each country received for the indicator.

While monitoring and evaluation is fully built into the major programme activities related to infant and young child feeding in 18 countries -Afghanistan, Bolivia, China, Costa Rica, Fiji, Gambia, Jordon, Kenya, Kuwait, Maldives, , Pakistan, Sao Tome & Principe, Saudi Arabia, Sri Lanka, Thailand, Uruguay, Vietnam and Zambia, it is there to some degree in Zimbabwe, Venezuela, Taiwan, Swaziland, Peru, Philippines, Nicaragua, Nepal, Mongolia, , Malawi, Lebanon, Korea, Kiribati, India, Guatemala, Ghana, El Salvador, Ecuador, Dominican Republic, , Brazil, Botswana, Bhutan, Bangladesh and Argentina. There is scope for improving the monitoring and evaluation system, as well as reporting to decision makers and programme managers in all countries.

Key finding

Only 18 have fully built monitoring and evaluation into the major programme activities related to infant and young child feeding.

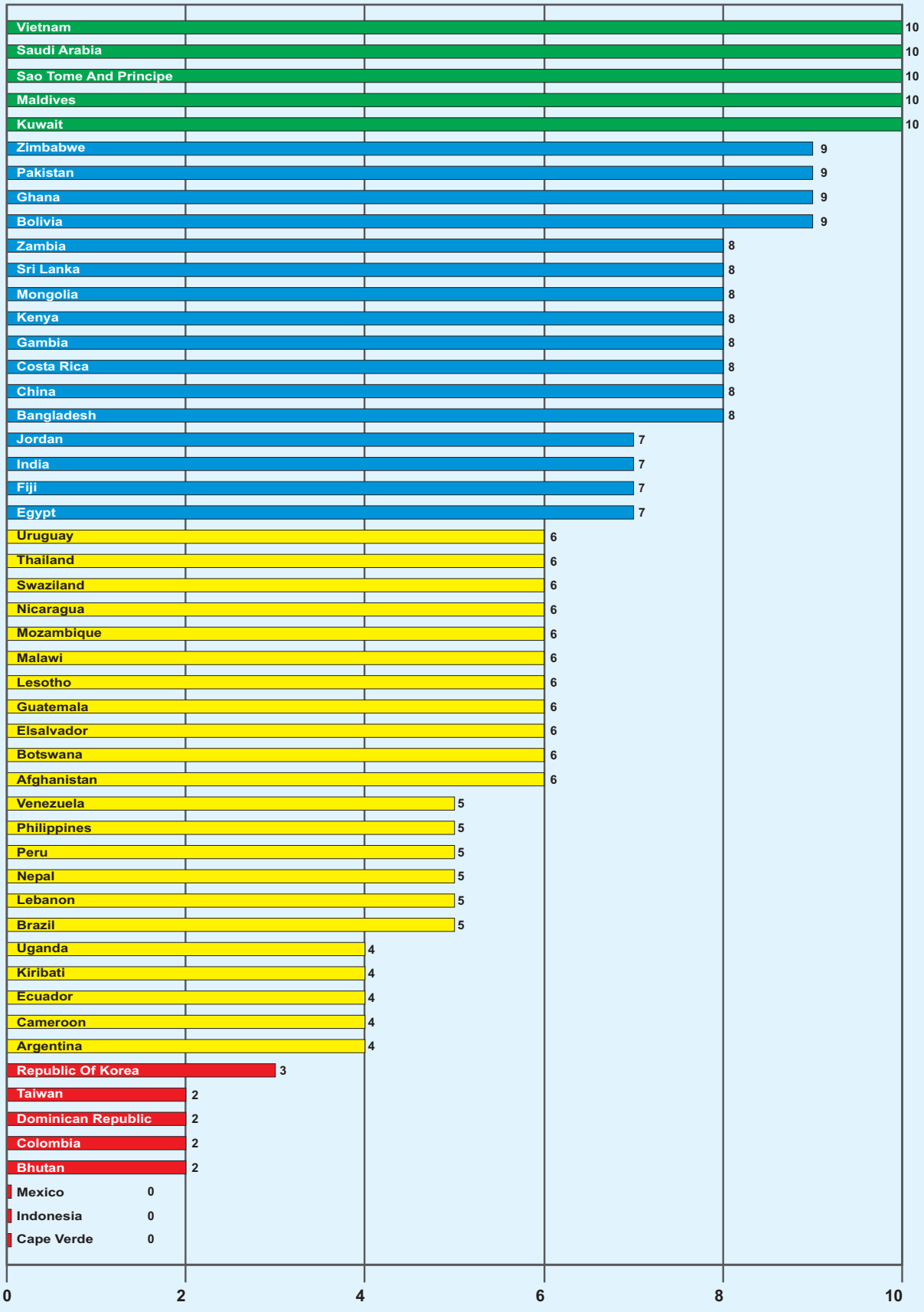
Table 24: Country scores for each criteria

Country	Total score of Indicator (out of 10)	Subset Scores				
		10.1	*10.2*	*10.3*	*10.4*	*10.5*
Afghanistan	6	2	1	1	1	1
Argentina	4	1	1	0	1	1
Bangladesh	8	1	2	1	2	2
Bhutan	2	1	0	1	0	0
Bolivia	9	2	2	1	2	2
Botswana	6	1	1	1	1	2
Brazil	5	1	1	1	1	1
Cape Verde	0	0	0	0	0	0
Cameroon	4	0	1	1	1	1
China	8	2	2	1	2	1
Colombia	2	0	0	0	0	2
Costa Rica	8	2	2	2	2	0
Dominican Republic	2	1	0	0	0	1
Ecuador	4	1	0	1	1	1
El Salvador	6	1	1	1	1	2
Egypt	7	0	2	2	1	2
Fiji	7	2	0	2	1	2
Gambia	8	2	1	2	2	1
Ghana	9	1	2	2	2	2
Guatemala	6	1	0	2	2	1
India	7	1	1	1	2	2
Indonesia	0	0	0	0	0	0
Jordon	7	2	2	1	1	1
Kenya	8	2	1	1	2	2
Kiribati	4	1	1	1	1	0
Korea	3	1	0	1	1	0
Kuwait	10	2	2	2	2	2
Lebanon	5	1	0	1	1	2
Lesotho	6	0	2	1	1	2
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
Sao Tome & Principe	10	2	2	2	2	2
Saudi Arabia	10	2	2	2	2	2
Sri Lanka	8	2	2	2	1	1
Swaziland	6	1	1	0	2	2
Taiwan	2	1	0	0	1	0
Thailand	6	2	1	1	1	1
Uganda	4	0	1	1	1	1
Uruguay	6	2	2	1	1	0
Venezuela	5	1	1	1	1	1
Vietnam	10	2	2	2	2	2
Zambia	8	2	2	1	2	1
Zimbabwe	9	1	2	2	2	2

Key Recommendation

This is the key to all indictors and all countries should include IYCF practice indicators in national surveys and monitor them annually, or at least every two years. Use this data to inform policy.

Fig. 16: The State of Monitoring and Evaluation in 51 Countries on a Scale of Ten (10)



The Average, is Average

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.
The WBT*i* assessment pointed out that some countries had not collected data on infant and young child feeding practices. For instance, four countries - Korea, Taiwan, Venezuela and Vietnam - have no data on initiation of breastfeeding within one hour; with the last also having no data on exclusive breastfeeding rates; China, Gambia, Korea, Taiwan and Thailand have no data on median duration of breastfeeding; Bostwana, Cape Verde, China, Ecuador, Fiji, Gambia, Mexico, Nicaragua and Taiwan have no data on bottle-feeding rates; Cape Verde and Taiwan have no data on complementary feeding. Fig. 17 gives the score for each country on IYCF practices, out of a total of 50.

Table 24: Average rates for the 5 IYCF Practices in 51 countries

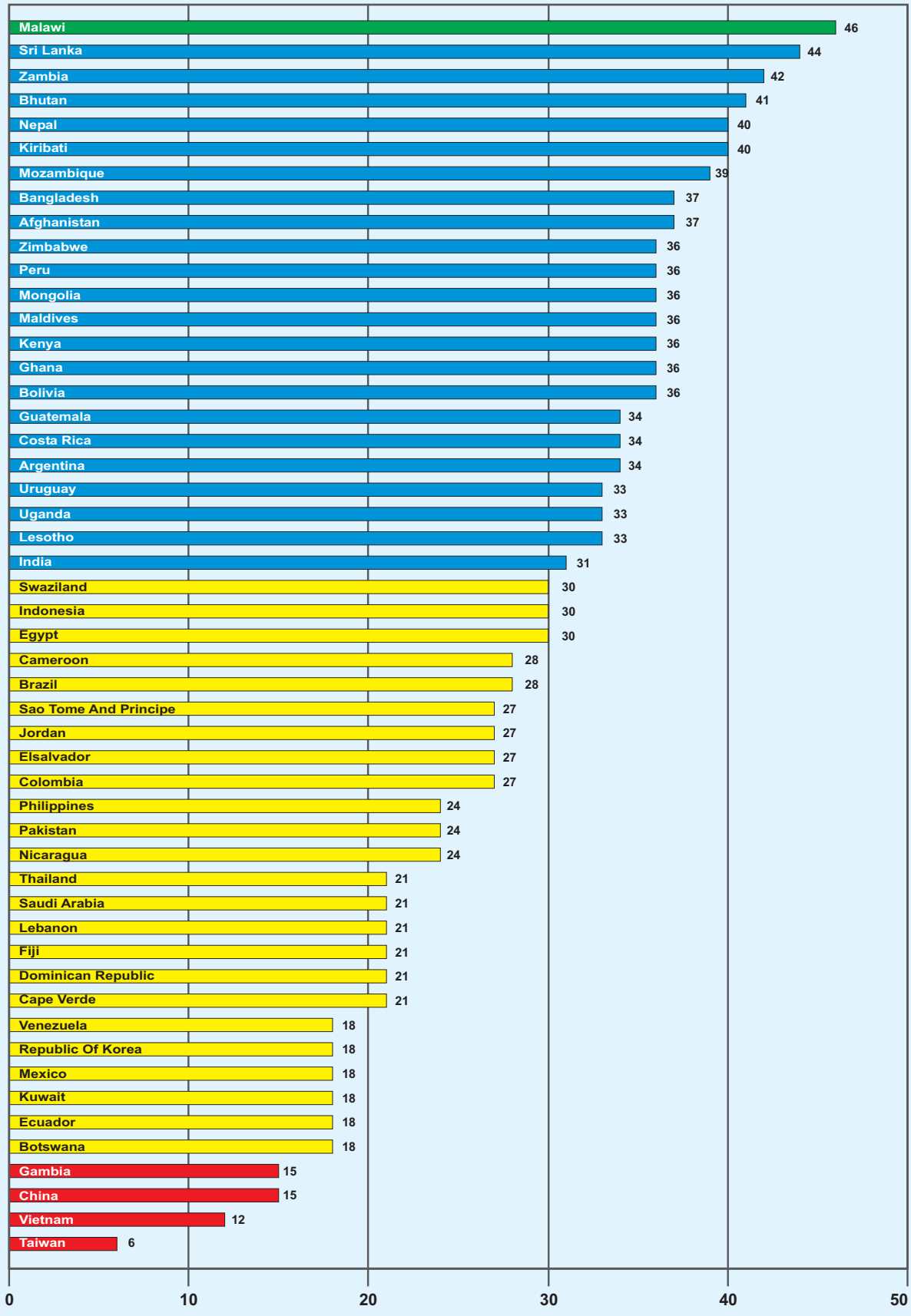
IYCF Practices (Indicators 11-15)	Average
Initiation of breastfeeding within 1 hour in percentage (average of 47 countries)	52.9%
Exclusive breastfeeding for the first six months in percentage (average of 50 countries)	41.4%
Median duration of breastfeeding in months (average of 46 countries)	18.1 months
Bottle feeding (<6 months) in percentage (average of 42 countries)	31.3%
Complementary feeding (6-9 months) in percentage (average of 49 countries)	67%

Fig. 17 shows that while only four countries are in the red level, there is not much difference in the number of countries in the yellow and blue levels; only a single country Malawi has reached the green level. Table 25 gives the average rates of five infant and young child feeding practices in the participating countries, where data was available.

The Table 24 shows clearly that the rates of optimal IYCF practices are far from satisfactory. Not a single indicator is in the green level; only the rate for initiation of breastfeeding within an hour of birth, which is just over 50%, is in the blue level. The rate of exclusive breastfeeding at 41.4% and the median duration of breastfeeding is at a low of 18 months. Complementary foods are introduced by the 6th to 9th month for only 67.% of infants. The rate of bottle-feeding of infants less than six months is 31.3%; put the score of this indicator in the red level. 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.

Fig. 17: The State of Practices on IYCF in 51 Countries on a Scale of Fifty (50)



11. Timely initiation of breastfeeding within one hour of birth

Timely initiation of breastfeeding within an hour of birth can significantly reduce the risk of neonatal mortality, if it is universalized. Ideally, all routine procedures such as bathing, weighing, umbilical cord care, administration of eye medications, should be carried out after the baby has been initiated into breastfeeding. 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.

According to "Step" 4 of the Baby Friendly Hospital Initiative (BFHI) guidelines, 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 within few hours of the general anaesthesia also.

Establishing early initiation of breastfeeding is an indication of a successful BFHI initiative. However, in many developing countries, and to some extent in industrialized countries, many women deliver their babies at home; such women also need support to establish breastfeeding within the first hour.

Question to be answered and criteria for scoring

Question: Percentage of babies breastfed within one hour of birth
Key: 0.1-29% scores as 3/Red; 30-49% as 6/Yellow; 50-89% scores as 9/Blue; 90-100% scores as 10/Green.

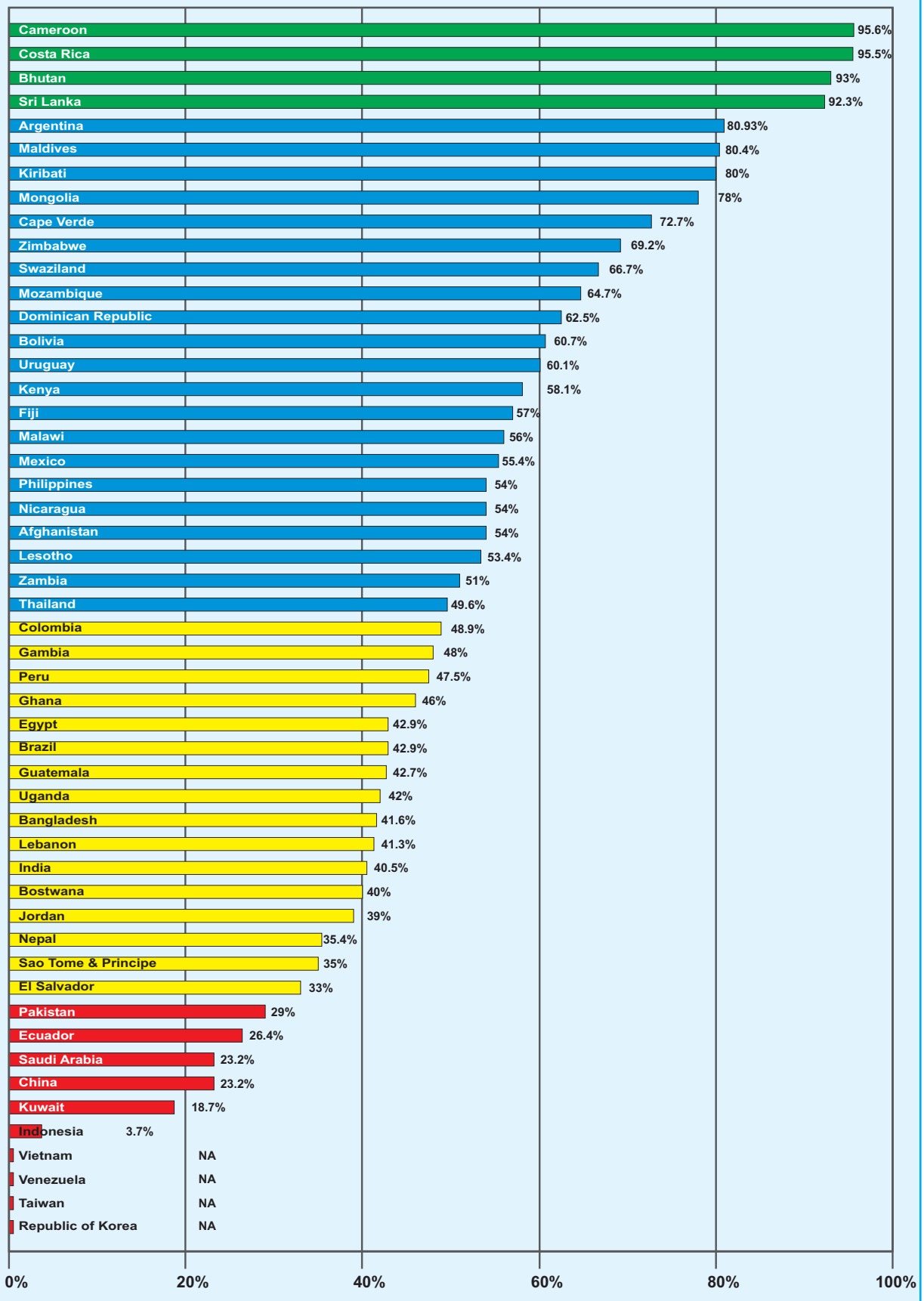
Findings

No data on rate for initiation of breastfeeding within an hour of birth was available for three countries Korea, Taiwan, Venezuela and Vietnam; Costa Rica did not have this data in its previous assessment; however, since then, data for this indicator is being collected in national surveys. The average rate for the remaining 47 countries is 52.9%. The rates for individual countries show wide variation, ranging from a mere 3.7 per cent in Indonesia to 95.6% and 95.5% in Cameroon and Costa Rica respectively.

Of the 47 countries which have data on this indicator, Cameroon, Costa Rica, Bhutan and Sri Lanka (with 95.6%, 95.5%, 93% and 92.3% respectively) are in the green level. Twenty one countries are in the blue level - Thailand, Zambia, Lesotho, Afghanistan, Nicaragua, Philippines, Mexico, Malawi, Fiji, Kenya, Uruguay, Bolivia, Dominican Republic, Mozambique, Swaziland, Zimbabwe, Cape Verde, Mongolia, Kiribati, Maldives and Argentina. Sixteen countries are in the yellow level - El Salvador, Sao Tome & Principe, Nepal, Jordan, Bostwana, India, Lebanon, Bangladesh, Uganda, Guatemala, Brazil, Egypt, Ghana, Peru, Gambia and Colombia. Six countries are in the red level - Pakistan, Ecuador, Saudi Arabia, China, Kuwait and Indonesia.

Fig. 18 gives each country's percentage of children who are breastfed within an hour of birth, for the countries for which data is available.

Fig. 18: Percentage of Initiation of Breastfeeding within One Hour in 51 Countries



12. Exclusive Breastfeeding

Babies need nothing other than breastmilk for the first six months of their lives. Exclusive breastfeeding raises the chances of survival, improves growth and development of the infant, and lowers the risk of illness, particularly from diarrhoeal diseases. It also prolongs lactation amenorrhoea in mothers.

Studies have also shown that in areas with high HIV 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.

Question to be answered and criteria for scoring

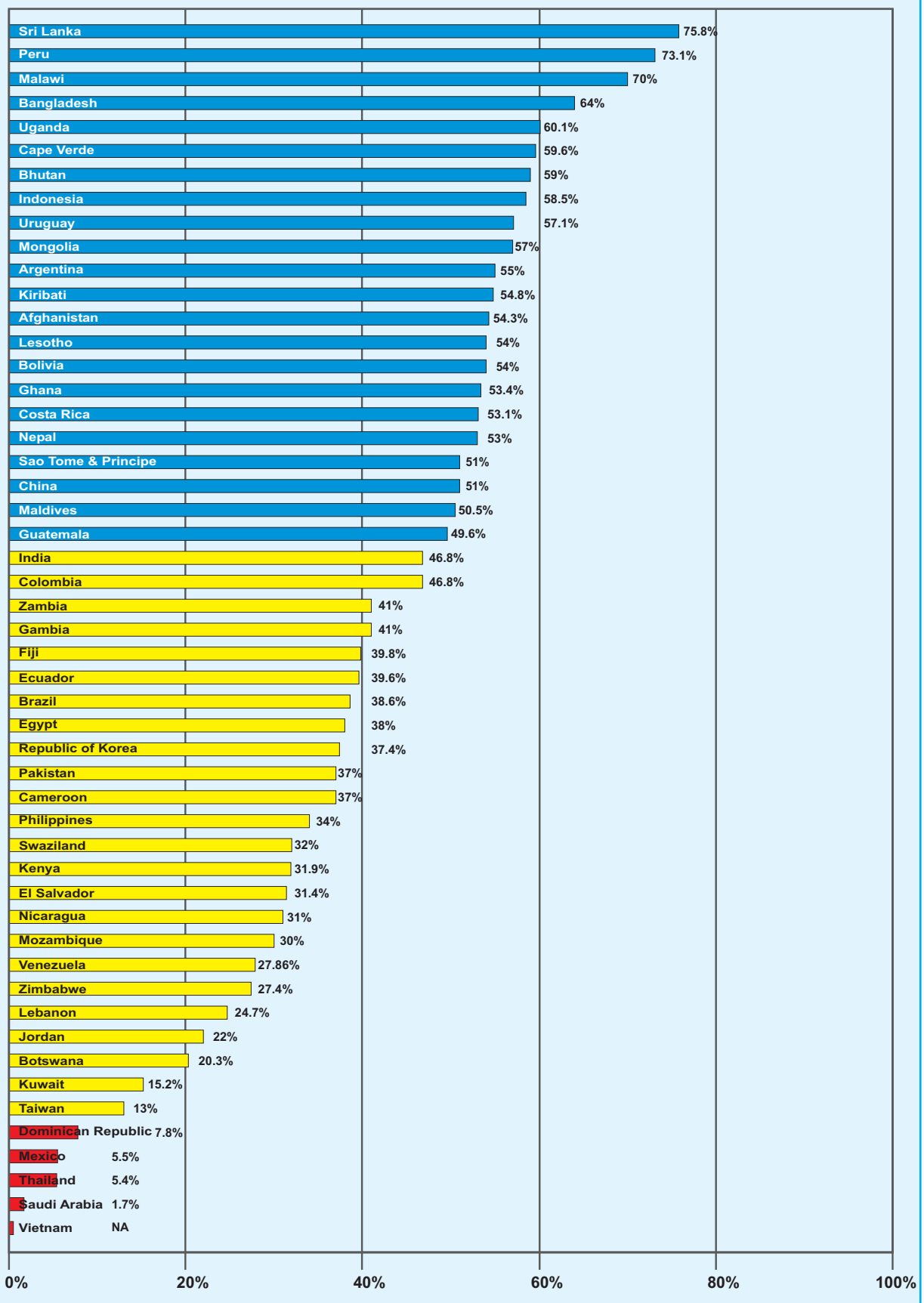
Question: Percentage of babies 0<6 months of age exclusively breastfed in the last 24 hours?
Key: 0.1-11% scores as 3/Red; 12-49% as 6/Yellow; 50-89% scores as 9/Blue; 90-100% scores as 10/Green.

Findings

The average rate for Indicator 12 for 50 countries is 41.4%; no data was available for Vietnam. It should be noted that Bhutan, which had no data for this indicator in the 2008 assessment, has included the indicator in its national surveys since then, and data is now available for it. The percentages of exclusive breastfeeding range from 75.8% for Sri Lanka to 1.7 % for Saudi Arabia. It should be noted that 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.

Fig. 19 gives the percentage of babies who are exclusively breastfed between birth and six months for each country, and the colour coding. While no country is in green for this indicator, 22 countries are in the blue level Guatemala, Maldives, China, Sao Tome & Principe, Nepal, Costa Rica, Ghana, Bolivia, Lesotho, Afghanistan, Kiribati, Argentina, Mongolia, Uruguay, Indonesia, Bhutan, Cape Verde, Uganda, Bangladesh, Malawi, Peru and Sri Lanka. Twenty four countries are in the yellow level and four in the red - Dominican Republic, Mexico Thailand, Saudi Arabia and Vietnam.

Fig. 19: Percentage of Infants 0-6 months of Age Exclusively Breastfed in the last24 hours in 51 Countries



13. 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: 0.1-17 months scores as 3/Red; 18-20 as 6/Yellow; 21-22 scores as 9/Blue; 23-24 or beyond scores as 10/Green.

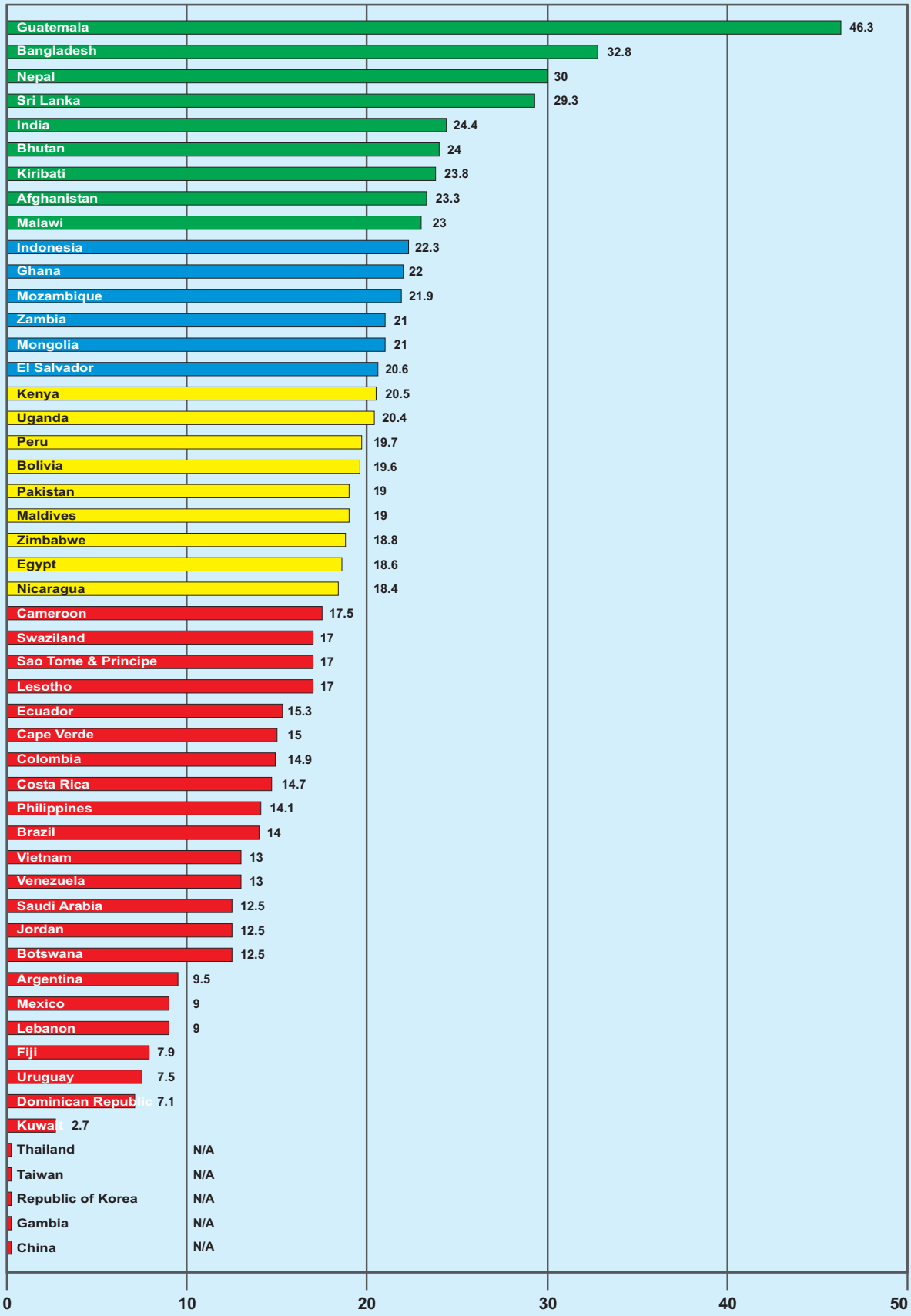
Findings

Data for this indicator was only available in 46 countries; China, Gambia, Korea, Taiwan and Thailand did not have this data. The average median duration of breastfeeding for these countries is 18.1 months, with values ranging from 46.3 months in Guatemala to 2.7 months in Kuwait.

The median duration of breastfeeding is over 23 months in nine countries, putting them in the green level Guatemala, Bangladesh, Nepal, Sri Lanka, India, Bhutan, Kiribati, Afghanistan and Malawi. The highest number 22 are in the red level, with the median duration of breastfeeding being less than 18 months Kuwait, Dominican Republic, Uruguay, Fiji, Lebanon, Mexico, Argentina, Bostwana, Jordan, Saudi Arabia, Venezuela, Vietnam, Brazil, Philippines, Costa Rica, Colombia, Cape Verde, Ecuador, Lesotho, Sao Tome & Principe, Swaziland and Cameroon. Nine countries are in the yellow level, and six in the blue.

Fig. 20 gives the colour coding for each country along with the median duration of breastfeeding.

Fig. 20: Median Duration of Breastfeeding in 51 Countries



14. Bottle-feeding

The Global Strategy recommends exclusive breastfeeding for the first six months, and continued breastfeeding thereafter for two years and beyond, along with the introduction of adequate and appropriate soft complementary foods. While most mothers make their feeding decisions before the baby is born, often lack of proper information as well as support may cause mothers to choose to bottle feed their babies very early. Non-supportive work situations also lead to higher rates of bottle feeding.

Bottle feeding entails several disadvantages, including reducing opportunities to bond with the baby, as well as reduced health gains than is available with breastfeeding; feeding equipment requires washing, boiling, and sterilizing while the milk may require refrigeration. In all cases, access to potable water is vital, and to fuel for boiling both the water and the equipment. Inadequate hygiene can lead to infections; formula feeding itself is associated with risks of obesity and with non-communicable diseases in later life.

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; 0.1-2% scores as 10/Green.

Findings

Data for this indicator was unavailable in nine countries - Botswana, Cape Verde, China, Ecuador, Fiji, Gambia, Mexico, Nicaragua and Taiwan. The average rate for 42 countries was 31.3%, with percentages ranging from 3% in Zimbabwe to 89.8% in Saudi Arabia.

Fig. 21 gives the percentage of bottle-fed babies in the assessed countries, along with their colour coding. Only four countries - Nepal, Zambia, Malawi and Zimbabwe are in the blue level, while 17 are in the red level Korea, Bolivia, Uruguay, Kuwait, Colombia, Philippines, Argentina, Brazil, Costa Rica, Jordan, Venezuela, Lebanon, El Salvador, Cameroon, Dominican Republic, Vietnam and Saudi Arabia. The rest, 21 countries, are in the yellow level. No country is in the green level.

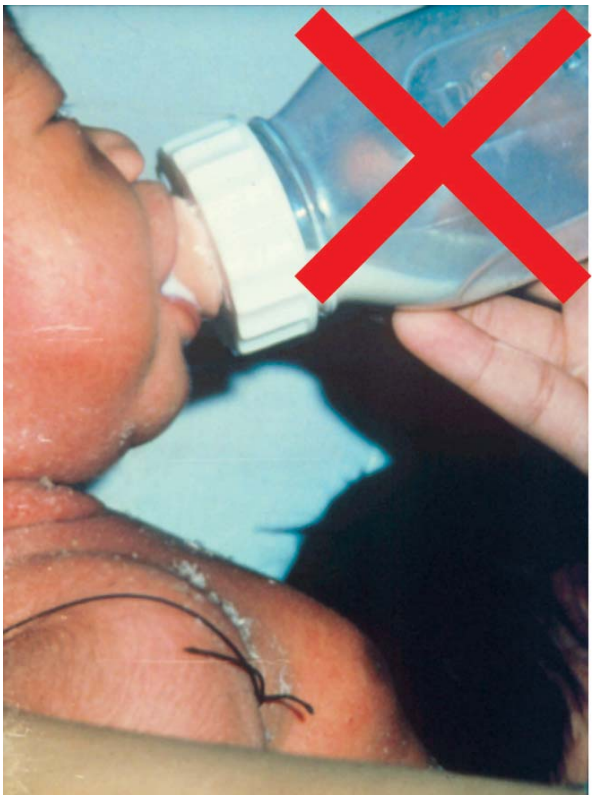
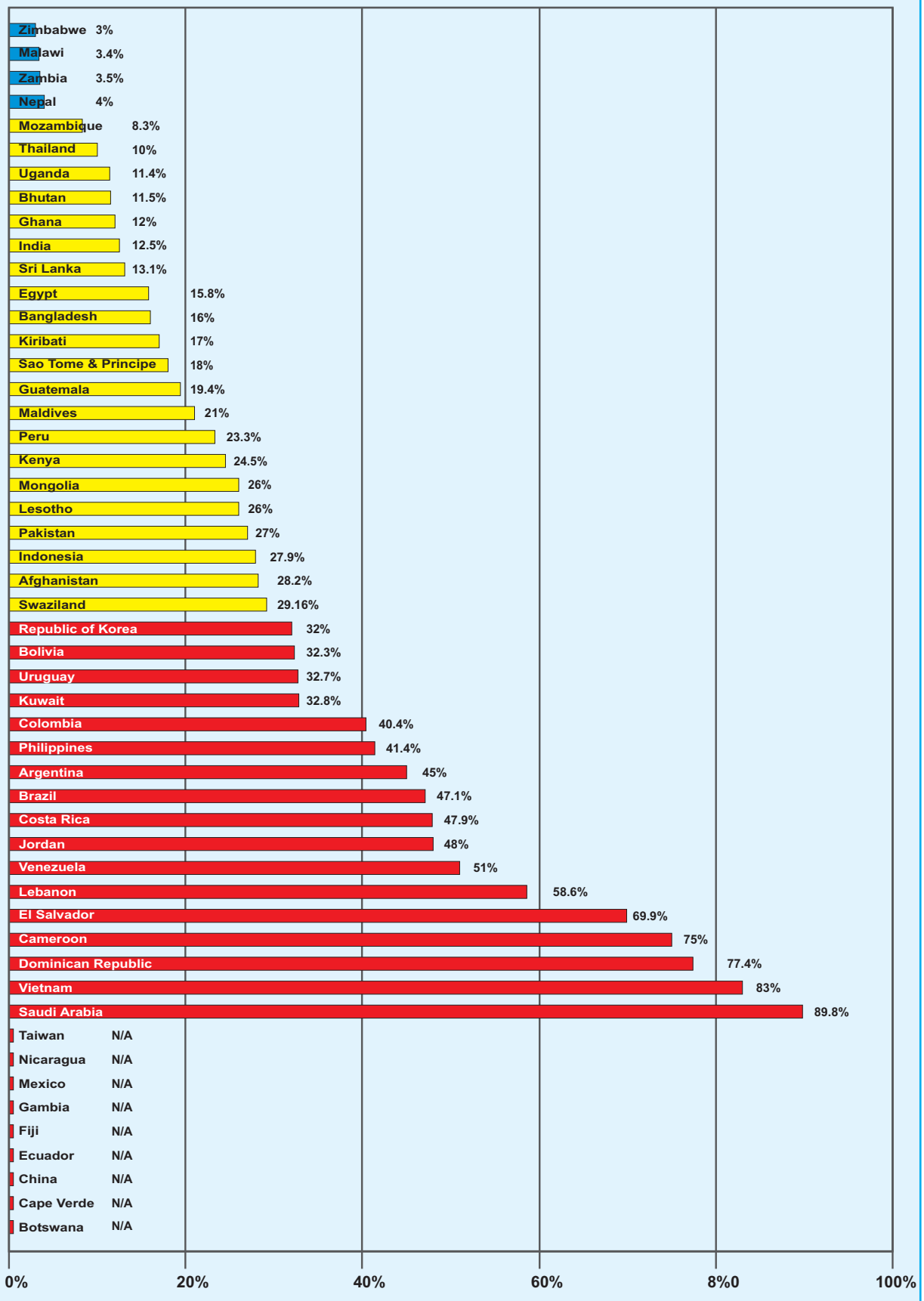


Fig. 21: Percentage of Infants who are Bottle-fed in 51 Countries



15. Complementary Feeding

Once babies have completed their sixth month, they require additional nutrition to breastmilk. Complementary feeding should begin soft, mashed foods, prepared with locally available indigenous foods as they are affordable and sustainable. Babies need to be fed in small quantities 3-5 times a day, and the density and frequency should be gradually increased as the baby grows. By the time a baby is 9 months to a year old, he or she can eat all the family foods. 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: 0.1-59% scores as 3/Red; 60-79% as 6/Yellow; 80-94% scores as 9/Blue; 95-100% scores as 10/Green.

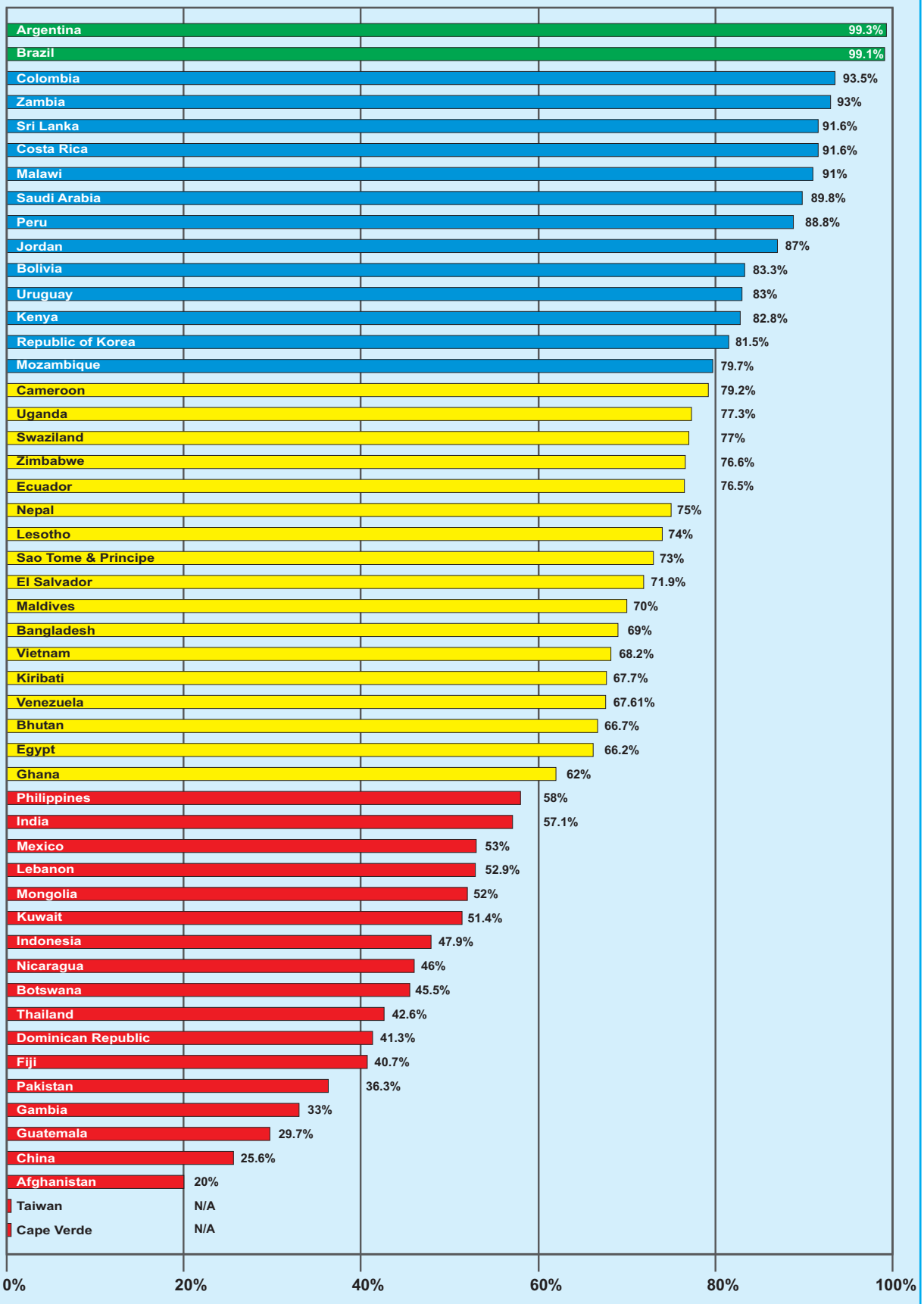
Findings

Data for this indicator was available in all countries except Cape Verde and Taiwan. The average is 67, with Argentina having the highest percentage at 99.3% followed by Brazil at 99.1%; Afghanistan comes last with 20%.

This indicator finds two countries Argentina and Brazil in the green level. However, both the yellow level and the red level have 17 countries each. Thirteen countries Mozambique, Korea, Kenya, Uruguay, Bolivia, Jordan, Peru, , Saudi Arabia, Malawi, Costa Rica, Sri Lanka, Zambia and Colombia are in the blue level, and the remaining 17 countries in yellow.

Fig. 22 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.

Fig. 22: Percentage of Breastfed Infants Between 6 and 9 months Receiving Complementary Foods in 51 Countries



A Long Way to Go

An analysis of the situation

This chapter analyses the findings and reports of individual country in detail, with a view on actions that can emerge from the WBT*i* assessment.

We have done the analysis of the reports from each country and specially looking at finer details of answers to the sub-set of questions. While the country reports give a clear cut information on gaps to give rise to recommendations in each area of action, there are certain recommendations that do emerge from the sub sets and are highly relevant to generate and sustain action on infant and young child feeding. We have also analysed this along side available scientific information.

Lutter and Morrow, in their paper *Protection, Promotion, Support and Global Trends in Breastfeeding*[1], showed that implementation of the Global Strategy is associated with improvements in exclusive breastfeeding, and potentially, with breastfeeding duration over a 10 to 20 year period, especially in Brazil and Colombia. They concluded that there a significant association between implementation of the *Global Strategy* and national improvements in exclusive breastfeeding rates.

An infant's right to breastfeed is 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. Engesveen, analyzing breastfeeding from the human rights perspective, 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.[2] The 51-country WBT*i* assessment highlights the need for actions that must be taken by the State to create this enabling environment provision of adequate maternity protection, creating facility and community based support systems based on availability of skilled counseling, and strict implementation of the International Code of Marketing of Breastmilk Substitutes, and subsequent World Health Assembly (WHA) resolutions. The assessment report stresses that governance systems must both increase the capacity of countries for carrying out these actions and make available the financial resources required for this.

The national assessment teams in each country identified the gaps that exist in policy and made recommendations for bridging them. However, while these recommendations were country-specific, many of them were common to all countries. These included strengthening policies

and making them comprehensive, ensuring adequate budgets for implementing the entire policy, strengthening human resources for IYCF as well as the capacity of health providers to provide skilled counseling, implementation of the International Code and provision of adequate maternity protection and community based support to women to breastfeed. For example, all the teams recommended that whether the country has a history of disasters and emergencies or not and no matter how low the incidence of HIV was, policies were needed to cover IYCF in these difficult circumstances. Based on the findings and analysis, this chapter examines these areas that need urgent attention from national and international governance systems, and some action taken in these areas.

1. Policy, coordination, and financing

This section deals with Indicators 1 and 10, while it affects all other indicators in their ability to scale up interventions to universal level. Bryce et al, in their paper[3], draw attention to the need for creating national policies and action plans; they also stress on the need for political will and commitment, without which no significant change can occur. They further identify creating legislation as a partial measure to protect effective actions from political change. Lutter and Morrow, in their 2012 analysis, have validated this call. Victora[4] 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 counseling and other such measures in place. The recent 6-country programme review on IYCF calls for comprehensive action on policy and coordination[5].

Country after country has noted the need for both increased human resources as well as financial allocations if they have to successfully enhance breastfeeding rates. This seems to be most striking feature of each report and rightly so. Development of policies, plans of action, legislation, and guidelines for the implementation are key factors for enhancing breastfeeding rates, and both the development and its implementation have financial implications. As noted in a submission to New Zealand's Health Select Committee, while political will is needed to translate policies into action, they are essential to demonstrate political leadership and ensure effective investment.[6] A written evidence based policy clearly spelling out priority areas for action and a budget estimate assist in advocacy for investment. For example, the *US Surgeon General's Call for Action to Support Breastfeeding* in 2011 has been used by the United States Breastfeeding Committee to call for the appropriation of $15 million from the Prevention and Public Health Fund for FY 2012 to support breastfeeding. [7]

Policies on their own cannot change IYCF practices, as they are impacted by decisions taken in several sectors such as health, welfare, labour; IYCF policy needs to be integrated into these sectors as well as into poverty reduction programmes. Effective implementation of the policy thus requires strong coordination with accountability. Currently, as the analysis of Indicator 1 reveals, though several countries have a National Breastfeeding/IYCF committee, headed by a coordinator with specific terms of reference, the committee meets rarely; often it does not have representation of the other sectors that affect IYCF practices. This results in ad hoc actions rather than the implementation of a comprehensive strategy at scale.

And finally, monitoring and evaluation of policies and programmes on a regular basis is essential for fine tuning both policy and action. The results of such exercise must inform both policy makers as well as those who are implementing the policy through programmes. 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.

2. Health facilities and standards of care

This section covers Indicator 2. The Baby Friendly Hospital Initiative involves 10 steps to successful breastfeeding and it was launched as early as 1992 in order to improve breastfeeding practices in the health facilities. Though it does not seem to evoke the same level of interest anymore, especially from global institutions, it remains one of the interventions that drew huge demand and mobilisation towards breastfeeding.

Scientific evidence backs the action to rejuvenate BFHI in whatever form to provide support and services related to interventions needed at the time of birth of babies. Several studies such as the PROBIT Trial in Belarus[8], the Brazilian study[9], and the Bartick and Reinhold study in the US[10] have highlighted that implementing all the 10 steps - particularly rooming in, skilled counseling by trained personnel and non-availability of formula in hospitals - can lead to enhanced rates of timely initiation of breastfeeding, exclusive breastfeeding and increased family and national savings by reduction in infections in the new born. PROBIT in particular, demonstrated links between BFHI and longer breastfeeding duration (19.7% vs. 11.4% at 12 months, $P < .001$) and exclusivity (43.3% vs. 6.4% at 3 months, $P < .001$), reductions in gastrointestinal episodes and rashes, higher verbal IQ scores, and longer exclusive breastfeeding rates for subsequent children. A recent study from Korea has shown that rooming-in has several advantages including the good formation of attachment between mother and infant, emotional stability, protection from infection, and increased breastfeeding rate.[11]

Ten Steps

- 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

However, it is essential to implement all the 10 steps of BFHI concurrently. A study from South Africa highlighted the importance of the establishment and implementation of breastfeeding policies, of appropriate and continuous breastfeeding training and better referral systems to ensure initiation and establishment of early breastfeeding, exclusive breastfeeding practices and support on an ongoing basis to ensure the best start in life for infants.[12] 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.

All the countries that have participated in the WBT*i* assessment felt the need to revive BFHI by

integrating it in the health system and establishing a community linkage. Jordan has recommended establishing a breastfeeding committee to advocate for BFHI; Egypt has included an on-going process for reviving BFHI in its 5-year plan; Lebanon has recommended converting all public sector hospitals and health facilities to BFHI, through upgrading training and providing refresher courses to existing BFHI hospital staff; Swaziland has recommended that BFHI be incorporated in the national quality assurance programme. All the countries noted the need for governments to strengthen the human resource capacity for BFHI, as well as the need for governments and donor agencies to invest both in financial and human resources for this intervention.

3. Capacity of health providers at the level of the facility and the community to provide adequate feeding support

This section deals with Indicators 5, 6 and 8. There is an identified need to effectively link the health facility with family level action and so is the need to strengthen curriculum of health workers who deliver these services, building their skills appropriate to the needs of breastfeeding women.

Universalizing access to skilled counseling requires that the entire health and nutrition system in the country - from medical and nursing personnel to field level workers provide the same information to mothers, that they are equipped with listening and counseling skills to support the woman to practice optimal breastfeeding. This needs special skills to build confidence in women and strengthen the oxytocin reflex a crucial hormone needed to make effective milk transfer from breast to the baby. As this hormone is dependant on the state of mind of the mother, it becomes critical to deal with this skillfully. Skilled workers are required to prevent and solve breastfeeding problems that can commonly make a woman give up. Almost all the countries conducting the WBT*i* assessment identified an immediate need to incorporate IYCF at all levels of pre-service and in-service training. Curricula must be updated according to the latest recommendations and refresher courses must be conducted for health personnel at all levels.

The need for updating curricula is particularly important in the context of HIV, which poses special challenges to optimal IYCF, particularly to breastfeeding. The risk of HIV transmission through breastfeeding has to be balanced against the risk of death due to artificial feeding. Additionally, there is evidence 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 breastmilk[13], it also leads to increased morbidity and mortality due to common childhood illnesses.[14] However, as the WBT*i* assessment shows, several countries do not adequately incorporate infant feeding and HIV in either their policies or their training curricula. Some countries, such as Uruguay and Bhutan, do not offer informed choice to women with HIV, and babies of these women are exclusively fed on formula. Findings such as the impact of antiretroviral drugs in curtailing transmission of HIV from mother to child has led to changes in international guidelines.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%. These findings need to be harmonized in both policy and training of health workers at all levels.

In its Implementing the *Global Strategy for Infant and Young Child Feeding*, WHO identifies the need for building up teams of experienced trainers, clinical practice sessions, refresher courses and close monitoring as critical requirements of an effective capacity building

programme. WHO also identifies the need to have training programmes that include breastfeeding, complementary feeding, infant feeding and HIV and growth monitoring.

The countries participating in the assessment reiterated these points, and stressed the need for countries to have a training programme that imparted the same basic knowledge to the health providers, so that mothers would get the same messages at every level of the health and nutrition system. The countries have also noted the need for adequate budgeting for capacity building.

4. Implementation of International Code, subsequent resolutions of the World Health Assembly.

This section deals with Indicator 3, 8 and 9. 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 Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions. At the same time World Health Assembly resolution 65.6 calls on member States to develop mechanisms of dealing with conflicts of interests in Nutrition programmes and policy development. All the countries have identified the need to create public awareness of the Code and national legislation and the subsequent WHA resolutions, train health workers on the Code, and give specific training to code monitors to identify violations and take action.

Almost all the countries of the world have ratified the International Code for Marketing of Breastmilk Substitutes and subsequent WHA resolutions to protect breastfeeding. However, as the assessment shows, far more work still needs to be done for effective enforcement of the Code. While 10 countries - Afghanistan, Bangladesh, Brazil, Costa Rica, Dominican Republic, Gambia, Ghana, Malawi, Mongolia, and Zimbabwe have scored a full 10 for this indicator, data on IYCF practices reveals that Dominican Republic, Costa Rica, Brazil, Afghanistan and Mongolia have bottle feeding rates of 77.4%, 47.9%, 47.1%, 28.2% and 26% respectively. This shows clearly that enforcement is weak.

The WBT*i* assessment shows that several countries have yet to adopt the Code in full, or even in part. Different countries have used different mechanisms for adopting the Code: Indonesia, has passed decrees, Pakistan has issued regulations. The Uruguayan Decree 315/94 does not include bottles, teats and other items used in artificial feeding, or the subsequent WHA Resolutions, which complement the Code. Egypt has consolidated the various existing decrees and directives which give effect to different aspects of the Code, but gaps continue to exist; the assessment team recommends that some of these gaps, such as those related to labeling can be addressed through strengthening other existing laws such as the food or labeling laws; it also recommends that an advisory committee free from conflict of interest be set up to oversee the administration of the laws. Lesotho, Swaziland and Kenya have draft laws whose processing needs to be fast tracked. On the other hand, Botswana has a law that is at odds with the implementation of the South African Customs Union (SACU); the assessment team noted the need to sensitise members of SACU to immediately pass their own laws to implement the Code; they also recommended the reinstating of repealed articles in the food labeling laws of the country.

5. Dealing with difficult circumstances

Countries like Malawi, Ghana, Lesotho, Swaziland, Uganda, Zambia and Zimbabwe, where the prevalence of HIV/AIDS amongst the population between 15 and 49 years of age is 11%, 1.8%, 23.6%, 25.90%, 6.5%, 13.5% and 14.3% respectively, have a policy on HIV and infant

feeding, that fully implements the International Code. Yet, 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 (PPTCT)programmes, as well as lack of adequate attention to the food and nutritional security of infants with HIV.

Implementing the Code and national legislation becomes particularly important during emergencies and disasters. Women, especially lactating women, are extremely vulnerable to stress, and this affects their ability to breastfeed successfully, especially during disasters, where they bear the greater part of the burden of providing care and food for the family. 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 percent 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.

6. Making maternity protection universal

This section deals with Indicator 4.
The International Labor Organization (ILO) in its Convention 102 and 183, set standards of maternity benefits, including paid maternity leave; they state:

- The benefits should extend throughout the period of leave .
- They should be adequate to maintain the health and living standard of a woman and her child.

Today, there are several studies that establish the link between postnatal leave and breastfeeding. A study from California[15] concluded that postpartum maternity leave may have a positive effect on breastfeeding among full-time workers, particularly those who hold non-managerial positions, lack job flexibility, or experience psychosocial distress, and that pediatricians should encourage patients to take maternity leave and advocate for extending paid postpartum leave and flexibility in working conditions for breastfeeding women. This finding was reiterated by a study from South Carolina[16], which found that compared with those returning to work within 1 to 6 weeks, women who had not yet returned to work had a greater odds of initiating breastfeeding, continuing any breastfeeding beyond 6 months, and predominant breastfeeding beyond 3 months. Women who returned to work at or after 13 weeks postpartum had higher odds of predominantly breastfeeding beyond 3 months.

Studies from Europe further strengthen this conclusion. A review of literature on the length of maternity leaves and health of mothers and children to evaluate the Swiss situation in view of the maternity leave policy implemented in 2005, concluded that there was a positive association between the length of maternity leave and mother's mental health and breastfeeding duration.[17] The UK Millennium Cohort Study[18] found that mothers employed part-time or self-employed were more likely to breastfeed for at least 4 months than those employed full-time. Mothers were also more likely to breastfeed for at least 4 months if their employer offered family-friendly, or they received Statutory Maternity Pay (SMP) plus additional pay during their maternity leave rather than SMP alone. The Study concluded that policies should aim to increase financial support and incentives for employers to

offer supportive work arrangements.

A study from Lebanon[19] found that breastfeeding depended on the duration of the maternity leave, the possibility of breaks for breastfeeding and the presence of nurseries at work, and that a rapid return to work could cause physical and psychological problems. The authors called for urgent interventions to prolong maternity leave and promote breastfeeding among working women. Another study from Turkey[20] identified the factors that improve long-term breastfeeding are successful exclusive breastfeeding in the first few months, intention of the mother to breastfeed and sufficient duration of maternity leave.

Though there is growing acceptance of the need for maternity protection, including adequate maternity leave to enhance breastfeeding rates, the WBT*i* assessment shows this intervention has not received good support; this indicator received the second lowest average score amongst the 10 indicators assessed. 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. The assessment reveals that only eight countries offer women in the informal or unorganized sector the same level of protection as offered in the formal sector, while 10 offer some measure of protection; the rest of the countries offer no protection to women working in the unorganized sector. All the countries have noted the need to strengthen maternity protection, including extending the period of leave for six months to enable breastfeeding; in addition they have recommended massive public awareness campaigns to inform women of their rights to maternity protection.

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What Next?

The way forward and recommendations

The WBT*i* is an idea whose time has come! Several countries have successfully used the tool with impressive results. A recent study by Lutter and Morrow has shown that it is possible to increase breastfeeding rates provided countries work on policy and programmes.

There is also evidence being generated that specific interventions, particularly skilled counseling and maternity protection, do lead to enhanced breastfeeding rates. The following recommendations have mostly emerged from the national reports as well as the analysis of the situation.

In each of the policy and programme indicators we have highlighted the key finding and recommendations that can be taken note of while taking action in a local context. However, in this chapter we have tried to provide recommendations for different levels of stakeholders.

General recommendations for countries

1. Countries that have begun the WBT*i* process need to organise their coordination and funding immediately and adequately, in order to quickly scale up interventions to increase breastfeeding rates. They should also plan for re-assessments after 3-5 years to study the trends and review action to be taken, and aim to reach the next level of performance.
2. Those who have not yet started using the WBT*i* could begin using this tool.

Specific recommendations to countries

- Develop a comprehensive, cross-sectoral, multi-level IYCF policy with a plan of action and a timeline. Budget the policy action and raise resources for its implementation. Appoint a coordinating body, with representation from all sectors involved, to oversee its comprehensive implementation.
- Rejuvenate BFHI with a timeline to cover all hospitals. Ensure that adequate human and financial resources are available for this action.
- Legislate the International Code and all relevant subsequent WHA resolutions and stringently implement it. Raise public awareness on the Code/national legislation and train Code Monitors to take note of violations for further action.
- Extend maternity leave for all women to six months to enable exclusive breastfeeding. Extend maternity protection to women working in the informal/unorganised sector and raise adequate resources for this.
- Integrate IYCF, including the International Code, Infant Feeding in HIV and Infant Feeding during Emergencies, in pre-service

and in-service training of health and nutrition workers, at all levels of the health and nutrition system.
- Build community outreach into the IYCF policy. Make communities baby friendly by ensuring the provision of easy access to skilled counselling and child-care services.
- Develop a specific communication strategy for IYCF.
- Integrate HIV and infant feeding into the IYCF policy, IYCF training for all levels of health providers and IYCF communication strategy.
- Integrate infant feeding during emergencies into the IYCF policy, and disaster management planning including breastfeeding support services, as a part of the supply chain.
- Include IYCF practice indicators in national surveys and monitor them annually, or at least every two years. Use this data to inform policy.

Specific recommendations to the global community

- Build implementation of the Global Strategy for Infant and Young Child Feeding as a key priority in the future agenda of child health and survival.
- Create budget lines for implementing the Global strategy commensurate with the need.
- Dedicate specific budget lines to address breastfeeding and IYCF interventions under child health or nutrition programming.
- Global community should focus on policy advocacy for legislation on the International Code of Marketing of Breastmilk Substitutes (Code) and subsequent World Health Assembly resolutions , keeping it clear of conflicts of interests.
- In order to increase exclusive breastfeeding for the first six months, encourage the use of the WBT*i* tool to initiate action under the UN Secretary General's Global Strategy for Women's and Children's Health, or the WHO's Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition
- Donors could choose to help increase breastfeeding rates by supporting specific countries with low WBT*i* scores or those LDC countries where resources are constrained.
- Donors could also choose to support specific indicators with low scores in many countries e.g. International Code of Marketing of Breastmilk Substitutes(Code), infant feeding policy during emergencies, or maternity protection.

WBT*i* Works

The Impact: The national action that WBT*i* has generated

The World Health Organisation has recognised the tool for its usefulness in one of their Statements issued at the time of World Breastfeeding Week 2012.

WBT*i* is now being recognised as a valid tool to study the impact of implementing the *Global Strategy on IYCF* practices. The study by Lutter and Morrow[1] looked at the impact of implementing the Global Strategy in twenty-two WBTi countries in Africa, Asia, the Middle East, and Latin America, using baseline data collected 13 to 25 years earlier, national infant feeding survey data collected between 2002 and 2011, and the WBT*i* survey conducted between 2008 and 2012 . They found a statistically significant median annual increase in exclusive breastfeeding for the first six months to be 1.0% per year in countries in the upper fiftieth percentile of WBT*i* scores, while the median increase in exclusive breastfeeding was only 0.2% per year in countries with the lowest WBT*i* scores. This annual increase was not associated with maternal demographic factors such as urban residence, paid employment, education or gross national income.

The World Breastfeeding Trends Initiative (WBT*i*) consists of two distinct activities, one is to assess, analyse and document the IYCF policy and programmes, and second is to use the gaps thus found for advocacy to call for a change at national level. The entire process is founded on the principle, that if people know their problems they tend to fix them. In this chapter, we try to assess the impact of our work so far on national actions both in general and specific terms.

The WBT*i* provides an ideal tool for improving both policy and action, 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 prioritize 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 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.

General Impact

Using the ABCDE of the World Breastfeeding Trends Initiative (WBT*i*) we analyse general impact.

A- Action: It is quite evident that the initiative

did lead to much needed action. Many countries have shown progress in scores in individual indicators or all together. IBFAN groups at national level coordinated the assessment process, and thus their own capacity in data collection and analysis got enhanced. There is some impact which is general in nature setting up good process in a country and others are more specific on overall policy and WBT*i* score, as well as on individual indicators.

B-Bringing together: As many 51 countries have used it successfully. 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. Governments have been serious partner in conducting assessments (see the list of partners) in most countries. The fact that more than 480 partners took part in 51 countries makes it a major impact. The governments led the process at many places.

C-Consensus building: This has helped to reach a consensus on what actions need to be taken on a priority basis based on which they developed a set of recommendations.

D: Demonstration of achievement and gaps: Countries successfully used the findings and the colour coding to country stakeholders and policy makers.

E-Efficacy /improvement of programmes: This is what we describe in following sections. Today, 82 countries are involved in conducting the WBT*i* assessment, of which 51 have completed the task of assessment and also used the findings for national advocacy to call for change. They include 14 countries from the Latin American and Caribbean region, 14 from Africa, eight from South Asia, five from the Arab World, four each from East Asia and Southeast Asia, and two from Oceania. Of the 51 countries where WBTi analyses has been conducted between 2008 and 2012, five countries in the South Asian region Afghanistan, Bangladesh, Bhutan, India, and Sri Lanka have completed the assessment thrice, first in 2005, 2008 and 2012, two countries in the Latin American and Caribbean region Costa Rica and Dominican Republic have conducted two assessments each, one in 2008 and the other in 2012. The rest have conducted just one assessment, though some of the countries in the African region are in the process of conducting a second assessment.

Gain of overall scores

When WBT*i* was launched, study of trends every 3-5 years was recommended. The impact of WBT*i* on government action started becoming evident after South Asian countries conducted their first assessment in 2005. Action was initiated in other countries. In 2008, the tool was introduced in several countries in East and Southeast Asia, Africa and Latin America and Caribbean Region. The WBT*i* assessment underlines the need for political will to mainstream breastfeeding and IYCF policy and programme in national action. This political will has to translate into action on several fronts to bring a change. Scoring and color coding have been effective tools in building this political will, as in the case of Bhutan and Afghanistan, which were in the red zone in 2005-06 assessment, and did not have data on breastfeeding indicators began doing this. They moved upwards in the reassessment in 2009-10. Political will is also apparent in the remedial actions taken by several countries after analyzing results of the assessment.

The Box 3 gives an expression of a country coordinator of Lebanon regarding what WBT*i* did for them.

In South Asia

The following section provides analysis of the

Box 3 WBT*i*: A tool for transforming ideas into action

A Report of Impact from Lebanon

" After more than 20 years of work in planning and developing programs with international organizations, we found WBT*i* assessment tool: practical, simple, scientifically accurate, easy to be used by multidisciplinary team and help a lot for passing from assessment to planning and monitoring progress. It offers opportunities to develop partnership between national partners, building national capacity, progressing by doing and working together, and networking with potential actors. It is useful tool for internal or external monitoring. The WBT*i* tool helped us to create the joint committee with the Ministry of Health (MoH) and to lead the team in the process of the assessment and facilitate their participation in evaluation and rating; we transformed the assessment to a national event by implementing a national workshop for building one national vision and plan under the umbrella of the MoH; the assessment helped us to mobilize the MoH staff to support our idea to create a national program for optimal infant and young child feeding. It is worth to note the special support we receive from H.E the Minister and the General Director; the program will be responsible for planning, implementing, and coordinating national efforts to achieve step by step the ultimate goal and the president of LAECD is designated to be the national coordinator of the Program. IBFAN Arab World is a nonvoting member of the committee like WHO and UNICEF. Two international organizations (represented by their branches in Lebanon) - World vision Foundation and International Orthodox Christian Charities - joined the committee. One of the main outcomes of the processes was the huge work on collecting, analyzing national data from surveys (1991-1992, 1996, 2000, 2004, 2009), available breastfeeding data during 2006 emergency, SIM (2006), and evaluations studies done during the past 20 years of work for protecting and supporting and promoting breastfeeding. This work led by the President of LAECD but published as national reference with three Logos; MoH, IBFAN Arab World, and LAECD."

Dr. Ali El Zein, WBT*i* Country Coordinator Lebanon

impact of WBT*i* in the South Asia on key areas of areas identified by the Global Strategy. These are based on the reports of the country coordinators.

The World Breastfeeding Trends Initiative (WBT*i*) 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. The third assessment in 2012 has been conducted by five countries from South Asia namely (Afghanistan, Bangladesh, Bhutan, India and Srilanka)

Fig. 23 shows the average scores for all indicators for the five South Asian countries that have completed their third assessment Afghanistan, Bangladesh, Bhutan, India and Sri Lanka. The figure reveals that the score for all the indicators, except for Indicator 2 (BFHI), and Indicator 10 (monitoring and evaluation) have improved. The

Fig. 23: Average Scores for indicators 1-10 for 5 South Asian Countries 2005-2012

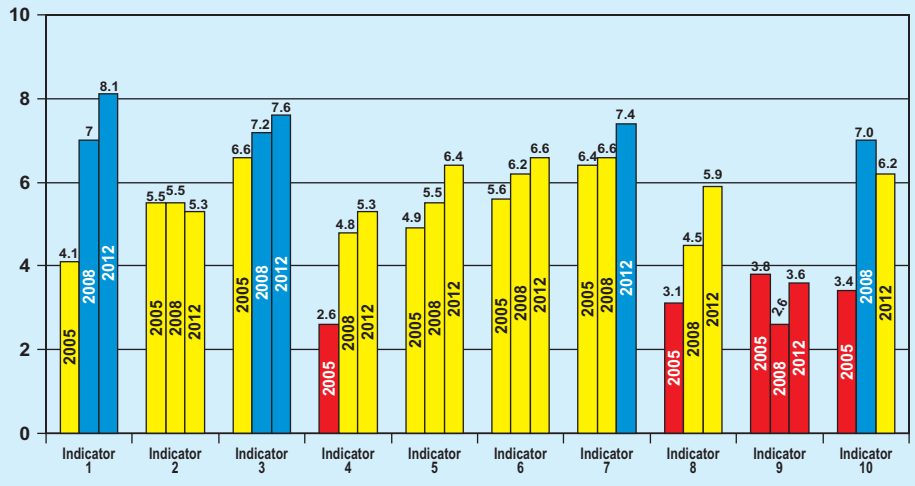
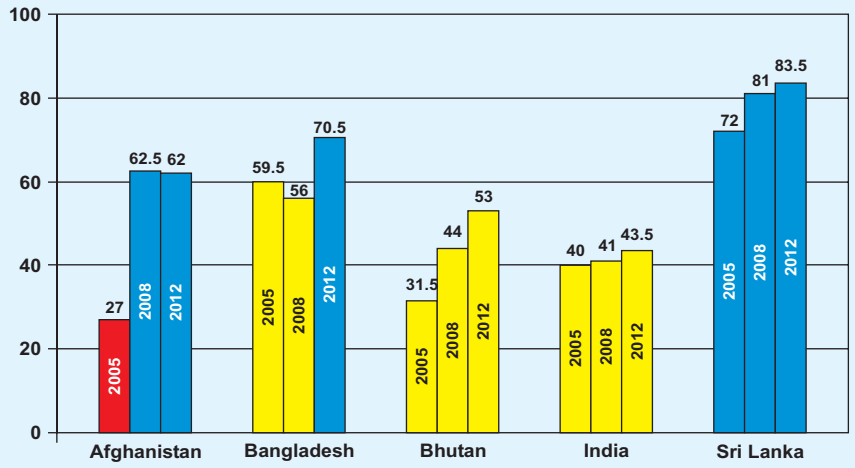


Fig. 24: Total scores for the three assessments for indicators 1-10 for 5 South Asian Countries 2005-2008

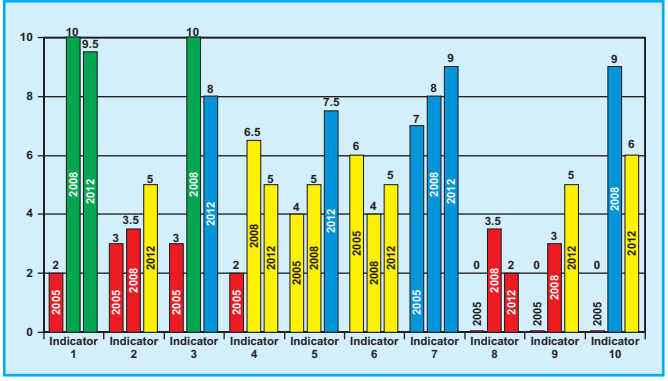


rise in the score is particularly evident in the case of Indicator 1(national policies, programmes and coordination), Indicator 3 (implementing the International Code), Indicator 4 (maternity protection), Indicator 7 (information support) and Indicator 8 (infant feeding and HIV). In all indicators, the rise has been steady, from one to next assessment. The decrease in the score of the indicator on BFHI could be attributed to the difficulty these countries face in raising funds for reactivating BFHI or lack of priority given to the intervention. Lack of support the indicator receives from international bodies such as WHO and UNICEF is another reason. The score for indicator 9 (Infant feeding during emergencies), continues to be in red, meaning that countries have not yet begun to realize its importance. This is in spite of the fact that almost all the countries of the region have been experiencing natural disasters and conflict situations.

Fig.24 gives the total scores the countries got for at each assessment as per the policy and programmes i.e. out of 100. All the countries have improved their scores significantly from the first assessment, with Bhutan moving from red to yellow and Afghanistan from red to blue over the last 8 years. The first assessment highlighted a lack of data on IYCF practices in both the countries, which immediately put into place data collection mechanisms; the data so collected on IYCF practices were reflected in the increased scores for the 2008 assessment. This serves to underline the conclusions of Lutter and Morrow that putting policies in place, and implementing them can effectively enhance optimal IYCF practices.

Again, all the countries, except Afghanistan, show an increase in the scores from the 2nd to the 3rd assessment, with Bangladesh having the highest increase. The detailed rating for Afghanistan makes it evident that though the country has taken several actions to protect, promote and support breastfeeding; their scores for Indicator 3 (implementation of the International Code) and Indicator 10 (monitoring and evaluation) have dropped. The reason for this could be the prevailing conflict situation in the country, and also its extreme dependency on foreign aid for implementing any programme or initiating any action. (Fig. 25)

Fig. 25: Afghanistan- Trends in scores of indicators 1-10 (2005-2012)



Bangladesh has shown significant improvements in the indicator on National Policy and Programme Coordination, where the score has risen from 6 in 2008 to 10 in 2012; and in Maternity Protection the score has risen from 1 to 4.5 and the indicator has moved from red to yellow colour rating. Two more indicators on policy and programmes have moved up from yellow to the next level blue and the total score for Bangladesh, including the score for the five practice indicators, has taken a significant leap from 87 to 110.5. Even two indicators pertaining to exclusive breastfeeding for the first six months and bottle feeding rates, have moved up to a greater level of achievement. (Fig. 26)

Bhutan has improved its scoring on policy, programme and coordination from 2 (red) in 2005, to 7 (blue in 2008) and then reached the green level with the maximum score of 10 in 2012. However, its scores have not changed significantly for other indicators. It shows action though in slow motion. (Fig. 27)

Sri Lanka has moved up from yellow to the next level blue and even greater to green in two of the ten indicators of policy and programmes. (Fig. 28)

In India, there has not been much change. This is because India has failed to capitalize upon the early 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. However, lack of action on the other indicators has resulted in insignificant rise in three indicators on policy and programmes. (Fig.29)

Fig. 26: Bangladesh- Trends in scores of indicators 1-10 (2005-2012)

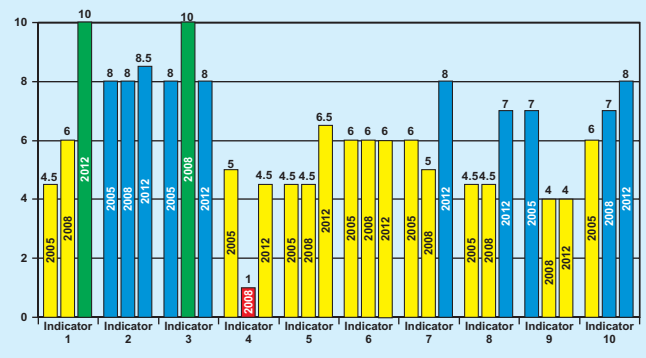


Fig. 27: Bhutan- Trends in scores of indicators 1-10 (2005-2012)

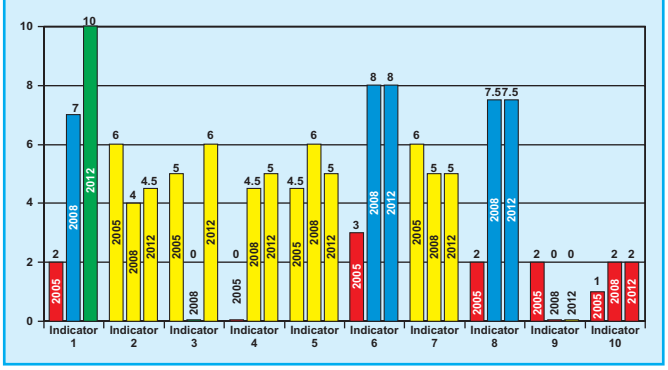


Fig. 28: Sri Lanka- Trends in scores of indicators 1-10 (2005-2012)

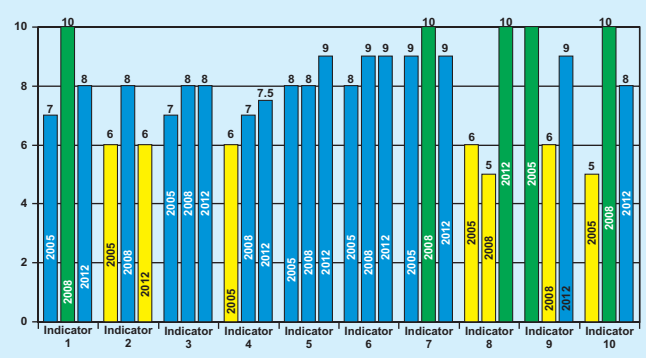
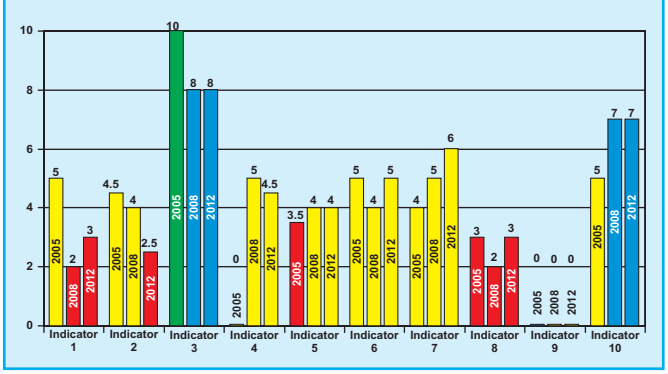


Fig. 29: India- Trends in scores of indicators 1-10 (2005-2012)



In Latin America and Caribbean

Costa Rica and Dominican Republic, as mentioned earlier, have each conducted two assessments the first in 2009 and the second in 2012. Fig. 30 gives their average scores for indicators 1-10 for both the assessments.

The Fig. 30 shows that other than for Indicator 2 (BFHI) and Indicator 3 (International Code) there has been an increase in the scores of all indicators, with the highest increase of 2.5 points being for Indicator 1 on National Policy, Programme and Coordination. The scores for Indicator 5 (Health and nutrition), Indicator 6 (Community outreach) and Indicator 8 (infant feeding and HIV) have risen by two points each.

Fig. gives the total scores the countries got at each assessment.

The Fig. 31 & 32 once again underscore the value of WBT*i*. In the period between the two assessments, both countries have improved both their total scores for all indicators as well as their ranking, with Costa Rica moving its score from 95 to 100 and its ranking from 9th rank to 8th, and Dominican Republic raising its score from 58.5 to 82, and its ranking from 27th position to the 21st; however both the countries are still within the earlier colour, with Costa Rica remaining in blue and Dominican Republic in yellow. It is interesting to note that the reduction in Costa Rica's scores for policies and programmes by 5

Fig. 30: Average score 1-10 for 2 Latin America Countries 2008-2012

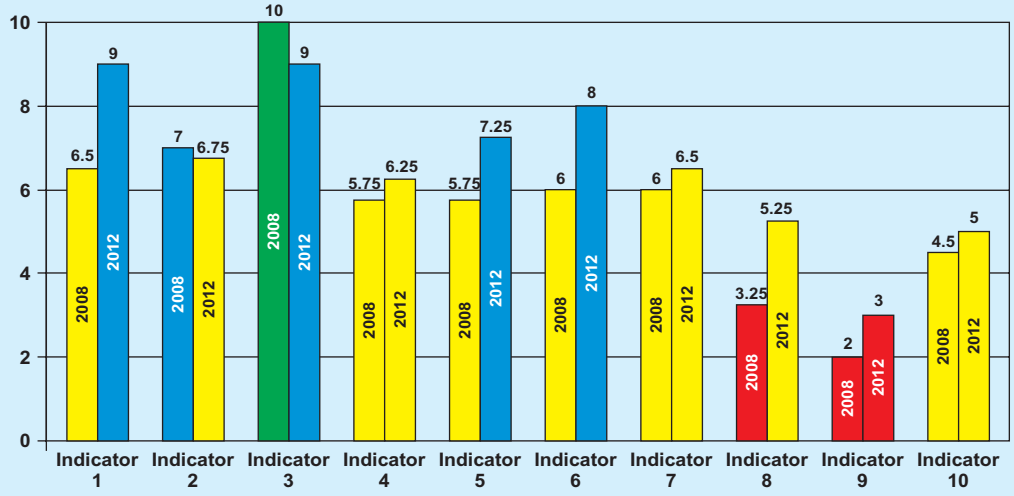


Fig. 31: Total scores for the indicators 1-15 for 2 LAC 2005-2012

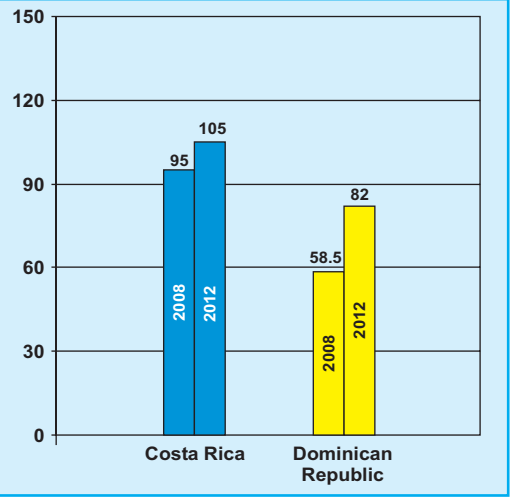
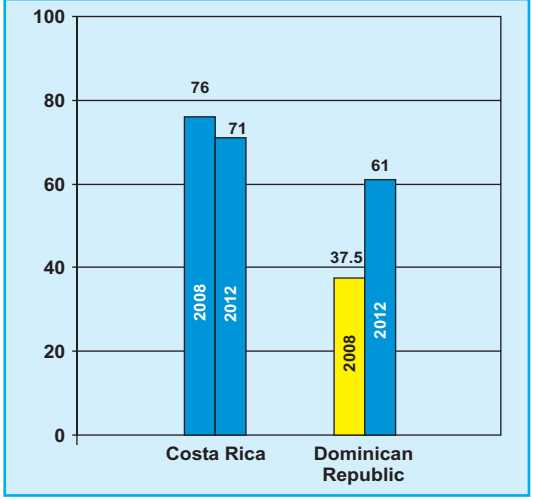


Fig. 32: Total scores for the indicators 1-10 for 2 LAC Countries 2008-2012



points is offset by its improvement in scores for practices; this improvement could be because the country, which had little data on practices during the first assessment, prioritized data collection once this gap was identified by the time of the second assessment.

Dominican Republic, in contrast, has significantly improved its scores on policies and programmes, jumping from 37.5 (yellow) to 61 (blue). However, as there has been has no new national level data collection on practices since 2007, the impact of the policy changes are not reflected in the score for IYCF practices, which thus remains the same for both 2008 and 2012, and which has kept the country in the yellow level. It is probably for this reason that the country assessors have recommended that the monitoring and evaluation system needs to be strengthened.

Impact on Specific Action Areas

Here we describe the impact more specific to each indicator for change in policy and programmes. This is based on reports from about 30 countries. The impact shows satisfying results when we look at the analysis of findings.
Policy development, coordination and financing

In the area of policy development, action has been generated in all regions Asia, (South Asia, East Asia and Southeast Asia), Africa and the Latin American and Caribbean (LAC) region.

In Asia region

After the first assessment, Bhutan and Afghanistan came up with a draft IYCF policy and strategy, with Bhutan also preparing an operational plan after the first assessment in 2005. Afghanistan's Ministry of Public Health has a specific IYCF policy, and has also developed an estimate of the financial resources required for its implementation.
Other noteworthy impacts in the area of policy in Asia include the following:

- After the second assessment, Bhutan allocated 2.5million Ngultrum for IYCF activities for the fiscal year 2011-2012.
- Following the assessment in 2008, Afghanistan organized a national breastfeeding campaign in 2010, and doing a similar campaign in 2012-2013.
- China is revising its national strategy on IYCF with the support of WHO. The recently issued China National Programme for Child Development (2011-2020) has included a major objective to raise the rates of exclusive breastfeeding of babies under six months to over 50%.
- In Thailand, IYCF has been linked to the Integrated surveillance of child development by the community, wherein the community is involved in the monitoring the development of children between 0 and 72 months of age, in collaboration with local public health outlets and administrative offices.

In Africa region

As the government led the WBT*i* assessment in several African countries, there were very significant impacts of the assessment.

- The National Nutrition Agency of the Gambia validated a new Nutrition Policy that was developed as a result of the assessment conducted in 2010.
- In Uganda, the assessment led to the development of National Policy Guidelines for IYCF and to district specific 5-year strategic plans for implementing the guidelines.
- In Kenya, the new WHO guidelines on HIV and Infant Feeding was adapted and included in the "Maternal, Infant and Young Child Nutrition" (MIYCN) policy, strategy and guidelines; the MIYCN interventions have, in turn, been incorporated into the Food and Nutrition Security Policy (Session paper No. 1/2012); the National Nutrition Action Plan and Scaling up Nutrition. Kenya has also used the WBTi Score card to involve more media houses in broadcasting breastfeeding information.

Box 4 WBT*i*: Experience in Africa

Since the launch of the WBT*i* in 2008, 22 countries have undergone the training and assessment process. Fourteen reports have been completed and three countries have conducted re-assessments. The WBT*i* process has brought together in the different countries, partners from different sectors to dialogue and hold discussions on progress and achievement made in infant and young child feeding policy and programming. This coming together of partners forms the core component of the WBT*i*. The ensuing interrogation of the assessment results and the consensus which is reached generates a very healthy environment and brings to the fore the realisation that infant and young child nutrition and development is everybody's business. Non-health sector personnel have found the process both educative and informative. During one of our meetings in Zimbabwe, the participants called for closer collaboration between the Ministries of Health and Child welfare (Nutrition) and that of Labour and Social welfare so that they could strategise together on how to harmonise the message of six months exclusive for infants and the current maternity leave conditions for working women. The discussion and appreciation of the benefits of exclusive breastfeeding facilitated by the WBT*i* which has not happened before may explain why the indicator on maternity protection is one of the poorest performing in all assessed countries.

For the Regional Office, the WBT*i* reports and summary report cards generated have proved invaluable advocacy tools during meetings with policy makers and programme managers. At a glance, they are able to see the performance of their countries in implementation of the Global Strategy for Infant and Young Child Feeding. The meetings always end with a resolve to ensure that the gaps identified will be bridged so that the next assessment should give a perfect score of ten for each indicator! The WBT*i* tool is indeed provoking action for change and improvement in breastfeeding practices and rates for optimal health and development of our infants.

Joyce Chanest, Regional Coordinator, IBFAN Africa

In LAC region

- The impact of the WBT*i* assessment done in 2008-10 is very visible in the LAC region.
- Costa Rica developed a National Breastfeeding policy, and the National Breastfeeding Commission based its operational plan on this policy. The policy also has clear institutional guidelines on infant feeding in emergencies, particularly in the context of management of shelters. National standards have also been developed for Human Milk Banks.
- Dominican Republic developed a comprehensive policy on infants and young children including infant feeding in emergency situations, National Breastfeeding Committee has begun working, and formulated the Infant Feeding Strategic Plan 2009-2012. While the financing is still being negotiated, the process is being supported by UNICEF and PAHO. They have also developed a policy on infant feeding and HIV. Ecuador has developed National Breastfeeding Committee by enacting a legislation as well as policy of human milk banking and infant feeding in disasters.
- Colombia has developed a comprehensive strategy on early childhood care in people affected by displaced by violence and included infant feeding in disaster situations. Its on high level attention within the President's programme strategy of Hunger Zero.
- In El Salvador, the Minister of Health officially established the National Breastfeeding Commission, while the National Congress declared the whole month of August as the month of breastfeeding. A law on breastfeeding was also submitted to the Congress, using the WBT*i* assessment as the supporting document to lobby with the representatives.
- Uruguay enacted the National Breastfeeding Policy as Ministry order in 2009, as recommended by WBT*i* assessment.
- Guatemala used the WBT*i* assessment and moved the National Breastfeeding Committee to develop a 5-year strategic plan for enhancing breastfeeding rates.

Box 5 WBT*i*: Process in Latin American and the Caribbean

One of the most important aspects of the WBT*i* evaluation in LAC is that it is a national participatory process. Since its inception, the coordinating team in each country has clearly aimed to involve a range of significant actors, including program directors, policy-makers, civil society organizations, academics and UN agencies. The purpose of this has been to guarantee that the evaluation results will be widely discussed and gaps clearly identified in order to define necessary courses of action. Thus, with the participation of both government, civil society and academia actors, priorities have been defined and proposals for improvement developed. Not only evaluation results but also mechanisms for solutions are shared in the process. These are then brought before the national public since the necessary changes should have the backing of the people, organized or not. In this way, the evaluation is complemented by necessary mobilization, action, and vigilance among the most interested sectors among groups of mothers and women, consumers, and others, who, in turn, become real allies for program directors, who understand that most of the time nothing happens without sufficient pressure on those in power.

In Latin America and the Caribbean, the WBT*i* process has been an instrument for change. Out of 22 countries in the region, 14 have conducted a WBT*i* evaluation between 2008 and 2012. Two of these countries, Costa Rica and the Dominican Republic, have performed a second evaluation, allowing them to measure the impact of the WBT*i* tool in the change process. The gaps identified in these evaluations have led to the development of: a 5-year strategic plan for the National Breastfeeding Commission of Dominican Republic with the support of the United Nations; a national policy on breastfeeding for Costa Rica; and, in both countries, policies on infant feeding in emergency situations with clearly guidelines, above all in the wake of the Haiti earthquake and a revitalization of the Baby Friendly Hospital Initiative. Costa Rica now has an indicator in the National Survey about the initiation of breastfeeding in the first hour after birth. The Dominican Republic developed exemplary systems and services for forming and supporting lactation consultants that help train others, including at the Haitian border.

In the other 11 countries, the impact of the WBT*i* process is notable in improvements like the strategic strengthening of National Breastfeeding Commissions which are exercising a straight-forward role in infant-feeding policies; official monitoring of the International Code, as well as formal complaints against the companies that violate it and internal mechanisms to keep industry marketing out of the health systems; and national struggles to increase maternity leave, with clear advances in Venezuela, Brazil and Chile. And, most importantly, the WBTi process has left each country with groups that are experts in the current state of infant-feeding programs and policies in their countries and will serve as academic and political references, as well as nuclei of national action and networking with other countries in the region and the world.

Marta Trejos, Regional Coordinator, IBFAN LAC

In key areas required for action following impact has been reported

Maternity Protection

- Recognising the large gaps that exist in the area of maternity protection, and its vital importance in supporting women to practice optimal IYCF, several countries, especially in Africa, LAC and Asian regions initiated action in this area.
- In the Gambia, the findings of the WBT*i* assessment were used successfully during the enactment of the Women's Bill leading to the incorporation of maternity protection in the legislation.
- Three countries in the LAC region Ecuador, Colombia and Peru established laws that allow breastfeeding in public places, and have set up places for women to use breast pumps with ease.
- In Uruguay, a draft was presented to the Congress to extend maternity leave and part-time employment during the period of lactation, and to harmonize maternity benefits available in the public and private sectors.
- In Dominican Republic ILO's C183 presented to Congress
- In El Salvador a government and private fundraising campaign has been developed in to raise awareness on women's rights, including their right to breastfeed.
- The Brazilian government, working with IBFAN and PAHO, has developed a training module to help public and private institutions set up mother and baby friendly facilities at the workplace; 22 local governments are

participating in monitoring this.

- In Vietnam, Asia, successful advocacy was led to extension the period of maternity leave to six months.
- In Bangladesh, the Prime Minister issued an order extending paid maternity leave to six months.
- In China, "The Special Rules on the Labor Protection of Female Employees was issued on Apr. 28, 2012, replacing the previous Regulations Concerning the Labor Protection of Female Staff and Workers (1988). These Rules extend maternity leave are from 90 days to 98 days, with the basic payment being covered by maternity insurance. Government employees in Hong Kong are entitled to five days of fully paid paternity leave from April 2012.
- The Royal Government of Bhutan issued an executive order allowing every lactating mother to work from home every Tuesday till the baby is two years of age to promote breastfeeding.
- In Philippines, the WBT*i* process of building consensus was particularly useful in enacting the new law on Expanded Breastfeeding Promotion Act that was passed in early 2010 to enable women to breastfeed at the workplace.
- In Lebanon, a new law concerning maternity leave is in process to be enacted in the Parliament to scale up the maternity leave from the current 60 days for the public and 6 weeks for the private sector to 10 weeks.

BFHI, capacity building of health providers and community outreach

Several countries took steps to resurrect the BFHI.

- Bangladesh saw a major improvement in BFHI revitalization, extending accreditation to 63 hospitals at first round with a plan to cover 499 hospitals in next two years.
- Mongolia translated the WHO/UNICEF IYCF counseling manual into Mongolian.
- China initiated a pilot of Baby Friendly Communities in Huairou district in Beijing.
- Zambia developed an IYCF Community package for training the community in IYCF.
- Dominican Republic implemented a Rescue Plan for BFHI in 2011-12, and 11 training modules were updated to train instructors who can train community instructors in Haiti border, a very successful experience that builds ties with the BFHI.
- In Guatemala, the Deputy Hospital Minister launched a policy which includes compliance of the 10 steps, with constant evaluation indicators and results. The budget and hospital supplies are subject to fulfilment of this.
- In Lebanon, the BFHI was re-launched after a ten-year freeze, with an IEC campaign and the participation of 18 public and private hospitals, where workshops were held. Twenty eight persons were trained as Trainers of Trainers, while 14 others were trained as external assessors. A further 20-hours course was conducted for 45 staff from 10 hospitals, and repeated for all hospitals in September. The WHO/UNICEF resource material on breastfeeding promotion and support was translated into Arabic. Funds for all these activities were raised from World Vision.
- In Zambia, the criteria for accreditation were updated, assessment tools were identified and trainings conducted for both hospital staff and the assessors.

Action on International Code

As baby food companies continue their aggressive marketing and promotion of their foods for infants and young children it became too important for countries to take action.

- Protection of breastfeeding through implementation of the International Code is probably the area where the WBT*i* has had the maximum impact.
- Indonesia successfully used the WBT*i* assessment to include three articles related to breastfeeding in their Health law N. 23/1992.

- China started the revision of the Regulations on Marketing of Breastmilk Substitutes; the draft of revised regulations was submitted to the State Council who collected comments among general public during November of 2011. The Minister of Health and related government sections are in the process of approving final revision; the country has also conducted a Code training course for heads in provincial offices of the China Consumer Association, which will compose a network of Code monitors.
- Hong Kong put in a policy that prevents public hospitals from accepting free supplies of infant formula; further, as a result of advocacy, eight to the 10 private hospitals in the country have stopped accepting donations of infant formula.
- Bangladesh has strengthened its laws on the BMS Code to include subsequent WHA resolutions.
- In Thailand, the cabinet acknowledged the controlling measures on baby milk marketing and advertisement as proposed by the Ministry of Public Health.
- Ecuador saw the development of a regulation of food advertising, especially baby food; in additing, responded to the National Nutrition Plan resulting from the WBTi assessment, the new regulation included a regulation on publicity of infant feeding.
- Mexico has been using the assessment to conduct advocacy on implementing the laws relating to the International Code.
- Costa Rica held two Code Trainings in 2011 and 2012 with financial support from PAHO. Nicaragua used the score card effectively to raise US$ 6000 from UNICEF to conduct advoacy for implementing the Code.
- In Swaziland, the Code of marketing has been included in the Public Health Act which is in its final stages before enactment.
- Uganda used the WBT*i* assessment to raise US$ 100,000 from UNICEF for a yearlong project to support work on the International Code and BFHI.
- After a delay in implementing the new Lebanese Law 47/08, the National Breastfeeding Committee, in its first meeting,, formed three subcommittee to deal with various aspects of the implementation.
- Kuwait has begun to develop a local code or policy document as first step before the drafting a law.

Endnote:

1. Lutter C, Morrow AL. 2012. Protection, Promotion and Support and Global Trends in Breastfeeding. Advances in Nutrition. (in press)

About WBT*i* and the Process

The World Breastfeeding Trends Initiative (WBT*i*) is an innovative initiative of the International Baby Food Action Network (IBFAN), spearheaded by its Asia regional office, for tracking, assessing and monitoring implementation of 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 action to protect, promote and support breastfeeding 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 accord priorities to them. The WBT*i* assessment is not conducted by an external agency, but by the people in countries themselves. The WBT*i* team at IBFAN Asia receives findings from the national team, and initiates a process of verification; particularly sources of the information supplied, and then look for a national consensus. Once the national team agrees to the assessment findings, the WBT*i* team uploads the report on to the web-tool that provides the score and rating/colour coding.

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

Objectives of WBT*i*

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 for the exercise and strengthens national partnerships for effective actions to bridge the existing gaps.

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

The WBT*i* 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 WBT*i*. 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.

The WBT*i* 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 WBT*i* 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 WBT*i* 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 to make the scoring objective and also to make it user-friendly.

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

WBT*i* 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

A tool to motivate policy makers to act

WBT*i* 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 WBT*i* Works?

The WBT*i* involves a three-phase process.

Phase 1

The first phase involves initiating national assessment of the implementation of the *Global Strategy*. The WBT*i* 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 data and 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.

The WBT*i* 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 WBT*i* process includes consensus building, the multiple stakeholders become committed to the action and to giving it the priority it deserves. For the WBT*i*, 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, WBT*i* uses the findings of the national assessment and provides scoring, colour based on IBFAN Asia's Guidelines for WBT*i* assessment.

Each indicator related to policies and programmes has a subset of questions, based on the Global Strategy that the country must answer with a documentary proof. 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 and colour rates each indicator as well as the entire set of indicators.

- Red *(bad)*,
- Yellow *(insufficient)*,
- Blue *(needs improvement)*, and
- Green *(acceptable)*

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

Phase 3

In the third phase, WBT*i* 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 and 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.

The 15 Indicators of the WBT*i*

The WBT*i* 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.

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 rating has come down for national guidelines, because no steps were taken between 2005 and 2012.

Why WBT*i* 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, WBT*i* 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 for 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' 'HIV & Infant feeding' 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, trainings for this work were organized for 22

International WBT*i* training in Geneva

more countries in Arab World and Afrique region.

6. In 2011, trainings were organized for Oceania region and Timor-Leste. These trainings were conducted by resource persons from IBFAN Asia and IBFAN Oceania office.
7. Among all the countries that underwent a training for thr assessment, 51 has completed the task and their reports are uploaded on the web-portal of WBT*i*.
8. 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.
9. The national groups finally reach a consensus on the findings and develop a set of recommendations based on the gaps found.
10. The final findings are shared 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 51 countries Stand!
11. As many as 475 partners were involved in all the 51 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.

Arab World

Afrique

East Timor

Africa

East Asia & Southeast Asia

475 Partners including Government organization involved in WBT*i* assessment process in 51 Countries

1. **AFGHANISTAN**
   1. Health promotion department/MoPH
   2. UNICEF
   3. WHO
   4. WFP
   5. FAO
   6. BASICs
   7. OXAF NOVIB
   8. SAVE THE CHILDREN
   9. Care of Afghan Families (CAF)
   10. HEALTH NET INTERNATIONAL
   11. Agha Khan Health services Afghanistan (AKHS)
   12. MDG Fund
   13. Micronutrient Initiatives (MI)

2. **ARGENTINA**
   14. Ministry of Health
   15. CLACYD Foundation
   16. UNICEF Argentina
   17. Argentina Pediatric Association
   18. LLL Argentina
   19. IBFAN Buenos Aires, Mendoza, Córdoba, Neuquén, Salta, Corrientes, Santa Fe and Chubut

3. **BANGLADESH**
   20. Ministry of Health and Family Welfare (MOHFW)
   21. Director General of Health Services (DGHS)
   22. Directorate General of Family Planning (DGFP)
   23. Community Clinic (CC)
   24. United Nations Children's Fund (UNICEF)
   25. World Health Organization (WHO)
   26. Plan Bangladesh
   27. Concern World Wide Bangladesh (CONCERN)
   28. Bangladesh Institute of Development Studies (BIDS)
   29. International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B)
   30. Bangladesh Neonatal Forum (BNF)
   31. Bangladesh prenatal Society (BPS)
   32. LAB-AID
   33. Bangladesh institute of Research and Rehabilitation in Diabetes Endocrine and Metabolic (BIRDEM)
   34. Square Hospital
   35. Sir Salimullah Medical Collage (SSMC)
   36. Centre for Women and Child Health (CWCH)
   37. World Vision-Bangladesh
   38. Social Marketing Company (SMC)
   39. Dhaka Medical Collage and Hospital (DMCH)
   40. Bangladesh Paediatrics Association (BPA)
   41. Kumudini Medical College
   42. Helen Keller International (HKI)
   43. Institute of Public Health Nutrition, (National Nutrition Service) (IPHN, NNS)
   44. Food & Agriculture Organization (FAO)
   45. National Institute for Population Research and Training (NIPORT)
   46. Care Bangladesh
   47. Bangladesh Medical Association (BMA)
   48. Micronutrient Initiative (MI)
   49. Thengamara Mohila Sabuj Sangha (TMSS)
   50. Dhaka Shishu Hospital (DSH)
   51. Save the Children (SC)
   52. Save the Children Found (SCF)
   53. Dusto Shastho Kendro (DSK)
   54. Alive & Thrive
   55. Research Training Management International (RTM)
   56. Institute of Public Health (IPH)
   57. Hope and Health Hospital (XWMC)
   58. Revitalization of Community Health Care Initiative in Bangladesh (RCHCIB)
   59. Bangabandhu Sheikh Mujib Medical University (BSMMU)
   60. Bangladesh Rural Advancement Committee (BRAC)
   61. Obstetrics and Gynaecological Society of Bangladesh (OGSB)
   62. Shaheed Suhrawardy Medical College (ShSMC)
   63. Eminence Associate (Eminence)
   64. Bangladesh Institute of Health Services (BIHS)
   65. Institute of Child and Mother Health (ICMH)
   66. James P Grant School of Public Health, JPGPH
   67. Bangladesh Bureau of Statistic (BBS)
   68. Rangpur Dinajpur Rural Services (RDRS)
   69. Urban Primary Health Care (UPHC)
   70. Dhaka Medical Collage (DMC)
   71. Bangladesh Breastfeeding Foundation (BBF)

4. **BHUTAN**
   72. Nutrition Program, Ministry of Health
   73. Pediatricians, JDWNRH

5. **BOLIVIA**
   74. International Action for Health AIS BOLIVIA
   75. International Baby Food Action Network for IBFAN Bolivia
   76. Defense Committee for Consumer's Rights CODEDCO.
   77. Foundation for Nature and Life FUNAVI

6. **BOTSWANA**
   78. MOH
   79. AED
   80. MLG
   81. PMH PNW
   82. BOBA
   83. TAB HOSPITAL
   84. SSKB CLINIC
   85. PMH DIETETICS
   86. HEALTH STATS.PME
   87. NRH
   88. HIS (LOBATSE)
   89. NFTRC
   90. UNIVERSITY OF BOTSWANA
   91. LSS/HQ
   92. PATHFINDER
   93. UNICEF

7. **BRAZIL**
   94. IBFAN Brazil

8. **CAPEVERDE**
   95. Ministry of Health
   96. National Nutrition Program-Cape Verde
   97. INE (National Institute of Statistics of Cape Verde)

9. **CAMEROON**
   98. Ministry of Public Health
   99. WHO
   100. UNICEF
   101. ILO
   102. WABA
   103. IBFAN
   104. Hellen Keller Foundation
   105. Plan International
   106. Cameroon Link

107. CAMNAFAW
108. Vine Yard - Central Africa Region

10. CHINA
109. Ministry of Health
110. WHO China Office
111. UNICEF China Office
112. China Advertising Association, Leagal Services Center
113. China Consumer Associate
114. China Preventive Medicine Association, Society of Child Health
115. Capital Institute of Pediatrics

11. COLOMBIA
116. Ministry of Social Protection
117. Guillermo Fergusson Foundation
118. IBFAN Colombia
119. Colombian Institute for Family Welfare
120. Profamily
121. National Institute of Health
122. Antioquia University
123. PAHO Colombia
124. UNFPA Colombia
125. UNICEF Colombia
126. Institute for Surveillance of Medicines and Foods INVIMA
127. Javeriana University
128. Bogotá District of Health
129. District Group for the Promotion, Protection and Support of Breastfeeding
130. Corporation Promoter of Health Saludcoop
131. Secretary of Health of Bogota

12. COSTA RICA
132. National Breastfeeding Commission.
133. Ministry of Health.
134. Ministry of Public Education.
135. Ministry of Economy, Industry and Trade.
136. Costa Rican Social Security Entity.
137. Costa Rican Institute for Research and Education on Nutrition and Health.
138. School of Nutrition at the University of Costa Rica.
139. Costa Rican Union of Associations and Chambers of Private Enterprise.
140. National AIDS Program.
141. National Emergency Commission.
142. Feminist Center for Information and Action CEFEMINA.
143. WABA Focal Point for Latin America and the Caribbean.
144. Association for Breastfeeding Promotion APROLAMA
145. United Network for Mothers-Babies and their Nutrition - RUMBA.
146. International Baby Food Action Network IBFAN Costa Rica
147. UNICEF Costa Rica
148. PAHO Costa Rica

13. DOMINICAN REPUBLIC
149. State Secretariat of Public Health and Social Assistance.
150. National Breastfeeding Program SESPAS.
151. National Breastfeeding Commission.
152. International Baby Food Action Network IBFAN Dominican Republic.
153. PAHO Dominican Republic.
154. State Secretariat of Education.
155. State Secretariat of Industry and Trade.
156. State Secretariat of Environment.
157. State Secretariat of Women.
158. State Secretariat of Agriculture.
159. Dominican Social Security Institute.
160. Autonomous University of Santo Domingo.
161. Dominican Republic Pediatric Society.
162. National Council for Childhood.
163. Dominican Institute of Food and Nutrition.
164. Dominican Republic Caritas.
165. La Leche League.
166. Maternal-Infant National Research Center CENISMI.
167. Project Hope.
168. Sexually Transmitted Diseases and AIDS General Direction.
169. General Emergencies Direction

14. ECUADOR
170. Nutrition Coordination of Ministry of Health
171. Ministry for Economic and Social Coordination
172. Nutritionists DPSG
173. FUNBBASIC. Foundation
174. International Baby Food Action Network IBFAN Ecuador.
175. Standardization MSP, Health Surveillance MSP.
176. South Hospital MSP, DIPLASEDE MSP.
177. HIV AIDS Program MSP.
178. World Food Program WFP.
179. UNICEF
180. International University San Francisco de Quito.
181. Association of Faculties of Health AFEME.
182. Central University of Ecuador.
183. National Council of Women CONAMU.
184. Equinoctial Technological University.
185. Direction of Public Health of Guayas.
186. Catholic University of Guayaquil.
187. Guayaquil State University.
188. Obstetrics College of the State University.
189. Mariana de Jesus Maternity.
190. Guayaquil Hospital
191. Municipal Social Development Office.
192. Cantonal Council for Childhood and Adolescents

15. EL SALVADOR
193. Ministry of Health
194. Food and Agriculture Organization FAO
195. Social Development Foundation FUNDESO
196. National Institute of Development for Women ISDEMU
197. Salvadorian Institute of Social Development ISSS
198. PAHO El Salvador
199. Salvadorian Women Organization ORMUSA
200. UNDP El Salvador
201. University of El Salvador UES
202. University Research Co. LLC URC
203. HIV Unit Ministry of Health
204. Nutrition Unit Ministry of Health
205. INTERVIDA
206. Plan El Salvador
207. Save the Children
208. University Jose Matias Delgado
209. Centre for Supporting Breastfeeding - CALMA

16. EGYPT
210. Ministry of Health
211. IBFAN Arab World
212. Egyptian Lactation Consultants Association (ELCA)
213. UNICEF

17. FIJI
214. National Food and Nutrition Centre, Ministry of Health
215. UNICEF Fiji
216. Consumer Council of Fiji
217. International Labour Organisation, Fiji Office
218. National Advisory Committee on AIDS
219. IBFAN Oceania

18. GAMBIA
220. National Nutrition Agency (NaNA)
221. Department of State for Health and Social Welfare
    i. Reproductive and Child Health Unit
    ii. Regional Health Team

iii. Prevention of Parent To Child Transmission
iv. Integrated Management of Neonatal and Childhood Illness Unit

222. Non Governmental Organisations
i. Gambia Food and Nutrition Association (GAFNA)
ii. Gambia Family Planning Association (GFPA)
iii. Christian Children's Fund (CCF)

223. United Nations
i. UNICEF
ii. WHO

224. Gambia College School of Nursing & Midwifery
225. Labour Commission
226. National Nutrition Agency NaNA
227. National AIDS Secretariat (NAS)
228. Media
i. Association of Health Journalists (AOHJ)
ii. Gambia Radio and Television Services (GRTS)
229. Department of Community Development (DCD)
230. Gambia Bureau of Statistics

19. GHANA

231. The Ministry of Women and Children's Affairs (MOWAC)
232. Ghana Infant Nutrition Action Network (GINAN)
233. The Ghana Health Service (GHS)
234. The Ghana Broadcasting Corporation (GBC)
235. The Nurses and Midwives Council
236. The Ghana Medical School
237. The Rural Health Training School.

20. GUATEMALA

238. Ministry of Economy
239. Ministry of Education
240. National Breastfeeding Commission, CONAPLAM
241. UNICEF
242. FANTA, USAID
243. USAID Health Care Improvement Project / HCI
244. Antigua Hospital
245. San Juan de Dios Hospital
246. Secretary of Food and Nutrition Health SESAN
247. Estrategy Guatemala Healthy and Productive
248. Secretary of Social Work First Lady Office SOSEP
249. World Food Program PMA
250. Breatfeeding Committee Roosevelt Hospital
251. La Leche League, Guatemala
252. IBFAN Guatemala
253. Office of Assistance and Attention of Consumers DIACO
254. National School of Nurses of Guatemala ENEG
255. National Office for Women, ONAM
256. Department of Working Women, Ministry of Work
257. University del Valle, UVG
258. University Rafael Landívar, URL
259. School of Nutrition, San Carlos University USAC
260. University Francisco Marroquín, UFM
261. Institute of Social Security of Guatemala IGSS
262. Association for Benefit of the Family in Guatemala, APROFAM
263. Association of Nutritionists of Guatemala, ANDEGUAT
264. Infant Health MoH, MSPAS
265. Departament of Regulation and Control of Food
266. Departament of Food Control
267. Youth Organization Mothers, Babies and their Nutrition RUMBA
268. National Contact WABA Guatemala
269. Municipality of Guatemala
270. League of Consumers LIDECON
271. National Coordination for the Reduction of Disasters CONRED
272. Proyect for Developmet Santiago, PROEDUSA, MSPAS
273. Departament of Regulation of the Programmes to Assist Persons, Unit of Communication DRPAP
274. Maternity Periférica El Amparo
275. Plan International
276. Save the Children

21. INDIA

277. National Institute of Public Cooperation and Child Development
278. University College of Medical Sciences & Guru Tegh Bahadur Hospital
279. Maulana Azad Medical College & LNJP Hospital
280. Trained Nurses Association of India (TNAI)
281. National Commission for Protection of Child Rights (NCPCR)
282. Lady Hardinge Medical College
283. Breastfeeding Promotion Network of India
284. Initiative for Health, Equity and Society

22. INDONESIA

285. Indonesian Ministry of Health.
286. Asosiasi Ibu Menyusui Indonesia (AIMI) Indonesian Breastfeeding Mothers Association.
287. SELASI Sentra Laktasi Indonesia Indonesian Breastfeeding Center.
288. Perinasia Indonesian Perinatology Association.

23. KOREA

289. The Academy of Breastfeeding Medecine Korea
290. The Korean association of Pediatric Practioners
291. The Korean Society of Obstetrics and Gynecology
292. The Korean Society of Neonatology
293. Consumers Korea

24. JORDAN

294. MOH
295. UNICEF
296. FDA

25. KUWAIT

297. Primary Health Care Administration
298. Food & Nutrition Administration/ Research Section
299. Members of Kuwait BF Promotion & BFHI Implementation Committee

26. KENYA

300. Ministry of Public Health and Sanitation
301. Division of Nutrition
302. World Health Organization
303. IBFAN-Kenya
304. MCHIP-USAID/Kenyatta University
305. Kenyatta National Hospital
306. University of Nairobi

27. KIRIBATI

307. Ministry of Health and Medical Services
308. Ministry of Health
309. Ministry of Health, Safe Motherhood
310. Kiribati Nursing School
311. IBFAN Oceania

28. LEBANON

312. Ministry of Labour
313. MOPH
314. LAECD
315. MOSA
316. Higher Council of Children
317. Parliament commission
318. WHO
319. ILO

29. LESOTHO

320. MOHSW Nutrition Programme
321. MOHSW -Dietetics Department
322. MOHSW IMCI
323. MAFS Nutrition
324. FNCO
325. MAFSNutrition

326. UNICEF-Health & Nutrition
327. BCMC-L
328. EGPAF
329. IBFAN Africa

30. MALAWI
330. Ministry of Health (Nutrition Unit)
331. Heath Information Management System
332. Office of the President and cabinet ,the department of Nutrition, HIV and AIDS
333. Kamuzu Central Hospital

31. MALDIVES
334. Ministry of Health & Family
335. Centre for Community Health & Disease Control (CCHDC)
336. Maldives Food & Drug Authority

32. MEXICO
321. AC MAT Mexico
322. IBFAN Mexico
323. LLL Mexico

33. MONGOLIA
324. Ministry of social welfare and labour (ILO project)
325. Ministry of Health (Child health, Nutrition, maternal health, MIS)
326. Public health Institute
327. WHO, Mongolia
328. Maternal and Child Health Research center
329. Mongolian Paediatric association
330. Mongolian Midwifery association
331. Health Science University of Mongolia (Dep-t of pediatrics, Der-t of family medicine)
332. Child and adolescent support center NGO

34. MOZAMBIQUE
333. Ministry of Health
334. Department of Nutrition
335. Health Department for Women and Child
336. Lawyer Advisor's Cabinet

35. NEPAL
337. Nepal Breastfeeding Promotion Forum (NEBPROF)
338. Nepal Paediatric Society (NEPAS)
339. Perinatal Society of Nepal (PESON)
340. Department of Child Health, IOM
341. Maharajganj Nursing Campus, IOM
342. TU Teaching Hospital
343. Nutrition Section, Child Health Division
344. Kanti Children's Hospital
345. Bhabisya Nepal
346. Terredes Homes
347. Democracy for Election Alliance
348. Stupa College of Nursing
349. Mother and Infant Research Activity (MIRA)

36. NICARAGUA
350. Ministry of Health
351. Ministry of the Family
352. Ministry of Agriculture MAG-FOR
353. Integral Attention of Nicaraguan Children Program - AIN
354. Integral Attention of Women Program AIN
355. Community Program of Health and Nutrition - PROCOSAN
356. National Program of Micronutrients
357. National Program of Breastfeeding
358. Attention for Vulnerable Groups Program
359. WFP Nicaragua
360. National Program for Eradication of Infant Chronic Malnutrition 2008-2015
361. Politecnic University - UPOLI
362. National Breastfeeding Commission CONALAMA
363. Breastfeeding Counselors Network
364. Infant Community Kitchens Friends of Mothers and Children CICO
365. National system for the Prevention, Mitigation and Attention of Disasters
366. Information System of the Government of National Unity SIGRUN

37. PAKISTAN
367. Ministry of Health
368. Ministry of Law, Justices and Human right
369. Ministry of Planning
370. The National Nutrition Program
371. The MNCH program
372. The national Program for Family Planning and Primary Health Care
373. Provincial Health departments of all four provinces.
374. Pakistan Paediatric Association
375. Public Health Specialist
376. USAID
377. PAIMAN
378. UNICEF
379. WHO
380. Save the children US
381. Save the children UK

38. PERU
382. Ministry of Health
383. Ministry of Education
384. Ministry of Work and Promotion of Employment
385. Ministry of Women
386. Center for Social Studies and Publication CESIP
387. IBFAN Peru
388. Multisectorial Commission for the Promotion, Protection and Support of Breastfeeding
389. Institute for the Defense of the Competence and Protection of Intellectual Property (INDECOPI)
390. IBCLC Consultants

39. PHILIPPINES
391. Department of Health (DOH)
392. UNICEF
393. WHO
394. ARUGAAN
395. Trade Union Congress of the Philippines (TUCP) Women's Desk

40. SRI LANKA
396. Ministry of Health
397. Medical Research Institute
398. WHO
399. UNICEF
400. Health Education Bureau
401. AIDS Control Prog.
402. World Bank
403. Sarvodaya Women's Movement
404. Nutrition Department, MRI

41. SAO TOME & PRINCIPE
405. Ministry of Health
406. Ministry of Education
407. Ministry of Agriculture and Fisheries
408. WFP
409. WHO
410. UNICEF
411. International Medical Assistance
412. Chamber of Commerce

42. KINGDOM OF SAUDI ARABIA
413. Ministry of Health
414. IBFAN Arab World
415. International Board Certified Lactation Consultant (IBCLC)

43. SWAZILAND
416. Ministry of Health

417. Ministry of Agriculture
418. Children's Coordinating Unit
419. National Nutrition Council
420. UNICEF
421. WHO
422. World Vision
423. Action against Hunger
424. IBFAN Africa
425. EGPAF
426. SINAN

44. TAIWAN
427. Chinese Women Consumers Association (CWCA)
428. Chinese Dietetic Society (Taiwan)
429. Taiwan Academy of Breastfeeding.

45. THAILAND
430. Ministry of Public Health
431. Department of Health
432. Thai Breastfeeding Center Foundation

46. UGANDA
433. Ministry of Health
434. World Food Programme
435. Save the Children in Uganda
436. IBFAN Uganda

47. URUGUAY
437. Ministry of Labor and Social Security.
438. National Directorate of Employment.
439. Uruguayan Network to Support Nutrition and Infant Development RUANDI.
440. International Baby Food Action Network IBFAN Uruguay.
441. Social Security Bank.
442. Master in Nutrition UCUDAL.
443. Committee on Nutrition of the Pediatrics Uruguayan Society and Pediatrics Deputy Prof.
444. MYSU - Women and Health in Uruguay.
445. MSP - Food Department.
446. UNICEF's Communication Area.
447. UNDP Development Project School of Nutrition and Dietetics.
448. Uruguayan Network of Milk Banks
449. Breastfeeding Committee Pediatrics Uruguayan Society.
450. Montevideo Municipality.
451. Gender Department PIT-CNT.
452. Primary Care Network ASSE.

48. VENEZUELA
453. Ministry of Popular Power for Health
454. National Breastfeeding Programme
455. Faculty of Medicine Central University of Venezuela
456. School of Nutrition and Diet Central University of Venezuela
457. National Director of Health Programmes Ministry of Health
458. National Director of Attention to Mothers, Children and Adolescents
459. IBFAN Venezuela

49. VIETNAM
460. Heath Mother and Child Department, MoH
461. National Obstetric Hospital
462. National Paediatrics Hospital
463. Communication and Health Education department
464. UNICEF Vietnam
465. National Institute of Nutrition
466. LIGHT
467. CEPHAD

50. ZAMBIA
468. Ministry of Health
469. National Food and Nutrition Commission
470. Natural Resources Development College

51. ZIMBABWE
471. National Nutrition Unit, Ministry of Health and Child Welfare
472. UNICEF
473. Harare City Health
474. GOAL Zimbabwe
475. SAVE the Children UK

Methods to Derive Colour Coding/Rating

Each indicator of WBT*i* 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 WBT*i* 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 i.e. Red, Yellow , Blue or Green.

In the case of 10 policy and programme indicators, the WBT*i* ratings are given as 'Green' for the best achievement and 'Red' 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 and Colour-Rating

Part 1: IYCF Policies and Programmes

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

Score	*Colour*
0-3	RED
4-6	YELLOW
7-9	BLUE
9.1-10	GREEN

Part 1: Total

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

Score	*Colour*
0-30	RED
31-60	YELLOW
61-90	BLUE
91-100	GREEN

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 and color-rating are provided according to IBFAN Asia's guidelines for WBT*i*. 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 WBT*i*	
	Key to rating	*Score*	*Colour*
Initiation of Breastfeeding (Within 1 hour)	0.1-29%	3	RED
	30-49%	6	YELLOW
	50-89%	9	BLUE
	90-100%	10	GREEN
Exclusive Breastfeeding for the First Six Months	0.1-11%	3	RED
	12-49%	6	YELLOW
	50-89%	9	BLUE
	90-100%	10	GREEN
Media Duration of Breastfeeding	0-17 months	3	RED
	18-20 months	6	YELLOW
	21-22 months	9	BLUE
	23-24 months	10	GREEN
Bottle-feeding (<6 months)	30-100%	3	RED
	5-29%	6	YELLOW
	3-4%	9	BLUE
	0.1-2%	10	GREEN
Complementary Feeding (6-9 months)	0.1-59%	3	RED
	60-79%	6	YELLOW
	80-94%	9	BLUE
	95-100%	10	GREEN

Part 2: Total

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

Score	*Colour*
0-15	RED
16-30	YELLOW
31-45	BLUE
46-50	GREEN

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*
0-45	RED
46-90	YELLOW
91-135	BLUE
136-150	GREEN

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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 organisations 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.

gbics the global breastfeeding initiative for child survival

IBFAN GIFA INTERNATIONAL CODE DOCUMENTATION CENTRE BPNI WABA

WBTi

World Breastfeeding Trends Initiative (WBTi)

PUBLISHED BY:

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