

World Breastfeeding Trends Initiative (WBTi)

Has Your Nation Done Enough to BRIDGE THE GAPS?

84 country report on status and progress of implementation of the Global
Strategy for Infant and Young Child Feeding 2008-2016



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Has Your Nation Done Enough to BRIDGE THE GAPS?

84 country report on status and progress of implementation of the Global
Strategy for Infant and Young Child Feeding 2008-2016

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Dr. Shoba Suri**

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MESSAGE

The year 2016 has seen numerous calls for action to protect, promote and support breastfeeding. In January, new science published in the Lancet called for action based on the incredible economic, health and survival benefits of breastfeeding. In April, the World Bank called for greater action with calculations showing a 35-fold return on investment for increasing rates of exclusive breastfeeding. Also in April, the United Nations declared a Decade of Action on Nutrition, calling for implementation of a Framework for Action that highlights five key actions on breastfeeding: implementation of the Code, protection of working mothers, improved health services, women's empowerment, and policies in humanitarian crises.



This report on the World Breastfeeding Trends Initiative (WBTi) rounds out the year by calling countries to greater action in fully implementing the Global Strategy for Infant and Young Child Feeding. The report clearly demonstrates that while progress has been made in many countries, no country has fully implemented the Global Strategy. Gaps are particularly apparent in the protection of breastfeeding in emergency situations and in the implementation of the Baby Friendly Hospital Initiative.

The WBTi process demonstrates the power of bringing people together to examine national efforts to protect, promote and support breastfeeding.

By convening players from multiple sectors within and outside of government, WBTi serves to identify gaps in current policies and programmes but also helps chart a course for the future. WBTi also demonstrates the power of data to drive action.

As we move forward to implement these calls to action, tools to take stock of our progress will be necessary. We can only hope that more and more countries will implement the WBTi in the coming years. Perhaps the next WBTi report can include twice as many countries as the 2016 report.

Francesco Branca

*Director, Department of Nutrition for Health and Development
World Health Organization, Geneva, Switzerland*

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**Arun Gupta & Shoba Suri
IBFAN Asia**

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EXECUTIVE SUMMARY

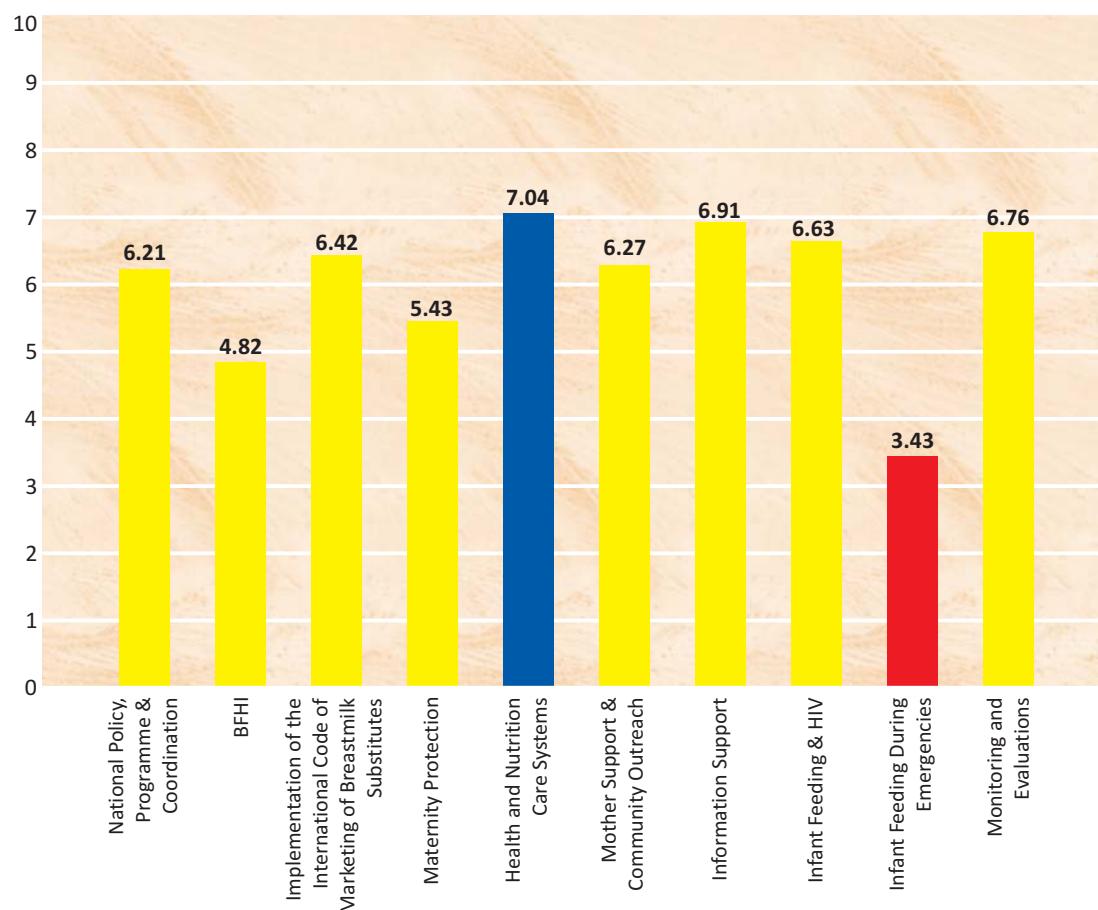
The World Breastfeeding Trends Initiative (WBTi) is an innovative tool adapted from the WHO's "Infant and Young Child Feeding - A tool for assessing national practices, policies and programmes" developed by International Baby Food Action Network (IBFAN) Asia for assessing and monitoring the state of implementation of the Global Strategy for Infant and Young Child Feeding.

The WBTi tool initiates a process in the country for change is one thing, what it does results in a national report and report card in each country by measuring inputs into the state of implementation of the Global Strategy. Findings have been helpful

in advocating for change. Further WBTi objectively scores each indicator on a maximum score of 10, and provides colour codes e.g. Red, Yellow, Blue and Green in ascending order of performance based on level of achievement.

This global report, "Has Your Nation Done Enough to Bridge the Gaps" highlights gaps in state of implementation of the Global Strategy for infant and Young Child Feeding in 84 countries. The report reveals that all indicators are doing just **average** on overall policy and programme scores as seen in Figure below. AVERAGE IS AN AVERAGE. One has to move beyond their averages to

Average score of 10 indicators on policy and programmes



achieve meaningful results on breastfeeding and infant and young child feeding practices.

Infant Feeding during Emergencies scores just 3.43 out of 10 stands the most neglected and is coded Red. It explains how we lack preparedness in an area so critical. Health and Nutrition Care Systems gets 7.04 out of 10. Coded Blue, it is the highest score. None of the indicators have achieved Green code in the 84 countries, meaning thereby they have not yet implemented the Global Strategy in its entirety, a step that is so essential.

Indicator Wise Key Findings

Indicator 1: National Policy, Programme & Coordination

This indicator scores an average of 6.21 and is coded Yellow. This indicator is important, being an over-arching for all others. On the face of it having an average of 6.21 out of 10 does not look bad, but devil lies in the detail. Coordination of such programmes is critical and report shows it does not work in more than 50% countries. Analysis also reveals majority of countries do have good policy and even plans but these are not adequately funded in about 70% countries. This is a big constraint in implementing the global strategy. As they say 'Money Makes the Mare Go' there is a specific need to finance this area if we want to bridge all the gaps. All including governments, donor agencies, bilateral's and multilaterals need to pitch in.

Indicator 2: Baby Friendly Hospital Initiative

This indicator scores an average of 4.82, the second lowest among all indicators and coded Yellow. Inadequate attention and lack of interest has led to the programme taking a back seat with only 42 countries report

having more than 50% of the hospitals achieving BFHI status. Though 68 countries report that the majority of the BFHI hospitals used 18-20 hour training as a standard practice for health workers, still only half the countries have system for reassessment in place. This indicator has a direct link to the rates of early initiation of breastfeeding and can be scaled up easily if countries put it as top priority. Evidence shows that community support (step 10 of 'Ten steps' to successful breastfeeding) appears to be essential for sustaining breastfeeding impacts of BFHI in the longer-term.

Indicator 3: Implementation of the International Code of Marketing of Breastmilk Substitutes

The average for this indicator is 6.42 and coded Yellow. Weak implementation of the International Code is a glaring gap in almost all countries. Countries having legislation need to work on effective implementation and monitoring. The subsets reveal that the Code has been legislated in only half the countries studied. Very few countries have adopted the WHA resolutions. Continued violations from baby food manufacturers pose a major threat to breastfeeding and thus the efforts to strengthen monitoring and enforcement measures are critical.

Indicator 4: Maternity Protection

This indicator is at an average of 5.43 and coded Yellow. Findings indicate a profound lack of support to women in each of the assessed countries. Only 10% of countries assessed provide more than 26 weeks of maternity leave. Women in the unorganized and informal sector which form 90% of the working women, are neglected on maternity

protection by 77% (64) countries. Breastfeeding and child care facilities at work are provided by only 46 countries. Maternity protection is the most crucial for the success of breastfeeding and has been the most neglected so far.

Indicator 5: Health & Nutrition Care System

Though this indicator has received the highest average score 7.04 and the only one coded Blue, gaps remain in the area of implementation. Major gap was inadequate training of health workers on the implementation of the International Code and their responsibility towards it, is the key to enhance infant and young child feeding practices. Adequate pre-service plan was found lacking in majority of countries which is an important link to reduce the load on in-service training.

Indicator 6: Mother Support and Community Outreach

This indicator is at an average of 6.27 and coded Yellow. All women need access to skilled counseling and daycare services at work sites. Community outreach of support to women to practice optimal breastfeeding and infant and young child feeding practices was highly inadequate, with only 17 countries having community health workers trained on skilled counselling. Only 26 countries informed that all pregnant and lactating women have access to services. Countries need to enhance counselling capacity of community health workers for better support to mothers and providing the right information.

Indicator 7: Information Support

Information Support gets an average of 6.91 and coded Yellow. This indicator is most easily achievable with the availability of vast

digital medium these days. Women lack full information support on breastfeeding and infant and young child feeding with only 42% countries having a policy.

Indicator 8: Infant Feeding and HIV

This indicator gets an average of 6.63 and coded Yellow. HIV and Infant Feeding are not fully integrated in IYCF policies and programmes with only 51 countries having developed a national policy. Lack of training of health workers, with only half the countries training their health staff in HIV and Infant Feeding. Support to mothers in making informed choice is a major gap, with less than half (37) countries having them. The situation remains unacceptable and overall, much remains to be done to ensure mothers and babies are protected and supported within a comprehensive continuum of services.

Indicator 9: Infant Feeding during Emergencies

The indicator shows glaring gaps and has the lowest average of 3.43 among the 10 indicators and coded Red. Only 21 countries have a policy that includes infant feeding during emergencies and having appointed a person responsible for infant and young child feeding during emergencies. The resources for implementation of the emergency preparedness plan has been identified in just 19 countries. Less than half the countries have built-in infant feeding in emergencies in their pre-service curriculum. This indicator seems most neglected and countries need to take an urgent call before disaster strikes. Lack of preparedness is harmful to vulnerable population like women and children.

Indicator 10: Monitoring and Evaluation

This indicator scores 6.76 and is coded Yellow. The results indicate weak monitoring and evaluation with less than half the countries having monitoring and evaluation in-built in the programmes. Only 48 countries undertake monitoring of key IYCF practices integrated in their nutrition surveillance. Monitoring is an important tool to learn and improve policy and programme and also implementation is in place.

Indicator 11-15: Infant and Young Child

Feeding Practices

The average rate of initiation of breastfeeding within 1 hour of birth as reported by 80 countries is just above 50%. Exclusive breastfeeding for the first 6 months as reported by all 84 countries is 37.90%. The median duration of breastfeeding is 15.5 months. Bottle-feeding as reported by 75 countries is 39%. The percentage of breastfed babies receiving complementary foods at 6-8 months is 68.16%. Some countries do not even have national data of these indicators

WBTi

The WBTi brings people together to discuss and analyse as well as build consensus. WBTi encourages countries to go for repeat assessment after 3-5 years to analyse trends in policy, programme and practices and identify areas still needing improvement. We studied the progress over the years in 35 countries having done reassessments and found that 29 countries have made good progress, and have reported a gain in score as well as moved to the next level of color coding. This demonstrates effectiveness of WBTi and shows change is coming. For example, Afghanistan was at bottom of the

chart in South Asia with lowest WBTi score of 30 out of 150 and coded RED. After their first WBTi, they never looked back and rapidly jumped to next colours Yellow and then to Blue, and now stand at a score of 117 out of 150. Bangladesh, El Salvador and Venezuela constituted National Breastfeeding Committees with coordinators. Argentina, Bolivia, Costa Rica developed breastfeeding policies. Vietnam and Costa Rica made BFHI standards compulsory in all maternity facilities.

Armenia, Bolivia, and Vietnam implemented the Code as law with full provisions. As a combination of efforts, particularly from women's rights defence groups and with many other key actors, some advances have been made by countries on maternity protection, be it extending Maternity Leave to 6 months or providing maternity benefits. Afghanistan, Bangladesh, Bhutan and Gambia have led to successful integration of breastfeeding at the curriculum level in in-service training and orientation programmes on IYCF for Government doctors and nurses as well as for students in schools and colleges. Bhutan, Gambia and Vietnam have also done training and information programme in basic IYCF to reach all women through their workers. Gambia has **integrated infant feeding into the PMTCT policy.** Afghanistan, Bangladesh, Bhutan, Costa Rica, Dominican Republic, Ecuador, Timor Leste, Vietnam and Gambia, they all showed positive response to infant feeding in emergencies in their national programmes and policies in different ways.

Analysis of practice indicator shows many countries gaining early breastfeeding relatively higher than others. It is much more likely because it requires one sector intervention. In case of exclusive

breastfeeding there has been fall in rates for 10 countries; rest have shown substantial gain or no change. Exclusive breastfeeding is complex behaviour and requires multisector interventions. Same is true about complementary feeding and bottle feeding. It is important to mention that before WBTi some countries didn't even have this indicator in their national surveys. This goes to show if national action is stimulated on policy and programmes, there is rise in practice indicator as well.

What Next?

The report makes a point that overall national planning and coordination is lacking. This should be a priority. From the Indicator number 1, which is kind of overarching all others, if there is no plan or there is a plan and no budget attached, it is likely to be neglected or result in ad-hoc actions. We recommend a two-prong approach, internationally and nationally.

International Level

WHA resolution should be adopted to call

upon Member States for action on this specific recommendation such as "budget line" for breastfeeding/IYCF interventions in the child health and/or nutrition budgets along with timeline. It should then be reported every two years to WHA.

National Level

- All countries need to strengthen their national planning and coordination process as a priority and commit to implement and bridge gaps for all indicators including BFHI, Implementation of the International Code, Infant Feeding in Emergencies and Maternity Protection in order to achieve high breastfeeding rates.
- All countries should create a budget line for breastfeeding/IYCF interventions and develop institutional mechanism to monitor and evaluate the implementation of the global strategy.
- All countries need to invest in breastfeeding policies and programmes and comprehensively implement the Global strategy in its entirety.

INTRODUCTION

“Supporting breastfeeding makes economic sense for rich and poor countries and this latest breastfeeding study proves it”

Cesar G. Victora

Author of the Lancet Series on Breastfeeding 2016

Today, the importance of optimal breastfeeding and infant and young child feeding practices is acknowledged by everyone, especially the role of early and exclusive breastfeeding for the first six months, in improving child health, development, in reducing childhood morbidity and mortality and both under and over nutrition. The World Health Organization's (WHO) Comprehensive Implementation Plan on Maternal Infant and Young Child Nutrition identifies this as one of the targets: “Increase exclusive breastfeeding rates in the first six months up to at least 50% by 2025”.¹ The WHO has also identified high-priority actions for protecting, promoting and supporting breastfeeding as (i) Actions at the national and legislative levels, (ii) Actions through the health care system, (iii) Actions in the community and (iv) Actions in exceptionally difficult circumstances.²

UNICEF has identified factors for success as “....the large-scale implementation of comprehensive, multi-level programmes to protect, promote and support breastfeeding with strong government leadership.....”.³ Needless to say, a large scale action is required at national level applying several strategies, while UNICEF and WHO are leading global

advocacy efforts through Breastfeeding Advocacy Initiative (BAI).⁴

The Global Strategy for Infant and Young Child Feeding adopted by the World Health Assembly in 2001 and later by the UNICEF Executive board in the same year, has in its framework ten areas of action to achieve optimal feeding practices.⁵ WHO developed a tool⁶ “Infant and Young Child Feeding-A Tool for assessing practices, policies and programmes” to monitor it. However, the progress to implement it has been visibly slow even after a decade of its existence.

Based on these tools, the International Baby Food Action Network (IBFAN) Asia/Breastfeeding Promotion Network of India (BPNI) developed the World Breastfeeding Trends Initiative (WBTi) in 2004-2005. This has 15 indicators, 10 for policy and programmes and five for infant and young child feeding practices. This tool fulfills the need for measuring inputs at national level plus generates action, which is inbuilt in its process.

This global report “Has Your Nation Done Enough to Bridge the Gaps?” showcases implementation of the Global Strategy in 84 countries highlighting gaps and achievements in 15 indicators of the WBTi tool.

This is the third in the series of WBTi global reports since 2010. The first was “The State of Breastfeeding in 33 countries” in 2010 and the second report titled “Are Our Babies Falling Through the Gaps?” was launched at the World Breastfeeding Conference in 2012.

This report is based on information from 84 countries of which 27 completed their assessment between 2008-2012 and 57 did it between 2013 to 2016.

The report describes methodology, process, findings, impact of WBTi action, including some case studies and experiences from countries having positive gains using WBTi tools. The report analyses impact of WBTi in generating action in 35 countries

that were able to conduct repeated assessments. In the way forward section, it provides recommendations for action at the international and national level.

Note: Based on the feedback from field experiences of having used the WBTi tool, an expert group reviewed the tool in the year 2013 for its process and content.⁷ The revised WBTi assessment tool, updated as on September 2014 is available on our website <http://worldbreastfeedingtrends.org/>. In the revised tool the subset questions and scores have been slightly changed to balance for policy and programmes to give more weightage to implementation for some of its indicators.



¹ WHO 2014. Comprehensive implementation plan on maternal, infant and young child nutrition. http://apps.who.int/iris/bitstream/10665/113048/1/WHO_NMH_NHD_14.1_eng.pdf?ua=1

² WHO 2007. Planning guide for national implementation of the Global Strategy for Infant and Young Child Feeding. http://apps.who.int/iris/bitstream/10665/43619/1/9789241595193_eng.pdf?ua=1

³ UNICEF 2011. Programming Guide: Infant and Young Child Feeding. http://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf

⁴ UNICEF 2015. Advocacy Strategy-Breastfeeding Advocacy Initiative. http://www.unicef.org/nutrition/files/Breastfeeding_Advocacy_Strategy-2015.pdf

⁵ WHO & UNICEF 2003. Global Strategy for Infant and Young Child Feeding. http://www.who.int/nutrition/topics/global_strategy/en/

⁶ WHO 2003. Infant and Young Child Feeding. A Tool for assessing practices, policies and programmes. <http://apps.who.int/iris/bitstream/10665/42794/1/9241562544.pdf?ua=1>

⁷ Global World Breastfeeding Trends Initiative Review Workshop. <http://worldbreastfeedingtrends.org/wbti-tool-review/>

BACKGROUND

World over about 132 million babies are born every year, only 51 million are able to practice exclusive breastfeeding and 81 million are NOT. There is thus a need to reach all families of the world.

Globally, optimal infant and young child feeding data shows (as seen below) only 44% of the children born initiate breastfeeding within one hour of birth, only 38% are exclusively breastfed for 6 months, 65% get adequate and appropriate complementary foods at 6-8 months and just 49% continue to breastfeed for at least two years.⁸

Role of Optimal Infant and Young Child Feeding Practices

Breastfeeding provides short term and long-term health, economic and environment advantages to children, women, and society. However, in spite of the overwhelming

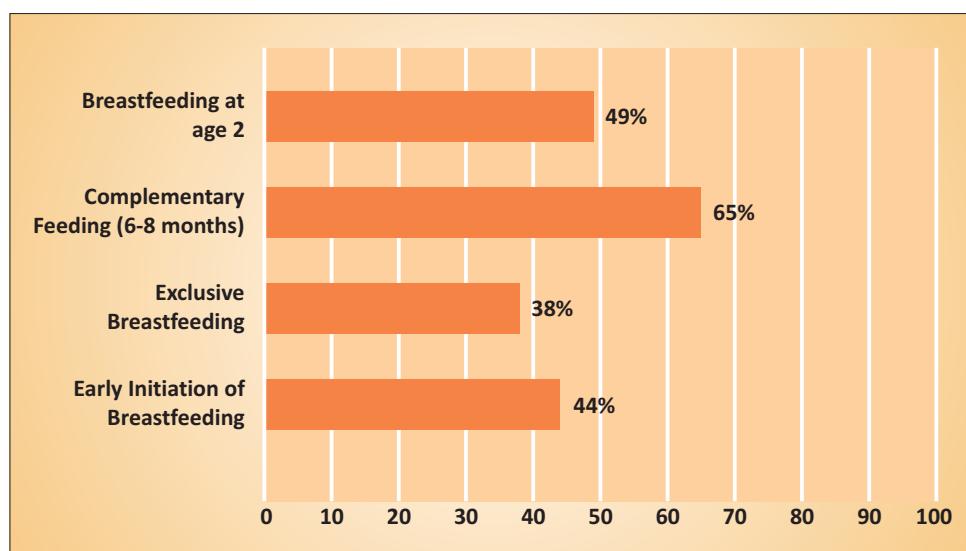
In spite of the advantages, globally nearly two out of three infants under 6 months are not exclusively breastfed-a rate that has not improved in two decades

WHO-UNICEF-IBFAN Report on Marketing of Breastmilk Substitutes 2016

evidence on the health and economic benefits of breastfeeding, the rates are low almost all over the world.

According to Victora et al (2016) and Rollins et al (2016)⁹⁻¹⁰ breastfeeding could save 820,000 lives annually, i.e. preventing 13% of all deaths of children under five. Breastfeeding could reduce one third of respiratory infections and about half of all diarrhea episodes in low and middle income countries. Breastfeeding improves the survival, health and development of all children. It saves women's lives and

Global Rates of Breastfeeding & Infant and Young Child Feeding Practices





Countries can rapidly improve breastfeeding practices by scaling up known interventions, policies and programmes

Lancet Breastfeeding Series 2016

contributes to human capital development. The benefits span populations living in high-income, middle-income, and low-income countries. Grossly, it concluded, “*Not breastfeeding is associated with lower intelligence and economic losses of about \$302 Billion annually or 0.49% of world Gross National Income.*” Extensive marketing by formula makers remains a big barrier to increase the number of breastfed children. Low and middle-income countries lose more than \$70 billion annually, while high-income countries lose more than \$230 billion annually due to low rates of breastfeeding.

Children who are breastfed longer have been found to have higher intelligence than those who are breastfed for shorter periods. This crucial difference could be 3 points across all income levels, in rich or poor, on average. Studies have shown it translates to improved academic performance, increased long term earnings and productivity as well.¹¹ The health benefits extend to the mother as well, with reductions in risk of breast and ovarian cancer, rise in breastfeeding could prevent extra 20,000 deaths from breast cancer each year globally. Evidence suggests 7% protection in breast cancer incidence with increased duration of breastfeeding.¹⁰ Breastfeeding contributes to environmental sustainability, as breastmilk is a renewable food produced and delivered without pollution, unnecessary packaging or waste in

Breastfeeding is associated with improved performance in intelligence tests 30 years later, and might have an important effect in real life, by increasing educational attainment and income in adulthood

Cesar G Victora Lancet Glob Health 2015

comparison to milk formula. To realize these gains, political support and financial investment is needed to protect, promote and support breastfeeding.

Global Commitments

The Global Strategy for Infant and Young Child Feeding adopted by the World Health Assembly in 2001 and later by the UNICEF Executive board in the same year, has in its framework ten areas of action to achieve optimal feeding practices. The aim of this strategy is to improve through optimal feeding the nutritional status, growth and development, health and thus the survival of infants and young children. The specific objectives are:

- To raise awareness regarding the main problems affecting infant and young child feeding, identify approaches to their solution, and provide a framework of essential interventions;
- To increase the commitment of governments, international organizations and other concerned parties for optimal feeding practices for infants and young children;
- To create an environment that will enable mothers, families and other caregivers in all circumstances to make and implement informed choices about optimal feeding practices for infants and young children.

The Second International Conference on Nutrition (ICN2) in 2014¹² focused global attention on addressing

malnutrition in all its forms. The framework of action recommended the following actions to protect, promote and support breastfeeding:

- Adapt and implement the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions.
- Implement policies and practices, including labour reforms as appropriate, to promote protection of working mothers.
- Implement policies, programmes and actions to ensure that health services promote, protect and support breastfeeding, including the Baby-Friendly Hospital Initiative.
- Encourage and promote through advocacy, education and capacity building an enabling environment where men, particularly fathers, participate actively and share responsibilities with mothers in caring for their infants and young children, while empowering women and enhancing their health and nutritional status throughout the life course.

Breastfeeding is linked to many SDGs like the first goal (poverty); second goal (on nutrition); third goal (good health & well being); fourth goal (education); eighth goal (inclusive economic growth), and the tenth goal (reducing inequalities)

Cesar G Victora, Lancet 2016

- Ensure that policies and practices in emergency situations and humanitarian crises promote, protect and support breastfeeding.

The global Sustainable Development Goals (SDGs)¹³ is a first accounting of where the world stands at the start of our collective journey to 2030. There are 17 proposed goals applicable to developed and developing countries alike, covering broad issues such as climate change, poverty reduction but also more specific issues including 1) ending hunger and improving nutrition (and tackling obesity); 2) ensuring healthy lives and promoting well-being; 3) ensuring equitable education and 4) ensuring sustainable agricultural production and consumption. Breastfeeding, is a simple, smart and cost effective practice that contributes to the realization of all four of these specific goals.

The Comprehensive implementation plan on maternal, infant and young child nutrition endorsed by the Health Assembly in resolution WHA 65.6

urges member states to put into practice, as appropriate, the plan including:

"(1) developing or, where necessary, strengthening nutrition policies so that they comprehensively address the double burden of malnutrition and include nutrition actions in overall country health and development policy, and establishing effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions with particular emphasis on the framework of the global strategy on infant and young child feeding; (2) developing or, where necessary, strengthening legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes; (3) establishing a dialogue with relevant national and international parties and forming alliances and partnerships to expand nutrition actions with the establishment of adequate mechanisms to safeguard against potential conflicts of interest; (4) implementing a comprehensive approach to capacity building, including



workforce development”

Recognising that a special push is needed to enhance optimal breastfeeding and infant and young child feeding practices keeping in view the landscape analysis on political commitment for programmes to protect, promote and support breastfeeding by UNICEF¹⁴ and the crucial link between breastfeeding and achieving the Sustainable Development Goals, UNICEF and WHO, led a global advocacy initiative¹⁵ in 2013 to increase political commitment to call for investment for breastfeeding as the cornerstone of child nutrition, health and development. This advocacy strategy reflects a shared vision in which partners commit to accelerate progress towards the ultimate goal of creating an environment enabling mothers everywhere to breastfeed.

Interventions on Breastfeeding COST

Protecting, promoting and supporting breastfeeding does not come free; it costs money. As the World Breastfeeding Trends Initiative (WBTi) analysis of the implementation of the Global Strategy for Infant and Young Child Feeding shows, very few of the 84 countries that conducted the assessment could implement all the strategies on the ten areas of action. The primary obstacle was lack of adequate resources, especially financial resources. There are existing estimates that considered promotion aspect.¹⁶ Several actions including effectively enforcing the *International Code of Marketing of Breastmilk Substitutes* and 'maternity protection' needed to be considered. In 2012, International Baby Food Action Network Asia (IBFAN Asia) estimated the minimal cost of implementing the *Global Strategy* in its entirety through the *World Breastfeeding Costing Initiative* (WBCI).¹⁷

“Increase the rate of exclusive breastfeeding in the first six months up to at least 50%”: WHO Global target 2025 to improve maternal, infant and young child feeding

This estimation was based on 216 countries, giving both one time and recurring costs to put in place a package of interventions to create an enabling environment for breastfeeding. At this time an excel tool was developed to give real time local cost based on the country situation and interventions to be implemented.¹⁸ More recently a study¹⁹ has estimated the costs of not breastfeeding across South Asian countries, to be saving US\$1.6 billion annually through breastfeeding, along with improved cognition alone through higher IQ and earnings. The World Bank in its nutrition investment framework,²⁰ targets to boost investments in cost-effective interventions; exclusive breastfeeding being one of them. It recommends investment in order to achieve the WHA targets for exclusive breastfeeding “increase the rate of exclusive breastfeeding in the first six months up to at least 50%”.

Efforts are being made to put investments upfront to mobilize donors and agencies. It is important to note that investment in nutrition provides very high economic returns²¹. According to this report, the cost- benefit of investments to increase rates of exclusive breastfeeding are particularly high e.g. \$35 in returns for every dollar invested, much higher than others like stunting (\$11), Anemia in women (\$12) and wasting (\$4). Increasing exclusive breastfeeding targets globally in next ten years is estimated to avert 520,000 child deaths, and it will add 105 million more

babies exclusively breastfed. Over a period of 10 years \$5.6 billion is the estimated investment for this purpose.

Evidence²² indicates a significant association between implementation of the Global Strategy and national improvements in breastfeeding rates.

The Breastfeeding Advocacy Initiative aims at achieving the World Health Assembly (WHA) global target calling on governments to increase exclusive breastfeeding rates for children under six months of age to contribute to this, along with efforts to increase early initiation of breastfeeding for newborns as a foundation to optimal practices and to promote continued breastfeeding for up to two years or beyond, with appropriate complementary foods.

The recent effort by WHO and UNICEF, calling for a global congress on the Baby-Friendly Hospital Initiative (BFHI Congress)²³, to celebrate the successes over the past quarter century and to set a future course on how to use the lessons learned to

ensure that every newborn receives appropriate care. The Baby-Friendly Hospital Initiative (BFHI) is a 25-year-old initiative by WHO and UNICEF, providing a framework to protect, promote and support breastfeeding in hospital and maternity facilities. The initiative follows the 'Ten Steps for Successful Breastfeeding' and ensures adherence to the Code of Marketing of Breast-milk Substitutes. The 2016 report on Marketing of Breastmilk Substitutes: National Implementation of the International Code⁴ in its recommendations for action calls for countries to scale up efforts for funding into the national budgeting processes, so as to ensure sustainability.

The World Breastfeeding Trends Initiative (WBTi) steps in to fulfill the need of assessment of policy and programmes that impact infant and young child feeding, enlist gaps and put forth recommendations to bridge them. And it generates much needed action at the national level to complement the global efforts.

⁸. UNICEF 2015. State of World Children.<http://data.unicef.org/resources/the-state-of-the-worlds-children-report-2015-statistical-tables/#>

⁹. Victora CG, Bahl R, Barros AJD, Franca GVA, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N, Rollins NC, for the Lancet Breastfeeding Series Group. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet* 2016; 387: 475-90

¹⁰. Rollins NC, Bhandari N, Hajeebhoy N, Horton S, Lutter CK, Martines JC, Piwoz EG, Richter LM, Victora CG, on behalf of the Lancet Breastfeeding Series Group. Why invest, and what it will take to improve breastfeeding practices? *Lancet* 2016; 387: 491-504.

¹¹. Victora CG, Horta BL, de Mola CL, Quevedo L, Pinheiro RT, Gigante DP, Goncalves H, Barros F. Association between breastfeeding and intelligence, educational attainment, and income at 30 years of age: a prospective birth control study from Brazil. *Lancet Glob Health* 2015; 3: e199-205. [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(15\)70002-1.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)70002-1.pdf)

¹². ICN 2 Second International Conference on Nutrition. <http://www.fao.org/about/meetings/icn2/en/>

¹³. The Sustainable Development Goals Report

2016.<http://unstats.un.org/sdgs/report/2016/The%20Sustainable%20Development%20Goals%20Report%202016.pdf>

¹⁴. United Nations Children's Fund, Breastfeeding on the Worldwide Agenda: Findings from a landscape analysis on political commitment for programmes to protect, promote and support breastfeeding, New York, UNICEF, 2013

¹⁵. WHO & UNICEF 2015. Advocacy Strategy Breastfeeding Advocacy Initiative

http://apps.who.int/iris/bitstream/10665/152891/1/WHO_NMH_NHD_15.1_eng.pdf?ua=1

¹⁶. Horton S, Shekar M, McDonald C, Mahal A, Brooks JK. Scaling up Nutrition What will it cost? World Bank 2010.

<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/ScalingUpNutrition.pdf>

¹⁷. The World Breastfeeding Costing Initiative. The need to invest in babies 2014. <http://www.worldbreastfeedingcosting.org/wbci/The-Need-to-Invest-in-Babies.pdf>

¹⁸. The World Breastfeeding Costing Initiative tool 2014. http://www.worldbreastfeedingcosting.org/wbci/WBCI_Ver_1_2016.xls

¹⁹. Walters D, Horton S, Siregar AYM, Pitriyan P, Hajeebhoy N, Mathisen R, Phan LTH, Rubert C. The cost of not breastfeeding in Southeast Asia. *Health Policy and Planning* 2016, 1-10.

²⁰. Shekar M, Kakietek J, Eberwein JD, Walters D. An Investment Framework for Nutrition: Reaching the global targets for stunting, anemia, breastfeeding and wasting. World Bank 2016. <http://documents.worldbank.org/curated/en/847811475174059972/pdf/108645-REVISED-PUBLIC-1700369-GlobalTargets-Execsum-Web-10-3-16.pdf>

²¹. Alderman, Behrman and Puett 2016; Copenhagen Consensus Center 2015; Hoddinott et al. 2013).

²². Lutter CK and Morrow AL. Protection, Promotion, and Support and Global Trends in Breastfeeding. *Adv Nutr* 2013; 4: 213-219.

²³. WHO & UNICEF 2016. Baby-friendly hospital initiative congress http://www.who.int/nutrition/events/2016_bfhi_congress_24to26oct/en/

ABOUT WBTi

PROCESS AND SCORING GUIDELINES

The WHO in 2003 provided *Infant and Young Child Feeding: A tool for assessing national practices, policy and programmes*. In 2004, the International Baby Food Action Network (IBFAN) launched the World Breastfeeding Trends Initiative (WBTi) a collaborative initiative to assess and monitor key breastfeeding policies and programmes based on the framework of action of the *Global Strategy for infant and Young Child Feeding*. The WBTi has used the questionnaire and other materials from the WHO's tool. It has been adapted based on the feedback from countries in all regions including Latin America, Asia, and Africa.

Process

It works in two phases. Phase 1 of national assessment and phase 2 of making it universally accessible through WBTi web-portal.

The **first phase** involves initiating a national assessment through coordinating a **Core group** and local partners working together. They identify gaps in policies and programmes and stimulate action to bridge them. Documentation of gaps in existing practices, policies, and programmes takes place.

The WBTi thus helps in establishment 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*.

The core group helps facilitate debates and discussions around this area to a larger audience locally. It assists in

formulating plans of action that are effective in improving infant and young child policies and allocation of resources. Such actions are likely to change feeding practices for positive.

In the second phase, each country's results are publicly displayed on the WBTi website, providing further impetus to government leaders to act decisively.

WBTi findings of phase 1 are fed into the web-based toolkit to provide color coding and scoring, based on IBFAN Asia's Guidelines for WBTi, thus building some healthy competition among the countries in the region or among regions.

The web tool has the capacity to generate visual maps or graphic charts to assist in developing reports for advocacy at all levels e.g. national, regional and international.

WBTi Elements

- A:** is Action oriented
- B:** Brings people together
- C:** is Consensus and commitment building
- D:** Demonstrates achievements and gaps
- E:** is Efficacious in improving programmes



WBTi is thus a tool not only to track policy and programmes but it has action built within its process. Its components can be easily described as ABCDE as action, bringing people together, building consensus, demonstration of achievements and efficacy in improving programmes.

Trends Study and Re-assessment

WBTi calls for re-assessment after 3-5 years, to analyze trends in programmes and practices and identify areas that still need more investment/action. This can also be used to study the impact of a particular intervention over a period of time.

The 15 indicators of WBTi

The WBTi is based on a wide range of indicators, which provide an impartial global view of key factors. The WBTi has identified 15 indicators. Each indicator has its specific significance.

Part I has 10 indicators dealing with policies and programmes and Part II has 5 indicators, these are based on the WHO's

Infant and Young Child Feeding: A tool for assessing national practices, policy and programmes

Part I: WBTi takes into consideration most of the targets of the *Global Strategy*. For each indicator, there is a subset of questions. Answers to these can help identify achievements and gaps. This reveals how one country is doing in a particular area of action on infant and young child feeding.

Part II: Infant and young child feeding practices in Part II ask for specific numerical data on each practice, based on data from a random household survey that is **national in scope**.

Each indicator has the following components:

- A key question that needs to be investigated.
- A list of criteria as a subset of questions for identifying gaps and achievements with guidelines for scoring.
- Background on why the practice, policy or programme component is important.

INDICATORS

Part I

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

Part II

1. Percentage of babies breastfed within hour of birth
2. Percentage of babies 0<6 months of age exclusively breastfed in the last 24 hours
3. Babies are breastfed for a median duration of how many months
4. Percentage of breastfed babies less 0-12 months of age, who are fed with any foods or drinks (even breastmilk) from bottles
5. Percentage of breastfed babies receiving complementary foods at 6-8 months of age

IBFAN Asia Guidelines for Scoring & Colour Coding

Each indicator in policy and programmes has a subset of questions that go into finer details of the achievements or gaps. In Part I, each question has a possible score of 0-3 and the indicator has a maximum score of 10.

In Part II the IYCF practices, the method of the cut-off point for each level of achievement has been adapted from the WHO tool.²⁴ Each practice indicator is assigned according to its achievement a 'score' and 'colour coding' as per IBFAN Asia's guidelines. The cut off points for each of these levels of achievement were selected systematically, based on an analysis of past achievements on these indicators in developing countries.

Five indicators dealing with infant

and young child feeding practices reveal how effectively a country has implemented its policies and programmes. The countries need to use secondary data which is national in scope as information source. The WBT*i* does not undertake primary household surveys.

The maximum score for indicators 1-10 of policies and programmes is 100, and for 11-15 on practices are 50, thus an overall score totals to 150. The level of achievement on each indicator **then coded Red, Yellow, Blue and Green based on the guidelines as suggested below**. In the WBT*i* tool, a score of 90% and above is coded green and considered to be maximum achievement. The other three colours in descending order of performance are Blue, Yellow and Red.

Tables below provide guidelines for colour coding based on objective scoring.

Part I: IYCF Policy & Programme Indicators-scores & colour coding (maximum score 10)

IBFAN Asia Guidelines for WBT <i>i</i>	
Scores	Colour- coding
0-3.5	RED
4-6.5	YELLOW
7-9	BLUE
> 9	GREEN

Part I: Total score & colour coding of IYCF Policy and Programme Indicator 1-10 (out of 100)

Scores	Colour- coding
0-30.9	RED
31-60.9	YELLOW
61-90.9	BLUE
91-100	GREEN

Part II: IYCF Practices- scores & colour coding (maximum score 10)

Indicator 11	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guidelines for WBT <i>i</i>	
		Scores	Colour- coding
Initiation of Breastfeeding (within 1 hour)	0.1-29%	3	RED
	29.1-49%	6	YELLOW
	49.1-89%	9	BLUE
	89.1-100%	10	GREEN

²⁴ WHO 2008. Indicators for assessing infant and young child feeding practices. <http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/>

Indicator 12	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guidelines for WBTi	
Exclusive Breastfeeding (for first 6 months)		Scores	Colour- coding
	0.1-11%	3	RED
	11.1-49%	6	YELLOW
	49.1-89%	9	BLUE
	89.1-100%	10	GREEN

Indicator 13	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guidelines for WBTi	
Median Duration of Breastfeeding		Scores	Colour- coding
	0.1-18 Months	3	RED
	18.1-20 "	6	YELLOW
	20.1-22 "	9	BLUE
	22.1- 24 or beyond "	10	GREEN

Indicator 14	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guidelines for WBTi	
Bottle Feeding (0-12 months)		Scores	Colour- coding
	29.1-100%	3	RED
	4.1-29%	6	YELLOW
	2.1-4%	9	BLUE
	0.1-2%	10	GREEN

Indicator 15	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guidelines for WBTi	
Complementary Feeding (6-8 months)		Scores	Colour- coding
	0.1-59%	3	RED
	59.1-79%	6	YELLOW
	79.1-94%	9	BLUE
	94.1-100%	10	GREEN

Part II: Total score & colour coding of IYCF Practice Indicators 11-15 (out of 50)

IBFAN Asia Guidelines for WBTi	
Scores	Colour- coding
0-15	RED
16-30	YELLOW
31-45	BLUE
46-50	GREEN

Part I & II: Total score & colour coding of IYCF Policy, Programme & Practices (out of 150)

Scores	Colour- coding
0-45.5	RED
46-90.5	YELLOW
91-135.5	BLUE
136-150	GREEN

WHERE 84 COUNTRIES STAND ON IMPLEMENTING THE GLOBAL STRATEGY?

In this chapter we present the overall state of implementation of the Global Strategy based on scoring of all WBTi indicators. Firstly measured on a scale of 100 for policy and programmes and secondly measured out of a total of 150 score on policy, programme and practice indicators. As some countries have done repeat assessments, we have taken into consideration the scores from latest assessments.

Figure 1 gives colour coding and total scores on 10 indicators of policy and programmes on a scale of 100. The average score of the 84 countries is 59.9.

Sri Lanka has the highest score at 88 and Libya is lowest at 19.

Almost half of the countries (39) are

coded Yellow and are below 61. Remaining countries (43) are coded Blue, scoring between 61 and 90. Only two countries are coded Red with scores below 30. None of the countries have yet scored enough to be coded Green.

Figure 2 provides the total score and colour coding with all the 15 indicators including practices and score out of 150. Sri Lanka with a score of 132, is at the top.

Of the total 84 countries, 44 are coded Blue scoring between 91-135 and 37 score between 46-90 are coded Yellow, only 3 countries are coded Red, scoring less than 45. Figure 1 also show regional spread of how global strategy is being implemented.

Figure 1: The state of policy and programmes on infant and young child feeding in 84 countries on a scale of 100

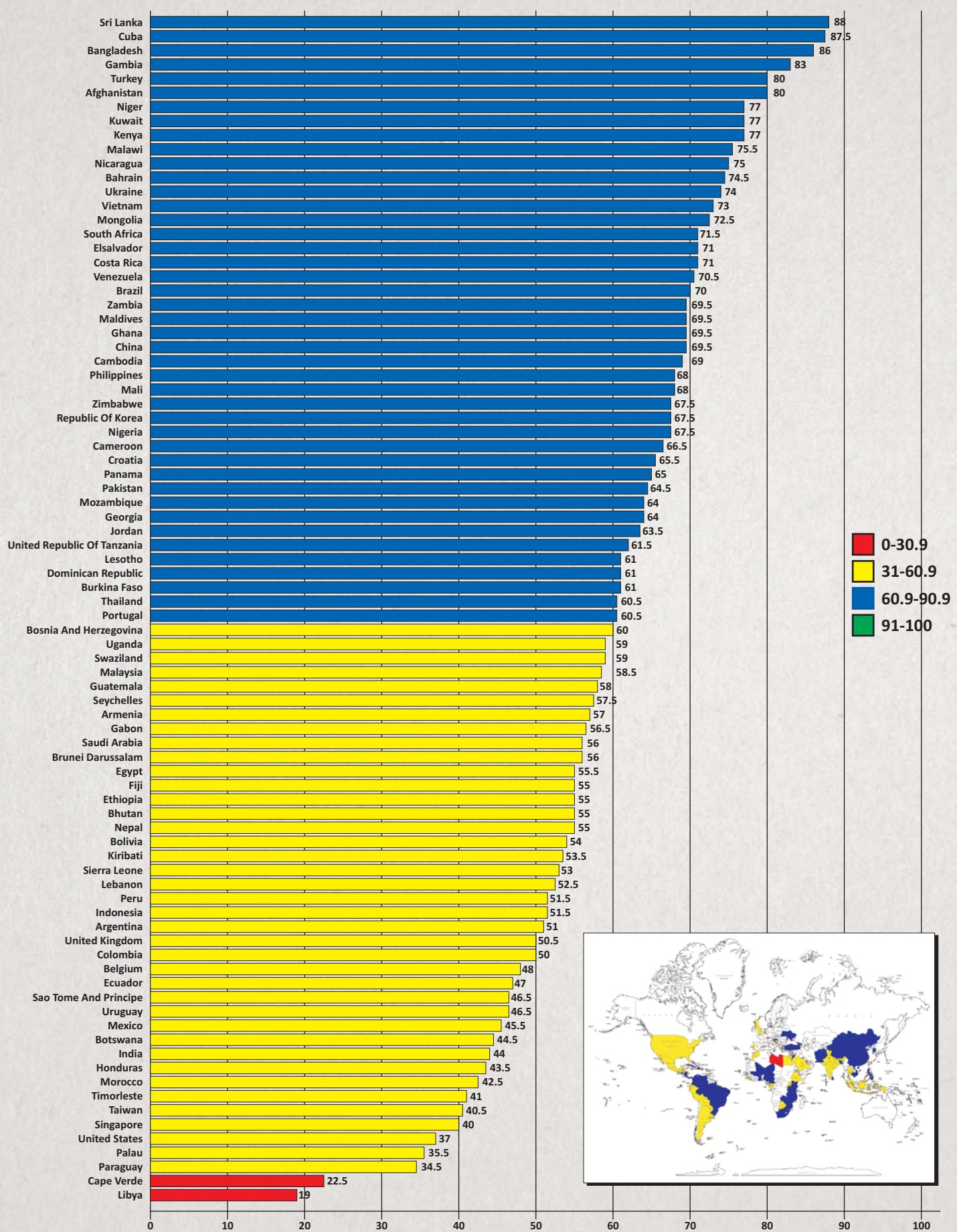
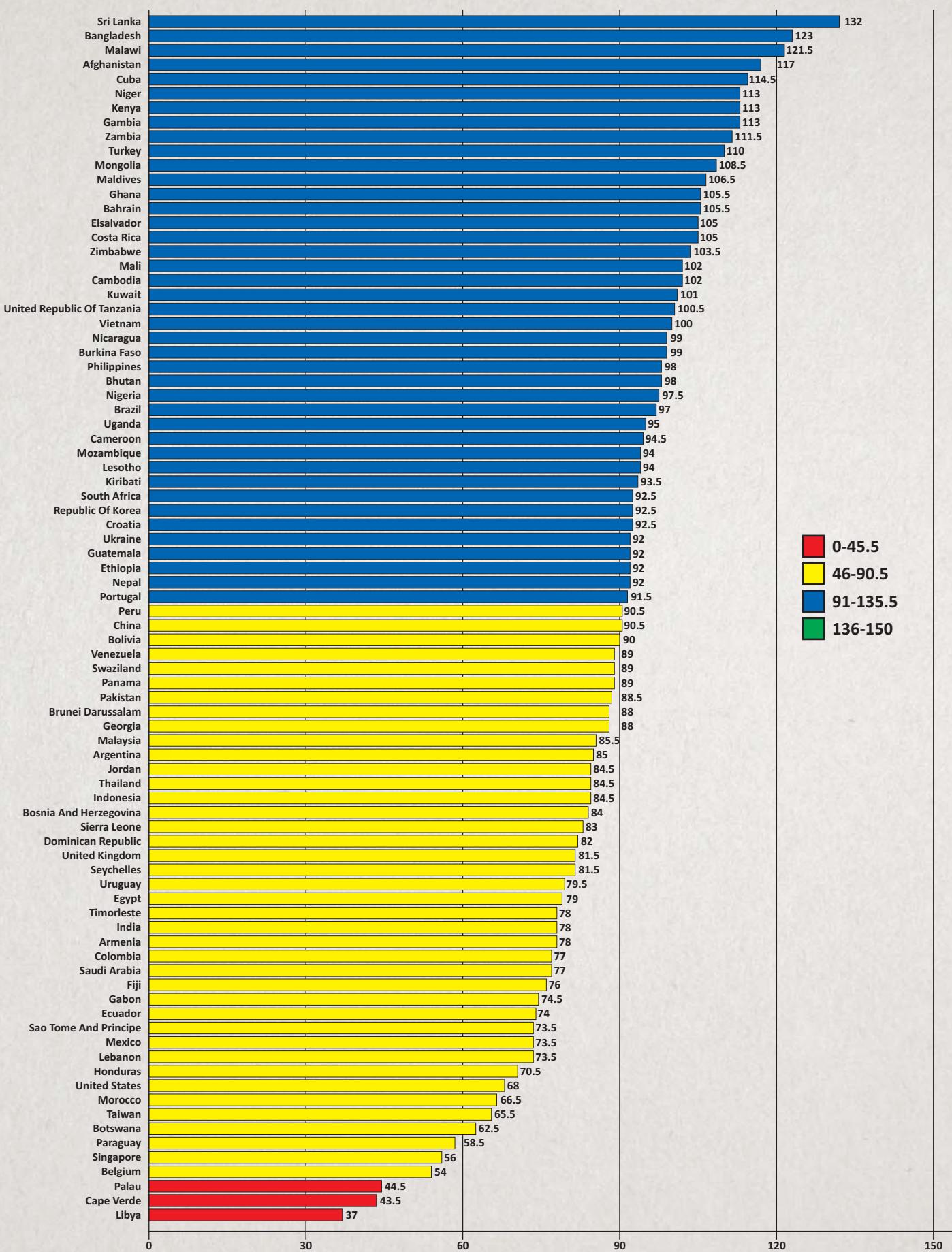


Figure 2: The state of policy & programme and practices on infant and young child feeding in 84 countries on a scale of 150



FINDINGS & ANALYSIS

STATUS OF EACH INDICATOR ON POLICY AND PROGRAMMES

This chapter gives average score for the policy and programme indicators followed by findings, analysis and conclusive remarks for each of the 10 indicators of policy and programme and 5 indicators on practices in all 84 countries.

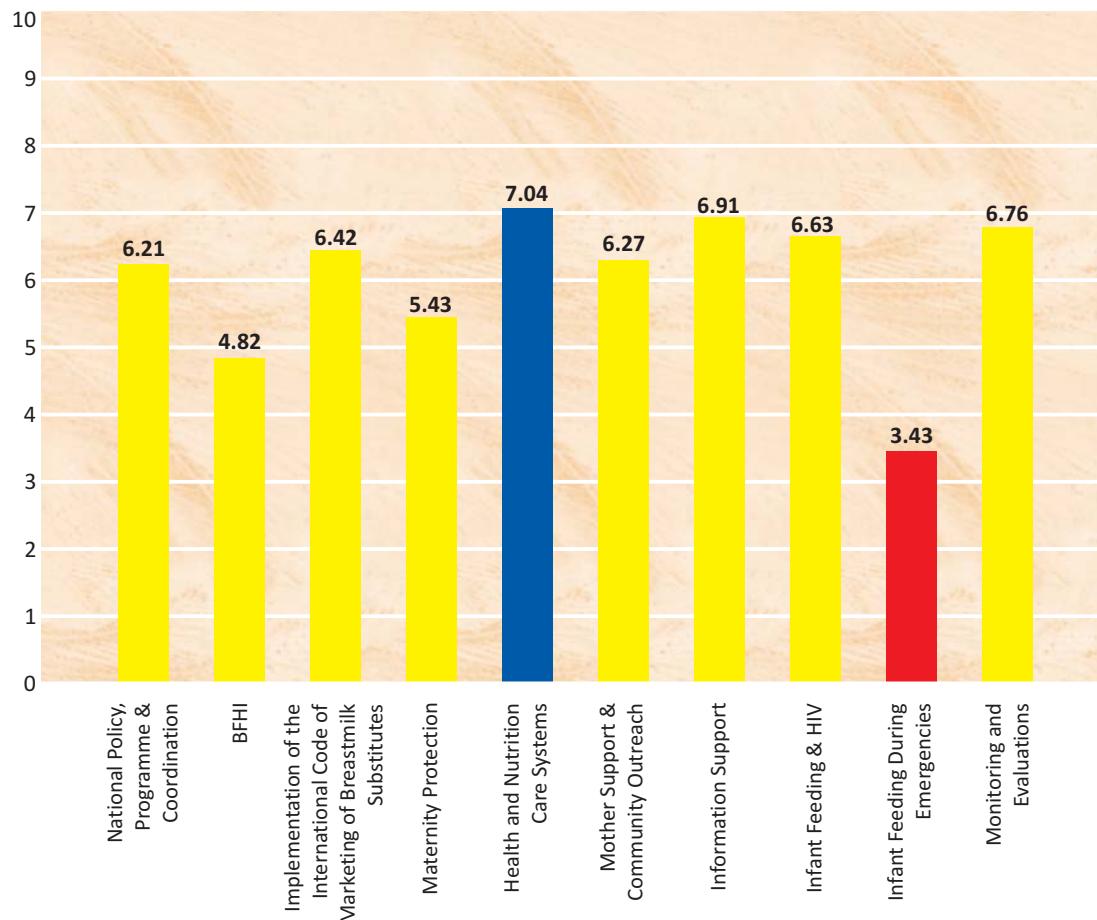
Average score of 10 indicators on policy and programmes

Figure 3 shows the average score along with colour coding for each indicator on policy and programmes on a scale of 10. Most

indicators are coded Yellow, except for health and nutrition care systems (indicator 5), which is coded Blue and infant feeding during emergencies, which is coded Red. The average score ranges from 3.43 for Infant Feeding during Emergencies to 7.04 out of 10 for Health and Nutrition Care Systems.

It is clear that many of these indicators have a long way to go to achieve optimal rates of breastfeeding.

Figure 3: Average score of 10 indicators on policy and programmes



1 National Policy, Programme and Coordination

The “Innocenti Declaration was adopted in 1990. It recommended all governments to have national breastfeeding committees and coordinators as established mechanisms to protect, promote and support breastfeeding in the country. The Global Strategy for Infant and Young Child Feeding (2002) calls for an urgent action from all member states to develop, implement, monitor and evaluate a comprehensive policy on IYCF. The Innocenti Declaration on Infant and Young Child Feeding (2005) captures the renewed commitments made at this historic anniversary meeting and records the additional five operational targets that were identified as part of the ongoing global strategy on Infant and Young Child feeding including the WHA resolutions regarding IYCF. The Planning Guide for national implementation of the Global Strategy for

Need for countries to translate policies into action plans with adequate budget

Infant and Young Child Feeding (2007) calls for implementation of the Global Strategy for Infant and Young Child Feeding into concrete focused national strategy, policy and action plans.

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

Table 1: Key question & subset questionnaire for the indicator on national policy, programme and coordination and scoring criteria

Key question: Is there a national infant and young child feeding/breastfeeding policy that protects, promotes and supports optimal infant and young child feeding and the policy is supported by a government programme? Is there a mechanism to coordinate like National infant and young child feeding committee and a coordinator for the committee?

Guidelines for scoring	Check all that apply
Criteria	
1.1) A national infant and young child feeding/breastfeeding policy has been officially adopted/approved by the government	1
1.2) The policy recommended exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	1
1.3) A national plan of action developed based on the policy	2
1.4) The plan is adequately funded	2
1.5) There is a National Breastfeeding Committee/IYCF Committee	1
1.6) The national breastfeeding (infant and young child feeding) committee meets, monitors and reviews on a regular basis	2
1.7) The national breastfeeding (infant and young child feeding) committee links effectively with all other sectors like health, nutrition, information etc.	0.5
1.8) Breastfeeding Committee is headed by a coordinator with clear terms of reference, regularly communicating national policy to regional, district and community level.	0.5
	/10

the policy has an attached plan and budgetary allocation for putting the plan in action, as well as status of implementation. (Table 1)

This indicator gets an average score of 6.21 out of 10. Figure 4 shows that only seventeen countries scored between 9.5-10, 22 countries scored between 7 and 9, 30

countries scored between 3 and 6.5, and 15 received a score below 3 of which 5 countries scored 0.

Figure 5 shows that most of the regions need to work hard to get their national policy, programmes and coordination on going to be able to move breastfeeding interventions.

Figure 5: Status of 84 countries on national policy, programme and coordination based on colour coding

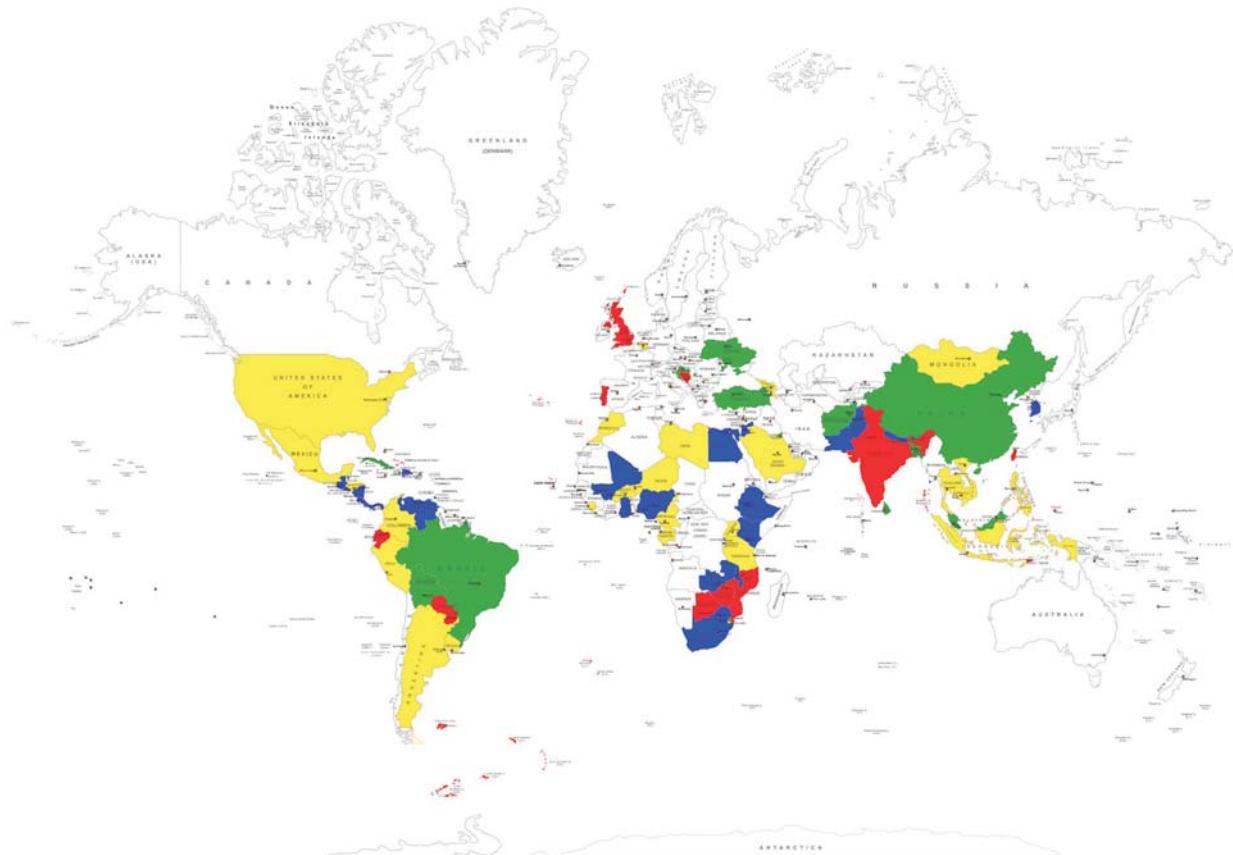
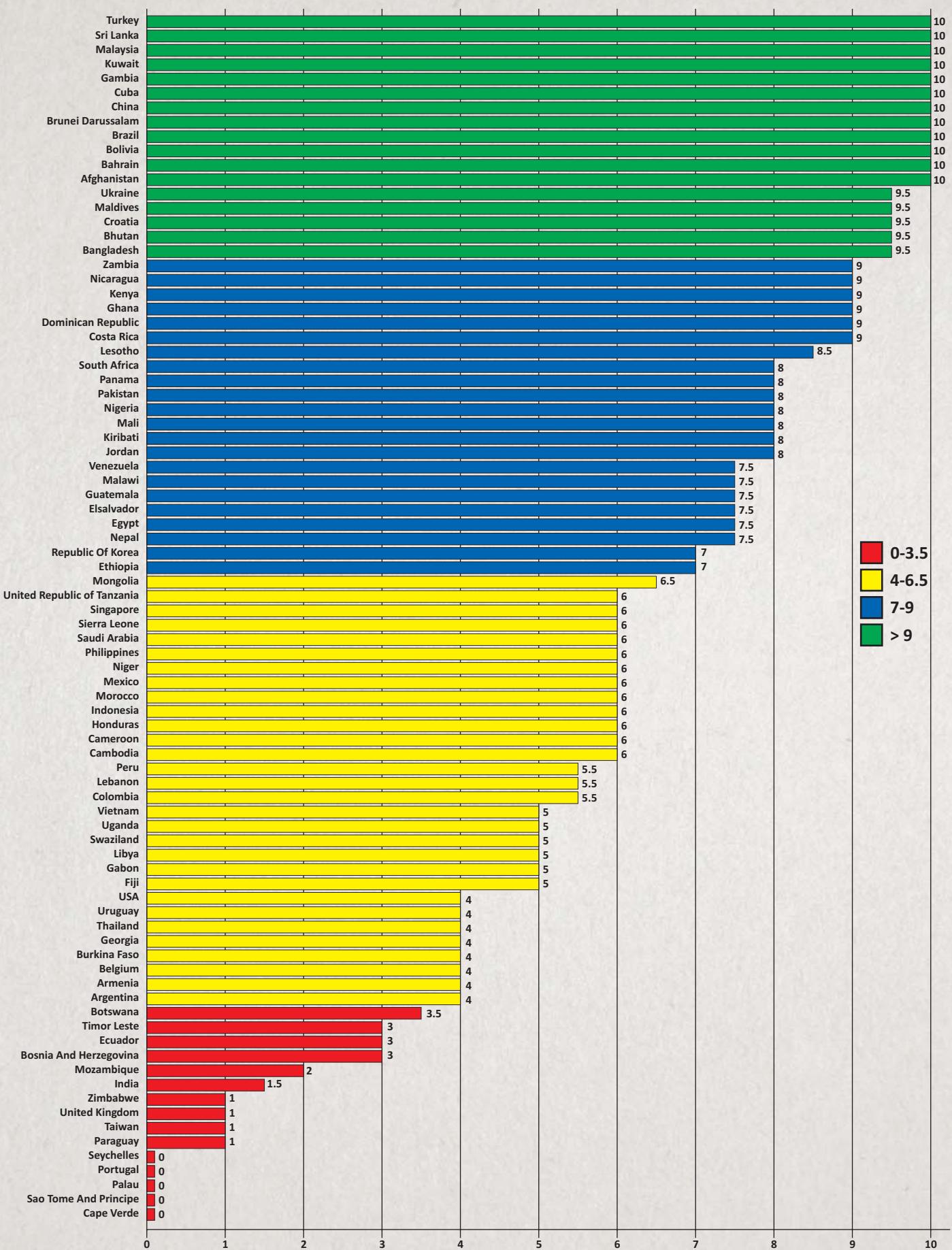


Figure 4: The state of national policy, programme and coordination in 84 countries on a scale of 0-10



Analysis and Conclusion

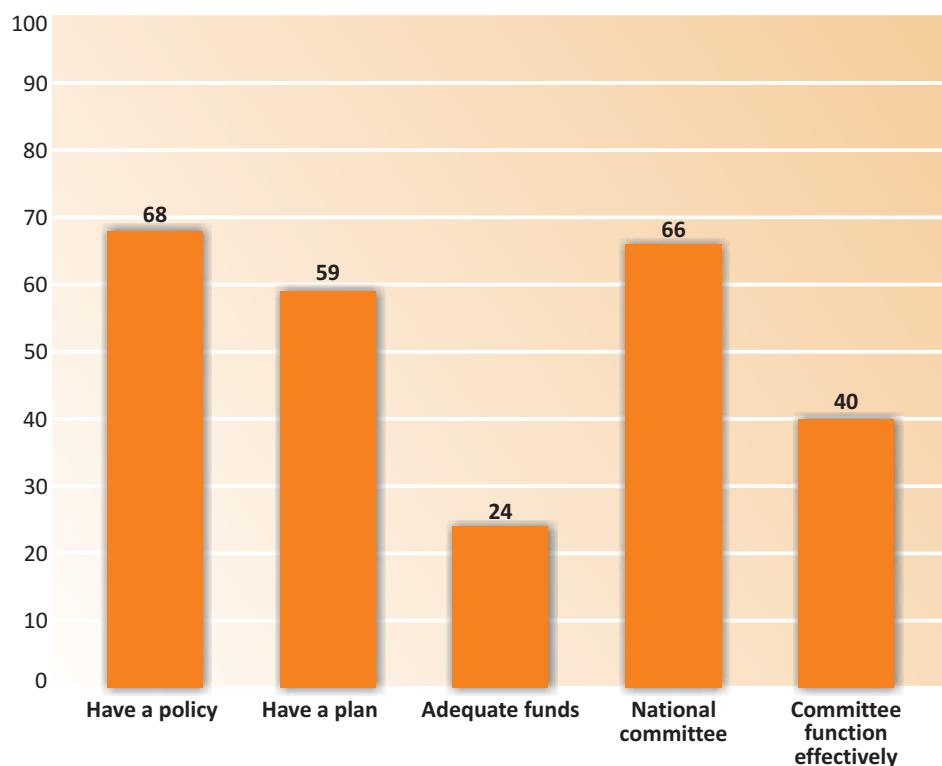
A detailed analysis of the indicator points out exactly where the gaps are and therefore gives an idea of what needs to be done with regard to establishing policy and coordination for enhancing optimal breastfeeding rates.

Figure 6 reveals that 68 out of 84 countries report having a policy, but 59 have a plan and only 24 report that the plan is adequately funded. Similarly, while 66 countries have national committees but only

40 function effectively.

It is evident from the assessment that there is a need for countries to translate policies into action plans with adequate budget through well coordinated national processes in order to enhance optimal breastfeeding and infant and young child feeding practices. Availability of resources/funding has been lacking in 70% of the countries, which poses a big challenge in the implementation of the policy & programmes.

Figure 6: Status of subset questions for indicator on national policy, programme and coordination in 84 countries



CASE STUDY

GAMBIA



WBTi helped make headway in the area of policy implementation. Strong advocacy led to incorporation of infant and young child feeding during the development of national policies including the National Nutrition Policy 2010, 2020, the National Health Policy 2012-2020, the Early Childhood Policy and the Women's Act 2010. The National Nutrition Council and the National Assembly have also been sensitized about the importance of optimal maternal and child nutrition including IYCF. An extensive social and behavioral change communication using both modern and traditional structures has been and is still ongoing to raise awareness among the general population. A National Technical Advisory Committee (NTAC) comprising technical experts from diverse institutions has been established, which meets on a quarterly basis to discuss, review progress and share best practices on nutrition and related interventions including those on IYCF. A National Nutrition Agency (NaNA) has been established and a Programme Officer identified and responsible for overseeing the implementation of IYCF.

Malang N. Fofana
Programme Manager,
National Nutrition Agency (NaNA), The Gambia

CASE STUDY

Vietnam



WBTi got some major changes in Vietnam policy in maternity protection; paid maternity leave for 6 months to government and private sectors. Another milestone was passing a Decree 100/2014/ND-CP to formula milk advertisement on trading and using of nutritional products for infant feeding bottles and dummies. WBTi contributed to progress in policy scores; get data of the real situation on breastfeeding and Infant and young child feeding in Vietnam for advocacy to policy makers, leaders of Ministries, Committee for Social Affair of the National Assembly, National Organization, National Ob/Gyn hospitals, mass organizations etc.

Dr. Quan Le Nga,
Country Coordinator, Vietnam

Baby-Friendly Hospital Initiative (10 steps to successful breastfeeding)

All countries need to prioritize and take action to support women when they come to deliver their babies

The Joint WHO/UNICEF Statement: *Protecting, promoting and supporting breastfeeding: the special role of maternity services*, in 1989 called on the leadership of those working in maternity services to sustain or if necessary to re-establish a “breastfeeding culture”. The *Innocenti Declaration* of 1990 calls on governments to ensure that all maternity services fully practice all ten of the *Ten Steps to Successful Breastfeeding*.

The ten steps to successful breastfeeding established there, became the cornerstone of the global Baby-friendly Hospital Initiative (BFHI) launched in 1992 by both agencies. Several countries initiated action on BFHI and progress made so far has been in numbers mostly and reports suggest that fall back happens if the skills of health workers are not sufficiently enhanced. The Global Strategy for Infant and Young Child Feeding indicates the need for implementation of BFHI, monitoring and reassessment of already designated facilities (materials developed in 1998) and expanding the Initiative to include clinics, health centers and paediatric hospitals. The Global Criteria continue to be the minimum requirement for all baby-friendly facilities. The Global Criteria were revised in 2005, both to update them to take account of new evidence regarding best practices and to

insure that the needs of non-breastfeeding mothers were fully met, as well as to provide new criteria for HIV and infant feeding and mother-friendly care, which could be included at the discretion of the national authority for BFHI.

The revised, updated and expanded for integrated care material published in 2009 is the comprehensive document to guide the implementation, monitoring and reassessment. It contains a training course of 20 hours for all health workers and a special programme for countries with a prevalence of 20% of HIV positive mothers and/or a Prevention of Mother-to-Child Transmission (PMTCT) programme. The 2009 BFHI material includes specific new modules for the support of non-breastfeeding mothers and for mother-friendly care and recommendation for baby-friendly expansion up to complementary feeding. The focus on compliance with the International Code is reinforced.

This indicator assesses the BFHI both quantitatively and qualitatively as well the process of re-assessment. It looks at the percentages of hospitals and maternity facilities designated as BFHI; how it is monitored and evaluated and the expansion of the programme. (Table 2)

The average score for the indicator is 4.82 out of 10, clearly showing that the BFHI has not yet become fully integrated into the health system in almost all the countries. Figure 7 shows that only two out of 84 countries from European region namely Turkey and Croatia fall in the green

Table 2: Key question & subset questionnaire for the indicator on BFHI and scoring criteria

Key questions:

- What percentage of hospitals and maternity facilities that provide maternity services have been designated as “Baby Friendly” based on the global or national criteria?
- What is the quality of BFHI program implementation?

Guidelines - Quantitative Criteria

2.1) ____ out of ____ total hospitals (both public & private)and maternity facilities offering maternity services have been designated or reassessed as “Baby Friendly”in the last 5 years _____ %

Guidelines for scoring

Criteria

0
0.1 - 20%
20.1 - 49%
49.1 - 69%
69.1-89 %
89.1 - 100%

Total rating

✓ Check all that apply
0
1
2
3
4
5
----- / 5

Guidelines - Qualitative Criteria

Quality of BFHI programme implementation:

Guidelines for scoring

Criteria

2.2) BFHI programme relies on training of health workers using at least 20 hours training programmeⁱ
2.3) A standard monitoringⁱⁱ system is in place
2.4) An assessment system includes interviews of health care personnel in maternity and post natal facilities
2.5) An assessment system relies on interviews of mothers.
2.6) Reassessmentⁱⁱⁱ systems have been incorporated in national plans with a time bound implementation
2.7) There is/was a time-bound program to increase the number of BFHI institutions in the country
2.8) HIV is integrated to BFHI programme
2.9) National criteria are fully implementing Global BFHI criteria

Total Score

Total Score

✓ Check all that apply
1.0
0.5
0.5
0.5
1.0
0.5
0.5
0.5
0.5
----- / 5
----- / 10

ⁱIYCF training programmes such as IBFAN Asia's '4 in1' IYCF counseling training programme, WHO's Breastfeeding counseling course etc. may be used.

ⁱⁱ Monitoring is a dynamic system for data collection and review that can provide information on implementation of the *Ten Steps to assist* with on-going management of the *Initiative*. It can be organized by the hospitals themselves or at a higher level in the system. Data should be collected either on an on-going basis or periodically, for example on a semi-annual or yearly basis, to measure both breastfeeding support provided by the hospitals and mothers' feeding practices.

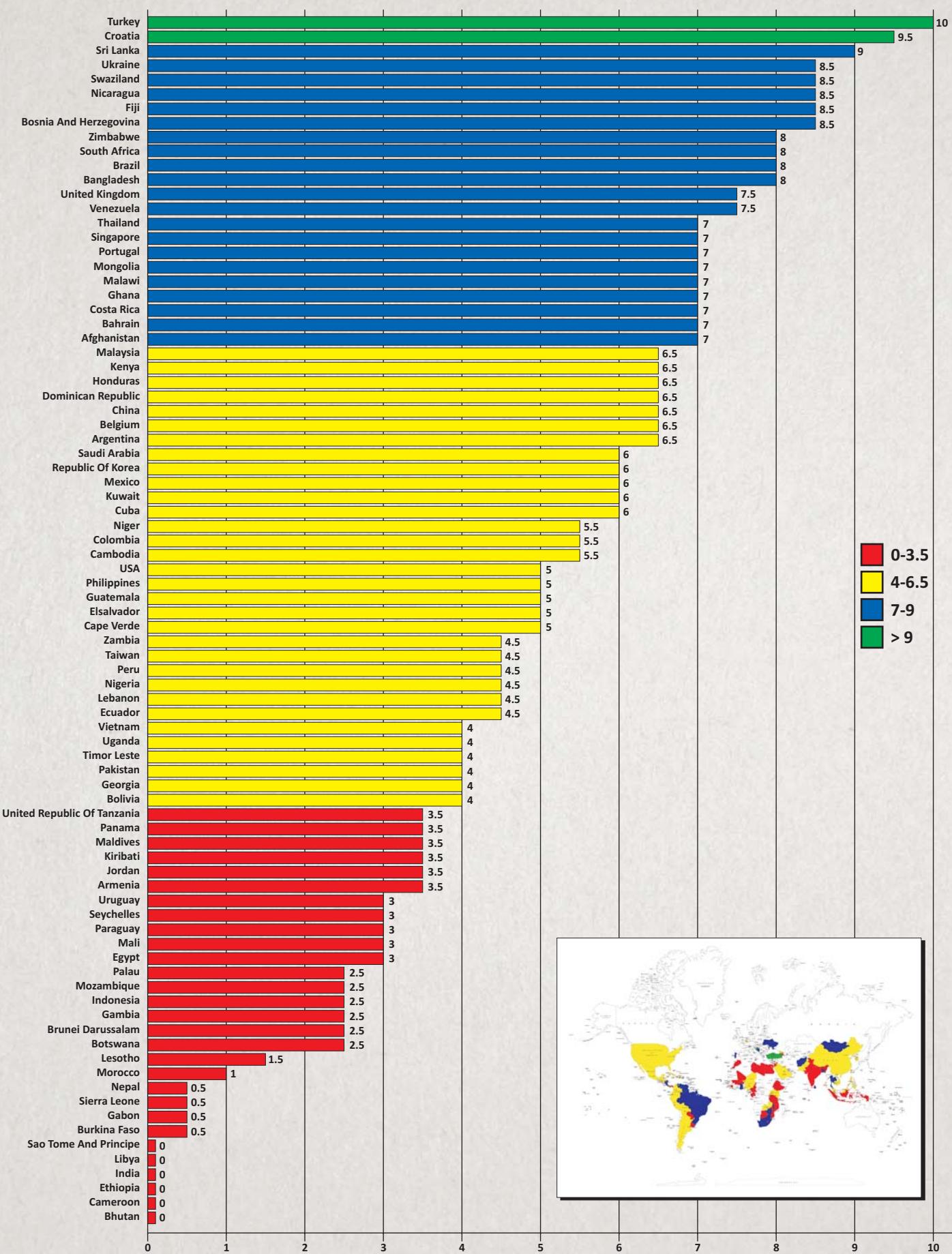
ⁱⁱⁱ Reassessment can be described as a “re-evaluation” of already designated baby-friendly hospitals to determine if they continue to adhere to the Ten Steps and other baby friendly criteria. It is usually planned and scheduled by the national authority responsible for BFHI for the purpose of evaluating on-going compliance with the Global Criteria and includes a reassessment visit by an outside team. Because of the human and financial resources required, in many countries it may be feasible to reassess hospitals only once every three years, but the final decision concerning how often reassessment is required should be left to the national authority.

color rating scoring 10 and 9.5 respectively. Twenty Nine countries are coded Red, scoring below 3.5, of which six countries score 0; indicating no action on BFHI taking place. Thirty two countries are coded Yellow and 21 are coded Blue.

It is evident from the colour coding

that many countries are not doing efforts to revive the BFHI programme or sustain efforts to implement the ‘ten steps’ of breastfeeding. It is clear from Figure 7 that most regions need to strengthen efforts if they want to score better and move on the next level of achievement.

Figure 7: The state of Baby Friendly Hospital Initiative in 84 countries on a scale of 0-10



Analysis and Conclusion

The detailed analysis of this indicator (Figure 8) shows that only 42 countries report having more than 50% of the hospitals achieving BFHI status. Further, 68 countries report that the majority of the BFHI hospitals used 18-20 hour training as a standard practice for health workers. Half of the countries (42) out of 84 indicate that there are systems of re-assessment in place.

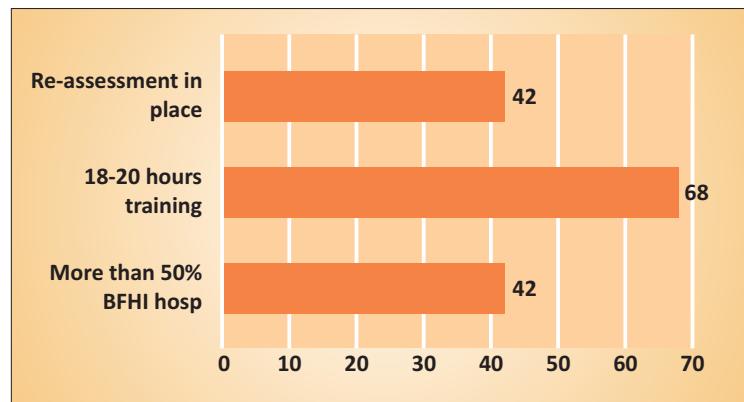
In case of the Baby Friendly Hospital Initiative (BFHI), the programme has taken a back seat and lack of interest in this intervention seems to be a major problem. The subset findings indicate the specific actions that individual countries need to take to mainstream BFHI, with less than half the hospitals following 'Ten' steps to successful breastfeeding. This indicator has a direct link to the rates of early initiation of breastfeeding, and can be scaled up easily.

All countries need to prioritize and take

action to support women when they come to deliver their babies. Published evidence from 19 countries shows that there is a dose response relationship between the number of BFHI steps women are exposed to and the likelihood of improved outcomes (early breastfeeding initiation, exclusive breastfeeding at hospital discharge, any breastfeeding and exclusive breastfeeding duration). Community support (step 10) appears to be essential for sustaining breastfeeding impacts of BFHI in the long term.²⁵

A recent analysis²⁶ of situation towards revitalization of the BFHI in Latin America and the Caribbean concludes that "increasing the number of baby friendly maternity facilities requires sustained commitment from practitioners and policy makers at multiple levels, as well as financial and human resources."

Figure 8: Status of subset questions for indicator on Baby Friendly Hospital Initiative in 84 countries



²⁵ Perez-Escamilla R, Martinez JL, Segura-Perez S. Impact of the baby-friendly hospital initiative on breastfeeding and child health outcomes: a systematic review. *Maternal & Child Nutrition* 2016, 12: 402-17.

²⁶ The Baby Friendly Hospital Initiative in Latin America and the Caribbean: Current status, challenges, and opportunities http://iris.paho.org/xmlui/bitstream/handle/123456789/18830/9789275118771_eng.pdf?sequence=1&isAllowed=

Implementation of the International Code of Marketing of Breastmilk Substitutes

The “*Innocenti Declaration*” calls for all governments to take action to implement all the articles of the *International Code of Marketing of Breastmilk Substitutes* and the subsequent World Health Assembly resolutions. The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The “State of the Code by Country” by the ICDC on countries’ progress in implementing the Code provides sufficient information on the action taken.

Nations are supposed to enact legislations as a follow-up to the International Code. Several relevant subsequent World Health Assembly resolutions, which strengthen the *International Code* have been adopted since

then and have the same status as the Code and should also be considered. The Global Strategy for infant and young child feeding calls for heightened action on this target. According to WHO-UNICEF-IBFAN 2016²⁷ report 135 out of 194 member states had at least some form of legal measure in place covering some provisions of the Code. A total of 39 countries have comprehensive legislation or other legal measures reflecting all or most provisions of the Code. The report also highlighted dismal status of the global implementation of the International Code and lack of political will to legislate and enforce the Code, and continued interference from baby food manufacturers as the major challenges in ensuring effective implementation of the Code and subsequent relevant WHA resolutions.

The 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; also it includes implementation and enforcement of the Code. (Table 3)

The average score for this indicator is 6.42 out of 10. Seven countries are coded Green by scoring 9 and above; with five countries scoring a perfect 10. Thirty eight countries score between 7 and 9, are coded Blue; the rest are below this level (Figure 9).

A look at the regions show gaps in many countries and no region doing well on this indicator.

Effective monitoring and enforcement of national Code legislation remains one of the key challenges in curbing inappropriate marketing practices

WHO-UNICEF-IBFAN Report on Marketing of Breast-Milk Substitutes 2016

Table 3: Key question & subset questionnaire for the indicator on implementation of the International Code of Marketing of Breastmilk Substitutes and scoring criteria

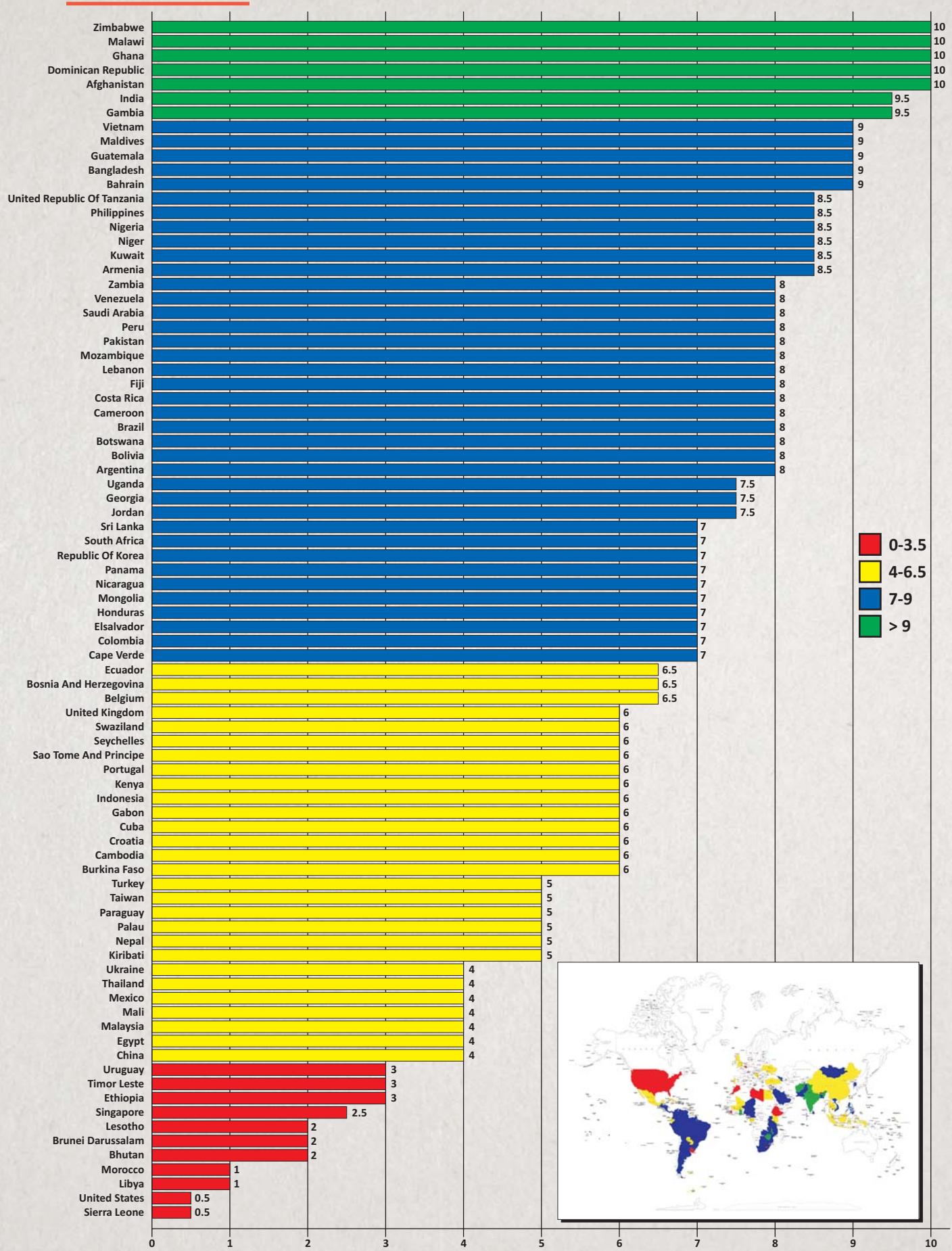
Key questions: Is the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolution are in effect and implemented? Has any new action been taken to give effect to the provisions of the Code?

Guidelines for scoring	Criteria (<i>legal measures that are in place in the country</i>)	Scoring
3a: Status of the International Code of Marketing		
✓ (Check that apply. If more than one is applicable, record the highest score.)		
3.1) No action taken	0	
3.2) The best approach is being considered	0.5	
3.3) National Measures awaiting approval (for not more than three years)	1	
3.4) Few Code provisions as voluntary measure	1.5	
3.5) All Code provisions as a voluntary measure	2	
3.6) Administrative directive/circular implementing the code in full or in part in health facilities with administrative sanctions	3	
3.7) Some articles of the Code as law	4	
3.8) All articles of the Code as law	5	
3.9) Relevant provisions of World Health Assembly (WHA) resolutions subsequent to the Code are included in the national legislation*		
a. Provisions based on at least 2 of the WHA resolutions as listed below are included	5.5	
b. Provisions based on all 4 of the WHA resolutions as listed below are included	6	
3b: Implementation of the Code/National legislation		
3.10) The measure/law provides for a monitoring system	1	
3.11) The measure provides for penalties and fines to be imposed to violators	1	
3.12) The compliance with the measure is monitored and violations reported to concerned agencies	1	
3.13) Violators of the law have been sanctioned during the last three years	1	
Total Score (3a + 3b)		/10

* Following WHA resolutions should be included in the national legislation/enforced through legal orders to tick this score.

1. Donation of free or subsidized supplies of breastmilk substitutes are not allowed (WHA 47.5)
2. Labeling of complementary foods recommended, marketed or represented for use from 6 months onward (WHA 49.15)
3. Health and nutrition claims for products for infants and young children are prohibited (WHA 58.32) are prohibited
4. Labels of covered products have warnings on the risks of intrinsic contamination and reflect the FAO/WHO recommendations for safe preparation of powder infant formula (WHA 58.32, 61.20)

Figure 9: The state of implementation of the International Code of Marketing of Breastmilk Substitutes in 84 countries on a scale of 0-10



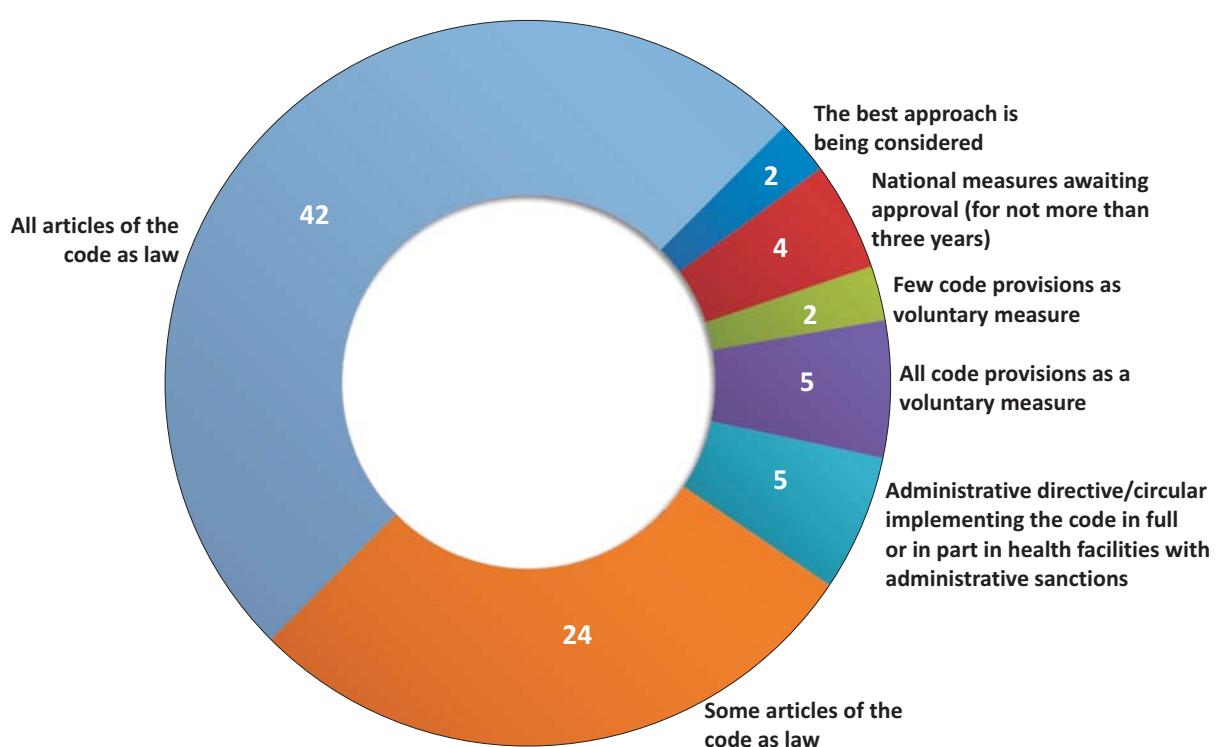
Analysis and Conclusion

Analysis of the indicator in terms of legal status of the Code (Figure 10) shows half the number of countries (42) have a comprehensive legislation on the Code, followed by 24 countries having some articles of the Code as law. This reflects on countries having adopted or amended strong legal measures incorporating the Code provisions.

Assessment findings indicated that there is huge scope for improvement to protect breastfeeding by adopting and implementing the International Code and subsequent WHA resolution. Many countries have shown improvement having legislated all articles of Code and also implementing;

IBFAN played a crucial role and there was a direct relation between achievement and the presence of IBFAN support in these countries. However, even countries having a legislation, need to work on effective implementation and monitoring, as merely having a law is not enough. The joint WHO-UNICEF-IBFAN 2016²⁷ report also endorses the fact that “countries continue to face significant challenges in ensuring effective implementation of the Code and the subsequent WHA resolutions”. It also emphasises on the lack of political will to legislate and enforce the Code as well as interference from baby food manufacturers in efforts to strengthen monitoring and enforcement measures.

Figure 10: Status of the International Code of Marketing in 84 countries



²⁷ WHO & UNICEF 2016. Marketing of Breast-milk Substitutes: National Implementation of the International Code Status Report. [Http://apps.who.int/iris/bitstream/10665/206008/1/9789241565325_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/206008/1/9789241565325_eng.pdf?ua=1&ua=1)

The Kuwait Breastfeeding Promotion and BFHI Implementation Committee did the WBT*i* assessments twice in collaboration with the Food and Nutrition Administration of Ministry of Health. The WBT*i* 2010 report was introduced to the decision makers and to the public during the first Kuwait IYCF conference in November 2011. According to the last WBT*i* 2015 report, most infant and young child feeding indicators have shown a consistent rise.

The impact of WBT*i* in bridging some of the major gaps in IYCF Policy & Programmes in Kuwait was evident. The WBT*i* report has contributed to advocacy efforts and investment toward the key indicators on Baby Friendly Hospital Initiative (BFHI) and implementation of the International Code that showed major improvements.

"The WBT*i* process is an excellent tool that would serve creating visibility for these issues and increasing the attention to the progress in implementation of the Global Strategy for infant and young child feeding and the Sustained Developmental Goals in Kuwait and globally.

Mona Alsumiae

Breastfeeding Promotion and BFHI Implementation Coordinator,
Community Nutrition Promotion Department, MOH, Kuwait

CASE STUDY

KUWAIT



CASE STUDY

BURKINA FASO



WBT*i* assessments have contributed to the strengthening and implementation of many policies like development and implementation of plan of IYCF scaleup at the national level; revival of the code review process in Burkina; advocacy and ratification of the ILO 183 convention; reinforcement of frameworks of dialogue and capacities of the actors of nutrition in Burkina. The results and recommendations from WBT*i* evaluations have been used for advocacy at the level of decision-makers for the strengthening of actions for the promotion of optimal IYCF practices; Improved IYCF indicators according to national surveys, for example, exclusive breastfeeding rates increased from 38.2% in 2012 to 50.1% in 2014. WBT*i* helped in mobilization of funds for the financing of actions of IYCF scaling plan 2013 - 2025 and WBW funded by UNICEF and other NGOs.

Edouard Zerbo
Regional Coordinator, Afrique

4 Maternity Protection

The Innocenti Declarations (1999, 2005) and WHO Global Strategy for IYCF (2002) call for provision of imaginative legislation to protect the breastfeeding rights of working women and further monitoring of its application consistent with ILO Maternity Protection Convention No 183, 2000 and Recommendation 191. The ILO's Maternity Protection Convention (MPC) 183 specifies that women workers should receive:

- Health protection, job protection and non-discrimination for pregnant and breastfeeding workers
- At least 14 weeks of paid maternity leave
- One or more paid breastfeeding breaks daily or daily reduction of hours of work to breastfeed

Furthermore, Recommendation 191 encourages facilities for breastfeeding to be set up at or near the workplace.

The concept of maternity protection involves 7 aspects: 1) the scope (in terms of who is covered); 2) leave (length; when it is taken, before or after giving birth; compulsory leave); the amount of paid leave and by whom it is paid employer or government; 3) cash and medical benefits; 4) breastfeeding breaks; 5) breastfeeding facilities; 6) health protection for the pregnant and lactating woman and her baby; 7) employment protection and non-discrimination.

Only a limited number of countries have ratified C183, but quite a few countries have ratified C103 and/or have national legislation and practices which are stronger than the provisions of any of the ILO Conventions.

Maternity protection is critical for success of breastfeeding and has been the most neglected so far

Maternity protection for all women implies that women working in the informal economy should also be protected. Innocenti Declaration 2005 calls for urgent attention to the special needs of women in the non-formal sector .

Adequate maternity protection also recognizes the father's role in nurturing and thus the need for paternity leave.

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 any measures (policies, regulations, practices etc.) (Table 4). This indicator, which measures the status of maternity entitlements, including maternity leave, breastfeeding breaks, paternity leave and non-discrimination, gets the third lowest score with an average of 5.43 out of 10. Not a single country has a perfect score of 10; only twenty-five countries score between 7-9 and are coded Blue, 37 countries are coded Yellow, and 22 countries score below 3.5 (Figure 11).

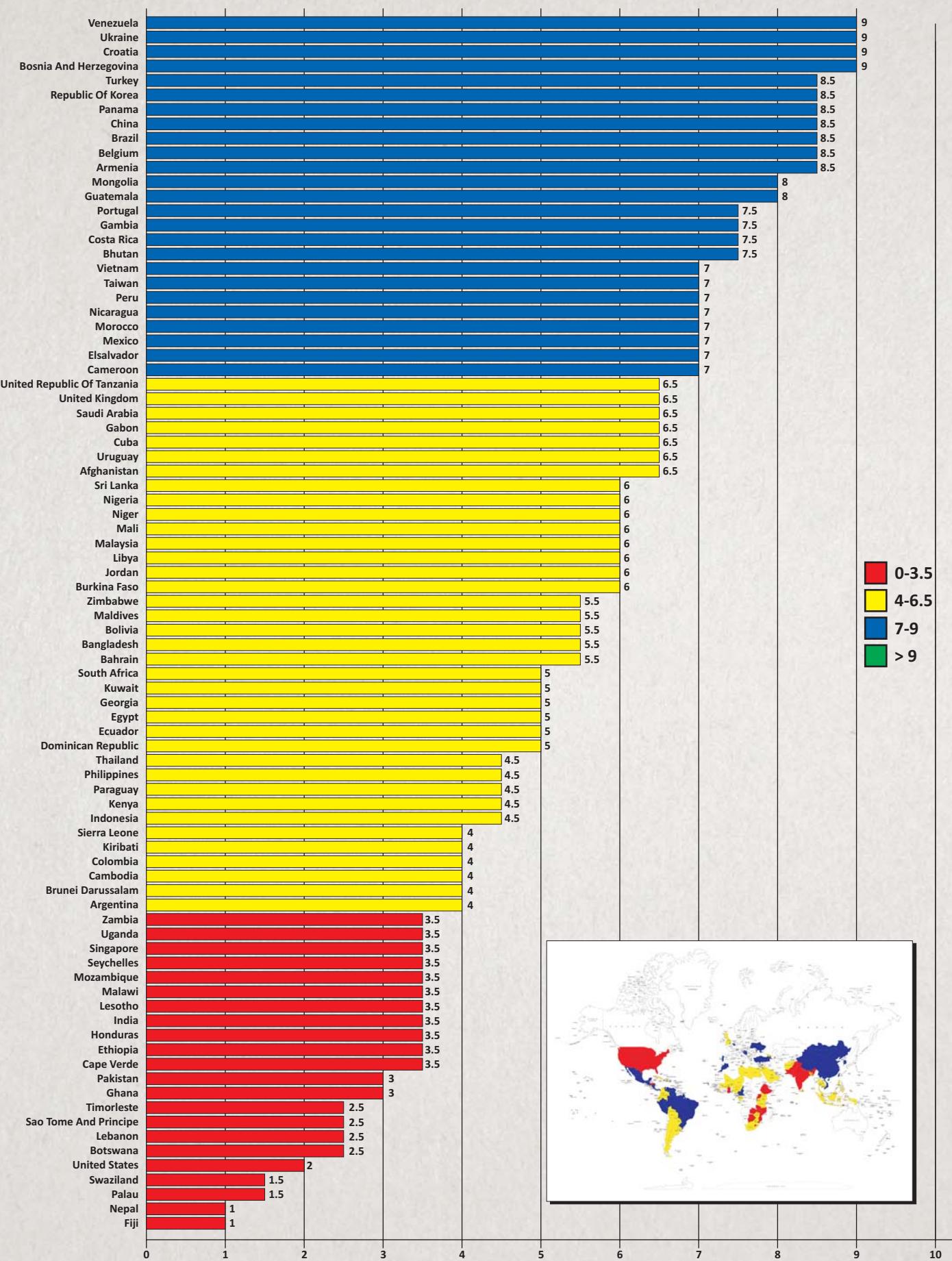
This figure also shows how regionally 84 countries are spread over, and how neglected they are with many in Red color coding.

Table 4: Key question and subset questionnaire for the indicator on maternity protection and scoring criteria

Key questions: Is there a legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labor Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including those working mothers in the informal sector?

Guidelines for scoring	Criteria	<u>Tick one which is applicable</u>
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 (more than one may apply)	a. Give at least 14 weeks paid maternity leave b. Paid nursing breaks.	0.5 0.5
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. (more than one may be applicable)	a. Space for Breastfeeding/Breastmilk expression b. Crèche	1 0.5
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). (more than one may be applicable)	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: 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.		1
Total Score:		/10

Figure 11: The state of maternity protection in 84 countries on a scale of 0-10



Analysis and Conclusion

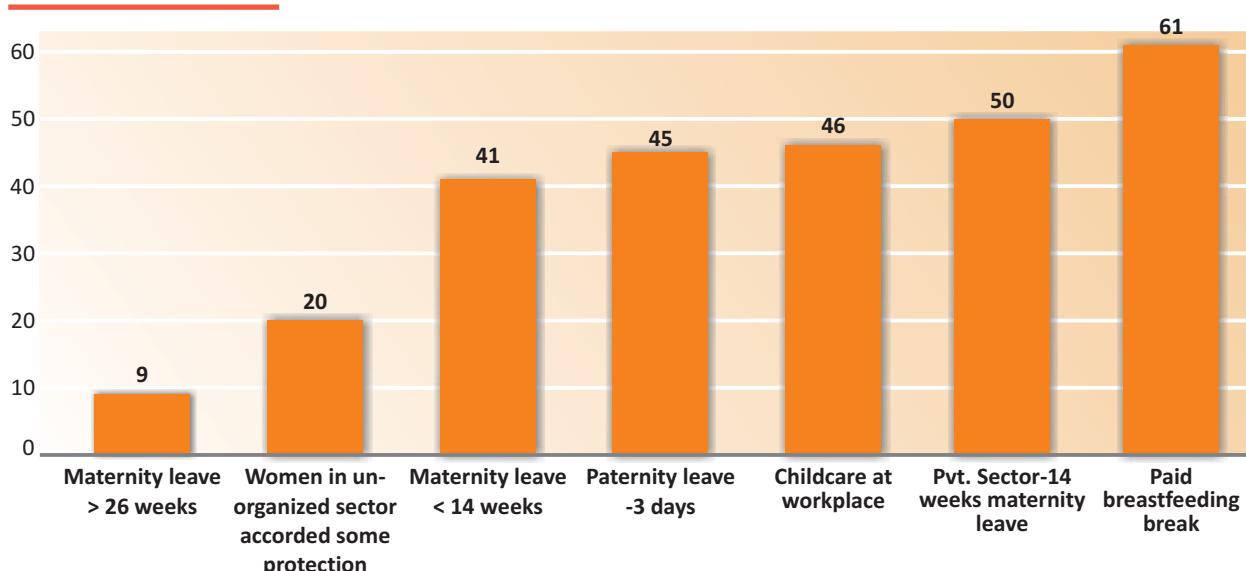
Figure 12 reveals only nine countries provide maternity leave of more than 26 weeks, and 41 give less than 14 weeks. At least one paid breastfeeding break is given in 61 countries, and 50 countries have legislation requiring the private sector to give at least 14 weeks of maternity leave. Twenty countries report similar levels of protection for women working in the unorganized sector.

Legislative provisions for accommodation for breastfeeding or childcare at worksites are provided in 46 countries only. Paternity leave of at least 3 days is provided in 45 countries.

These findings indicate a profound lack of support to women in each of the assessed countries. Only 10% of countries assessed provide more than 26 weeks of maternity leave, which is essential if exclusive breastfeeding has to succeed. There is a need to strengthen maternity protection, especially for working women in

all sectors, and provide support services like creches. Maternity protection is the most critical for the success of breastfeeding and has been the most neglected so far. The report "Labor Lost"-the WBTi assessment report on the status and enforcement of maternity protection laws across 57 countries²⁸, also reiterates the fact that maternity protection is vital to enhancing breastfeeding rates, but there is a need to create a conducive environment for women to successfully breastfeed. It is worldwide clear the gap between working men and working women in terms of opportunities, salaries, working conditions (women have particular needs if they are mothers, lactating, etc). There is a need to have a communication strategy that informs women about their maternity entitlements, and benefits of breastfeeding; concurrently legislation needs to be in place and implemented to restrict formula sales.

Figure 12: Status of subset questions for indicator on maternity protection in 84 countries



²⁸. Labor Lost 2015. The WBTi assessment report on the status and enforcement of Maternity Protection Laws across 57 countries 2015. [Http://www.bjni.org/report/Labour-Lost-WBTi.pdf](http://www.bjni.org/report/Labour-Lost-WBTi.pdf)

Health and Nutrition Care Systems

It has been documented that many of the health and nutrition workers lack adequate skills in counseling for infant and young child feeding which is essential for the success of breastfeeding.

Ideally, new graduates of health provider programmes should be able to support optimal infant and young child feeding practices from the outset of their careers. All providers who interact with mothers and their young children should attain the basic attitudes, knowledge and skills necessary to integrate breastfeeding counseling, lactation management, and

infant and young child feeding into their care. The topics can be integrated at various levels during education and employment. Therefore the total programme should be reviewed to assess this.

This indicator examines whether health care providers undergo skill 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. (Table 5)

Table 5: Key question and subset questionnaire for indicator on health and nutrition care systems and scoring criteria

Key question: Do care providers in these systems undergo *skills training*, and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place?

Guidelines for scoring Criteria	Scoring		
	Adequate	Inadequate	No Reference
5.1) A review of health provider schools and pre-service education programmes for health professionals, social and community workers 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 on their responsibility under the Code implementation / national regulation throughout the country.	1	0.5	0
5.5) Infant feeding and young child feeding information and skills are integrated, as appropriate, into training programmes focusing on (diarrhoeal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, breast cancer, women's health, NCDs etc.)	1	0.5	0
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country.***	1	0.5	0

	<u>Adequate</u>	<u>Inadequate</u>	<u>No Reference</u>			
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.						

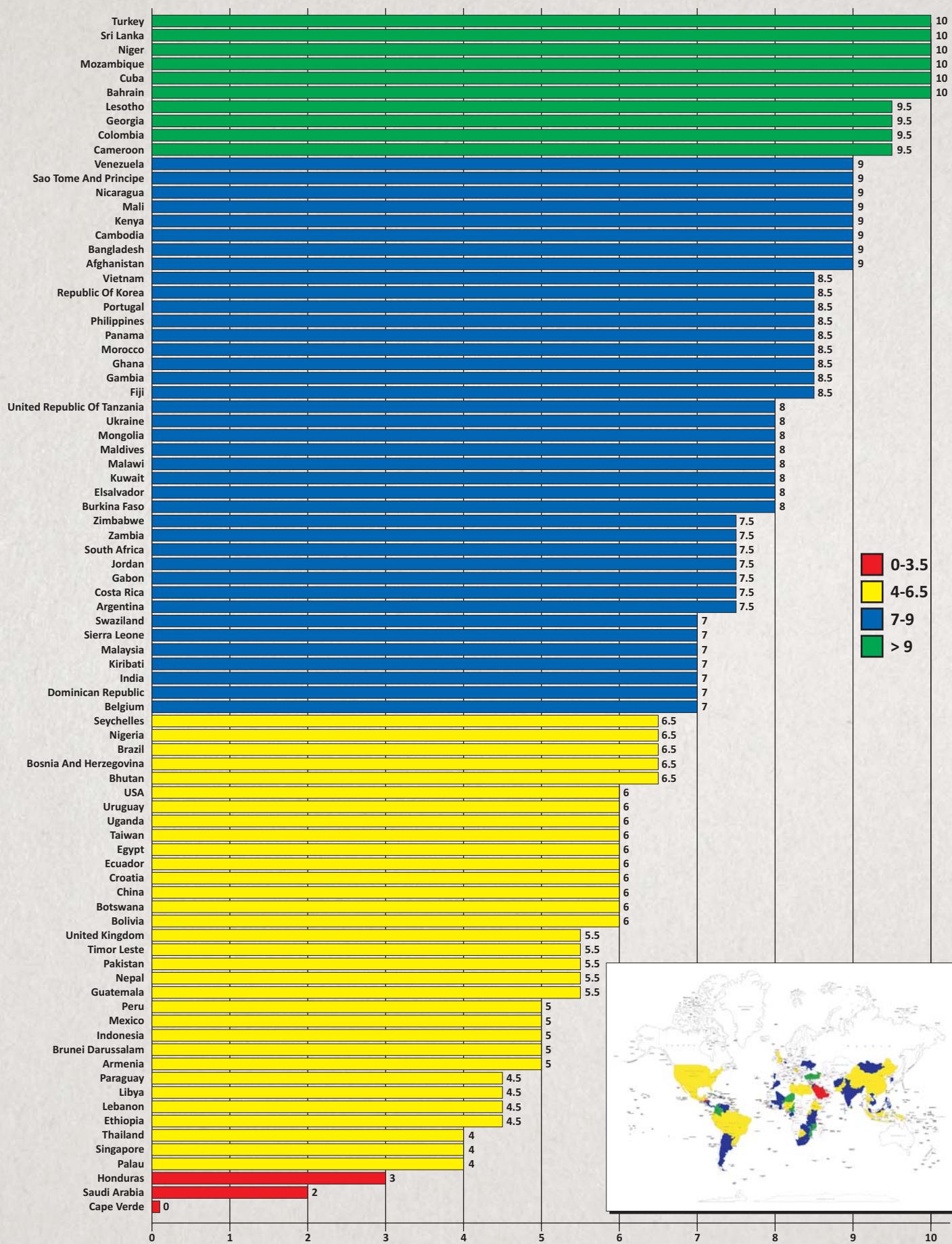
Only ten out of 84 countries have a full score of 10; the average score is 7.04 out of 10 (Figure 13). Almost half the countries (40) score between 7 and 9, 31 countries score between 4 and 6.5 and only three countries are coded red, of which one has a score of zero.

It shows all are making efforts. Few countries of Africa, Asia and Europe are coded Green. It shows they have capacity

building of health care providers in place. Africa sets an example specially after HIV crisis to have a combined approach not only medical and hospital interventions but also cultural, social and economic determinants are to be given attention, that peer counseling is crucial in mother support. Training of health workers and promoters needed to change the focus on prevention and support.



Figure 13: The state of health & nutrition care system in 84 countries on a scale of 0-10



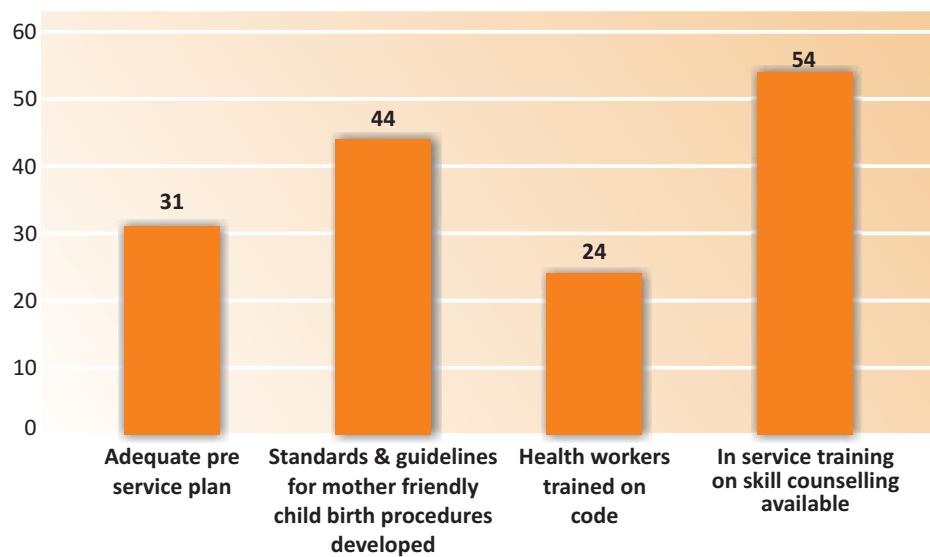
Analysis and Conclusion

Analysis of subsets (Figure 14) reveals that only 31 countries have adequate pre-service plans, in 44 countries standard guidelines on support at birth are in place and in 54 countries training programmes are in place. However, in only 24 countries health workers are trained about their responsibility towards Code implementation.

Analysis also reveals that most of the countries are working on integrating

IYCF in pre-service or in-service training and health workers are being trained in skilled counseling. However, there is a need to incorporate the International Code in the curriculum of health workers with emphasis on their responsibility towards its implementation as the key to enhance infant and young child feeding practices. The missing link of lack of pre service training need to be bridged and strengthened to reduce the load on in-service training.

Figure 14: Status of subset questions for indicator on health & nutrition care system in 84 countries



Mother support and Community Outreach: Community-based support for the pregnant and breastfeeding mother

Community-based support for women is essential for succeeding in optimal breastfeeding practices. Step 10 of BFHI as well as the Global Strategy for IYCF, which includes mother support and peer support, recognizes this need. Mother Support, as defined by the Global Initiative for Mother Support (GIMS) is “any support provided to mothers for the purpose of improving breastfeeding practices for both mother and infant & young child”.

Women need the support of evidence-based public health policies, health providers, employers, friends, family, the community, and particularly of other women and mothers in regards to preparation for breastfeeding which can come during the pregnancy and postpartum and after delivery. Reaching community level to give appropriate support, community volunteers or health workers under the health systems can offer and ensure sustained support to mothers. Their knowledge and skills have to be at the highest quality and they must have required training for giving support. It is necessary to have appropriate counseling in the community for motivation and increasing confidence in breastfeeding and home based complementary feeding. The support to mothers can be provided at the door steps by the women's groups- sometimes they are the mother support group (MSG) who are composed of some successful mothers and others of the same community. Mother support group is a core component of empowerment of the women. With

correct knowledge at community and outreach level, mothers can help themselves by giving exclusive breastfeeding up to six months and continue for two years or beyond and start home based appropriate complementary food by themselves when services and counselling are available by mother support groups and or health worker serving under the health services. Other important area is to consider the people living in remote areas where services are difficult to provide and receive.

Community counselling and services on IYCF are to be focused to new mothers, and various vulnerable groups. There is also need to provide adequate information to improve maternal nutrition without which IYCF action by mothers may be suboptimal as the mother is incapable to produce good quality milk and prepare and feed complementary foods appropriately.

Mother support is often seen as woman to woman (or more commonly known as mother-to-mother) but generally covers providing accurate and timely information to help a woman to build confidence; providing sound recommendations based on up-to-date research; providing compassionate care before, during and after childbirth; practicing empathy and active listening, providing hands-on assistance and practical guidance. It also includes support and counseling by health professionals and health care workers. Various community outreach services can also support women in optimal IYCF.

This indicator examines if there are mother support and community outreach systems in place to protect, promote and support optimal practices. (Table 6)

The indicator gets an average score of 6.27 out of 10, showing that in most countries pregnant women and women who have just given birth have some access to community-based support systems on IYCF. Six countries are coded Green, scoring a perfect 10. It is an interesting fact that these are developing countries who have

understood the need to use cultural and social existing networks to support mothers.

Thirty one countries score between 7-9 and are coded Blue. More than half the countries (45) score between 4-6 and only two countries namely Cape Verde and Libya scores zero, and are coded Red (Figure 15).

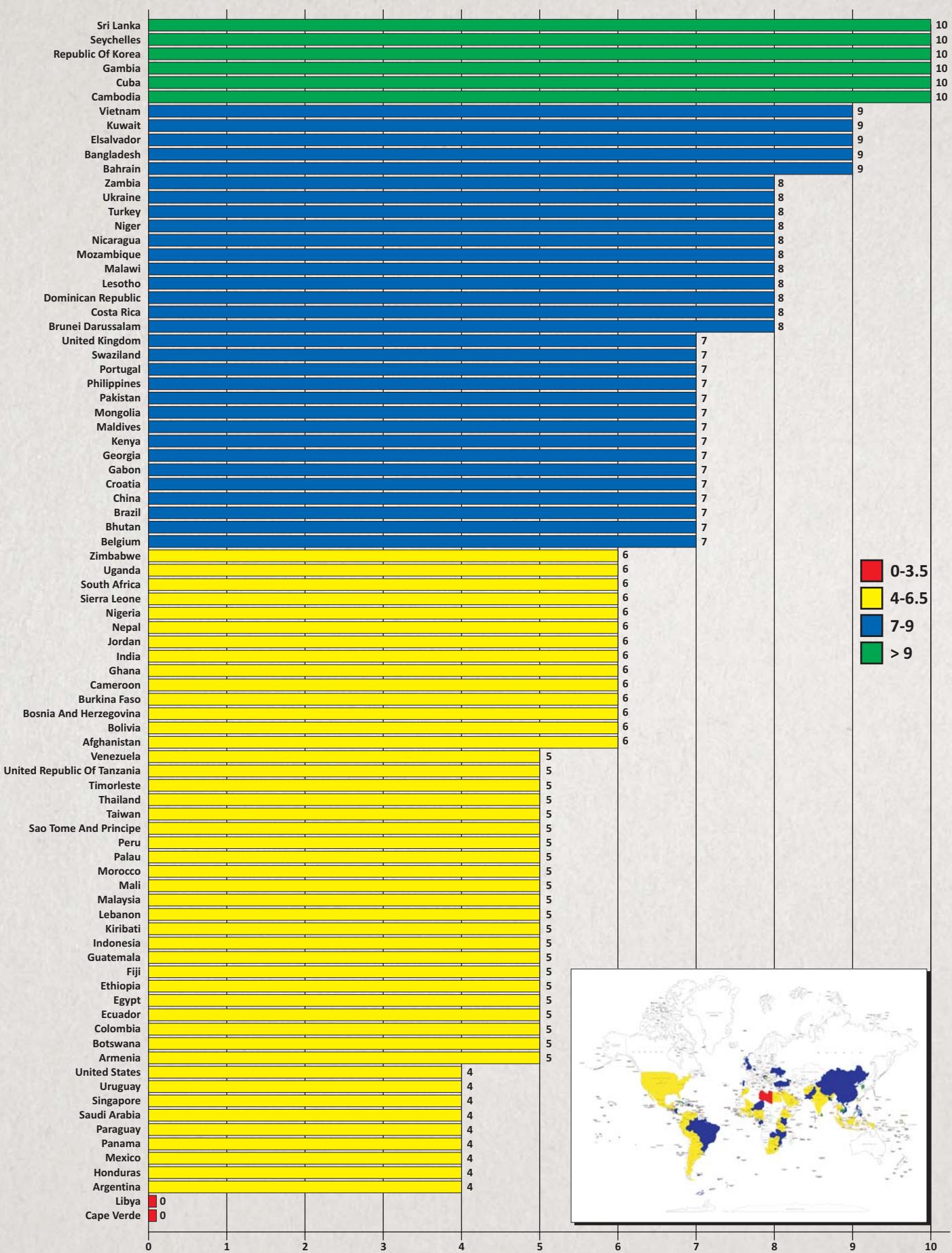
It seems all regions are faring average with more in the Yellow color coding. Some countries in Europe, Asia and Africa are doing better and achieved a blue color coding.

Table 6: Key question and subset questionnaire for indicator on mother support and community outreach and scoring criteria

Key question: Are there mother support and community outreach systems in place to protect, promote and support optimal infant and young child feeding

<u>Guidelines for scoring Criteria</u>	<u>Scoring</u> <input checked="" type="checkbox"/> <u>Check that apply</u>		
	<u>Yes</u>	<u>To some degree</u>	<u>No</u>
6.1) All pregnant women have access to community-based ante-natal and post - natal support systems with counseling services on infant and young child feeding.	2	1	0
6.2) All women receive support for infant and young child feeding at birth for breastfeeding initiation.	2	1	0
6.3) All women have access to counseling support for Infant and young child feeding counseling and support services have national coverage.	2	1	0
6.4) Community-based counseling through Mother Support Groups (MSG) and support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development policy IYCF/Health/ Nutrition Policy.	2	1	0
6.5) Community-based volunteers and health workers are trained in counseling skills for infant and young child feeding.	2	1	0
Total Score:	-----/10		

Figure 15: The state of mother support and community outreach in 84 countries on a scale of 0-10



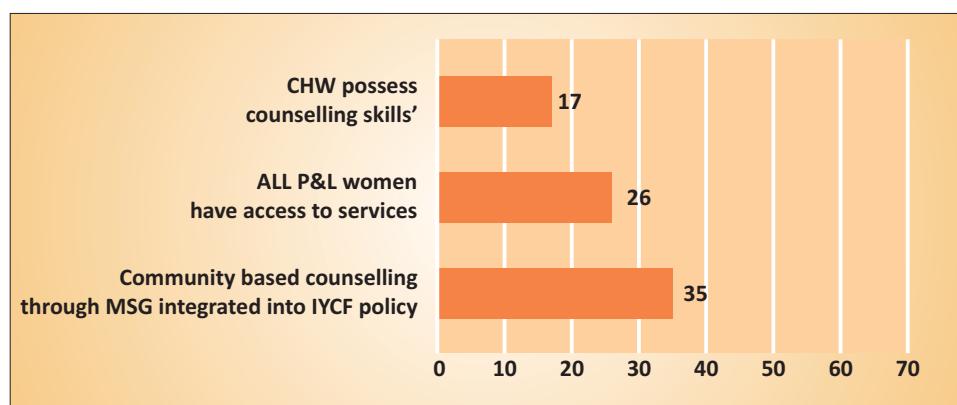
Analysis and Conclusion

Analysis of the subset of questions (Figure 16) reveals that although 35 countries report having community-based support integrated in the child health and development strategy, just 26 countries report that all pregnant and lactating women have access to such services. Similarly only 17 countries report that their community-based workers possess the skills and knowledge to counsel on breastfeeding/IYCF.

Analysis shows that some of the

countries are giving adequate training in information and counseling skills to the community workers, however overall community support to women to practice optimal IYCF is inadequate. All women need access to skilled counseling, and daycare services at work-sites. Countries need to enhance their counseling capacity of community workers, making available community based support to mothers and giving her access to right information and counseling as and when desired for enhancing optimal IYCF practices.

Figure 16: Status of subset questions for indicator on mother support and community outreach in 84 countries



WBTi assessments have been conducted twice in Mongolia in 2008 & 2013. WBTi has contributed to the achievements of MDG goals including goal 1- eradication of malnutrition and goal 4- for reduction of under-five and infant mortality rates. Advocacy based on first WBTi assessment led Ministry of Health take action on child feeding in emergencies and developed strategy on "IYCF in exceptionally difficult circumstances". *"The reassessment led to development of separate National IYCF strategy with more budget allocated per year by the Ministry of Health."* It also brought about the need to conduct survey on Code monitoring because of declining exclusive breastfeeding rates.

WBTi assessment reflected an improved implementation of IYCF and subsequent effects on child survival and nutrition indicators. This suggests that WBTi is useful and efficient tool for specific childhood preventive health interventions to improve child health and nutrition and to achieve the Sustainable Development Goal by 2030.

G. Soyolgerel, Mongolian Pediatric Society &
R. Galbadrakh, National Centre of MCH

CASE STUDY

MONGOLIA



CASE STUDY

EGYPT



There was improvement in various indicators owing to WBTi highlighting the gaps and suggesting recommendations. In Egypt in year 1992, more than 220 hospitals were designated as Baby Friendly but later there was no reassessment and so gradually these hospitals lost interest and the indicator was at 0 in 2011. After 2011 assessment, an ongoing process of reviving BFHI as a 5-year plan was formulated by the Ministry of Health and funded by the UNICEF (Egypt), training of Health Care Worker and BFHI assessors training was conducted. According to latest report 2016, 13 hospitals and 80 Primary Health Care units were accredited. The assessment gaps led to the monitoring of the implementation of the International Code of Marketing of Breastmilk Substitutes which highlighted many violations. The results were highlighted in a workshop to key decision makers. Advocacy efforts using WBTi helped to strengthen and extend *maternity protection* resulted in adopting in 2015 a new Civil Service law and all women are now entitled to a 4-month maternity leave instead of the previous 3 months.

Dr.Ghada Sayed
Regional Coordinator, IBFAN Arab World

Information Support

In many countries the IEC messages do not deal with WHO guidance on powdered infant formula preparations and its safety

Women and caregivers having the right to appropriate and objective support and information, education and communication (IEC) strategies are important aspects of a comprehensive programme to improve infant and young child feeding practices. However, because such programmes are expensive and often take place within a commercial context, they tend to attract inappropriate funding, for example, from the baby feeding industry. This can undermine the effectiveness of any

campaign and lead to unwise decision-making.

The first crucial step in an information strategy should be to ensure that baby food industry's influence of such messaging is kept to an absolute minimum. IEC approaches may include the use of electronic (TV, radio, video), print (posters, counseling cards, flip charts, manuals, newspapers, magazines), interpersonal (counseling, group education, support groups) and community activities to



communicate important information and motivational material to mothers, families and the community.

Information strategies are more likely to lead to positive behavior change if they are supported by counseling sessions, home visits, action-oriented group discussions and dramas focused on problem solving. IEC strategies are comprehensive when they ensure that all information channels convey concise, consistent, appropriate, action-oriented messages to targeted audiences at national, facility, community and family levels.

This indicator examines what kind

of information on IYCF is handed out by the State through media or other methods, whether it is technically correct or not, and what are the Information, Education and Communication (IEC) strategies. (Table 7).

The average score of this indicator is 6.91 out of 10 with only ten countries getting a full 10. Almost half of the countries (41) are coded Blue, scoring between 7 and 9; 24 countries score between 4 and 6 and nine score below 3.5 are coded Red (Figure 17).

There is regional variation as seen clearly in the Figure 17 and work cut out for all of them.

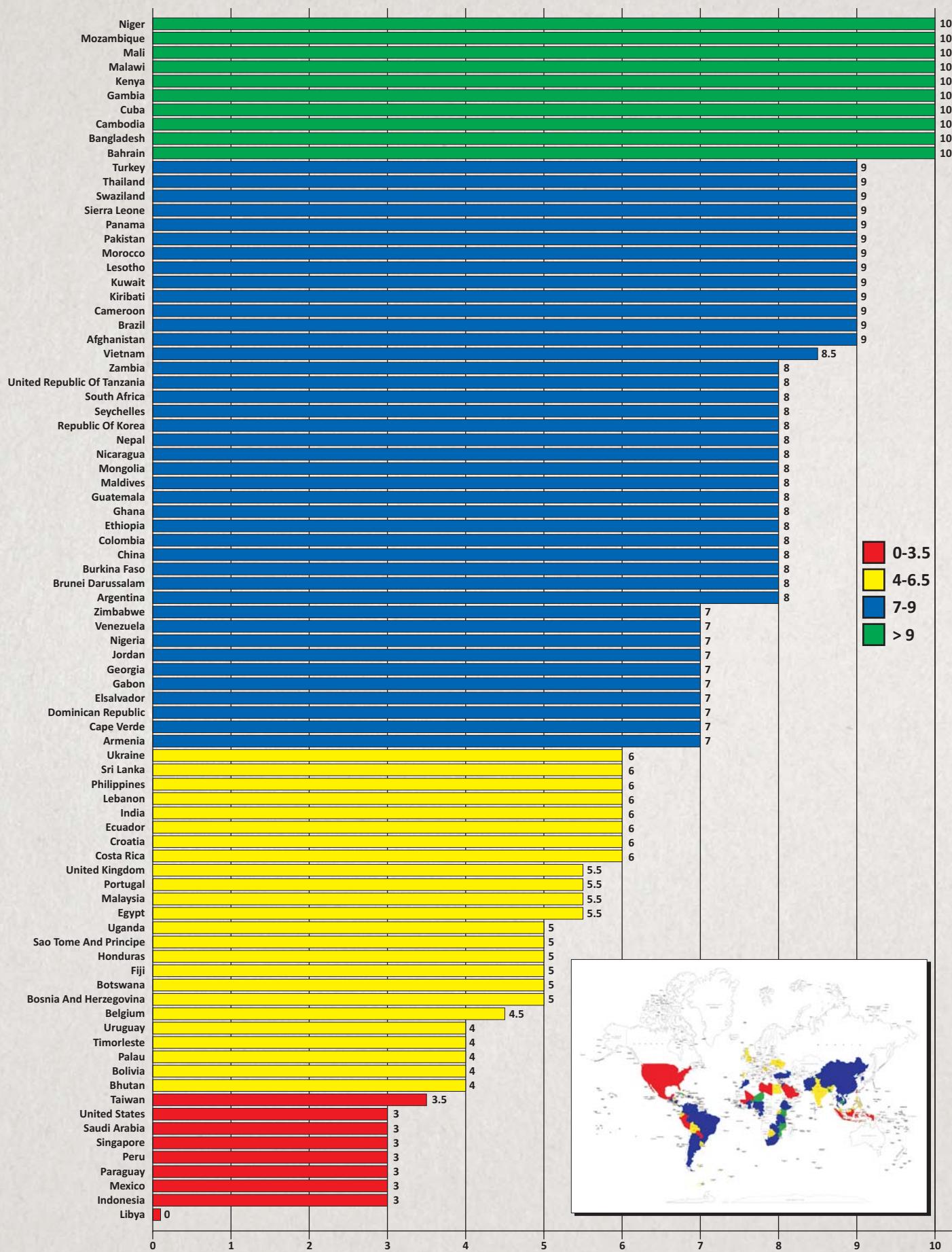
Table 7: Key question and subset questionnaire for indicator on information support and scoring criteria

Key question: Are comprehensive Information, Education and Communication (IEC) strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?

Guidelines for scoring Criteria	Scoring ✓ Check that apply		
	Yes	To some degree	No
7.1) There is a national IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence/potential conflicts or interest are avoided.	2	-	0
7.2a) National health/nutrition systems include individual counseling on infant and young child feeding	1	.5	0
7.2b) National health/nutrition systems include group education and counseling services on infant and young child feeding	1	.5	0
7.3) IYCF IEC materials are objective, consistent and in line with national and/or international recommendations and include information on the risks of artificial feeding	2	1	0
7.4. IEC programmes (eg World Breastfeeding Week) that include infant and young child feeding are being implemented at local level and are free from commercial influence	2	1	0
7.5 IEC materials/messages to include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF). *	2	-	0
Total Score:	-----/10		

* to ensure that clinicians and other health-care personnel, community health workers and families, parents and other caregivers, particularly of infants at high risk, are provided with enough information and training by health-care providers, in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately; and, where applicable, that this information is conveyed through an explicit warning on packaging;

Figure 17: The state of information support in 84 countries on a scale of 0-10



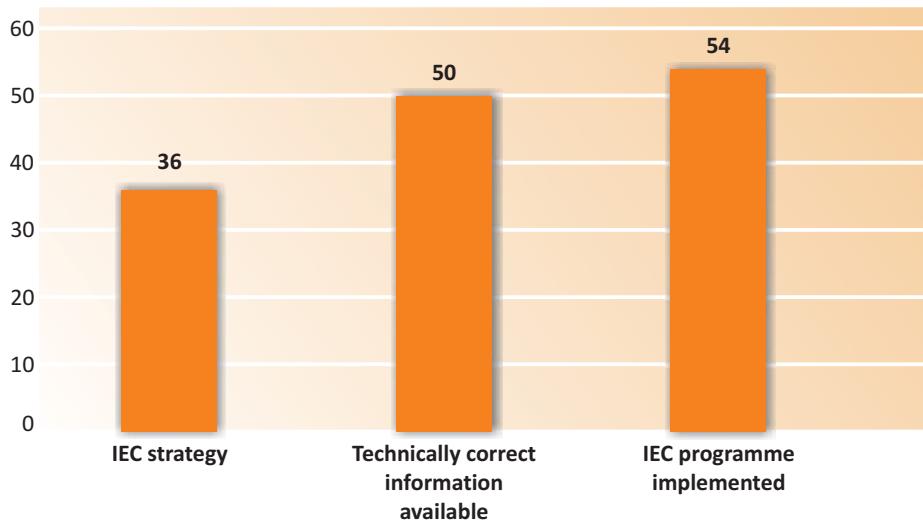
Analysis and Conclusion

An analysis of the indicator (Figure 18) shows that 50 countries provide technically correct information to their population, and only 36 have a comprehensive IEC strategy for improving IYCF practices. Fifty-four countries report that IEC programmes are being actively implemented at local levels.

The countries seem to be improving over years. However, this indicator should

aspire to get a maximum score of 10, as this is most easily achievable with the vast and digital medium available these days. There needs to be a comprehensive approach. With only 40% countries having a policy, there is a need to provide a clear direction for communication for improving breastfeeding or infant and young child feeding practices.

Figure 18: Status of subset questions for indicator on information support in 84 countries



WBTi assessments provided strong evidence for further policy making and programme planning to fill the gaps and were cited in official documents and project materials to call for concerns in baby friendly hospital performance, to increase early breastfeeding initiation and promote exclusive breastfeeding. WBTi tool has been introduced to training courses on Code and relevant WHA resolutions, interpreting the method to evaluate implementation in each country, measuring the gaps and raising awareness of the challenges to promote breastfeeding. WBTi advocacy led to development of the national programme of Baby Friendly Hospital reassessment (2014-2015) by the National Health and Family Plan Committee with local health authorities, to evaluate the performance of the health system and to refresh health workers' knowledge on breastfeeding.

Shuyi Zhang

Country Coordinator, China

Assistant Professor in Child Health,
Capital Institute of Pediatrics, China

CASE STUDY CHINA



CASE STUDY AFGHANISTAN



WBTi assessment provides evidences on infant and young child feeding indicators and helps us to show progress in each indicator along with trends over years. WBTi has shown progressive trend over the four assessments conducted by nutrition team at Ministry of Health. There have been specific achievements due to WBTi recommendations like development of IYCF policy and strategy approved by Ministry of Public Health, Government of Afghanistan; endorsement of the Breastmilk Substitute Code (BMS) with establishment of National BMS committee; improved numbers in baby friendly hospitals; capacity building of health staff on IYCF counseling; master trainers developed in provinces; funds generated for printing IYCF related IEC materials (TV & Radio spots, posters, brochures etc); developed campaign on National Breastfeeding Promotion and behaviour Change Communication.

Dr. Mohammad Hamayoun Ludin

Director of Public Nutrition Department,
Ministry of Public Health, Afghanistan

8 Infant Feeding and HIV

WHO guidelines on HIV and Infant Feeding in 2010²⁹ for the first time recommended the use of antiretroviral drugs to prevent postnatal transmission of HIV through breastfeeding. This resulted in a major change from an individualised counseling approach toward a public health approach regarding how maternal and child health services should routinely promote and support infant feeding practices among mothers living with HIV. The WHO 2016 'Updates on HIV and Infant Feeding' further reiterates the recommendation.³⁰

The fact that HIV can pass through breastfeeding and also that breastfeeding has life saving implications for infants and children, pose a dilemma to all, including policy makers, infant feeding counsellors and mothers who are HIV positive, whether to choose breastfeeding for their baby or give replacement feeding.

Optimal replacement feeding is rarely possible in resource-limited settings. Formula feeding is expensive and unreliable and consistent supplies of infant formula are difficult to maintain in countries with limited infrastructure for transport and storage. Even when formula is freely provided it may not be culturally acceptable and often puts the mother at risk of having her HIV status disclosed involuntarily to her family and community. In view of this, breastfeeding has remained the best feeding practice regardless of HIV status in most settings especially in the developing countries where HIV prevalence is high. Furthermore, evidence has shown that antiretroviral drugs

Much more needs to be done to prioritise action to support women with HIV to make informed choice about infant feeding

(ARVs), either lifelong antiretroviral therapy (ART) or antiretroviral drug prophylaxis, that is given to the breastfeeding mother and the infant can reduce the risk of breastfeeding transmission to as low as one percent. Policies and programmes to implement this effectively will require HIV Testing and Counselling (HTC) to be available and offered routinely to all mothers.

Furthermore support should be provided to ensure ARVs are made accessible to all breastfeeding mothers as per the national recommendations and support and follow up is provided to all mothers regardless of HIV status.

In an emergency situation, in countries that recommend exclusive breastfeeding with ARVs for HIV-infected mothers, the recommendation should remain unchanged, even if ARVs are temporarily not available.

In countries that recommend formula feeding for HIV-infected mothers, great care should be taken to ensure that Code-compliant infant formula is available only for those infants who need it.

This indicator examines what kind of support on IYCF is made available at policy and programme level to women who are found to be HIV-positive. (Table 8)

The average score of the 84 countries for this indicator is 6.63 out of 10,

with eight reaching the Green code. Forty-one countries score between 7-9 and are coded Blue. Fourteen countries are coded Red, scoring below 3.5. Twenty one countries are coded Yellow, scoring between 4-6, indicating that these countries have very inadequate policies and programmes related to infant feeding and HIV (Figure 19).

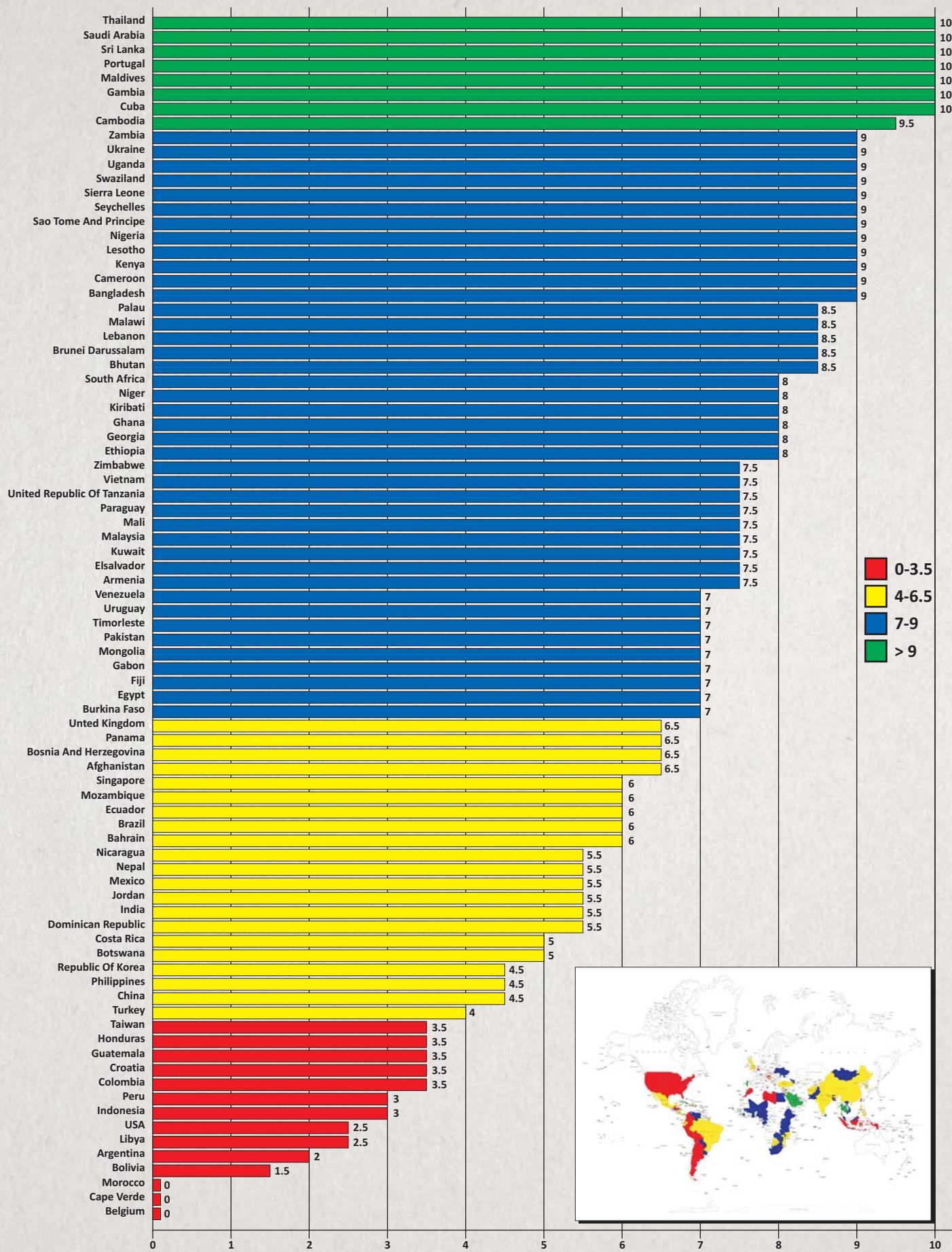
Regions like Europe, parts of Latin America, and South East Asia show red color coding and require strengthened efforts to prioritise action. Of all the regions studied, countries from the African region reported having adequately included infant feeding and HIV in their national policies.

Table 8: Key question and subset questionnaire for indicator on infant feeding and HIV scoring criteria

Key question: Are policies and programmes in place to ensure that HIV - positive mothers are supported to carry out the national recommended Infant feeding practice?

Guidelines for scoring Criteria	Results			
	✓ Check that apply	Yes	To some degree	No
8.1) The country has a comprehensive updated policy in line with international Guidelines 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) HIV Testing and Counselling (HTC)/ Provide Initiated HIV Testing and Counselling (PIHTC)/ 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 appropriate to local circumstances is provided to HIV positive mothers.		1	0.5	0
8.6) Mothers are supported in carrying out the recommended national infant feeding practices with further counselling and follow-up to make implementation of these practices feasible.		1	0.5	0
8.7) HIV positive breastfeeding mothers, who are supported through provision of ARVs in line with the national recommendations, are followed up and supported to ensure their adherence to ARVs uptake.		1	0.5	0
8.8) 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
8.9) 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
Total Score:			-----/10	

Figure 19: The state of infant feeding and HIV in 84 countries on a scale of 0-10

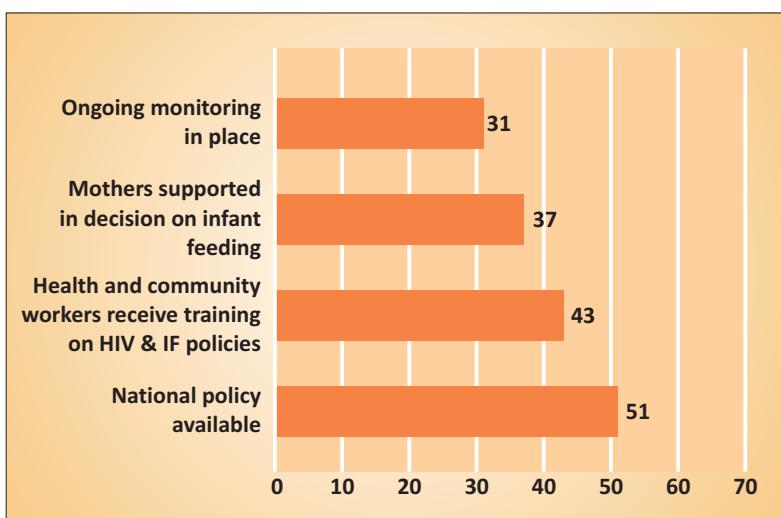


Analysis and Conclusion

The detailed analysis (Figure 20) shows that out of 84 countries assessed, 51 countries have a comprehensive national policy on IYCF that includes infant feeding and HIV. In 43 countries it is reported that health workers are trained in HIV and infant feeding. Only thirty-seven countries report that mothers are supported in their decisions on infant feeding, while 31 report that ongoing monitoring is in place.

Infant Feeding and HIV has shown good progress with many countries developing guidelines, and integrating HIV and Infant Feeding into the IYCF policy, also imparting training for health providers. Still countries need to do much more to prioritise action to support women with HIV to make informed choice about feeding their infants. An analysis from 57 countries on HIV and Infant Feeding based on WBT³¹ also indicates poor implementation and lack of progress in this area. The situation remains unacceptable and overall, much remains to be done to ensure mothers and babies are protected and supported within a comprehensive continuum of services that include prevention, care, treatment, support and follow-up, to prevent vertical transmission of HIV and ensure healthy outcomes for both mothers and their babies, whilst protecting, promoting and supporting optimal breastfeeding practices for the general population.

Figure 20: Status of subset questions for indicator on infant feeding and HIV in 84 countries



²⁹ WHO 2010. Guidelines on HIV and Infant Feeding. http://apps.who.int/iris/bitstream/10665/44345/1/9789241599535_eng.pdf

³⁰ WHO 2016. Updates on HIV and Infant Feeding. <http://apps.who.int/iris/bitstream/10665/246260/1/9789241549707-eng.pdf?ua=1>

³¹ HIV and Infant Feeding 2015. Global status of policy and programmes based on World Breastfeeding Trends Initiative assessment findings from 57 countries. <http://bpni.org/report/HIV-and-Infant-Feeding.pdf>

9 Infant Feeding during Emergencies

Infants and young children are among the most vulnerable groups in emergencies. Absence of or inadequate breastfeeding and inappropriate complementary feeding increase the risks of undernutrition, illness and mortality. In emergency and humanitarian relief situations, the emergency-affected host country and responding agencies share the responsibility for protecting, promoting and supporting optimal infant and young child feeding practices and minimizing harmful practices. Concise operational guidance³² on how to ensure appropriate feeding in emergency situations and comply with international emergency standards has been developed by an interagency Infant Feeding in Emergencies Core Group and was adopted at WHA 63.23 in 2010. Practical details on

Maximum countries ill-equipped to handle infant feeding in emergencies

how to implement the guidance summarized in the Operational Guidance are included in companion training materials, also developed through interagency collaboration as well as part of the UN Nutrition Cluster capacity building materials. All these resources are available at www.ennonline.net/IFE.

This indicator examines how women are supported during emergency or disaster situations to maintain feeding of their infants, and what kind of policy there is to protect and support mothers for appropriate feeding of their babies.(Table 9)

The indicator scored the lowest



Photo Credit: IBFAN Southeast Asia

Table 9: Key question and subset questionnaire for indicator on infant feeding during emergencies and scoring criteria

Key question: Are appropriate policies and programmes in place to ensure that mothers, infants and young children will be provided adequate protection and support for appropriate feeding during emergencies (IFE)?

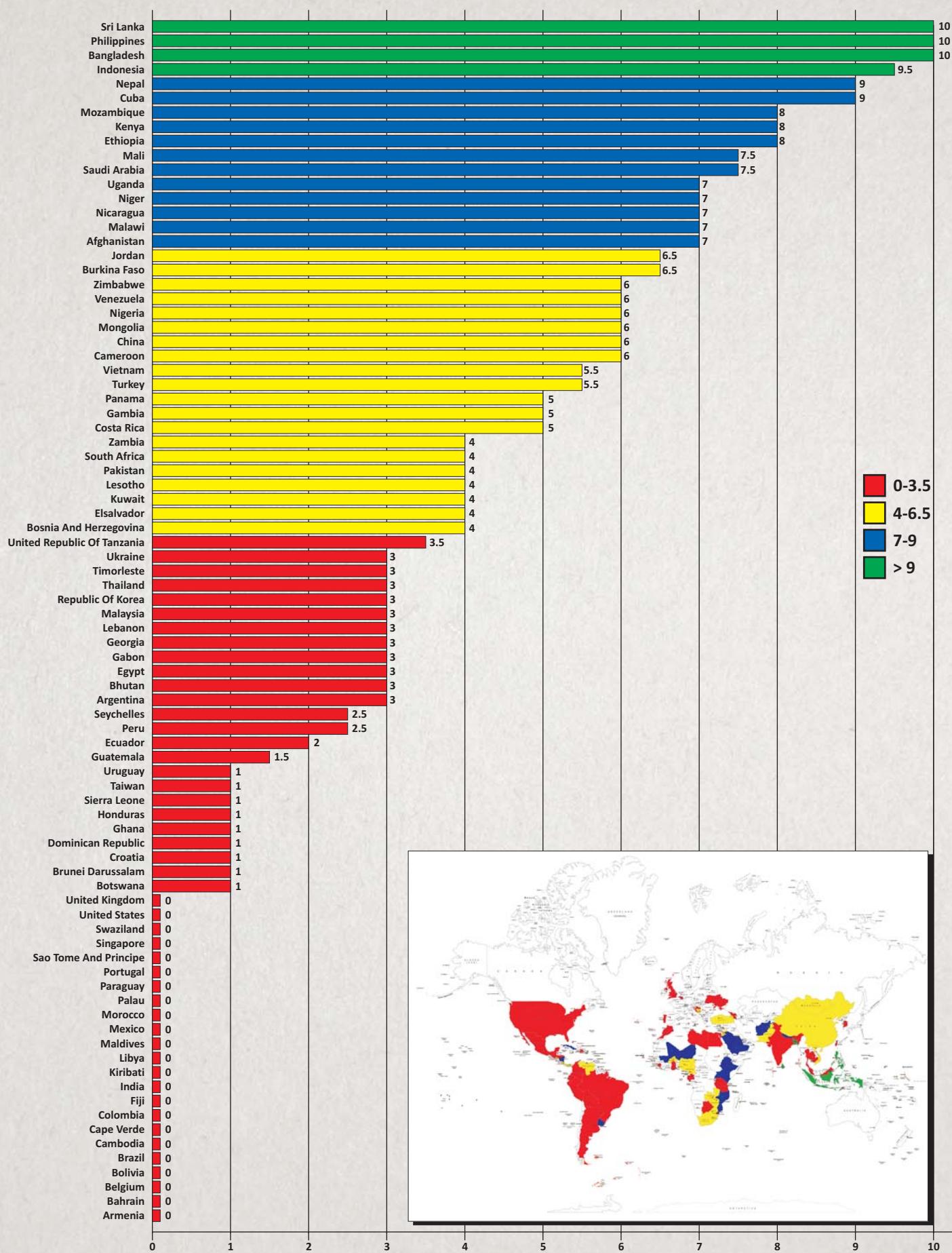
Guidelines for scoring Criteria	Scoring ✓ Check that apply		
	<u>Yes</u>	<u>To some degree</u>	<u>No</u>
9.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance	2	1	0
9.2) Person(s) tasked with responsibility for national coordination with all relevant partners such as 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 and response plan based on the practical steps listed in the Operational Guidance has been developed and put into effect in most recent emergency situations, and covers: a) basic and technical interventions to create an enabling environment for breastfeeding, including counseling by appropriately trained counselors, support for relactation and wet-nursing, and protected spaces for breastfeeding b) measures to minimize the risks of artificial feeding, including an endorsed statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsolicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions	1	0.5	0
9.4) Resources have been allocated for implementation of the emergency preparedness and response plan	2	1	0
9.5) a) Appropriate orientation and training 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. b) Orientation and training is taking place as per the national emergency preparedness and response plan	1	0.5	0
Total Score:	-----/10		

average of all indicators, at 3.43 out of 10, showing an overall lack of preparedness for such situations. Only four out of 84 countries score 9.5-10, having prioritized infant feeding during emergencies and included it in their policy on breastfeeding

and infant and young child feeding. The majority, 48 countries are coded red, with 23 countries scoring zero (Figure 21).

The situation is alarming with most regions in red color coding.

Figure 21: The state of infant feeding during emergencies in 84 countries on a scale of 0-10



Analysis and Conclusion

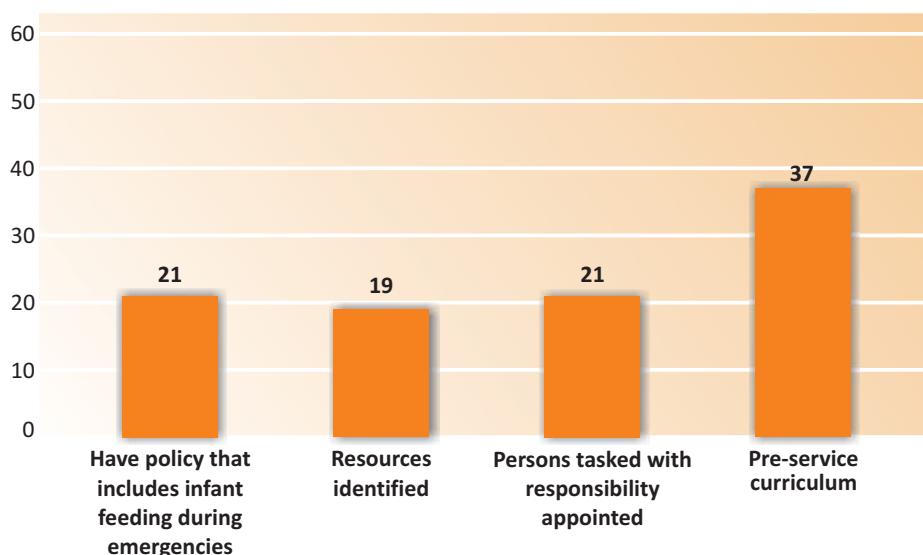
Twenty-one countries report having a policy that includes infant feeding in emergencies. In 21 countries persons have been given responsibility for this task, 19 have identified resources for implementation of their plan and 37 have put it into their pre-service curriculum (Figure 22). Analysis shows only a few countries are putting in efforts to bridge the gaps.

The assessment reveals the need for countries to develop a policy that includes Infant Feeding in Emergencies and the government must take responsibility for the same. During emergencies the system breaks at almost all levels, starting with the local one but reaching governments that fail to face the situation leaving it in the hands

of whatever help they get. So prevention becomes important, and clear policies and programmes BEFORE the emergencies occur - training needs to be part of the preparedness and should include basic actions such as facilitation of mothers being together, building towards re-establishing local provision of foods and less dependence on food coming from other countries, so not leaving people in the hands of the humanitarian groups and companies dumping formulas, complementary foods, bottles etc.

The countries need to appoint a focal person responsible for infant and young child feeding during emergencies and allocate specific resources both financial and human in their disaster management plan.

Figure 22: Status of subset question for indicator on infant feeding during emergencies in 84 countries



³². Infant and Young Child Feeding in Emergencies. Operational Guidance for emergency and relief staff and program managers, version 2.1, 2007, IFE Core group <http://www.enononline.net/resources/6>

Mechanisms of Monitoring and Evaluation System

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.

Periodic monitoring or management information system data should be collected systematically, analysed and considered by programme managers as part of the planning, management and implementation process. When appropriate, both baseline and follow-up data should be collected to measure outcomes. Unified criteria on the 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 to devise strategies to ensure that results of important evaluation are used to assure evidence-based decision making. This indicator examines if countries collect data routinely and whether these data are used to improve IYCF practices. (Table 10)

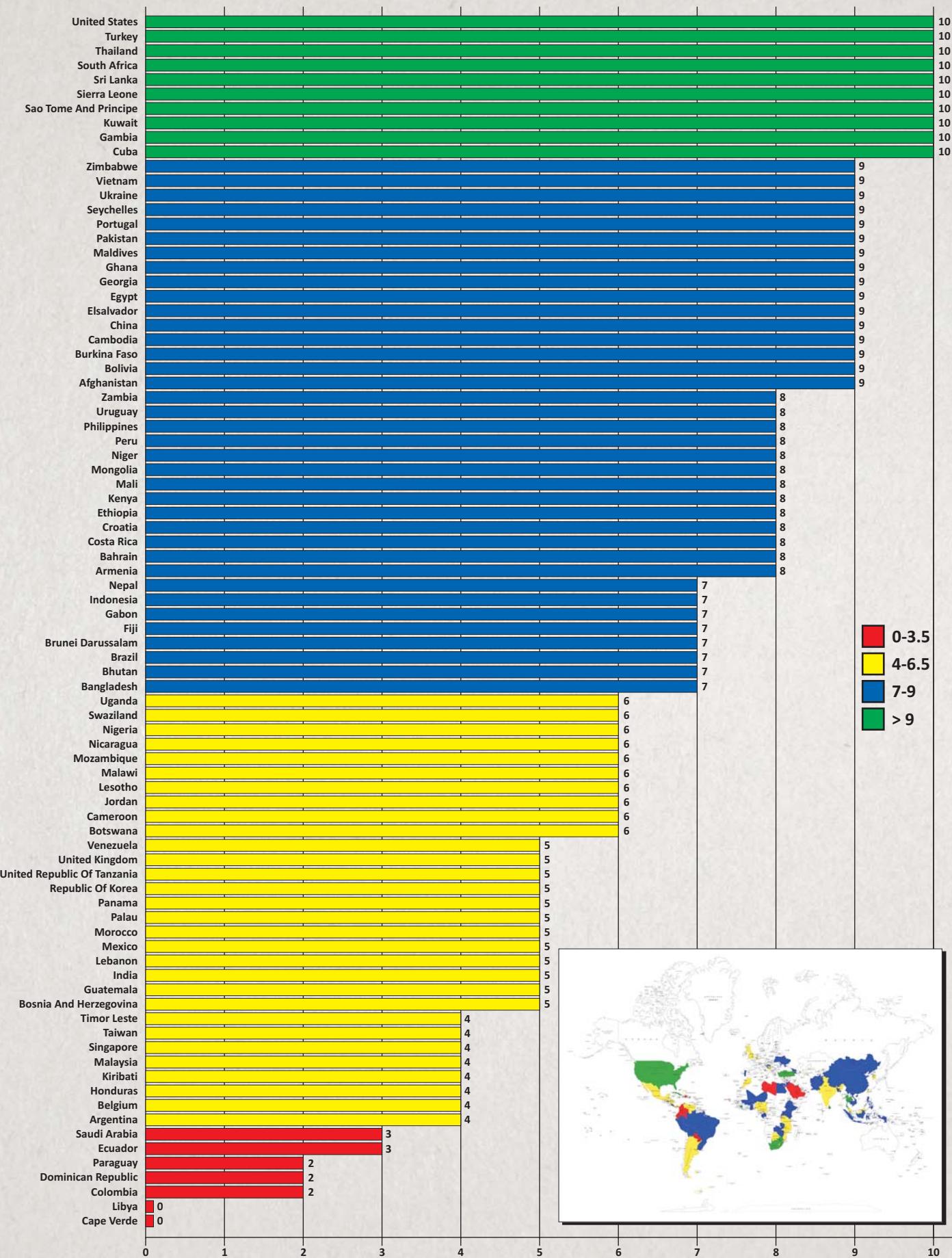
The average score for this indicator was 6.76 out of 10. Only ten out of 84 countries scored a perfect 10, with 37 countries scoring between 7 and 9 and 30 countries between 4 and 6. Seven countries are coded red, scoring below 3; of these, two countries score zero (Figure 23).

Table 10: Key question and subset questionnaire for indicator on mechanisms of monitoring and evaluation system and scoring criteria

Key question: Are monitoring and evaluation systems in place that routinely collect, analyse and use data to improve infant and young child feeding practices?

Guidelines for scoring Criteria	Scoring ✓ Check that apply		
	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) Data/information on progress made in implementing the IYCF programme are used by programme managers to guide planning and investments decisions	2	1	0
10.3) Data on progress made in implementing IYCF programme activities routinely collected at the sub national and national levels	2	1	0
10.4) Data/Information related to infant and young child feeding programme progress are reported to key decision-makers	2	1	0
10.5) Monitoring of key infant and young child feeding practices is integrated into the national nutritional surveillance system, and/or health information system or national health surveys.	2	1	0
Total Score:	-----/10		

Figure 23: The state of mechanisms of monitoring and evaluation system in 84 countries on a scale of 0-10



It shows all regions have monitoring systems in place; however the countries in red and yellow need to give more emphasis.

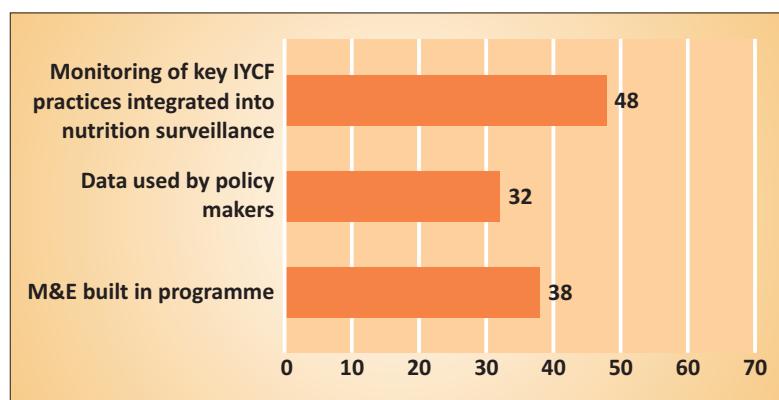
Analysis and Conclusion

Figure 24 reveals, only 38 countries report that monitoring and evaluation is built into their major programmes and 32 report that the policy makers use data from a management information system.

Monitoring of key IYCF practices is built into a broader nutrition surveillance or health monitoring system or surveys in 48 countries.

The analysis indicates the need for governments to undertake regular or periodical routine national surveys. The need for annual surveys on IYCF is much needed, as malnutrition peaks within the first two years of life; only then can interventions be fine-tuned according to needs. Monitoring is not just a tool to see if there is implementation in place but a tool to LEARN and improve policies and programmes. Countries need to give due emphasis to this indicator and work on establishing a national nutritional surveillance system, which would include IYCF indicators.

Figure 24: Status of subset questions for indicator on mechanisms of monitoring and evaluation system in 84 countries



INDICATORS ON IYCF PRACTICES

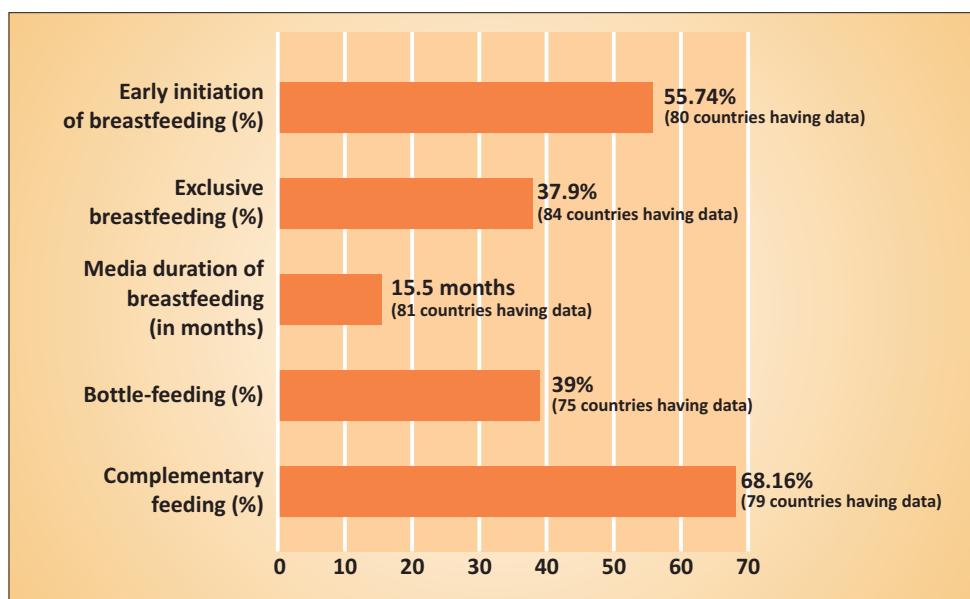
Optimal IYCF practices include initiation of breastfeeding within 1 hour of birth, exclusive breastfeeding for the first 6 months of life and addition of appropriate and adequate family foods for complementary feeding after 6 months, together with continued breastfeeding for 2 years or beyond. These five IYCF practices are collected from the available secondary data that is national in scope. While data on practices are based on actual figures, colour coding is done by using IBFAN Asia guidelines.

Figure 25 provides an average for each IYCF practice indicator from among the countries where these data were available

and reported.

The results indicate that IYCF practices in the assessed countries are nowhere near optimal. The average rate of initiation of breastfeeding within 1 hour of birth as reported by 80 countries is just above 50%. Exclusive breastfeeding for the first 6 months as reported by all 84 countries is 37.9%. The median duration of breastfeeding is 15.5 months. Bottle-feeding as reported by 75 countries is 39%. The percentage of breastfed babies receiving complementary foods at 6-8 months is 68.16%. It is important to note that some countries do not even have national data of these indicators.

Figure 25: Average rates for the five practice indicators



Timely Initiation of Breastfeeding within one hour of Birth

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 chances of establishing exclusive breastfeeding early and its success. Evidence has shown that early initiation of breastfeeding reduces neonatal and early infant mortality.

No data on rate of initiation of breastfeeding within one hour of birth was available from four countries namely Venezuela, Republic of Korea, Palau, and Belgium. Taiwan and Vietnam did not have data in its previous assessment; however now national data has been collected. Average rate for the remaining 80 countries is 55.74% (Figure 26). The rates for individual countries show a wide variation from 11% in Saudi Arabia and to 96% in Cameroon.

Of the 80 countries having data on this indicator, only 6 countries are coded Green. Almost half the countries (43) are coded Blue, twenty three are coded Yellow and eight are coded Red (Figure 27).

Conclusion

Evidence shows that this indicator has a significant impact on reducing child malnutrition, neonatal and infant mortality. All countries need to work hard to reach out to all women locally with correct information and to provide practical support for breastfeeding at the time of birth. There is need to strengthen efforts to link to BFHI to achieve it universally.

Key question to be answered and scoring criteria

Key question: What is the percentage of babies breastfed within one hour of birth?

Indicator 11	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
		Scores	Colour-rating
<i>Initiation of Breastfeeding (within 1 hour)</i>	0.1-29%	3	RED
	29.1-49%	6	YELLOW
	49.1-89%	9	BLUE
	89.1-100%	10	GREEN

Figure 26: Average rate of early initiation of breastfeeding within one hour of birth from 80 countries

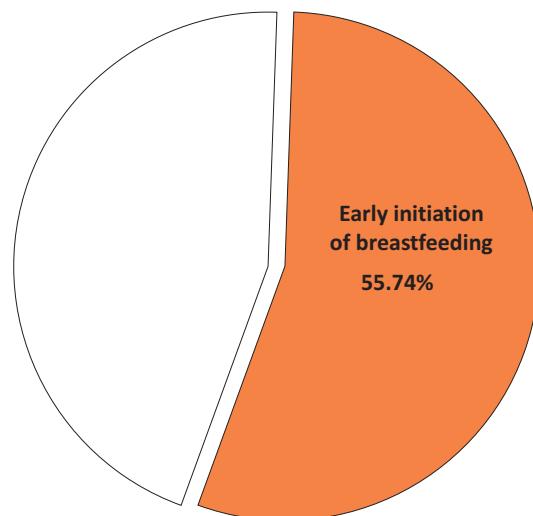
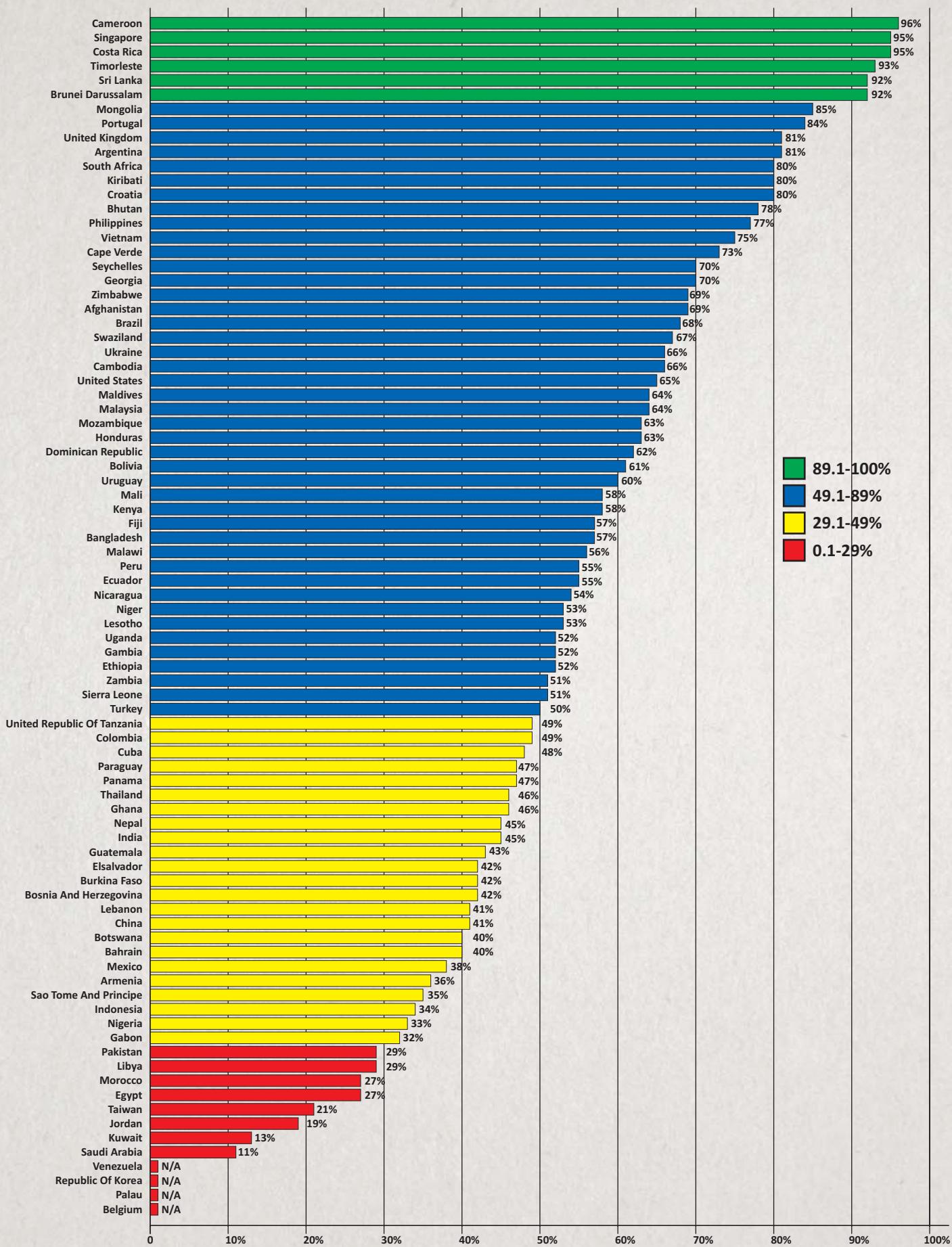


Figure 27: Percentage of early initiation of breastfeeding within one hour of birth in 80 countries



Exclusive Breastfeeding for the first six months

Lancet series on Breastfeeding 2016 clearly points out the role of exclusive breastfeeding during first six months for infant survival and development.

Average rate of exclusive breastfeeding for 84 countries is mere 37.9% (Figure 28). Vietnam did not have data for the same in the last assessment and have included in its national survey and data is available now. The percentage of exclusive breastfeeding range from 1 percent in Singapore to 75% in Sri Lanka. Figure 29 gives the percentage of babies who are exclusively breastfed between birth to six months for each country and colour coding. While no country is coded Green, 18 are coded Blue. Maximum (61) are coded Yellow and five are Red.

Conclusions

Exclusive breastfeeding is complex and needs behaviour change and social support at many levels. The main reason being mother's perception of "not enough milk", lack of correct information and interference by commercial sector. Women need skilled counselling on optimal IYCF practices on continued basis beginning from conception. Women also need support at work place in form of maternity leave, and other benefits that allows for exclusive breastfeeding for 6 months and creches.

Every country needs to make efforts to strengthen all support systems to create enabling environment to maintain and aspire for rise of exclusive breastfeeding both for nutrition and survival of babies.

Key question to be answered and scoring criteria

Key question: What is the percentage of babies 0<6 months of age exclusively breastfed in the last 24 hours?

Indicator 12	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
<i>Exclusive Breastfeeding (for first 6 months)</i>		Scores	Colour-rating
	0.1-11%	3	RED
	11.1-49%	6	YELLOW
	49.1-89%	9	BLUE
	89.1-100%	10	GREEN

Figure 28: Average of exclusive breastfeeding for the first six months from 84 countries

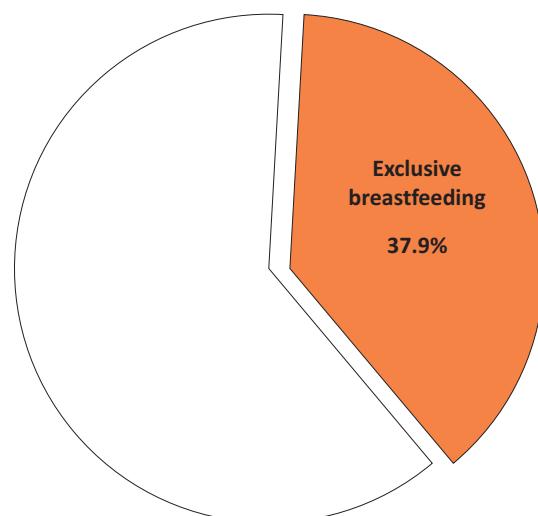
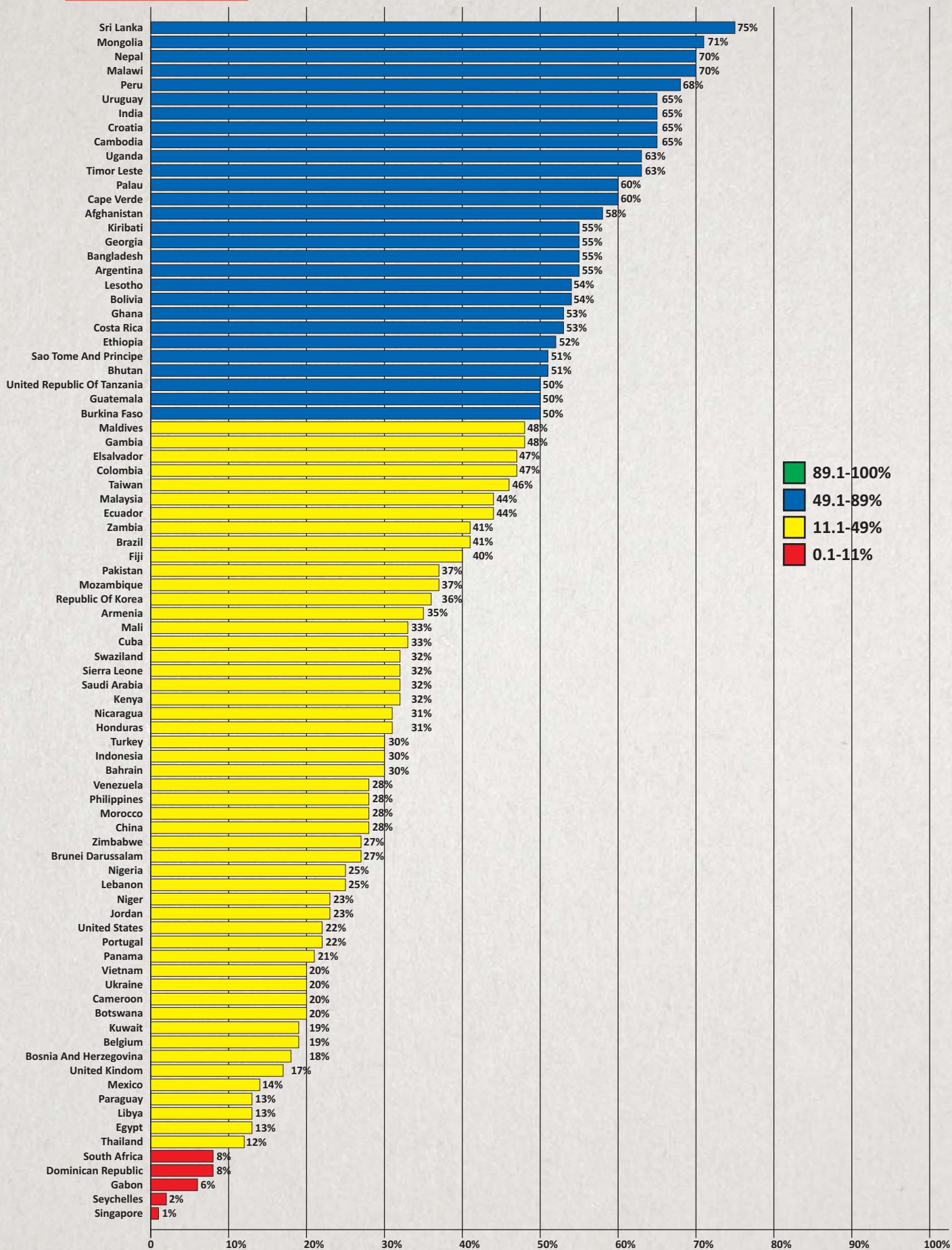


Figure 29: Percentage of exclusive breastfeeding for the first six months in 84 countries



13 Median duration of Breastfeeding

The Innocenti Declaration and the Global Strategy recommend that babies continue to 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.

Data for median duration of breastfeeding is available for 81 countries. Sao Tome Principe, Palau and Belgium do not have the data. Average median duration of breastfeeding for these 81 countries is 15.5 months with values ranging from 2 months in Singapore to 30 months in Nepal.

The median duration of breastfeeding is over 23 months in 14 countries. The highest number of countries (50) are coded Red. Eleven countries are coded Yellow and six coded Blue. (Figure 30)

Key question and scoring criteria

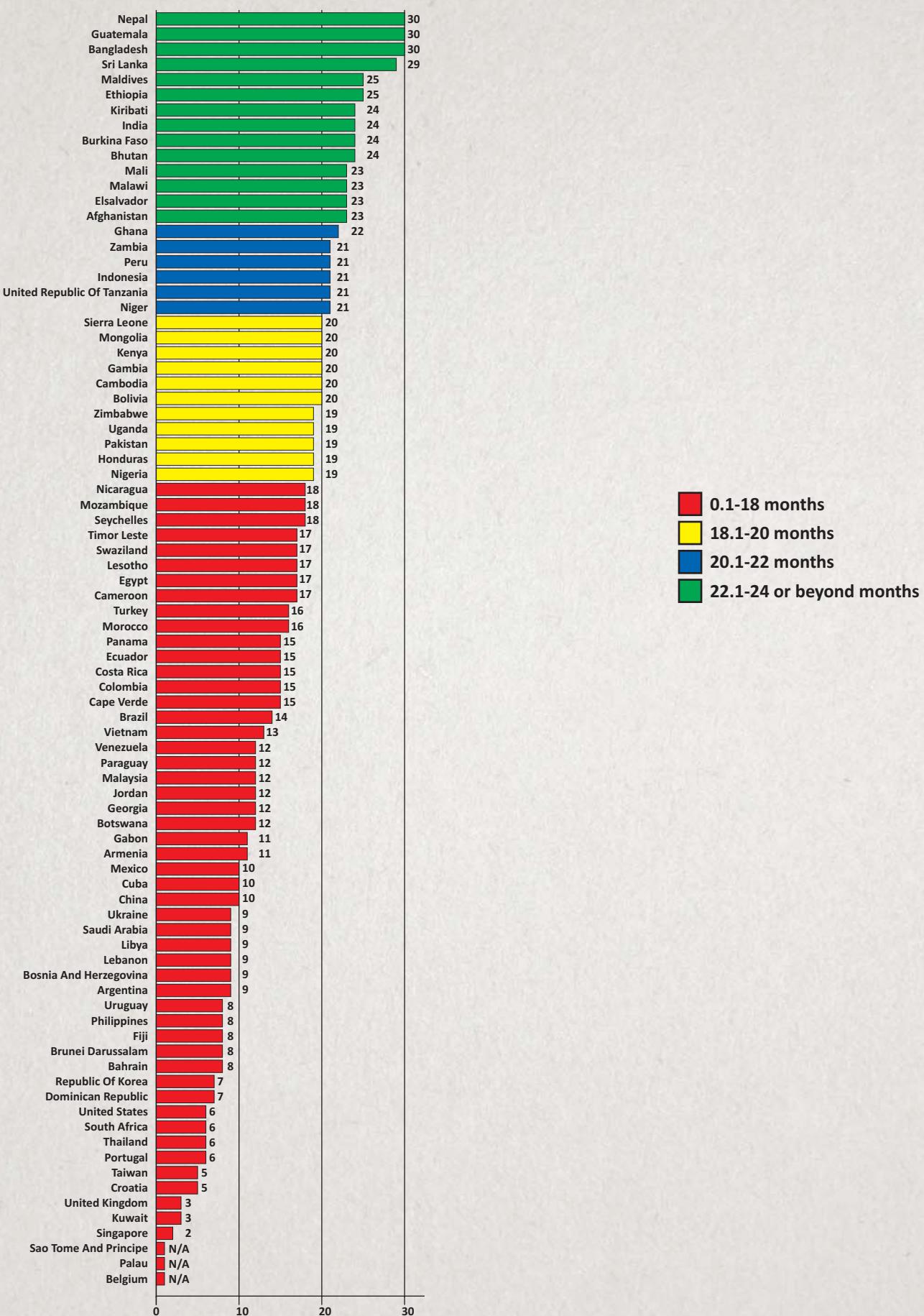
Key question: Babies are breastfed for a median duration of how many months?

Indicator 13	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
<i>Median Duration of Breastfeeding</i>		Scores	Colour-rating
	0.1-18 Months	3	RED
	18.1-20 "	6	YELLOW
	20.1-22 "	p	BLUE
22.1- 24 or beyond "	10		GREEN

Conclusions

Median duration of breastfeeding is very low due to varied reasons. Mothers quitting breastfeeding and introducing formula early, which is due to lack of correct information and insufficient support to women who are willing to continue breastfeeding. Women need skilled counseling on optimal IYCF practices on continued basis, beginning from antenatal period. Women also need information on value of breastfeeding during second year of life.

Figure 30: Median duration of breastfeeding (in months) in 81 countries



14 Bottle-feeding

Babies should be breastfed exclusively for the first six months of age and they need not to be given any other fluids, fresh or tinned milk formula as this would cause more harm to babies and replace precious breastmilk. Similarly, after six months, babies should ideally receive mother's milk plus solid complementary foods. If a baby cannot be fed the breastmilk from his/her mother's breast, s/he should be fed with a cup (if unable to swallow). Bottle-feeding means feeding infants with a bottle having nipple/teat. Information on bottle-feeding is useful because of interference of bottle-feeding with optimal breastfeeding practices and the association between bottle-feeding and increased diarrhoeal disease mortality and morbidity.

Data for this indicator is not available for 9 countries. The average rate of 75 countries (Figure 31) was 39% with percentages ranging from 1% to 98% in Burkina Faso and Seychelles respectively. Figure 32 gives the percentages of bottle fed babies in the assessed countries and colour coding. Only one country has lowest rate of bottle-feeding and is coded Green, four are coded Blue at 3% bottle-feeding, 29 countries are coded Yellow ranging from 5 to 29% bottle-feeding, and maximum countries (41) have high bottle-feeding rate from 30 to 98% and are coded Red.

Conclusions

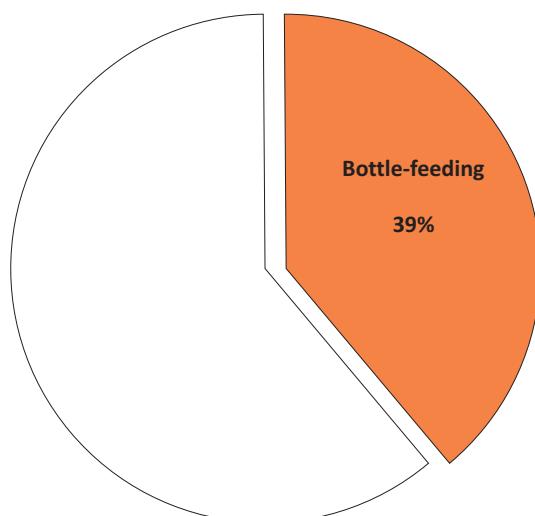
Bottle-feeding is more to do with change in lifestyle and urbanization. It has been looked upon as a modern and convenient method

Key question and scoring criteria

Key question: What percentage of breastfed babies 0-12 months of age, who are fed with any foods or drinks (even breastmilk) from bottles?

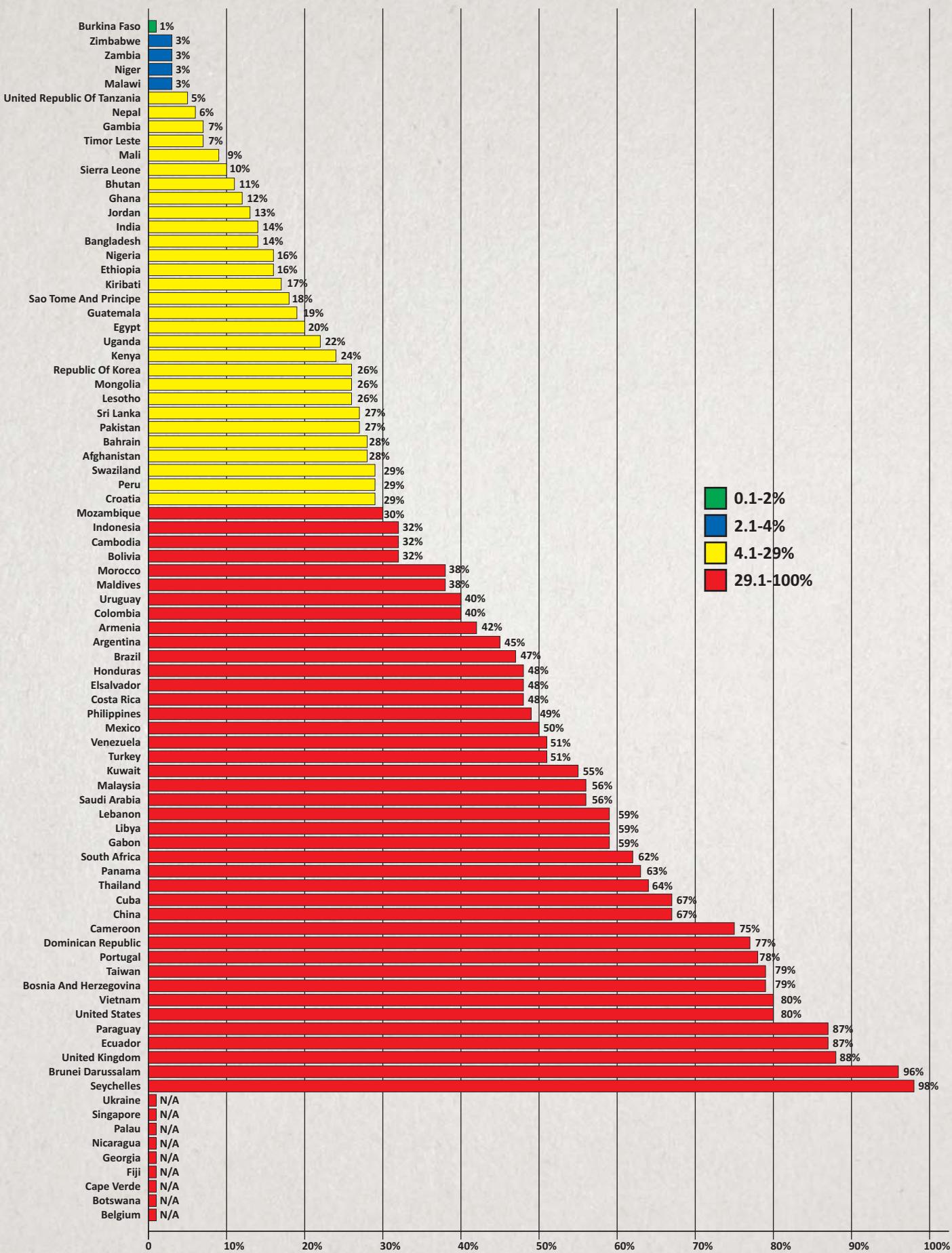
Indicator 14	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
		Scores	Colour-rating
Bottle Feeding (0-12 months)	29.1-100%	3	RED
	4.1-29%	6	YELLOW
	2.1-4%	9	BLUE
	0.1-2%	10	GREEN

Figure 31: Average rate of bottle-feeding from 75 countries



of feeding. There is lack of awareness on its harmful effects and being source of infection to the babies. There is need for effective communication to create public awareness about the dangers and risks of bottle and formula feeding.

Figure 32: Percentage of bottle-feeding in 75 countries



Complementary Feeding-Introduction of solid, semi-solid or soft foods

15

As babies grow they need additional nutrition along with continued breastfeeding, after they are 6 months of age, complementary feeding should begin with locally available indigenous foods being affordable and sustainable. They should be offered soft and mashed foods in small quantities 3-5 times a day. Complementary feeding should gradually increase in amount and frequency as the baby grows. Breastfeeding on demand should continue for 2 years or beyond.

Data for this indicator was available for 79 countries, average being 68.16%, with Portugal being the only country having universal coverage with 100% complementary feeding rate. Taiwan, Argentina and Bahrain were at 99%; and Libya having the lowest 6%. (Figure 33)

This indicator finds 9 countries are coded Green and 21, 26, and 23 countries fall in the Blue, Yellow and Red respectively. (Figure 34)

Conclusions

This indicator is of utmost importance but not understood fully. Here it only gives the percentage of children having initiated complementary feeding. There is lack of understanding of what adequate complementary feeding entails. There is a need to provide accurate information on the quality, quantity, and frequency of complementary foods to be given to infants. There is a need to provide skilled counseling to health workers to impart the correct knowledge to the community.

Key question and scoring criteria

Key question: Percentage of breastfed babies receiving complementary foods at 6-8 months of age?

Indicator 14	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
		Scores	Colour-rating
<i>Complementary Feeding (6-8 months)</i>	0.1-59%	3	RED
	59.1-79%	6	YELLOW
	79.1-94%	9	BLUE
	94.1-100%	10	GREEN

Figure 33: Average rate of introduction of complementary feeding (6-8 months) from 79 countries

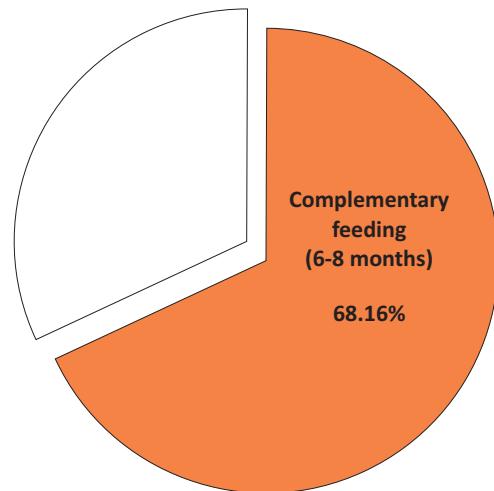
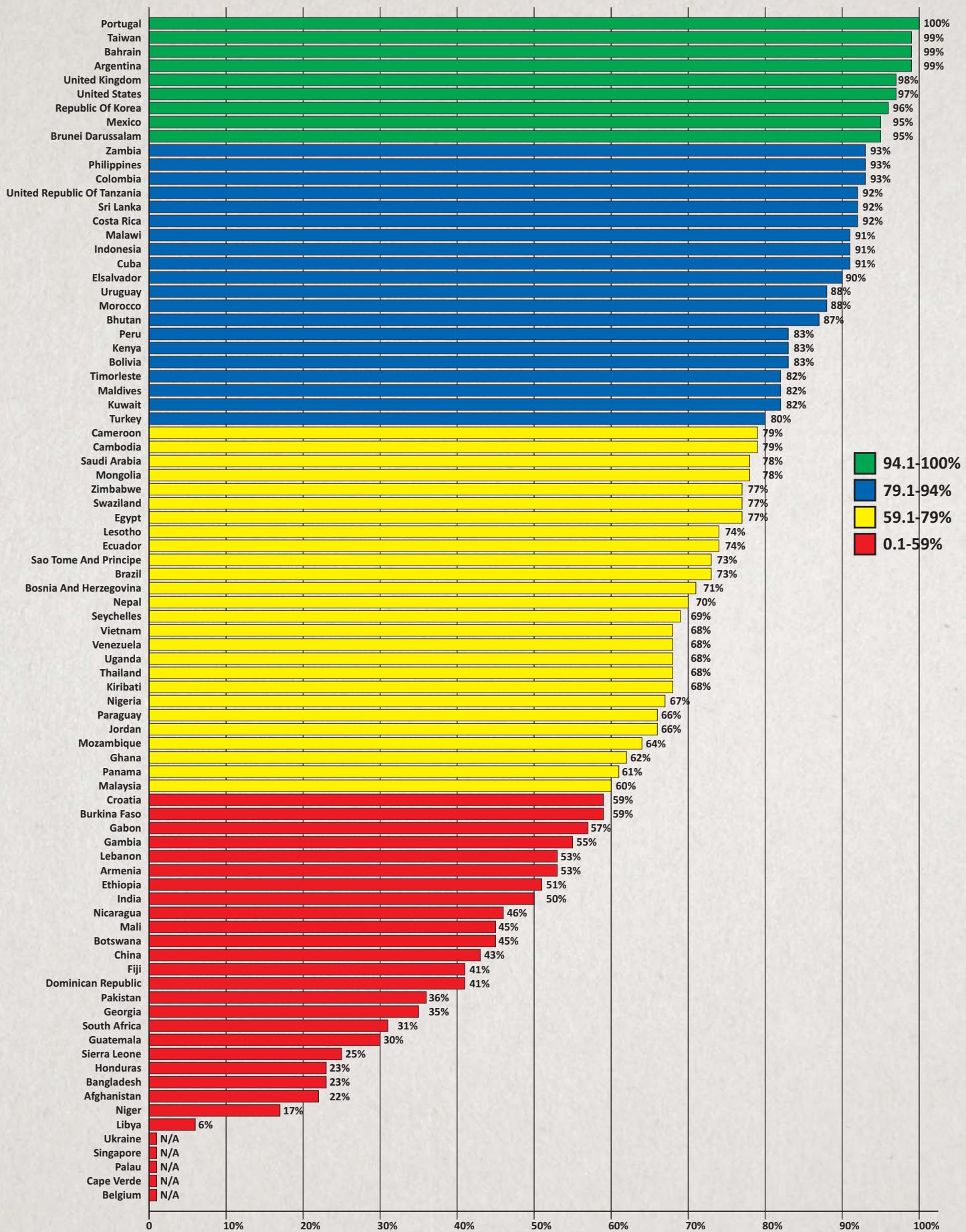


Figure 34: Percentage of introduction of complementary feeding (6-8 months) in 79 countries



The government officially adopted a national IYCF policy after the first WBT*i* assessment. Besides a National Plan of Action has been developed with the policy and a National Breastfeeding Committee was formed in order to have a regular monitoring on this matter. The WBT*i* contributed the advocacy efforts not only to the policy people but also to the beneficiaries to a great extent and also increased investment to some extent to promote early and exclusive breastfeeding in Bangladesh. The WBT*i* assessment results influenced the development of new policy and programme on breastfeeding/IYCF by the government like the BMS law in 2013; six months paid maternity leave in the public sector; infant and young child feeding is included adequately in medical curricula; inculcation of revitalization of Baby Friendly Hospital Initiative (BFHI) in the Operation Plan (2011-2016) as a part of priority component for promotion and support of IYCF to name a few.

Dr. S.K.Roy,
Country Coordinator, Bangladesh

CASE STUDY

BANGLADESH



CASE STUDY

URUGUAY

The WBT*i* developed in 2009 had a relative impact on the investment related to breastfeeding. WBT*i* systematization has specially provoked the sensitization of authorities and the need for a specific and comprehensive approach to promote breastfeeding. The WBT*i* re-evaluation in 2015, has been an important input to place the country as a reference to the rest of the world with unique indicators and it has been an instrument that showed the achievements of the actions carried out by the state. It has also shown gaps such as the Code and support groups. It highlighted the lack of systematic and continued action by governing bodies. WBT*i* has been useful especially in showing the gaps in relation to the training of health human resources and the need for allocation of direct funds for IYCF.

Florencia Cerruti and Carolina de Leon
RUANDI-National Network for the Support of the
Infant Nutrition and Development, Uruguay

IMPACT

In the year 2004, the World Breastfeeding Trends Initiative (WBTi) was first launched in eight countries of South Asia. All these countries conducted their first ever assessment of policies and programmes on infant and young child feeding and prepared their report cards. A south Asia report card and report was launched in Afghanistan in November 2006 in the presence of their Health Minister even though Afghanistan was at the bottom of the chart in South Asia. This led to an unprecedeted action to put breastfeeding on a priority in Afghanistan. Their Ministry of Public Health (MoPH) developed a specific IYCF policy and strategy. They did not have baseline data on IYCF practices in national surveys and ordered one. In fact, Afghanistan was at bottom of the chart in South Asia with lowest WBTi score of 30 out of 150 and coded 'RED'. But they never looked back and rapidly jumped to next colours Yellow and then to Blue, and

now stand at a score of 117 out of 150. Similarly, Bhutan government took note of gaps and found WBTi as an "eye opener". WBTi assessment of 2005 led to establishing the baseline data on the IYCF indicators. Since then, each assessment has shown that Bhutan is developing further programme interventions to protect, promote and support breastfeeding. Sri Lanka demonstrated a clear-cut coordinated effort to keep the policy and programmes in place, and to maintain the top slot among the 84 countries.

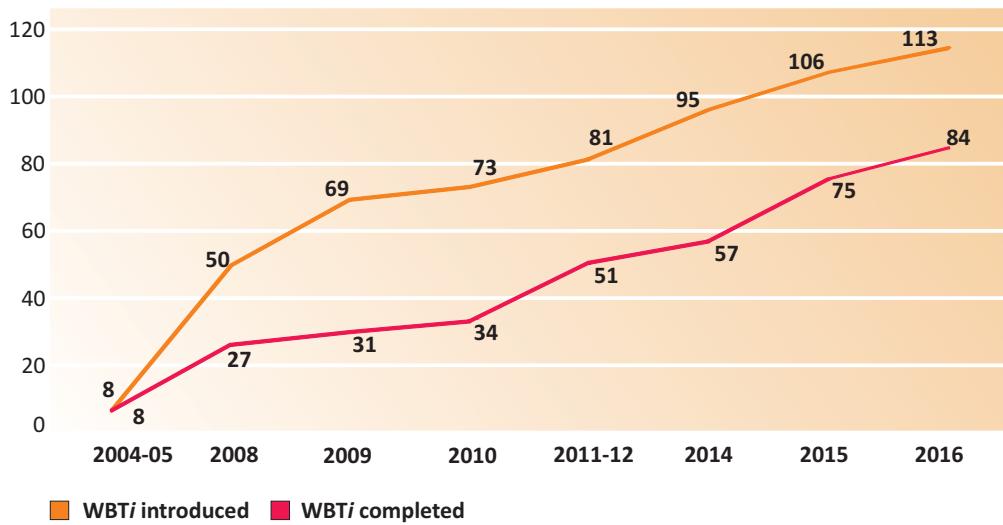
This encouraging response in South Asia made us look beyond and we moved to other regions of the world in 2008.

Going Global

In 2008, WBTi was introduced in other regions including East Asia, South East Asia, Africa, and Latin America & Caribbean. In 2010-11 Arab World, Oceania and Europe were also involved. As on today, we have 113 WBTi countries. Within these, 84 countries have completed the assessment process and reported at least once or more. Figure 35 shows the growth since 2004 from 8 to 113 countries in 2016.

Out of 113, 84 countries from across all regions have

Figure 35: Year-wise growth of countries introduced to WBTi tool and completed WBTi assessment



completed the task of assessment. Of these, 21 are from Asia, 20 from Africa, 18 from Latin America & Caribbean, 8 from Arab World, 9 from Europe, 4 from Afrique, 3 from Oceania and 1 from North America. They are also using the findings for national advocacy and achieving change. The rest of the countries (29) have not yet conducted the assessment process. Reasons being , some were not able to mobilize local resources, other faced local constraints, a few are still organizing the local coordinating teams or waiting for improvement of the political (or distress) conditions of the country or political will of government.

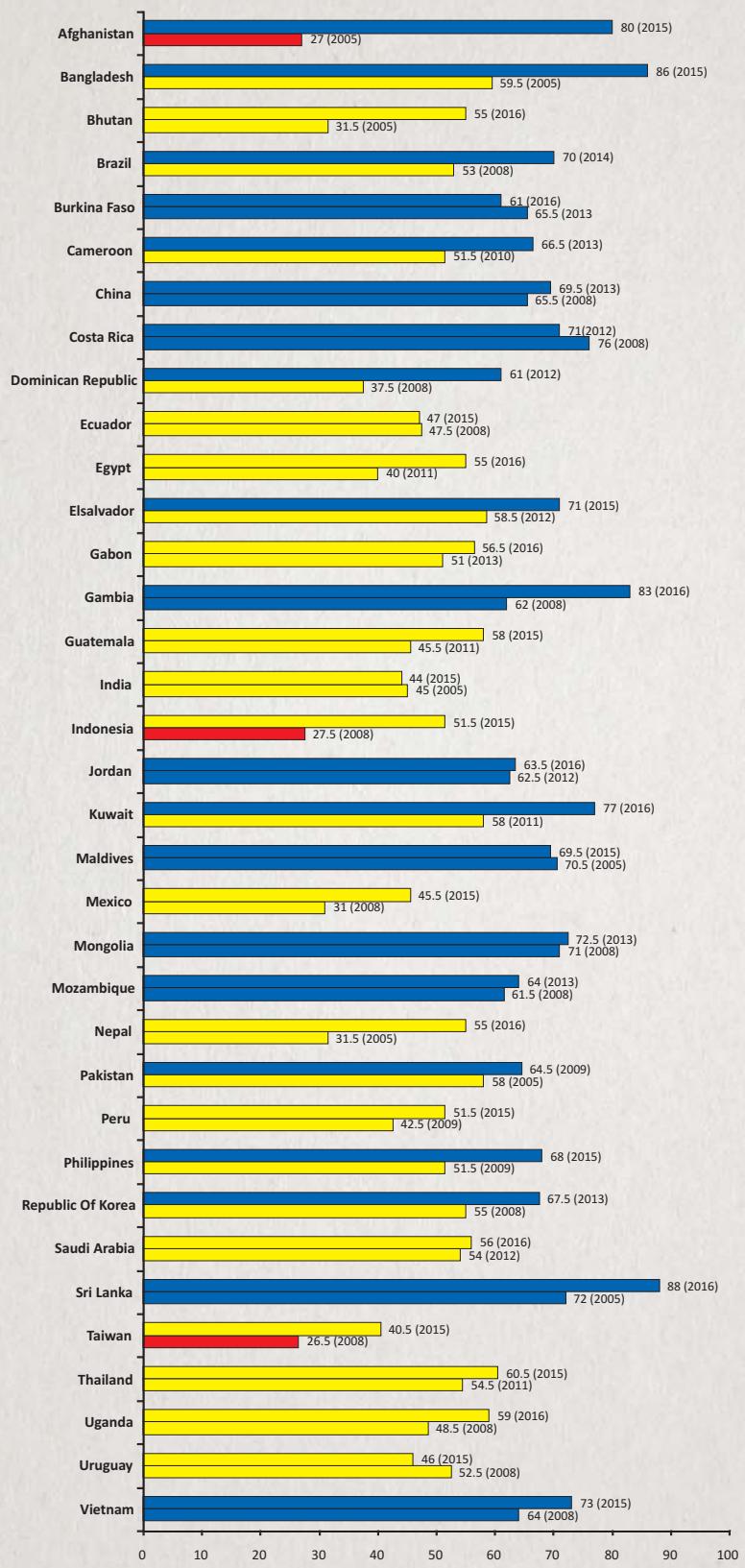
Progress of Change in Policy & Programmes

WBTi encourages countries to go for repeat assessment after 3-5 years to analyse trends in policy, programme and practices and identify areas still needing improvement. It also helps in studying impact of a particular intervention over a period of time. Between 2005 to 2016, thirty-five countries have conducted re-assessment. (See Figure 36) Six countries from South Asian region have done it four times, one country from South Asia did 3 times, twenty-eight countries from across regions of LAC, Afrique, Arab World, East Asia, South East Asia, and Africa have done two times each.

We studied the progress over the years in these countries on indicators of policy and programmes. What we found was that 29 countries have made good progress and have reported a gain in score as well as moved to the next level of color coding as one could clearly see in the (Figure 37) different region countries moving from Red to Yellow. This demonstrates effectiveness of WBTi and shows change is coming.

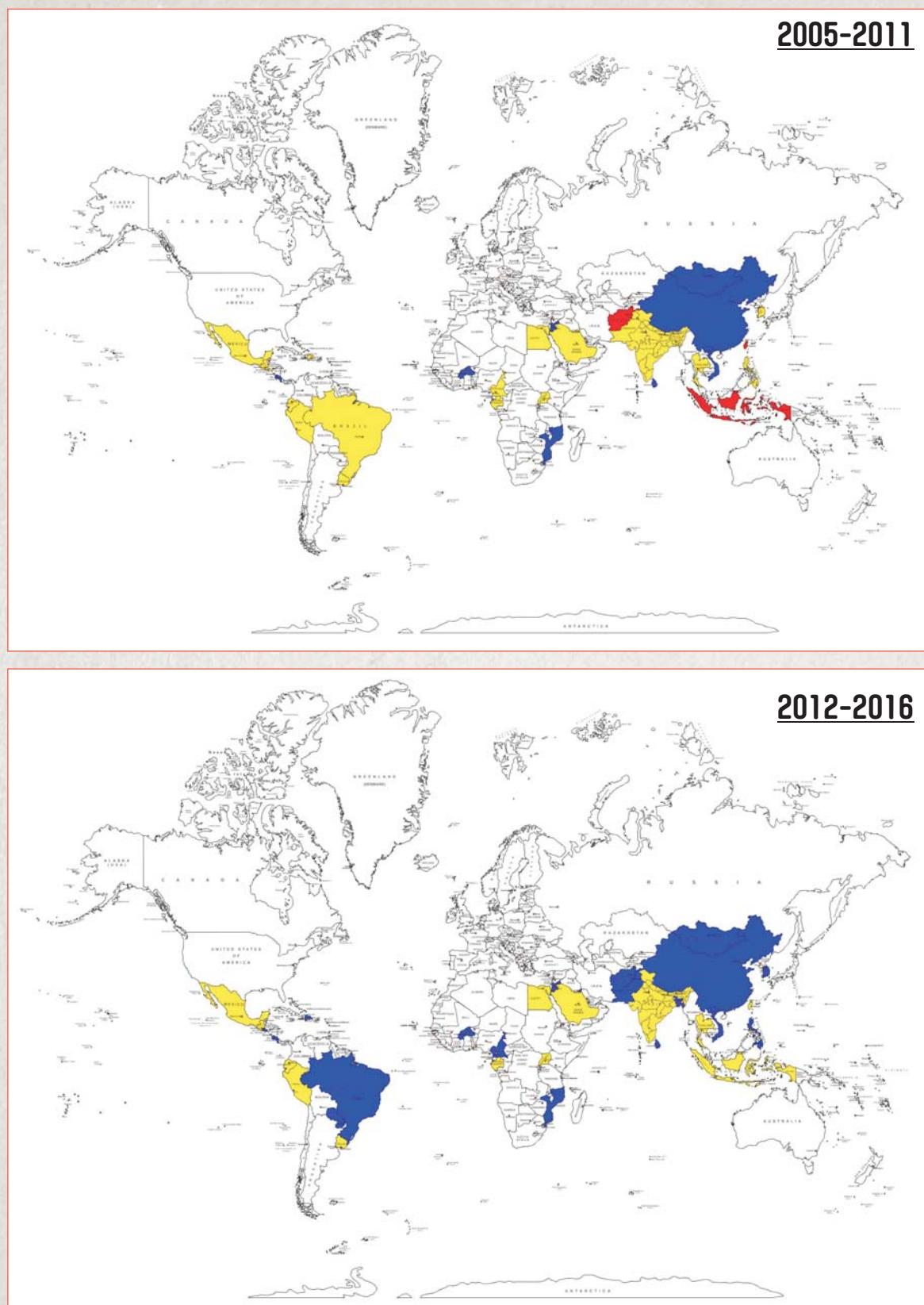
The changes in the policy and

Figure 36: State of policy & programme in 35 countries between two assessments on a scale of 100



Score	0-30	31-60	61-90	91-100
Colour				

Figure 37: Regional mapping showing colour coding between two assessments



programme scores are also objectively reflected in the Figure 36. Twenty-nine countries have shown substantial gain in scores in the policy and programme indicator out of a total of 100. Our analysis reveals that there is an average gain of about 14 points (from 50.06 and 64.44). Several countries made a big jump in scores like Afghanistan, Bangladesh, Dominican Republic, Indonesia, where the scores have doubled or more. It is also important to note that the 6 remaining countries showed scores which are almost same. This analysis clearly shows how almost one out of 3 WBTi countries who completed assessment took on repeated assessments, demonstrated change in scores of policy and programmes as result of use of WBTi findings. Some of the case studies available and personal communications from national processes during reporting, provided this information to us. This could be attributed to sustained advocacy at the national level.

This can be explained clearly by the WBTi process. It is a powerful tool in the hands of people and governments that assess, follow up together with public interest groups, academia or others at country level. It makes it a very inclusive tool that shows gaps, and it supports national plans of action and builds change through call for action with governments. This kind of sharing of lessons and partnerships at national level has worked.

Impact of Specific Action Areas

Here we present the impact more specific to each indicator for change in policy and programmes. This is based on information provided by countries. This also adds to the element of impact on policy and programme and contributes to scores and improvement

in the colour coding.

In the National Policy/

Coordination: Bangladesh, El Salvador and Venezuela constituted National Breastfeeding Committees with coordinators. Argentina, Bolivia, Costa Rica developed breastfeeding policies. Bhutan updated its existing policy. Ecuador and Timor Leste developed a high-level nutrition intervention guideline including IYCF. Hong Kong constituted a central committee on promotion of breastfeeding. Vietnam has officially adopted the national IYCF policy and is developing a national plan of action. Mongolia endorsed a new IYCF strategy that includes WHA resolutions. Gambia established a National Technical Advisory Committee to coordinate and review the IYCF policies and identified a Programme Officer responsible for overseeing the implementation of IYCF. Bolivia, Brazil, and Mexico established national nutritional programmes against hunger that include IYCF. India revived the national breastfeeding coordination committee, which had gone defunct for quite some time and also formed a national steering committee on breastfeeding & IYCF.

In BFHI, capacity building of health providers and community outreach:

Bangladesh developed a BFHI policy and revised tools in 2014. Bhutan is supporting revitalization. Timor Leste appointed liaison officers in main referral hospitals. Vietnam and Costa Rica made BFHI standards compulsory in all maternity facilities. Mongolia and Guatemala plans integration of BFHI in the hospital accreditation.

In International Code: Afghanistan and Maldives included all articles of Code and WHA resolutions as a law. Bangladesh has established the BMS monitoring system.

CASE STUDY

COSTA RICA

The WBT*i* has brought together a strong team of governmental institutions and public interest organizations to support the definition of priority actions and build change. Main achievements include the "Public Breastfeeding Policy" (2009) in addition to breastfeeding and IYCF in the National Emergency Commission's Manual of Procedures. The WBT*i* process influenced the creation of the First Human Milk Bank in the Hospital of San Ramón. It also accelerated the creation of Breastfeeding and Development Clinics in almost all hospitals in the country. This is a very creative initiative for mothers that can now be referred to specialized health professional and breastfeeding facilities all over the country. The WBT's national on-going process has contributed not only to achievements but as an advocacy tool, including the summary report card that has served as key data and used in various meetings with official authorities and ministry officials etc.

Amura Hidalgo

Country Coordinator, Costa Rica

CASE STUDY

DOMINICAN REPUBLIC

The application of the WBT*i* in the Dominican Republic has contributed methodologically to the elaboration and monitoring of the national breastfeeding plans, since the data collected is constituted as source of information, reference and guide for the actions and processes that generate changes in the indicators measured and analysed in WBT*i*. Culminating the process of the first report in 2008, they were able to develop critical evaluation and evidence of the gaps, among them a very important one: the non-budgetary allocation for the execution of the Plans. Based on the WBT*i* results, the National Breastfeeding Commission formulated the Strategic Plan 2008-2011.

Yndira Morales Del Orbe

Country Coordinator, Dominican Republic

CASE STUDY

PHILIPPINES

The WBT*i* Tool in the Philippines was very helpful in terms of its updated data and information analysis. It enables the policymakers and legislators to craft good laws to protect Infant and Young Child Feeding particularly protecting Breastfeeding rights. WBT*i* is a participatory action by different experts from leaders in both institution and community-based. It is participated by mothers whom the law is intended. After all it is for them, by them and about them. WBT*i* is a process that leads to discussion, debate, resolution and action. It has become an aid for legislation and helped in shaping the passage of the law for working mothers: Expanded Breastfeeding Promotion Act of 2009 at the Senate. The WBT*i* Global Report became the reference tool by the Congressmen/women who deliberated the passage of increase paid maternity leave for the Philippines. WBT*i* examines all facets of IYCF: the issue of Complementary Feeding is the weak link to continued breastfeeding in Asia. The WBT*i* Report and assessment in particular to the Philippines is the bicycle ride to change in Food Sustainability in particular to MIYCN fast action.

Ma. Ines Fernandez

Executive Director, ARUGAAN &

Sub Regional Representative, IBFAN South East Asia

Bhutan has sensitized high level decision makers. Philippines set up an online monitoring platform. Hong Kong passed legislation on nutrition composition and nutrition labeling of infant formula and follow on formula and pre packaged foods for infants and young children. Vietnam strengthened the decree on marketing of nutrition products for infants, bottles leading to lesser advertisement by food companies on mass media. Mongolia is doing regular monitoring of Code. In 2015, Armenia, Bolivia and Vietnam implemented the Code as law with full provisions. Paraguay and Honduras have now a law based on Code with few provisions.

In Maternity Protection: As a combination of efforts, particularly from women's rights defence groups and with many other key actors, some advances have been made. Afghanistan has made provisions for correct information and paid break in official organizations. Venezuela and Colombia have extended the concept of breastfeeding rooms to family rooms, combining breastfeeding with education and support. Saudi Arabia approved a new labour law, that grants working mothers paid maternity leave up to 10 weeks and includes 3 days of paid paternity leave. Bangladesh and Peru made a policy change for maternity leave/breastfeeding rooms at workplace. Bhutan and Brazil have increased maternity leave from 3 months to 6 months with full pay for mothers working in civil service. Philippines passed Bill on 3 months paid maternity leave plus 3 months unpaid leave. Hong Kong sanctioned paternity leave of 3 days by law. Vietnam enacted a law providing 6 months maternity leave, 5-14 days paternity leave and one hour of paid breastfeeding break. Mongolia approved

new regulation providing paid maternity leave for 6 months with job security. In Uganda, women in informal/unorganized and agriculture sector were provided protective measures similar to organized sector. In El Salvador special training is carried out with inspectors to follow up maternity protection at workplaces.

In Health & Nutrition Care Systems:

Afghanistan, Bangladesh, Bhutan and Gambia have led to successful integration of breastfeeding at the curriculum level in in-service training and orientation programmes on IYCF for Government doctors and nurses as well as for students in schools and colleges children. India has launched a breastfeeding promotion programme within its child health programme.

In Mother Support & Community Outreach:

Bangladesh has a National Strategy for Infant and Young Child feeding which includes access to counseling services. Bhutan, Gambia and Vietnam have also done training and information programme in basic IYCF to reach all women through their workers. Hong Kong has started a peer support pilot programme.

In Information Support: Bangladesh has established universal MIS system; Bhutan has strengthened communications on IYCF through development of IEC materials; and Hong Kong has produced printed and electronic public education resources on IYCF; Mongolia has started distributing handbooks on maternal and child health to pregnant mothers.

In Infant Feeding & HIV:

Bangladesh and Maldives have developed a comprehensive guideline for the prevention of mother to child transmission of HIV, Vietnam is conducting training of health care staff on IYCF, Mongolia has updated

child care (IMCI) guideline, which includes infant feeding and HIV, and Gambia has integrated infant feeding into the PMTCT policy. Ministry of Health, Government of India developed guidelines for IYCF counseling in the context of HIV/AIDS.

In Infant feeding during

Emergencies: Afghanistan, Bangladesh, Bhutan, Costa Rica, Dominican Republic, Ecuador, Timor Leste, Vietnam and Gambia, they all showed positive response to infant feeding in emergencies in their national programmes and policies in different ways.

In Monitoring & Evaluation:

Afghanistan has integrated indicators on infant and young child feeding into the national nutritional surveillance system. Bangladesh has included baseline and follow up data to measure outcomes of IYCF activities. Hong Kong has established monitoring and evaluation system through the committee on promotion of breastfeeding. Mongolia has included Code monitoring into health inspection policy and Gambia has included IYCF in the Gambia Demographic Health Survey and the District Health Information System.

Impact on Women's Rights

WBTi is an important tool to assist countries in advocacy for the right of mothers and their children to optimal nutrition and health. Women are increasingly defending their rights to be supported. Like in Latin America, massive demonstrations have mobilized different sectors of society against attempts to stop mothers from breastfeeding in public places and for public facilities to breastfeed anywhere, any time, as well as for men to fulfil their role in caring of their children. Parental leave is starting little by little to be protected in the region.

Women are more and more demanding to have proper facilities at work to express breast milk, and this goes way beyond the facilities to igniting a change in culture to value women's work as mothers and carers. Women have won important legal cases in Costa Rica to leave work earlier to breastfeed, even beyond the 6 months exclusive breastfeed

Progress of Change in Practices

Moving on to the practice indicators on early initiation of breastfeeding, exclusive breastfeeding, Bottle Feeding and Complementary Feeding and their trends over assessments. Figure 38 shows the rate of initiation of breastfeeding from 26 countries where data was available.

As you can see in Figure 38 most countries show a rise in early breastfeeding over the years. Only 7 countries show a little fall. Average rate increased from 46 to 51%.

Figure 39 shows trends of exclusive breastfeeding from 26 countries. Many countries show substantial or no change, while in 10 countries rates actually showed a downward trend.

Bottle-feeding rates showed an increasing trend over years, which is an alarming situation. As is evident from Figure 40 very few countries (7) have shown a fall in rate of bottle-feeding and most are either equal or shown rise in rate. Four countries did not have earlier data even.

Complementary feeding practice can be seen in Figure 41. The graph shows 13 countries showing rise in the rate of complementary feeding and few have maintained the rate over years. Some countries like Gambia, Indonesia, Kuwait and Thailand have shown substantial increase in complementary feeding rates.

Figure 38: Rate of initiation of breastfeeding from 26 countries (%)



Figure 39: Rate of exclusive breastfeeding for the first six months from 26 countries (%)

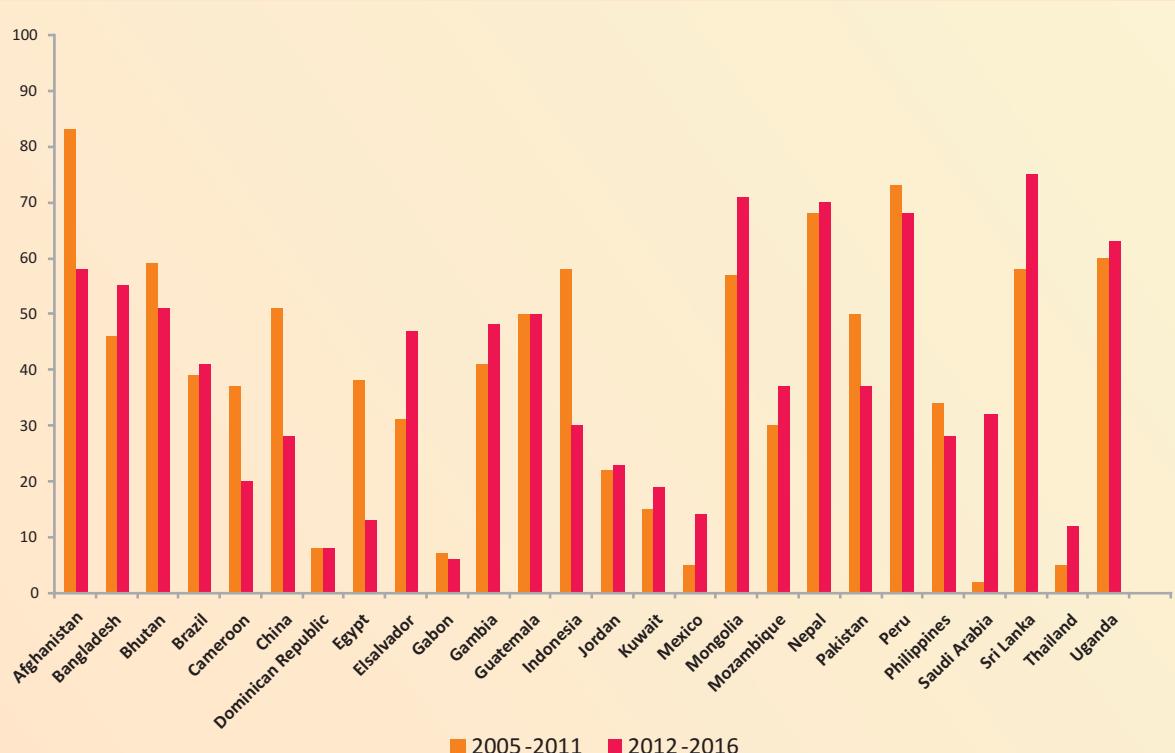


Figure 40: Rate of bottle-feeding from 26 countries (%)

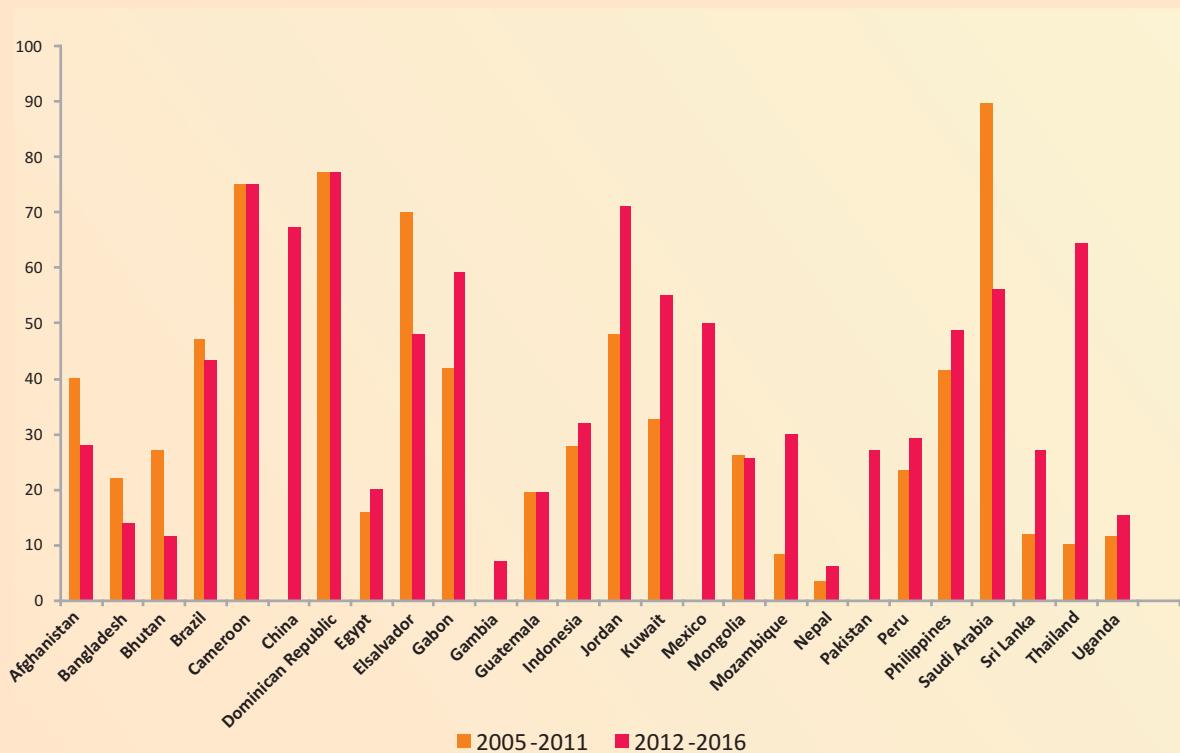
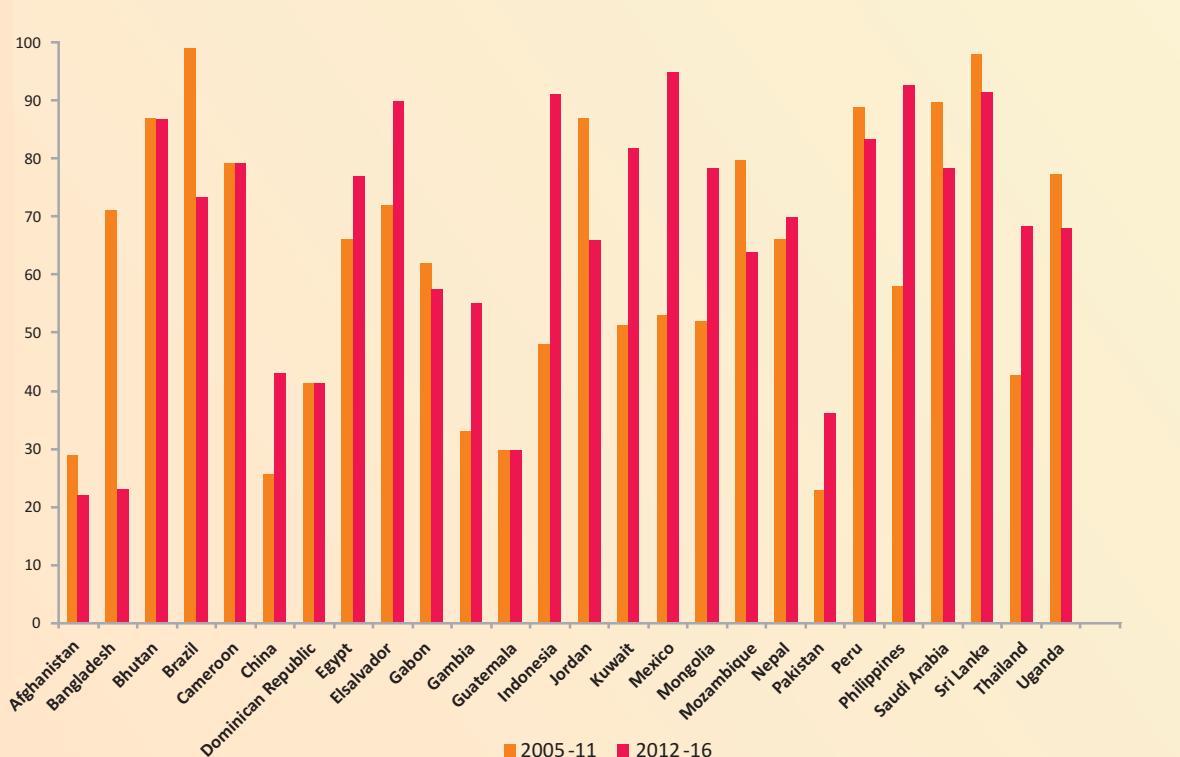


Figure 41: Rate of introduction of complementary feeding (6-8 months) from 26 countries (%)



The tool is different, it brings people together and makes data on policy and programmes on IYCF universally accessible

It is important to mention that before WBT*i*, some countries didn't even have this indicator in their national surveys. This goes to show that if national action is stimulated on policy and programmes, there is rise in practice indicator as well. Analysis of practice indicators shows many countries gaining on early breastfeeding is relatively high than others. It is much more likely because it requires one sector intervention. Exclusive breastfeeding is a complex behaviour and requires multisector interventions. Same is true about complementary feeding and bottle-feeding. These findings underline the fact that women need support at every level for breastfeeding rates to rise, in all indicators of policy and programmes that ensure protection promotion and support of breastfeeding and infant feeding practices. Policy interventions need to work in a coordinated manner for improving breastfeeding and IYCF practices.

Collaborations at National level

WBT*i* demonstrated that engaging with a variety of partners - including Governments, civil society, media, representatives of the United Nations (UN) and other development agencies, academicians, professional bodies and international NGOs - is important to raise awareness of IYCF issues and women's

rights, bring the debate centre stage, and identify specific actions for policy and program reforms or strengthening. Active dissemination of technical and analytical work is critical in translating it into programme and policy action to bring about systemic change. Longer and sustained engagement with governments and other partners and advocacy by all development partners and civil society organizations is required.

In the 84 countries having successfully completed the assessment, more than 750 partners took part, averaging to 9 persons being involved in assessment and led by governments at many places. It is critical that such partnerships are kept free of conflict of interest.

WBT*i* is a powerful action oriented tool initiating process of national assessment, bringing people together to build consensus on what actions need to be taken on a priority basis and subsequently helps demonstrate achievement to the policy makers and partners.

WBT*i* is a user friendly web based information tool. The web portal www.worldbreastfeedingtrends.org helps sharing of information and allows countries to compare their results with earlier results and identify what actions were most effective in bringing about change.

WAY FORWARD

There are gaps in almost all ten indicators of policies and programmes of the 84 -country reports. Country groups making use of WBTi results for advocacy to impact policies over these years has been a positive development as well when one looks at the change that has come in many countries.

However, despite the overwhelming evidence that breastfeeding works, contributes to child survival and development, the rates of infant and young child feeding practices specially exclusive breastfeeding have been stagnant. The World Health Assembly has set a target for 2025 to increase exclusive breastfeeding rates from 37 % to at least 50% that means up by 13% in the worldwide average. The World Bank has estimated that it would cost \$ 4.7 per birth for investing on core set of interventions including nutritional counseling, media promotion and development of appropriate policies and legislations to protect breastfeeding in low and middle income countries to achieve this target in next 10 years. (Total spending required amounts to about \$5.7 Billion). This is likely to increase 105 million more babies exclusively breastfed, and save 520,000 lives. According to World Bank estimates, it has very high economic returns and benefits of investing in increasing exclusive breastfeeding are very high; \$ 35 for every dollar invested. And it lays the foundation for development. However, this does not include maternity benefits, which would require additional \$24 billion from other sectors.

Countries should invest not just to fulfill their obligations to WHA targets, they should look at the benefits breastfeeding interventions provide both in short and long term to their populations. Victora (2016) and Rollins (2016) have clearly documented these benefits in the Lancet Series.

We also know that global strategy need to be implemented comprehensively to achieve high breastfeeding rates in order to achieve gains in child health, nutrition and development. All countries should think in this direction. Such an investment in breastfeeding policies and programmes goes a long way.

However, till the resources are available prioritization could be done based on gaps. Moving from Red to Yellow codes or Yellow to Blue could be one way to go to reach the Green.

The report makes a point that overall national planning and coordination is lacking. But this should be a priority. From the Indicator number 1, which is kind of overarching all others, if there is no plan or there is a plan and no budget attached to it, nothing will happen or ad-hoc actions will be happening. That's not what we want.

How this could be achieved. It requires two- prong approach, internationally and nationally.

At the international level, WHA resolution should be adopted to call upon Member States for action on this specific recommendation such as "budget line" for breastfeeding /IYCF interventions in the child health and/or nutrition budgets and

put a time line to it should then be reported every two years.

Secondly, there should be a mechanism to monitor the Global Strategy on a regular basis at national level. WHA resolution should also include recommendations to institutionalize the process of monitoring the Global Strategy and study of gaps every 3-5 years, and this should be reported at WHA.

At national level, every country should create a budget line for breastfeeding/IYCF interventions and develop an institutional mechanism to

monitor and evaluate the implementation of the Global Strategy by involving academia, civil society and other public interest relevant partners.

Finally, it is possible to increase breastfeeding if we invest in interventions to support women. This is essential, given all the evidence at hand and economic as well developmental benefits that it provides, we should invest in breastfeeding with an urgency and priority to create enabling environments for women fulfilling their and children's rights to health and nutrition.

Political support and financial investment are needed to protect, promote, and support breastfeeding to realise its advantages to children, women, and society

Lancet Breastfeeding Series 2016

WBTi PARTNERS LIST

Afghanistan

1. Public Nutrition Department, MoPH
2. Reproductive Health Directorate, MoPH
3. Child and Adolescent Department, MoPH
4. Health Promotion Directorate, MoPH
5. Community Based Health Care Department, MoPH
6. UNICEF
7. WHO
8. Save the Children International, Afghanistan
9. Action La Faim
10. Care of Afghan Families
11. Solidarity for Afghan Families
12. Health Net TPO
13. Swedish Committee for Afghanistan
14. World food Program
15. Aga Khan Health System
16. Afghanistan Midwifery Association
17. Pediatric association (APA)
18. Representative of maternity hospitals

Armenia

19. Maternal and Child Health Department at MOH of RA
20. Department of Pediatrics N 1 of YSMU
21. MCH Alliance of Armenia (a network of 47 NGOs, concerned in maternal and child health issues, including "Confidence" Health NGO- Member of IBFAN)

Argentina

22. Ministry of Health
23. CLACYD Foundation
24. UNICEF Argentina
25. Argentina Pediatric Association
26. LLL Argentina
27. IBFAN Buenos Aires, Mendoza, Córdoba, Neuquén, Salta, Corrientes, Santa Fe and Chubut

Bangladesh

28. Ministry of Health and Family Welfare (MOHFW)
29. Ministry of Women and Children Affairs (MOWCA)
30. Director General of Health Services (DGHS)
31. Director General of Family Planning (DGFP)
32. Institute of Public Health (IPH)
33. Institute of Public Health Nutrition (IPHN), National Nutrition Services (NNS)
34. United Nations Children's Fund (UNICEF)
35. World Health Organization (WHO)
36. World Food Programme (WFP)
37. United States Agency for International Development (USAID)
38. United Nations Development Programme (UNDP)
39. Food & Agriculture Organization (FAO)
40. Save the Children
41. Bangladesh Medical Association (BMA)
42. Bangladesh Pediatrics Association (BPA)
43. Obstetrics and Gynecological Society of Bangladesh (OGSB)

44. Plan International Bangladesh
45. Concern World Wide Bangladesh (CONCERN)
46. Maternal and Child Health Training Institute (MCHTI)
47. International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)
48. Bangladesh Institute of Research and Rehabilitation in Diabetes Endocrine and Metabolic (BIRDEM)
49. Centre for Women and Child Health (CWCH)
50. Dhaka Medical College and Hospital (DMCH)
51. Shaheed Suhrawardy Medical College (ShSMC)
52. Institute of Child and Mother Health (ICMH)
53. BRAC
54. Care Bangladesh
55. Max Foundation Bangladesh
56. Micronutrient Initiative (MI)
57. Thengamara Mohila Sabuj Sangha (TMSS)
58. Nutrition Society of Bangladesh (NSB)
59. Population Council
60. Eminence
61. Bangladesh Bureau of Statistic (BBS)
62. BAMANEH
63. Swanirvar Bangladesh
64. Bangladesh University of Health Sciences (BUHS)
65. Nari Maitree
66. Dhaka Ahsania Mission
67. Rupasi Bangla TV (USA), Dhaka office
68. Bangladesh Breastfeeding Foundation (BBF)

Bahrain

69. Ministry of health, Department of Nutrition, kingdom of Bahrain.

Belgium

70. Information on breastfeeding
71. Breastfeeding organisation
72. la leche league Flanders
73. la leche league Belgium

Bosnia And Herzegovina

74. Breastfeeding Advancement Group - IBFAN
75. NGO Association for support and education women "Magna"
76. AKAZ-Agency for health care quality and accreditation in the Federation of Bosnia and Herzegovina
77. Institute of Public Health of Federation of Bosnia and Herzegovina
78. Republic of Srpska, Public Health Institute
79. Ministry of Health and Social Welfare of Republic of Srpska
80. Ministry of Health of Federation of Bosnia and Herzegovina
81. Unicef Office for Bosnia and Herzegovina
82. Institute of Public Health of Canton Sarajevo
83. Health Center "Omer Masliæ" Sarajevo
84. Health Center Brèko
85. Faculty of Medicine, University of Sarajevo
86. Faculty of Medicine, University of Mostar
87. Faculty of Medicine, University of Banja Luka
88. Faculty of Health Studies, University of Sarajevo
89. Public Institution Secondary Medical School Sarajevo
90. Secondary Medical School Mostar
91. Public Institution "Agriculture and Secondary Medical School Brèko"

Bhutan

- 92. Nutrition Program, Ministry of Health
- 93. Pediatricians JDWNRH

Bolivia

- 94. Ministry of Health
- 95. International Action for Health AIS BOLIVIA
- 96. International Baby Food Action Network IBFAN Bolivia
- 97. Defense Committee for Consumer's Rights CODEDCO.
- 98. Foundation for Nature and Life FUNAVI

Botswana

- 99. Ministry of Health (MOH)
- 100. AED
- 101. MLG
- 102. PMH PNW
- 103. BOBA
- 104. TAB HOSPITAL
- 105. SSKB CLINIC
- 106. PMH DIETETICS
- 107. HEALTH STATS.PME
- 108. NRH
- 109. HIS (LOBATSE)
- 110. NFTRC
- 111. UNIVERSITY OF BOTSWANA
- 112. LSS/HQ
- 113. PATHFINDER
- 114. United Nations Children's Fund (UNICEF)

Brazil

- 115. Ministry of Health - General Coordination
- 116. Breastfeeding and Child Health (CGSCAM)
- 117. Food and Nutrition General Coordination
- 118. CGAN
- 119. STD / AIDS and Hepatitis viral
- 120. National Committee for Breastfeeding
- 121. Health Institute - SES -São Paulo
- 122. Universidade Federal de Minas Gerais (UFMG) -Nursery school
- 123. University of Taubaté - UNITAU
- 124. Human Milk Bank - Southern Regional Hospital -SES- SP
- 125. SMS - City of São Paulo
- 126. Department of Breastfeeding Brazilian Society of Pediatrics - SBP
- 127. Brazilian Association of Midwives and Nurses Obstetricians - National ABENFO
- 128. Human Milk Bank - Blumenau (SC)
- 129. IBFAN Brazil

Brunei Darussalan

- 130. Ministèrede la Santé du Burkina
- 131. Association Chant de Femme
- 132. Projet Alive & Thrive
- 133. IBFAN-GIFA

Burkina Faso

- 134. Direction de la Nutrition
- 135. Helen Keller International
- 136. CREDO
- 137. GRET/ NUTRIFASO

- 138. Action Contre la Faim (ACF)
- 139. Association Chant de Femme
- 140. APAIB
- 141. IBFAN Afrique

Cape Verde

- 142. Ministry of Health
- 143. National Nutrition Program-Cape Verde
- 144. INE (National Institute of Statistics of Cape Verde)

Cameroon

- 145. Ministry of Public Health
- 146. Ministry of Labour
- 147. Maternal and Child Health Protection Bureau, RDPH/Littoral
- 148. WHO
- 149. UNICEF
- 150. ILO
- 151. WABA
- 152. IBFAN
- 153. Hellen Keller Foundation
- 154. Plan International
- 155. Cameroon Link
- 156. CAMNAFAW
- 157. Commonwealth of Learning
- 158. FECABPA
- 159. National Media
- 160. Vine Yard - Central Africa Region
- 161. Bonassama District

Cambodia

- 162. National Nutrition Programme coordinator

China

- 163. Ministry of Health
- 164. WHO China Office
- 165. UNICEF China Office
- 166. China Advertising Association, Legal Services Center
- 167. China Consumer Associate
- 168. China Preventive Medicine Association, Society of Child Health
- 169. Capital Institute of Pediatrics
- 170. ILO

Colombia

- 171. Ministry of Social Protection
- 172. Guillermo Fergusson Foundation
- 173. IBFAN Colombia
- 174. Colombian Institute for Family Welfare
- 175. Profamily
- 176. National Institute of Health
- 177. Antioquia University
- 178. PAHO Colombia
- 179. UNFPA Colombia
- 180. UNICEF Colombia
- 181. Institute for Surveillance of Medicines and Foods INVIMA
- 182. Javeriana University
- 183. Bogotá District of Health
- 184. District Group for the Promotion, Protection and Support of Breastfeeding

185. Corporation Promoter of Health Saludcoop
186. Secretary of Health of Bogota

Costa Rica

187. National Breastfeeding Commission.
188. Ministry of Health.
189. Ministry of Public Education.
190. Ministry of Economy, Industry and Trade.
191. Costa Rican Social Security Entity.
192. Costa Rican Institute for Research and Education on Nutrition and Health.
193. School of Nutrition at the University of Costa Rica.
194. Costa Rican Union of Associations and Chambers of Private Enterprise.
195. National AIDS Program.
196. National Emergency Commission.
197. Feminist Center for Information and Action CEFEMINA.
198. WABA Focal Point for Latin America and the Caribbean.
199. Association for Breastfeeding Promotion APROLAMA
200. United Network for Mothers-Babies and their Nutrition - RUMBA.
201. International Baby Food Action Network IBFAN Costa Rica
202. UNICEF Costa Rica
203. PAHO Costa Rica

Croatia

204. Ministry of Health
205. Ministry of Social Policies and Youth
206. UNICEF Croatia
207. Croatian Public Health Institute
208. School of Public Health, Split-Dalmatia County
209. Croatian Paediatric Society
210. Croatian Society for Paediatric Gastroenterology, Hepatology and Nutrition
211. Croatian Paediatric Nurses' Society
212. Community Nurses' Society
213. Croatian Association of Breastfeeding Support Groups
214. Croatian Association of Lactation Consultants
215. RODA- Parents in Action

Cuba

216. Ministry of Health
217. Ministry of Education
218. National Institute for Hydraulic Resources
219. Ministry of Justice
220. Ministry of Culture
221. Centre for Youth Studies
222. National Centre for Sexual Education
223. Ministry of Interior
224. National Institute for Sports, Physical Education and Recreation
225. Cuban Institute of Radio and Television
226. National Office for Statistics
227. Pioneer Organization José Martí
228. Federation of High School Students
229. Federation of Cuban Women
230. National Staff of the Civil Defense
231. Ministry of Work and Social Security

Dominican Republic

232. State Secretariat of Public Health and Social Assistance.
233. National Breastfeeding Program SESPAS.

- 234. National Breastfeeding Commission.
- 235. International Baby Food Action Network IBFAN Dominican Republic.
- 236. PAHO Dominican Republic.
- 237. State Secretariat of Education.
- 238. State Secretariat of Industry and Trade.
- 239. State Secretariat of Environment.
- 240. State Secretariat of Women.
- 241. State Secretariat of Agriculture.
- 242. Dominican Social Security Institute.
- 243. Autonomous University of Santo Domingo.
- 244. Dominican Republic Pediatric Society.
- 245. National Council for Childhood.
- 246. Dominican Institute of Food and Nutrition.
- 247. Dominican Republic Caritas.
- 248. La Leche League.
- 249. Maternal-Infant National Research Center CENISMI.
- 250. Project Hope.
- 251. Sexually Transmitted Diseases and AIDS General Direction.
- 252. General Emergencies Direction

Ecuador

- 253. University San Francisco de Quito
- 254. FUNBBASIC/IBFAN Ecuador
- 255. Breastfeeding Counseling CENIDEL IBCLC
- 256. Msc IBCLC Hospital TMC IESS
- 257. Legal Office Ministry of Health
- 258. Breastfeeding Support Group
- 259. Technical department for Qualitative Information
- 260. Breastfeeding Training Group
- 261. Coordinator of School of Nutrition PUCE
- 262. Coordinator of Area of Health No. 3. Riobamba Province Chimborazo
- 263. Human Milk Bank Hospital Vicente Corral Moscoso MSP Cuenca Province Azuay
- 264. Coordinator of Area of Health No. 9. Quito
- 265. Coordinator of School of Nutriología UIDE
- 266. Presidency of Ecuadorian Association of Schools of Pharmacy and Nursery
- 267. Project Action in Nutrition of the Ministry of Coordination of Development Quito
- 268. Coordinator of Area of Health No. 9
- 269. Statistical Analysis Quito.
- 270. Coordinator of School of Nutrition Universidad ESPOL
- 271. Coordinator of Area of Health No. 3. Riobamba Province Chimborazo
- 272. Human Milk Bank Hospital Vicente Corral
- 273. Moscoso MSP Cuenca ProvinceAzuay
- 274. IBFAN Ecuador

Egypt

- 275. Directorate of Maternal & Child Health Care, Ministry of Health and Population
- 276. Egyptian Lactation Consultants Association ELCA
- 277. IBFAN Arab World IAW
- 278. UNICEF Egypt

El Salvador

- 279. Ministry of Health / Nutrition Unit
- 280. Pan American Health Organization, PAHO
- 281. National Council for Children and Adolescents, CONNA
- 282. Salvadoran National Nurses Association, ANES
- 283. Support Center Breastfeeding CALM

284. Ministry of Health / First level of attention
285. Ministry of Labour and Social Welfare, MTPS
286. Evangelical University of El Salvador / Race Nutrition and Dietetics
287. World Vision El Salvador
288. Plan El Salvador
289. Community Association Tonacatepeque, ABAZORTO
290. Support Center Breastfeeding CALM
291. Ministry of Health / HIV Program
292. NGO EDUCO Family Support Foundation, FUNDAFAM
293. Support Center Breastfeeding CALM

Ethiopia

294. Ethiopian Health and Nutrition Research Institute (EHNRI)
295. Jimma University
296. Hawassa University
297. UNICEF
298. Haramaya University
299. Federal Ministry of Health (FMOH)
300. Alive and Thrive
301. IBFAN Africa
302. World vision Ethiopia

Fiji

303. National Food and Nutrition Centre, Ministry of Health
304. UNICEF Fiji
305. Consumer Council of Fiji
306. International Labour Organisation, Fiji Office
307. National Advisory Committee on AIDS
308. IBFAN Oceania

Gabon

309. UNICEF
310. BRC IBFAN AFRIQUE
311. Direction Générale de la Santé (DGS)
312. DGDH
313. DGPC
314. DTR
315. DRSLO
316. Centre National de Nutrition (CNN)
317. PLIST/VIH/SIDA
318. SNESPS
319. MGBEF
320. Association Gabonaise pour la Promotion de l'Alimentation Infantile (AGPAI)

Gambia

321. National AIDS Control Programme
322. Health Promotion and Education
323. Reproductive and Child Health Unit, all of the Ministry of Health and Social Welfare
324. Child Fund
325. The Gambia Food and Nutrition Association
326. The Gambia Bureau of Statistics
327. UNICEF
328. National Nutrition Agency

Ghana

329. Ghana Infant Nutrition Action Network (GINAN)
330. The Ghana Health Service (GHS)

- 331. The Ghana Broadcasting Corporation (GBC)
- 332. The Ministry of Women and Children's Affairs (MOWAC)
- 333. The Nurses and Midwives Council
- 334. The Ghana Medical School
- 335. The Rural Health Training School.

Georgia

- 336. Georgian Pediatric Academy,
- 337. Sustaining Family Planning and Maternal and Child Health Services
- 338. Association of Pediatricians and Family Physicians, "CLARITAS XXI"
- 339. Ministry of Labor Health and Social Affairs of Georgia,
- 340. Batumi Maternity and Child Healthcare Hospital
- 341. Tbilisi State Medical University.

Guatemala

- 342. National Breastfeeding Commission
- 343. PAHO Guatemala
- 344. IBFAN Guatemala
- 345. School of Public Health Galileo University
- 346. Ministry of Social Development
- 347. Ministry of Presidency
- 348. Ministry of Work
- 349. Guatemalan Institute of Social Security
- 350. Ministry of Health and Social Assistance
- 351. Department of Regulation and Control of Food
- 352. RUMBA Guatemala
- 353. Department of Statistics
- 354. Nutrition Institute INCAP
- 355. UNICEF Guatemala

Honduras

- 356. Secretary of Health
- 357. University National Autonomous of Honduras
- 358. IBFAN Honduras

India

- 359. Breastfeeding Promotion Network of India (BPNI)
- 360. Public Health Resource Network (PHRN)
- 361. National Institute of Public Co-operation and Child Development (NIPCCD)
- 362. Alliance for Right to ECD
- 363. Working Group for Children Under Six (WGCU6)
- 364. Doctors ForYou
- 365. Lady Hardinge Medical College (LHMC)

Indonesia

- 366. Indonesian Ministry of Health
- 367. SELASI (Indonesian Breastfeeding Center)
- 368. Perinasia (Indonesian Perinatology Association)
- 369. IKMI (Indonesian Breastfeeding Counselors Association)
- 370. Perklini (Indonesian Breastfeeding Consultant Association)
- 371. WVI (World Vision Indonesia)
- 372. Yayasan Kakak (Kakak Foundation)

Jordan

- 373. Ministry of Health MOH
- 374. United Nations Children's Fund UNICEF
- 375. Food and Drug Administration FDA

Korea

- 376. Ministry of Health and Welfare, Korea
- 377. The Academy of Breastfeeding Medecine Korea
- 378. The Korean association of Pediatric Practioners
- 379. The Korean Society of Obstetrics and Gynecology
- 380. The Korean Society of Neonatology
- 381. Consumers Korea
- 382. Ewha Womans University
- 383. Korea Institute for Health and Social Affairs
- 384. Seoul Womens University
- 385. UNICEF, Korea

Kuwait

- 386. Administration of Primary Health Care of Ministry of Health.
- 387. Kuwait Breastfeeding Promotion & BFHI Implementation Committee.
- 388. Kuwait National Health Information Centre.
- 389. Kuwait Nursing College.
- 390. Kuwait University.
- 391. Research Section of the Food and Nutrition Administration of Ministry of Health.

Kenya

- 392. Ministry of Public Health and Sanitation
- 393. Division of Nutrition
- 394. World Health Organization
- 395. IBFAN-Kenya
- 396. MCHIP-USAID/Kenyatta University
- 397. Kenyatta National Hospital
- 398. University of Nairobi

Kiribati

- 399. Ministry of Health and Medical Services
- 400. Ministry of Health
- 401. Ministry of Health, Safe Motherhood
- 402. Kiribati Nursing School
- 403. IBFAN Oceania

Lebanon

- 404. Higher Council of Children
- 405. Lebanese Association for Early Childhood Development LAECD
- 406. Ministry of Labour
- 407. Ministry of Public Health MOPH
- 408. Ministry of Social Affairs MOSA
- 409. Parliament commission

Lesotho

- 410. MOHSW Nutrition Programme
- 411. MOHSW -Dietetics Department
- 412. MOHSW IMCI
- 413. MAFS Nutrition
- 414. FNCO
- 415. MAFSNutrition
- 416. UNICEF-Health & Nutrition
- 417. BCMC-L
- 418. EGPAF
- 419. IBFAN Africa

Libya

- 420. Health protection and promotion programs , Ministry of Health
- 421. Infant and Young Child Feeding IYCF Program, Ministry of Health

Malawi

- 422. Ministry of Health (Nutrition Unit)
- 423. Heath Information Management System
- 424. Office of the President and cabinet ,the department of Nutrition, HIV and AIDS
- 425. Kamuzu Central Hospital

Malaysia

- 426. Ministry of Health Malaysia
- 427. Ministry of Women and Family Development Malaysia
- 428. Ministry of Human Resource Malaysia
- 429. BFHI Training and Research Institute
- 430. National Defence University of Malaysia, Faculty of Medicine and Defence Health

Mali

- 431. Division Nutrition
- 432. UNICEF
- 433. Support Association in Populations Development Activities (ASDAP)
- 434. Save The Children
- 435. Research Center for Studies and Documentation for Child Survival(CREDOS)
- 436. IBFAN Mali

Maldives

- 437. Health Protection Agency
- 438. Society for Health Education
- 439. Maldives Food and Drug Authority
- 440. Society for Health Education
- 441. UNICEF
- 442. WHO

Mexico

- 443. IBFAN Mexico
- 444. Project feed
- 445. Institute of Medical Sciences and Nutrition Salvador Zubiran
- 446. Alliance for Food Health

Morocco

- 447. Child Health Department, Ministry of Health
- 448. National Program of Nutrition , Ministry of Health
- 449. Neonatology center, University of Rabat

Mongolia

- 450. Ministry of social welfare and labour (ILO project)
- 451. Ministry of Health (Child health, Nutrition, maternal health, MIS)
- 452. Public health Institute
- 453. WHO, Mongolia
- 454. Maternal and Child Health Research center
- 455. Mongolian Paediatric association
- 456. Mongolian Midwifery association
- 457. Health Science University of Mongolia (Dep-t of pediatrics, Dep-t of family medicine)
- 458. Child and adolescent support center NGO

Mozambique

- 459. Ministry of Health

- 460. Department of Nutrition
- 461. Health Department for Women and Child
- 462. Lawyer Advisor's Cabinet

Nepal

- 463. Ministry of Health, Child Health Division
- 464. Nepal Paediatric Society, Perinatal Society (NEPAS)
- 465. Department of Paediatrics, Institute of Medicine, Teaching Hospital
- 466. Mahajugunj Nursing Campus
- 467. Kanti Children's Hospital
- 468. Mother and Infant Research Activity (MIRA)
- 469. Nutrition Health Research & Community Services (NHRCS)
- 470. Civil service hospital
- 471. Helen Keller International (HKI)

Nicaragua

- 472. Ministry of Health
- 473. Ministry of the Family
- 474. Ministry of Agriculture MAG-FOR
- 475. Integral Attention of Nicaraguan Children Program - AIN
- 476. Integral Attention of Women Program AIN
- 477. Community Program of Health and Nutrition - PROCOSAN
- 478. National Program of Micronutrients
- 479. National Program of Breastfeeding
- 480. Attention for Vulnerable Groups Program
- 481. WFP Nicaragua
- 482. National Program for Eradication of Infant Chronic Malnutrition 2008-2015
- 483. Polytechnic University - UPOLI
- 484. National Breastfeeding Commission CONALAMA
- 485. Breastfeeding Counselors Network
- 486. Infant Community Kitchens Friends of Mothers and Children CICO
- 487. National system for the Prevention, Mitigation and Attention of Disasters
- 488. Information System of the Government of National Unity SIGRUN
- 489. IBFAN Nicaragua

Nigeria

- 490. Federal Ministry of Health
- 491. Independent Consultant
- 492. National Agency for Food and Drug Administration and Control (NAFDAC)
- 493. National Primary Health Care development Agency (NPHCDA)
- 494. Federal Ministry of Agriculture and Rural development (FMARD)
- 495. International Baby Food Action Network (IBFAN Africa)
- 496. University of Port Harcourt Teaching Hospital;
- 497. Ministry of Budget and National Planning- MB&NP (NPC)
- 498. Federal Ministry of Labour and Employment (FMLE)
- 499. Federal Ministry of Women Affairs and Social Development (FMWASD)
- 500. National Bureau of Statistics (NBS)
- 501. National Population Commission (NPoC)
- 502. Action Contre La Faim (ACF)
- 503. Centre for the Right to Health (CRH)
- 504. Civil Society- Scaling Up Nutrition in Nigeria (CS-SUNN)
- 505. Family Health International 360 (FHI360)
- 506. Helen Keller International (HKI)
- 507. Save the Children International (SCI)
- 508. Society for Family Health (SFH)
- 509. Strengthening Partnerships Results Innovations in Nutrition Globally (SPRING)
- 510. United Nations Children Fund (UNICEF)

511. WellBeing Foundation (WBF)
512. World Health Organization (WHO)

Niger

513. Direction Nationale de la Nutrition (DN)
514. GISLS
515. Groupe d'Action pour la Promotion de l'Alimentation Infantile au Niger (GAPAIN)
516. DS/MSP
517. MPPFPE
518. HCI 3N
519. Comité Nigérien de Lutte Contre les Pratiques Traditionnelles Néfastes (CONIPRAT)
520. SWAA NIGER
521. Direction Régionale de la Santé Publiqu (DRSP)
522. UNICEF
523. Save the Children
524. Direction des Statistiques Sanitaires
525. Direction Régionale de la Santé Publique/Nutrition
526. Groupe d'Action pour l'Alimentation Infantile au Niger

Pakistan

527. Ministry of Health
528. Ministry of Law, Justices and Human right
529. Ministry of Planning
530. The National Nutrition Program
531. The MNCH program
532. The national Program for Family Planning and Primary Health Care
533. Provincial Health departments of all four provinces.
534. Pakistan Paediatric Association
535. Public Health Specialist
536. USAID
537. PAIMAN
538. UNICEF
539. WHO
540. Save the children US
541. Save the children UK

Palau

542. Ministry of Health
543. Ulkerreuil A Klengar
544. Bureau of Public Health
545. Bureau of Hospital and Clinical Services
546. Primary and Preventive Health Services
547. Palau Red Cross Society
548. Olkeriil Era Kelulau
549. Palau Health Start Agency
550. Palau Community Action Agency
551. Kotel A Deurreng, Inc.
552. Minister for Community and Cultural Affairs

Panama

553. IBFAN Panama
554. Ministry of Health
555. Integral Health of Children and Adolescents Programme
556. Nutritional Health Programme
557. Sexual and Reproductive Health Programme

Paraguay

- 558. AMAMANTA PARAGUAY
- 559. National Breastfeeding Programme
- 560. Ministry of Public Health and Social Welfare -SPyBS
- 561. Legal Advise Department of MSPyBS
- 562. National Department of Health Surveillance MSPyBS
- 563. National Institute for Food and Nutrition MSPyBS
- 564. National Commission for First Infancy
- 565. Ministry of Education
- 566. National Secretary for Infancy and Adolescence)
- 567. Ministry of Work, Employment and Social Security
- 568. Ministry of Women
- 569. National Commission for Gender and Equity
- 570. Health Commission of Senate Chamber
- 571. Parliament Front for Children
- 572. Department of Preventive Medicine of the Institute of Social Prevention
- 573. Liga de La Leche Materna Paraguay
- 574. Red Cross Paraguaya
- 575. Mamá Canguro
- 576. IBFAN Paraguay

Peru

- 577. Centre for Social Studies and Publications CESIP
- 578. IBFAN Perú
- 579. Consumers and Users Association of Peru- ASPEC
- 580. UNICEF Perú
- 581. LactaRed Network
- 582. La Leche League Perú
- 583. Nacional Multisectorial Commission for the Promotion and Protection of Breastfeeding
- 584. Ministry of Health
- 585. Ministry of Labour
- 586. Ministry of Education
- 587. Ministry of Women and Vulnerable Populations
- 588. Pediatric Academy of Peru
- 589. National Institute for the Defense of Competition and Protection of Intelectual Property- INDECOPI

Philippines

- 590. Arugaan
- 591. Department of Health (DOH)
- 592. Philippine Pediatric Society (PPS)
- 593. Health Justice Philippines
- 594. WHO-WPRO
- 595. Gabriela Women's Partylist (feminist women's group)
- 596. Trade Union of the Philippines
- 597. Breastfeeding Pinays Inc.
- 598. Pinay Doulas Collective
- 599. LATCH, Inc.
- 600. Mother Support Groups from Batasan Hills
- 601. National Nutrition Council
- 602. AKBAYAN (Partylist for progressive multi-sectors)
- 603. Ang Nars Inc. (Partylist for the nurses sector)
- 604. Office of Congress/Rep. Lani Mercado-Revilla

Portugal

- 605. Gaia City Hall
- 606. Amamentos Clinic
- 607. Gaia City Parliament

- 608. Breastfeeding Friendly Pharmacies
- 609. Coimbra Health Technology College (ESTES) / Coimbra Polytechnic Institute (IPC)
- 610. Oeiras Health Center
- 611. Dr. Alfredo da Costa Maternity
- 612. São João do Estoril Family Health Unit, Cascais Health Center
- 613. Norton de Matos Community Health Center
- 614. Garcia de Orta Hospital, UNICEF Portugal, Baby Friendly Hospital Initiative
- 615. Oeiras Health Center
- 616. IBFAN Portugal

Seychelles

- 617. Ministry of Health (Maternity Unit, Family Health and Nutrition Programmes, HIV/AIDS Programme)
- 618. Ministry of Employment and Human Resources Development
- 619. Division of Risk and Disaster
- 620. Management, Ministry of Social Affairs
- 621. Community Development and Sports
- 622. IBFAN Africa

Sri Lanka

- 623. Family Health Bureau
- 624. Ministry of Health Sri Lanka National focal point for IYC

Sao Tome & Principe

- 625. Ministry of Health
- 626. Ministry of Education
- 627. Ministry of Agriculture and Fisheries
- 628. WFP
- 629. WHO
- 630. UNICEF
- 631. International Medical Assistance
- 632. Chamber of Commerce

Saudi Arabia

- 633. Albidayah Breastfeeding & Women's Awareness Center
- 634. AlMadinah Administration For Breastfeeding Support , General directorate of health affairs
- 635. IBFAN Arab World
- 636. King Saud bin Abdulaziz University for Health Science National Guard , Ryiad
- 637. Medical Assistant Services, Ministry of Health
- 638. National Assessors of Baby-Friendly Hospitals KSA
- 639. Saudi Arabian Breastfeeding Advisory Committee of the Ministry of Health

Sierra Leone

- 640. The Nutrition Unit
- 641. The Child Health Programme of the Ministry of Health

Singapore

- 642. Health Promotion Board
- 643. Sales of Infant Food Ethics Committee, Singapore (SIFECs)
- 644. Breastfeeding Mother Support Group, Singapore (BMSG)
- 645. National Trade Union Congress (NTUC) U Family
- 646. Enviromenta list, Lawyer

South Africa

- 647. Department of Health-Ministry of Health
- 648. IBFAN Africa

Swaziland

- 649. Ministry of Health
- 650. Ministry of Agriculture
- 651. Children's Coordinating Unit
- 652. National Nutrition Council
- 653. UNICEF
- 654. WHO
- 655. World Vision
- 656. Action against Hunger
- 657. IBFAN Africa
- 658. EGPAF
- 659. SINAN

Taiwan

- 660. Chinese Women Consumers Association (CWCA)
- 661. Chinese Dietetic Society (Taiwan)
- 662. Taiwan Academy of Breastfeeding

Thailand

- 663. Thai Breastfeeding Center Foundation
- 664. UNICEF
- 665. Department of Health, Ministry of Public Health
- 666. Bureau of Health Promotion
- 667. Bureau of Nutrition

Timor-Leste

- 668. The Ministry of Health, Nutrition Department
- 669. The Ministry of Health, Maternal and Child Health Department
- 670. The Ministry of Health, Communicable Diseases Department
- 671. The Ministry of Health, Health Promotion Department
- 672. United Nations Children's Fund (UNICEF)
- 673. World Health Organization (WHO)
- 674. International Labor Organization (ILO)
- 675. ALOLA Foundation
- 676. Dili National Hospital
- 677. Institute National of Health
- 678. International Baby Food Action Network (IBFAN) Asia
- 679. Arugaan Foundation (Support System for Women with Infants and Young Children)

Turkey

- 680. Turkish Public Health Institute, Department of Child and Adolescent Health, Ministry of Health
- 681. Ankara University, Health Sciences Faculty, Midwifery Department
- 682. Hacettepe University, Faculty of Medecine, Child Health and Diseases Department, Social Paediatrics Unite.
- 683. La Leche League Turkey
- 684. Temas, Breastfeeding and Breastmilk volunteer association

Uganda

- 685. Ministry of Health (MoH)
- 686. Ministry of Gender, Labour and Social Development
- 687. Ministry of Agriculture, Animal Industry and Fisheries
- 688. Ministry of Education, Sports, Science and Technology
- 689. Office of the Prime Minister (OPM)
- 690. United Nations Children's Emergency Fund (UNICEF)
- 691. World Health Organisation (WHO)
- 692. International Baby Food Action Network (IBFAN) Uganda

- 693. National Organisation of Trade Unions (NOTU)
- 694. Uganda Bureau of Statistics (UBOS)
- 695. Bishop Danstan Nsubuga Memorial Community Centre
- 696. Baylor Uganda
- 697. Food and Nutrition Technical Assistance (FANTA)
- 698. Strengthening Partnership Results Innovations in Nutrition Globally (SPRING)
- 699. Uganda AIDS Commission (UAC)
- 700. Elizabeth Glaser Paediatric AIDS Foundation (EGPAF)
- 701. World Food Programme (WFP)
- 702. Mulago National Referral Hospital (Department of Maternal and Child Health, Paediatrics and Child Health, Nursing and Midwifery School)

Ukraine

- 703. Ministry of health of Ukraine
- 704. WHO
- 705. UNICEF
- 706. National Medical Academy of Postgraduate Education named after PL. Shupyk
- 707. Center for Global Health/CDC

United Kingdom

- 708. Association of Breastfeeding Mothers
- 709. Baby Feeding Law Group
- 710. Baby Milk Action
- 711. Best Beginnings Breastfeeding Network
- 712. Child and Maternal Health Observatory
- 713. Department of Health
- 714. First Steps Nutrition Trust
- 715. Institute of Health Visiting
- 716. Lactation Consultants of Great Britain
- 717. La Leche League Great Britain
- 718. Maternity Action
- 719. National Infant Feeding Network
- 720. NCT
- 721. Northern Ireland Regional Breastfeeding Lead
- 722. Public Health England
- 723. Scotland Maternal and Infant Nutrition Coordinator
- 724. Unicef UK Baby Friendly Initiative

United Republic Of Tanzania

- 725. Ministry of Health and Social Welfare (MoHSW);
- 726. Ministry of Labour and Employment (MOLE);
- 727. Ministry of Community Development Gender and Children (MCDGC);
- 728. Tanzania Food and Nutrition Council (TFNC)
- 729. Tanzania Foods and Drugs Authority (TFDA)
- 730. World Health Organization (WHO);
- 731. United Nations Children Fund (UNICEF);
- 732. World Food Program;
- 733. Irish Aid Tanzania.
- 734. World Vision Tanzania (WVT);
- 735. Helen Keller International (HKI);
- 736. Management and Development for Health (MDH);
- 737. The Partnership for Nutrition in Tanzania (PANITA);
- 738. Muhimbili University of Health and Allied Sciences (MUHAS);
- 739. The Centre for Counseling, Nutrition and Health Care (COUNSENUTH)-The facilitator.

United States of America

- 740. American Breastfeeding Institute

- 741. Healthy Children Project, Inc
- 742. Carolina Global Breastfeeding Institute
- 743. Childbirth and Postpartum Professional Association (CAPPA)
- 744. Every Mother, Inc.
- 745. La Leche League USA
- 746. Lamaze International

Uruguay

- 747. Ministry of Labor and Social Security.
- 748. National Directorate of Employment.
- 749. Uruguayan Network to Support Nutrition and Infant Development RUANDI.
- 750. International Baby Food Action Network IBFAN Uruguay.
- 751. Social Security Bank.
- 752. Master in Nutrition UCUDAL.
- 753. Committee on Nutrition of the Pediatrics Uruguayan Society and Pediatrics Deputy Prof.
- 754. MYSU- Women and Health in Uruguay.
- 755. MSP - Food Department.
- 756. UNICEF's Communication Area.
- 757. UNDP Development Project School of Nutrition and Dietetics.
- 758. Uruguayan Network of Milk Banks
- 759. Breastfeeding Committee Pediatrics Uruguayan Society.
- 760. Montevideo Municipality.
- 761. Gender Department PIT-CNT.
- 762. Primary Care Network ASSE.

Venezuela

- 763. Ministry of Popular Power for Health
- 764. National Breastfeeding Programme
- 765. Faculty of Medicine Central University of Venezuela
- 766. School of Nutrition and Diet Central University of Venezuela
- 767. National Director of Health Programmes Ministry of Health
- 768. National Director of Attention to Mothers, Children and Adolescents
- 769. IBFAN Venezuela

Vietnam

- 770. Ministry of Heath
- 771. LIGHT
- 772. Central Gynecology and Obstetrics Hospital
- 773. National Ntutrition Institute
- 774. CEPHAD
- 775. Hanoi Gynecology and Obstetrics Hospital
- 776. Central Pediatrics Hospital

Zambia

- 777. Ministry of Health
- 778. National Food and Nutrition Commission
- 779. Natural Resources Development College

Zimbabwe

- 780. National Nutrition Unit, Ministry of Health and Child Welfare
- 781. UNICEF
- 782. Harare City Health
- 783. GOAL Zimbabwe
- 784. SAVE the Children UK

“The evidence on breastfeeding leaves no doubt that it is a smart and cost-effective investment in a more prosperous future. Let's ensure that every child and every nation can reap the benefits of breastfeeding.

Keith Hansen, The World Bank, Washington



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