The State of the World's Breastfeeding

South Asia Report

International Baby Food Action Network (IBFAN), Asia

Tracking Implementation of the Global Strategy for Infant and Young Child Feeding

February 2007

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Arun Gupta
Vasumathi Arora

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South Asia Report

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Dr. Arun Gupta

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Acronyms

ABM	Academy of Breastfeeding Medicine
ABPP	Afghanistan Breastfeeding Promotion Partners
ACF	Action Contre la Faim
AIDS	Acquired Immunodeficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ANC	Anti Natal Clinic
ANM	Auxiliary Nurse Midwives
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BBF	Bangladesh Breastfeeding Foundation
BFHI	Baby Friendly Hospital Initiative
BPHS	Basic Package of Health Services
BPNI	Breastfeeding Promotion Network of India
CAF	Afghanistan and Care of Afghan Families
CDD	Control of Diarrhoeal Diseases
DGFP	Director General of Family Planning
DGHS	Director General of Health Services
DGIS	Netherlands Ministry of Development Cooperation
DPH	Department of Public Health
DWCD	Department of Women and Child Development
EBM	Expressed Breastmilk
GLOPAR	Global Participatory Action Research
GOI	Government of India
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HMIS	Health Management Information System
HQ	Head Quarter
IBFAN	International Baby Food Action Network
ICMR	Indian Council of Medical Research
IEC	Information, Education and Communication
IFP	IBFAN Focal Point
ILCA	International Lactation Consultants Association
ILO	International Labour Organisation
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IMS Act	The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 as amended in 2003

IPHN	Institute of Public Health Nutrition
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
LHW	Lady Health Worker
LLLI	La Leche League International
M & E	Monitoring and evaluation
MDGs	Millennium Development Goals
MIS	Management Information System
MOH	Ministry of Health
MoPH	Ministry of Public Health
MPC	Maternity Protection Convention
MWCD	Ministry of Women and Child Development
NACO	National AIDS Control Organisation
NASP	National AIDS/STD Programme
NBC	National Breastfeeding Committee
NCAER	National Council of Applied Economic Research
NDMA	National Disaster Management Authority
NEBPROF	Nepal Breastfeeding Promotion Forum
NFHS	National Family Health Survey
NGOs	Non Government Organisations
NIPCCD	National Institute of Public Cooperation and Child Development
NMR	Neonatal Mortality Rate
NNF	National Neonatology Forum
NNP	National Nutrition Programme
PMCT	Preventing Mother to Child Transmission
PPTCT	Preventing Parent to Child Transmission
RCH	Reproductive and Child Health
RCO	Regional Coordinating Office
ROSA	Regional Office for South Asia
SAARC	South Asia Association for Regional Cooperation
SABPF	South Asia Breastfeeding Partners Forum
Sida	Swedish International Development Agency
SPARC	Society for the Protection of the Rights of the Child
SWM	Sarvodaya Women's Movement
UN	United Nations
UNICEF	United Nations Children's Fund
VCCT	Voluntary and Confidential Counseling and Testing
WABA	World Alliance for Breastfeeding Action
WBT*i*	World Breastfeeding Trends Initiative
WHA	World Health Assembly
WHO	World Health Organisation
WFP	World Food Programme

Preface

In the year 1990, the *Innocenti Declaration* set an international agenda with four ambitious targets for the countries to protect, promote and support breastfeeding – formation of a national committee/programmes, ensuring that the national health services meet the '10 steps to successful breastfeeding', giving effect to the *International Code of Marketing of Breastmilk Substitutes* and protecting the breastfeeding rights of working women.

The World Health Assembly (WHA) and the UNICEF Executive Board adopted the *Global Strategy for Infant and Young Child Feeding* in the year 2002. It set five additional targets to improve optimal infant and young child feeding practice worldwide. The *Global Strategy* calls for urgent action by all Member States to develop, implement, monitor and evaluate a comprehensive policy and plan of action on infant and young child feeding to achieve reduction in child malnutrition and mortality. In the year 2005, *Innocenti Declaration on Infant and Young Child Feeding 2005* calls for action on many areas including identifying and allocating sufficient resources to fully implement actions of the *Global Strategy for Infant and Young Child Feeding.*

In the year 2003, 38 countries adopted *The Delhi Declaration on Infant and Young Child Feeding* at the Asia Pacific Conference on Breastfeeding. One of the major actions emerged was to take stock of where countries stand on implementation of the *Global Strategy for Infant and Young Child Feeding*.

Following this, the International Baby Food Action Network (IBFAN) Asia Pacific has launched the 'World Breastfeeding Trends Initiative (WBT*i*)' - an innovative initiative to assess the status and benchmark the progress of the implementation of the *Global Strategy*. WBT*i* assists countries in assessing the strengths and weaknesses of their policies and programmes to protect promote and support optimal infant and young child feeding practices. It uses a special web-based toolkit www.worldbreastfeedingtrends.org to make it accessible to all, to rate, rank the status as well as track trends.

The State of the World's Breastfeeding: South Asia Report, is the result of a 3-year consultative process and assessment of eight countries of South Asia conducted in 2005 and the resultant action. The assessment process brought together many almost all concerned partners including governments and civil society together to study where they stand vis a vis the *Global Strategy.* During the assessment process, various gaps in policy and programmes were identified. The WBT*i* then provided rating and ranking to the assessments. The results of the assessment were then presented at a South Asia Breastfeeding Partners Forum-2.

The WBT*i* is based on that philosophy that once the gaps are identified, solutions can be found and corrective action taken. This was confirmed, as each country has demonstrated a

strong commitment and improvement in programmes related to IYCF, which has resulted in a tremendous increase in the interest and visible change in the programme. Countries developed their action plans and reviewed them after a year at the South Asia Breastfeeding Partners Forum-3 at Kabul in November 2006, and made fresh plans for 2007.

The South Asia Report is a compilation of the eight country assessments. The preparation of the report has been a learning experience. It enabled us to make a serious analysis of the findings and suggest appropriate measures for future action plans. It will be very useful to programme managers and policy makers at national and international level, civil society organisations, IBFAN focal points, donors/funding agencies and as well as UN agencies and all others concerned for advocacy to mainstream the component of infant and young child feeding in various nutrition, health and development programmes meant for children. It also allows prioritising investments in areas that need most attention.

The report will be particularly useful as a benchmark and repeated assessments will reveal the level of improvements.

I profoundly acknowledge the hard work of governments, and other groups involved in these assessments and action.

Dr. Arun Gupta
Regional Coordinator

Box 1

Team Members

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2. **Afghanistan:** Ministry of Public Health (MoPH), MOH, Government of Afghanistan and Care of Afghan Families (CAF)

3. **Bangladesh:** Government of Bangladesh, Bangladesh Breastfeeding Foundation (BBF)

4. **Bhutan:** Ministry of Health, Government of Bhutan

5. **India:** Government of India, UNICEF, Breastfeeding Promotion Network of India (BPNI) and National Neonatology Forum (NNF)

6. **Maldives:** Ministry of Health, Government of Maldives

7. **Nepal:** Government of Nepal and Nepal Breastfeeding Promotion Forum (NEBPROF)

8. **Pakistan:** Government of Pakistan, Society for the Protection of the Rights of the Child (SPARC) and Blue Veins (Women Welfare & Relief Services)

9. **Sri Lanka:** Family Health Bureau, Ministry of Health, Government of Sri Lanka and Sarvodaya Women's Movement.

South Asia at a Glance

Table 1: Key Maternal and Child Health Indicators

Background Data	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka	South Asia
Total population (thousands)	29,863	141,822	2,163	1,103,371	329	27,133	157,935	20,743	1,483,358
Infant mortality rate (under 1)	165	54	65	56	33	56	79	12	63
Under-5 mortality rate	257	73	75	74	42	74	99	14	84
% of infants with low birth weight	N/A	36	15	30	22	21	19	22	29
% of under-fives suffering from: underweight, moderate & severe	39	48	19	47	30	48	38	29	45
% under-fives with diarrhoea receiving oral rehydration and continued feeding	48	52	N/A	22	N/A	43	33	N/A	27
% under-fives with ARI	19	21	N/A	19	22	23	16	N/A	19
Maternal mortality ratio	1,600	320	260	540	140	540	530	43	N/A

Source: UNICEF 2007, The State of the World's Children.

Introduction

The *South Asia Report* takes stock of the state of implementation of the *Global Strategy.* This is a compilation of the eight country assessments conducted by the governments and civil society partners. IBFAN Asia Pacific acted as a catalyst and provided guidelines, relevant documents and questionnaire. The assessments were presented at the *South Asia Breastfeeding Partners Forum-2*, jointly organised by IBFAN Asia Pacific and UNICEF Regional Coordinating Office (ROSA), at Kathmandu in October 2005.

After verification, these findings were used by the web-based toolkit of the WBT*i*, which generated a score, colour rating and grading of the each of 15 indicators. *The State of the World's Breastfeeding: South Asia Report Card* and individual Country Report Cards were launched for a quick glance.

This consolidated report provides more detailed information on the findings and action taken by the countries over the past two years. The detailed analysis of infant and young child feeding practices, policies and programmes is discussed in two parts. Part I deals with infant and young child feeding practices and Part II with infant and young child feeding policies and programmes. The report also provides the background on the status of child malnutrition and survival in South Asia along with global and national commitments. New and updated information on the important indicators like timely initiation and exclusive breastfeeding has been included. Detailed information on objectives, methodology and process are also described. Further, detailed information on WBT*i* and its indicators are described in the chapter about WBT*i* . Impact of the assessment and actions already taken by the eight South Asian countries are discussed. Actions that need to be taken are in violet colour.

The section on Conclusion and Moving Forward outlines the imperative to take the *Global Strategy* forward and suggests some ways of doing it.

Annexures such as exclusive breastfeeding and bottle-feeding calculator, education check lists on IYCF topics, infant feeding and HIV recommendations, guiding principles for complementary feeding, guidelines for scoring and grading of the indicators have been included.

The preparation of the report has been a learning experience. It enabled us to make a serious analysis of the findings and suggest appropriate actions for the future.

The report will be very useful to programme managers and policy makers in the countries, agencies and NGOs working on child health, nutrition and development; UN agencies, and all others concerned for strengthening or mainstreaming infant and young child feeding component in the current programmes. It will be particularly helpful for policy makers to take decisions on priority areas that need investment.

We hope this work will serve as a catalyst for saving millions of babies in South Asia and beyond!

Background

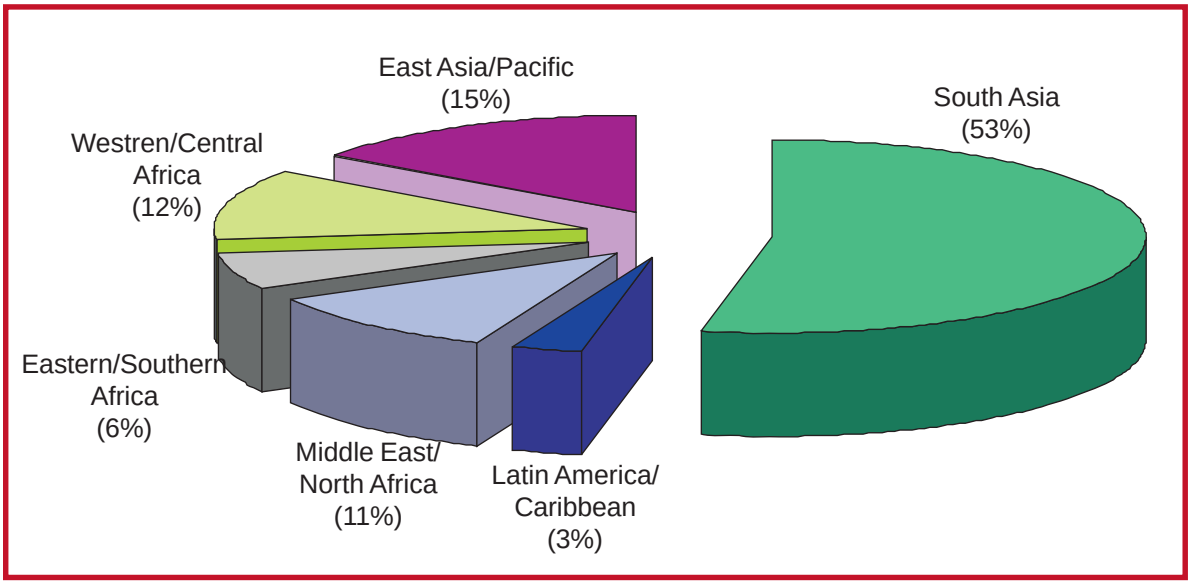
In this section detailed description is given on the status of child malnutrition and survival in South Asia, and what are our global and national commitments.

South Asia, home to about 1.4 billion people, has the highest number of under-five deaths and under-five children who are underweight. More than 70 million out of total of 146 million under-five under weight children are in South Asia (UNICEF 2006).

These countries are struggling to attain the required pace of reduction of child mortality according to the Child Survival Report Card (UNICEF 2004). South Asia has shown persistently high rates of infant mortality that has largely remained resilient to change. Current rates of annual reduction are dismal in spite of significant improvement in the survival and development of children over decades. Lot more needs to be done as according to estimates (IBFAN Asia Pacific 2006), the region has annual estimated births put as 37,145,000 with a very high under 5-mortality rate (U5MR) of 97 contributing significantly to the global burden of under-5 mortality. It also means that more than 77 million children under the age of five are underdeveloped and undernourished, thus unlikely to achieve their full growth and potential development.

According to the *Global Strategy for Infant and Young Child Feeding*, 'Malnutrition has been responsible, directly or indirectly, for 60% of the 10.9 million deaths annually among children under five. Well over two-thirds of these deaths, which are often associated with

Figure 1: Global Distribution of Underweight Children by Region



Source: ECHUI 2006

inappropriate feeding practices, occur during the first year of life. No more than 35% of infants worldwide are exclusively breastfed during the first four months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate or unsafe. Malnourished children who survive are more frequently sick and suffer life-long consequences of impaired development. Raising incidences of overweight and obesity in children are also a matter of serious concern. Because poor feeding practices are a major threat to social and economic development, they are among the most serious obstacles to attaining and maintaining health that face this age group….' (Global Strategy 2002). Optimal infant feeding contributes significantly to the overall development of those who survive, as its promotion leads to prevention of child malnutrition.

Global and National Commitments

The World Health Assembly (WHA) adopted the *Global Strategy for Infant and Young Child Feeding* in May 2002 and the UNICEF Executive Board in September 2002 endorsed it. In addition to four targets suggested by the *Innocenti Declaration* (1990), the *Global Strategy* provided five additional targets to achieve optimal infant and young child feeding practices as a means to prevent child malnutrition and reduce infant and young child mortality. *WHA Resolution 58.32* urges Member States to protect, promote and support exclusive breastfeeding for six months, as a global public health recommendation, taking into account the findings of the WHO Expert Consultation on optimal duration of exclusive breastfeeding, and to provide for continued breastfeeding up to two years of age or beyond. It reiterates full implementation of the *Global Strategy,* which encourages Member States, among many actions, to formulate a comprehensive national policy, a legal framework to promote maternity leave and a supportive environment for six months exclusive breastfeeding, a detailed plan of action to implement, monitor and evaluate the policy, and allocation of adequate resources for this process.

UN member countries, along with national and international partners, reaffirmed their commitment to further reduce infant and child mortality by adopting the Millennium Development Goals (MDGs) (UN 2001), which represent the widest possible commitment in history to address global poverty and ill health. The fourth goal (MDG-4), relates to reducing U5MR by two-thirds between 1990 and 2015. Public health experts predict that the MDG to reduce under-5 mortality by two-thirds cannot be met unless neonatal mortality is at least halved, which will require greater emphasis on measures to improve newborn health as well as to increase the reach to all. Recent commitments also include *Innocenti Declaration 2005 on IYCF* calling for protection, promotion and support of breastfeeding urgently for achievement of the Millennium Development Goals by 2015 (UN 2005).

The Challenge and the Evidence to Meet it

The challenge is especially significant in many countries of the South Asia region where neonatal mortality represents at least 50% of infant deaths (Dadhich & Paul 2004). A decade before the target date of 2015, many are already lagging behind in annual rate of reduction

Table 2

Contribution of Breastfeeding, Complementary Feeding, and Related Maternal Nutrition to the Millennium Development Goals

MDGs	Goals and Targets	Contribution of Infant and Young Child feeding (i.e., Early and Exclusive Breastfeeding, continued breastfeeding with complementary feeding and related maternal nutrition)
Goal 1	Eradicate extreme poverty and hunger	Breastfeeding significantly reduces early childhood feeding costs, and exclusive breastfeeding halves the cost of breastfeeding. Exclusive breastfeeding and continued breastfeeding for two years is associated with reduction in underweight and is an excellent source of high quality calories for energy. By reducing fertility, exclusive breastfeeding reduces reproductive stress. Breastfeeding provides breastmilk, serving as low-cost, high quality, locally produced food, and sustainable food security for the child.
Goal 2	Achieve universal primary education	Breastfeeding and adequate complementary feeding are prerequisites for readiness to learn. Breastfeeding and quality complementary foods significantly contribute to cognitive developmentand capacity. In addition to the balance of long chain fatty acids in breastmilk which support neourological development, initial exclusive breastfeeding and complementary feeding address micronutrient and iron deficiency needs and, hence, support appropriate neurological development and enhance later school performance.
Goal 3	Promote gender equality and empower women	Breastfeeding is the great equalizer, giving every child a fair start on life. Most differences in growth between sexes begin as complementary foods are added into the diet, and gender preference begins to act on feeding decisions. Breastfeeding also empowers women: • increased birth spacing secondary to breastfeeding helps prevents maternal depletion from short birth intervals, • only women can provide it, enhancing women's capacity to feed children • increases focus on need for women's nutrition to be considered
Goal 4	Reduce child mortality	By reducing infectious disease incidence and severity, breastfeeding could readily reduce child mortality by about 13%, and improved complementary feeding would reduce child mortality by about 6%. In addition, about 50-60% of under-5 mortality is caused by malnutrition due to inadequate complementary foods and feeding following on poor breastfeeding practices and, also, to low birthweight. The impact is increased in unhygienic settings. The micronutrient content of breastmilk, especially during exclusive breastfeeding, and from complementary feeding can provide essential micronutrients in adequate quantities, as well as necessary levels of protein and carbohydrates.
Goal 5	Improve maternal health	The activities called for in the Global Strategy include increased attention to support for the mother's nutritional and social needs. In addition, breastfeeding is associated with decreased maternal postpartum blood loss, breast cancer, ovarian cancer, and endometrial cancer, as well as the probability of decreased bone loss post-menopause. Breastfeeding also contributes to the duration of birth intervals, reducing maternal risks of pregnancy too close together, including lessening risk of maternal nutritional depletion from repeated, closely-spaced pregnancies. Breastfeeding promotes return of the mother's body to pre-pregnancy status, including more rapid involution of the uterus and postpartum weight loss (obesity prevention).
Goal 6	Combat HIV/AIDS, malaria, and other diseases	Based on extrapolation from the published literature on the impact of exclusive breastfeeding on MTCT, exclusive breastfeeding in a population of untested breastfeeding HIV-infected population could be associated with a significant and measurable reduction in MTCT.
Goal 7	Ensure environmental sustainability	Breastfeeding is associated with decreased milk industry waste, pharmaceutical waste, plastics and aluminum tin waste, and decreased use of firewood/fossil fuels for alternative feeding preparation, less CO_2 emission as a result of fossil fuels, and less emissions from transport vehicles as breastmilk is locally produced.
Goal 8	Develop a global partnership for development	The Global Strategy for Infant and Young Child Feeding fosters multi-sectoral collaboration, and can build upon the extant partnerships for support of development through breastfeeding and complementary feeding.In terms of future economic productivity, optimal infant feeding has major implications.

Source: SCN Breastfeeding and Complementary Feeding Working Group 2003/2004

in child mortality, particularly infant and neonate mortality. For MDG 4, Bangladesh seems to be on road, but others are lagging behind. Reducing deaths in the first week of life will be critical to this progress (UN 2006). The survival and health needs of neonates are being met in varying degrees in the countries of the region (Save the Children 2001). This is reflected in the wide range of neonatal mortality rates from 12 per 1000 live births in Sri Lanka to 44 in Nepal. There is not only wide variation among countries but also within countries. For instance, in India, the neonatal mortality rate (NMR) ranges from 11/1000 live births in the state of Kerala to 55 in Madhya Pradesh. In Bangladesh, NMR was estimated to be 42 in Chittagong while it was 85 in Sylhet.

In South Asia, more than 1,400,000 babies are estimated to die during first month of life, and another 2,200,000 during 2 to 12 months. In India alone, about 1,100,000 babies die during first month of life, and another 500,000 during 2 to 12 months of age (*Indian Paediatrics* 2005). The primary causes of these neonatal deaths are: neonatal infections (52%), asphyxia (20%), low birth weight (17%) (ICEN). Most of the infectious deaths are from diarrhoea and pneumonia. As about two-thirds of all child deaths occur during infancy, action is needed during that period.

Lancet's "Child Survival Series" of 2003 emphatically showed that breastfeeding (defined as exclusive breastfeeding for the first six months and continued breastfeeding for 6-12 months) is the number one intervention to reduce mortality in neonatal sepsis, pneumonia and diarrhoea. If universalised, this practice can be the single most effective preventive intervention to cut 13-15% of all child deaths. This coupled with adequate complementary feeding could prevent 19% of all child deaths (*Lancet* 2003, 2005). However, in South Asia, only 35% of babies are exclusively breastfed for the first 6 months, ranging from 10-68% for various countries. Unfortunately, many mothers and newborns do not receive the help they need to initiate breastfeeding within one hour, the recommended practice. The South Asia report lays bare the state of policy and programmes that support raising this practices.

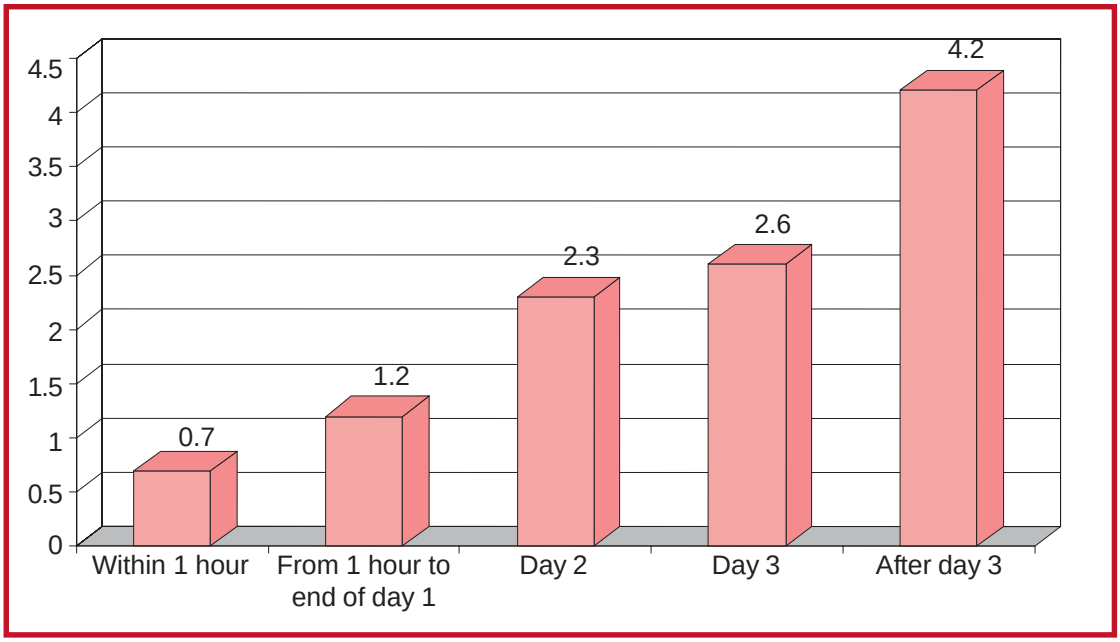
Why is it Critical to Initiate Breastfeeding within the First Hour of Birth?

A recent study from rural Ghana, based on 10947 breastfed singleton infants, has shown that initiation of breastfeeding within the first hour of birth reduced the infants' risk of death (Edmond et al 2006). There was a marked increase in risk with increasing delay in initiation. Overall, late initiation (after day 1) was associated with a 2.4-fold increase in risk. Giving pre-lacteal feeds also increased the risk of neonatal mortality.

The study concluded that if all women initiated breastfeeding within 1 hour of birth, 22% of the infants would be saved from death. In the Indian context, this means that 250,000 neonates can be saved from death annually by just one act – initiation of breastfeeding within 1 hour of birth. This impact was found to be independent of exclusive breastfeeding. In South Asia, rates of first hour breastfeeding vary from 23% (India) to 75% (Sri Lanka).

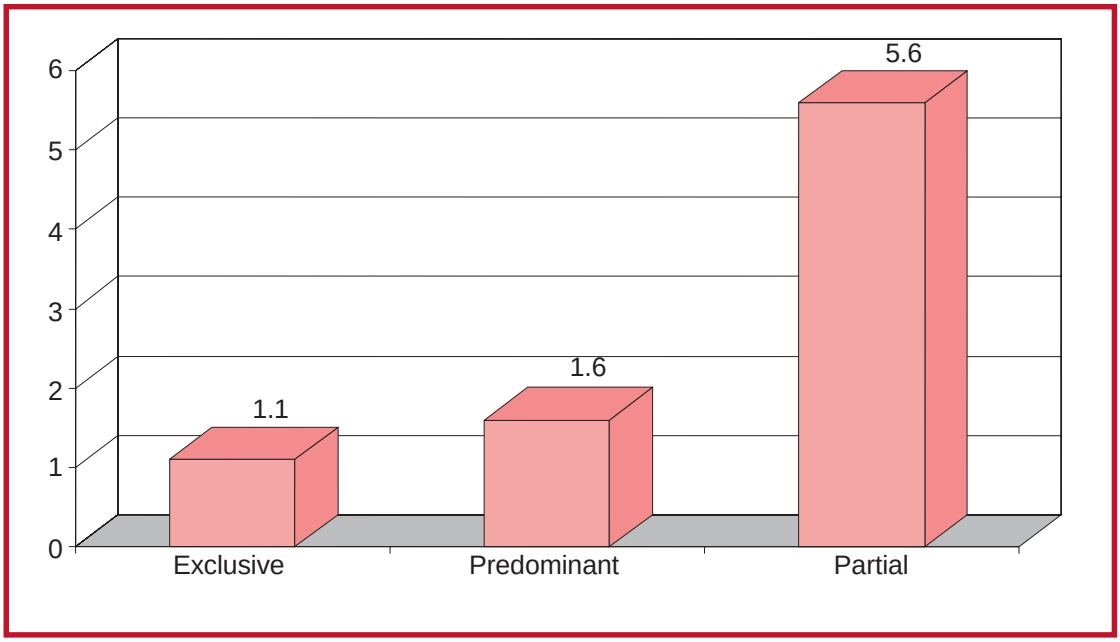
It is well known that malnutrition contributes to more than half of the child deaths. Most

Figure 2: Risk of Neonatal Mortality according to time of Initiation of Breastfeeding



Source: Edmont et al 2006

Figure 3: Risk of Neonatal Mortality according to Established Breastfeeding Pattern



Source: Edmont et al 2006

interventions to tackle malnutrition have been limited to providing mid day meals or nutrition supplements to young children as well as mothers. These supplements are aimed at children above 2 years or those attending preschool. However, evidence exists that malnutrition peaks during the first 12 months. It is also the most critical time in terms of growth and development, as 70% of brain also develops during this period. Thus, any intervention to tackle under nutrition effectively has to target infant nutrition.

Considering the importance of optimal feeding practices, and the dismal state of child survival and nutrition in the South Asia, an urgent action to scale up the proven interventions is justified, more so because the region has highest number of child deaths and undernourished children in the world. This action will be critical to achieving MDG-4.

World Food Programme and UNICEF have jointly initiated the upcoming *Ending Child Hunger and Undernutrition Initiative*, which recognises the importance of tackling under nutrition in early life with the focus in South Asia. The *Global Framework for Action* includes enhancing exclusive breastfeeding rates. This provides a ranking by prevalence of underweight and share of underweight children. Four South Asia countries figure among first ten. (ECHUI 2006)

The WBT*i* launched by the IBFAN Asia Pacific is a perfect opportunity to stimulate action on the *Global Strategy for Infant and Young Child Feeding.* This need is more critical in developing countries.

Table 3: Ranking by Global Share of Underweight Children

Country	Prevalence of underweight children in country (%)	Share of total underweight children in the world (%)	Cumulative total (%)
India	**47**	**39.0**	**39.0**
Bangladesh	**48**	**5.7**	**44.7**
Pakistan	38	5.5	50.2
China	8	4.8	54.9
Nigeria	29	4.4	59.3
Ethiopia	**47**	**4.2**	**63.5**
Indonesia	28	4.2	67.7
Democratic Republic of Congo	31	2.3	70.0
Philippines	28	1.9	71.9
Viet Nam	28	1.5	73.4

Source: UNICFE 2006, The State of the World's Children

Table 4: Ranking by Prevalence of Underweight Children

Country	Prevalence of underweight children in country (%)	Share of total underweight children in the world (%)
Bangladesh	**48**	**5.7**
Nepal	48	1.2
Ethiopia	**47**	**4.2**
India	**47**	**39.0**
Timor-Leste	46	0.1
Yemen	46	1.1
Burundi	45	0.4
Cambodia	45	0.6
Madagascar	42	0.9
Eritrea	40	0.2
Lao People's Democratic Republic	40	0.2
Niger	40	0.8
Afghanistan	39	1.4

Source: UNICFE 2006, The State of the World's Children

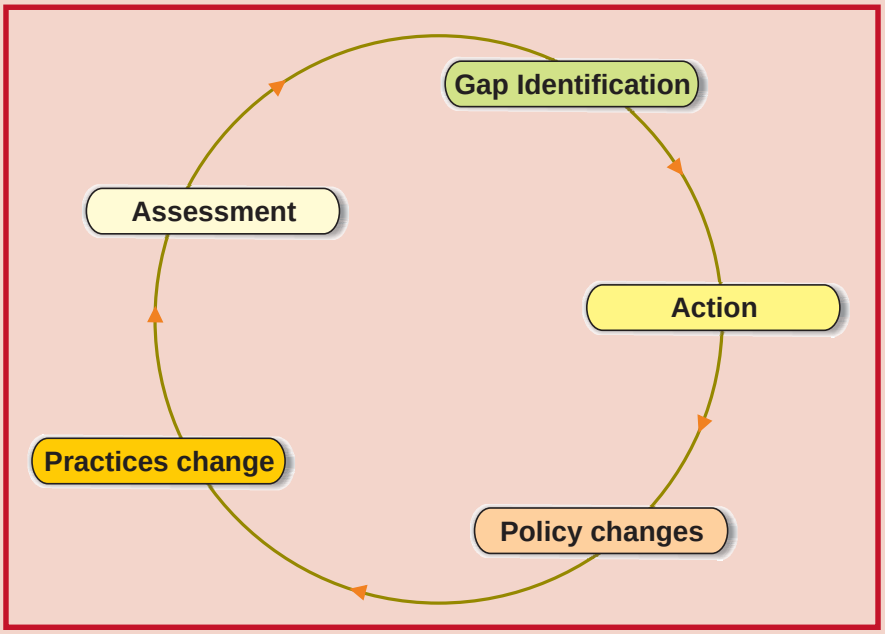
About WBT*i*

The World Breastfeeding Trends Initiative (WBT*i*) is an innovative initiative of the International Baby Food Action Network (IBFAN) Asia Pacific for tracking, assessing and monitoring the *Global Strategy for Infant and Young Child Feeding* in response to the global need for focus on infant nutrition and survival. The WBT*i* is a part of IBFAN Asia Pacific's *Strategic Plan 2003-2007* and aims at strengthening and stimulating breastfeeding action worldwide.

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

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

Figure 4: Working Structure of WBT*i*



and support breastfeeding. The WBT*i* is an extension of GLOPAR as it also tracks additional targets set by the *Global Strategy.*

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

Inspired by these two historical initiatives of WABA and WHO, WBT*i* aims to induce action. It is highly participatory and aims at stimulating worldwide action for improving infant and young child feeding practices through an assessment process that enhances national interest and solidarity between several key partners for support to infant feeding issues.

WBT*i* has Five Components

A: Action

B: Bringing people together

C: Consensus building and commitment

D: Demonstration of achievements and gaps

E: Efficacy, improving policy and programme

How WBT*i* Works?

WBT*i* involves a three phases process.

As a first phase involves initiating national assessment of the implementation of the *Global Strategy,* it guides countries and regions to document gaps in existing practices, policies and programmes. This is done by involving multiple partners based on national documents and their analysis and the process brings governments and other civil society partners together to analyse the situation in the country and find out gaps.

The gaps thus identified are used for developing recommendations for advocacy and action. The WBT*i,* thus helps in development of a practical baseline demonstrating to programme planners, policy makers where improvements are needed to meet the aims and objectives of the *Global Strategy*. It thus helps in formulating plans of action that are effective to improve infant and young child feeding practices and guide allocation of resources. It works on a consensus building process and helps to prioritise actions for implementing the Strategy. The initiative thus can impact on policy at the country level, leading to action that would result in better practices.

During the second phase, WBT*i* uses the findings of assessment to score, rate, grade and rank each country or region based on *IBFAN Asia Pacific's Guidelines for* WBT*i.* In this phase, it ranks countries where they stand. WBT*i* also ranks countries in order of their performance, thus building some competition among the countries in the region.

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

The 15 Indicators of the WBT*i*

The WBT*i* *focus is based on a wide range of indicators, which provide an impartial global view of key factors.*

The WBT*i* has identified 15 indicators. Each indicator has its specific significance. Part-I has 5 indicators dealing with infant feeding practices and Part–II has 10 indicators dealing with policies and programmes. Once assessment of gaps is carried out and data was verified, then data on 15 indicators is fed into the web-based toolkit. Scoring, colour rating and grading is done for each individual indicator. The toolkit objectively quantifies the data to provide a colour- rating and grading i.e. Red or 'Grade D', Yellow or 'Grade C', Blue or 'Grade B' and Green or 'Grade A'. The toolkit has the capacity to generate visual maps or graphic charts to assist in advocacy at all levels e.g. national, regional and international.

Each indicator has following components

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

Part I: Infant and Young Child Feeding Practices in Part I ask for specific numerical data on each practice based on data from random household survey that is national in scope and to help identify background data interact with these practices.

Part-I has 5 indicators:

1. Initiation of Breastfeeding (within 1 hour)
2. Exclusive Breastfeeding (for first 6 months)
3. Median Duration of Breastfeeding
4. Bottle Feeding (<6 months)
5. Complementary Feeding (6-9 months)

These practice indicators are used on those recommended by WHO for global use. The data thus collected is verified and then entered into the web-based toolkit through WBT*i* Questionnaire. The achievement on the particular target indicator is then scored, colour-rated and graded as per IBFAN Asia Pacific's Guidelines for WBT*i*.

Part II: A set of criteria has been developed for each target based on the *Innocenti* and

beyond, i.e. considering most of the targets of the *Global Strategy*. Part II consists 10 indicators which includes:

- National Policy, Programme and Coordination
- Baby Friendly Hospital Initiative
- Implementation of the International Code
- Maternity Protection
- Health and Nutrition Care
- Community Outreach
- Information Support
- Infant Feeding and HIV
- Infant Feeding during Emergencies
- Monitoring and Evaluation

For each indicator, there is a subset of questions leading to key achievements indicating how one country is doing in a particular area. Once information about the indicators is gathered and analysed then entered into the web-based toolkit through 'WBT*i* Questionnaire'. Further, the toolkit scored, colour-rated and graded each individual indicator as per IBFAN Asia Pacific's Guidelines for WBT*i*. This colour rating and grading is then used for mapping for easy visualisation.

Process for Assessment

Usually a country has to do the complete assessment i.e. IYCF Practices and IYCF Policies and Programmes to identify the implementation of the *Global Strategy*. If a country is unable to do the whole process it is advised to do at least IYCF Practice i.e. Part I.

Box 2

Who can use the Results of WBT*i*?

1. Governments wanting to take action on infant and young child feeding are potential users.
2. Donors to assess where the country's strengths and weaknesses related to infant feeding lie, and thus where its support might be best targeted. Donors can also choose to support countries.
3. Advocacy groups wanting to showcase how well the country is doing in order to pinpoint improvements or for gathering support.
4. Researchers can also use these results for documentation.
5. Media can effectively use for communication and help in advocacy.

Resource Required

To envisage the actions/process at the country level or regional level, it is required to constitute a team of experts for the assessment, to decide who should do what, prepare a work plan, collect data and gather requisite information from the secondary sources, compile the data and analyse to find out gaps, share details of assessment with the wider group for review and comments and prepare the final report. This work requires both human and financial resource.

- There is an identified need for coordination, analysis and reporting at regional level.
- **Capacity building and training:** training for the group or human resource to conduct the assessment is very essential. A regional 'Trainer' and 'Expert' can take lead in training at country or groups on how to gather the information, compile and analyse and after discussion how to complete the WBT*i* questionnaire.
- **Financial:** Assessment would require consultation, communication, and coordination. Meeting expenses as well as reporting, for all these activities, financial resources are required. Resources would also be needed for follow up and advocacy efforts.

How to Study Trends

WBT*i* uses the special web-based toolkit to track trends in infant and young child feeding. Data is entered year wise for rest to be done by the toolkit. It can generate reports in different form like maps, pie diagrams, bar charts, graphics etc. It is also recommended to carry out the assessment every 3-5 years depending upon the needs and already established processes. It will help to:

- Track trends on the various indicators for infant and young child feeding practices;
- Assess progress on implementation of the *Global Strategy for Infant and Young Child Feeding;* and study the impact of any intervention on practices over a period of time.

The Web–based toolkit

The web toolkit is specially designed for the WBT*i* to assess the status and benchmark the progress of implementation of the *Global Strategy*. It provides scoring, colour rating and grading to one particular indicator or all indicators together, or Part I / II. This allows viewers to quickly and easily identify specific areas where immediate action is critically needed – e.g. 'RED' or 'Grade D'. Colour rating and grading is provided for all 15 indicators.

Mapping and Graphics

The toolkit has capacity to generate graphics, pie charts, bar graphs and maps. One can rely on the web itself to print reports or copy and use in the Word. These graphics can help in quick analysis of status and progress.

Box 3

WBT*i* is an Initiative!

The **WBT*i*** is **Participatory**: It seeks to involve all working on infant and young child feeding including NGOs. It is highly participatory since the participants collect information, finding gaps and analyze the findings, and take action based on the results. In the process, the participants develop networking skills, investigative techniques and monitoring methods.

The **WBT*i* is Action-oriented:** It aims to stimulate action, not simply to collect information. Having more information is not helpful unless there are finding out gaps and suggestions about how to translate the information into tools for change and recognition of how to improve the situation.

Objectives, Methodology and Process

Breastfeeding has been accepted as the most vital intervention for reducing infant mortality and ensuring optimal growth and development of children. Given the high rate of infant mortality as well as childhood malnutrition in South Asian countries, it is evident that breastfeeding needs to be pushed. However, this aspect of infant nutrition has traditionally been left in the private domain of the home, as a relationship between the mother and the infant, governed primarily by the family and society. In fact it is often stated that these nations have a breastfeeding culture, thereby assuming that nothing further needs to be done. But optimal breastfeeding can only be practised if it is understood properly, if adequate information is available, and if societal and structural parameters that govern women's ability to breastfeed optimally exist. This, more often than not, requires planned national action for behavioural as well as structural changes in society. Such action, in turn, demands that breastfeeding become a priority in policy and programme.

The first step in ensuring optimal breastfeeding is a national level assessment of the state of breastfeeding in the country. Documentation helps to draw the attention of the governments, policy makers, and programme managers to the strengths and weaknesses of policies and programmes to protect, promote and support optimal infant and young child feeding practices. It has been shown that if key decision-makers and programme managers are engaged in making an assessment of their own policies and programmes, they are much more likely to accept the results and also take actions needed to bridge these gaps. The assessment helps to stimulate a campaign for action, effectively target strategies that can improve infant and young child feeding; it also provides the basis on which allocation of resources can be prioritised.

Objectives

The objectives of the assessment usually are:

- To find out gaps in the existing policies, programmes and practices with reference to infant and young child feeding;
- To build a consensus among all the partners.

Methodology and Process

In the year 2003, the first draft of the WBT*i* was presented at the 'Asia Pacific Conference on Breastfeeding', held in India. This was the first ever such conference in this region, that brought together over 500 participants from 38 countries and nearly every state of India, representing mothers, governments, public interest groups, professional bodies, United Nations agencies and other international organisations. Eleven representatives of overseas governments were also present. The representatives from 38 countries adopted *The Delhi*

Declaration on Infant and Young Child Feeding – a call for ten urgent actions for optimal infant and young child feeding. One of the major actions that emerged was to take stock of where countries stand on implementation of the *Global Strategy for Infant and Young Child Feeding*. The first design of the web based toolkit and project of WBT*i* was shared at this time, which led to a network decision to initiate monitoring of the current state of the implementation of the *Global Strategy for Infant and Young Child Feeding*. During the South Asia Breastfeeding Partners Forum-1 in 2004, the WBT*i* toolkit was introduced to the South Asian countries. A team from the Regional Coordinating Office (RCO) provided hands on experience/ training on use of the toolkit to the delegates of eight countries.

As a follow up, in the year 2005 IBFAN Asia Pacific proposed that all eight South Asian countries use the WBT*i* toolkit to conduct assessment of the Status of *Global Strategy for Infant and Young Child Feeding* and document the existing gaps. IBFAN focal points were assigned the task of coordination of the assessment process and to organise consultations/workshops with participation of government agencies, professional organisations, international agencies and NGOs. In some countries, like in Bhutan, Maldives and Sri Lanka, strong contacts were established with the government representatives to conduct the assessment.

The IBFAN Asia Pacific, RCO, situated in India, acted as the catalyst, bringing together governments and other civil society partners for this purpose and providing financial support. In some countries like Afghanistan, Bhutan, Maldives and Sri Lanka, national governments took up this challenging task; in the rest of the countries, IBFAN partners in the breastfeeding movement facilitated the assessment process in partnership with the respective governments.

A three-member team of experts – WBT*i* Coordinating Office **-** was constituted at RCO, that developed guidelines and the step-by-step process for conducting the assessment, which was shared with the coordinators in the respective countries, along with documents such as the *Global Strategy for Infant and Young Child Feeding*; WHA resolutions, HIV and Infant Feeding: Framework for Priority Action, etc.

Box 4

Suggested Process at Country Level

1. Identify a key person as 'Coordinator'.
2. Form a group of 4-5 'Core Members' that should consist of representatives from the Government, UN agencies, NGOs and other professional organizations. The Coordinator will act as the facilitator of this group.
3. Subsequently, conduct a brainstorming discussion/session to discuss –
   - who should do what;
   - prepare a work plan, followed by collection of data and gather related information.
4. Hold a meeting of group of core members for compilation of data and carry out analysis to find out the gaps.
5. Further, conduct a workshop/session to share the details of the assessment with a wider perspective for review and comments.
6. Incorporate comments or suggestions into the final outcome of the report to be shared with the WBT*i* coordinating office.

The national teams included governments, breastfeeding groups, IBFAN groups, key NGOs, policy-makers, infant and young child health and development programme managers, UN agencies and other civil society organisers. To avoid conflict of interests vis a vis the WHA Resolutions 49.15, 55.25, 58.32 and the *Global Strategy,* the core group was advised not include any representative from commercial sector in the team.

The process involved the following several steps:

1. Identification of a key person as Coordinator/ key contact

A key person was identified as 'Coordinator', who was responsible for coordinating assessment work in a country, and he/she was provided with a brief guideline to build a consensus among all the partners.

2. Reviewing the process

WBT*i* coordinating office suggested process, provided questionnaires and resources to the coordinator, who then reviewed all the process and prepared a plan and time line for the assessment and resource allocation.

3. Identification of the assessment team

The coordinator identified representatives from among the partners and formed a 'Core Members' group consisting of 4-6 representatives from government, NGOs and advocacy groups, key professional organisations, and from donor and international agencies such as WHO, UNICEF, etc.

4. Brainstorming session of the core group and gathering data

A brainstorming session was conducted and the core group developed a plan of action, allocating tasks. The members of the core group collected the required data from various authentic national sources. An initial orientation on the questionnaire and review of data was done.

5. Analysis and preparation of draft assessment

The collected data was analysed to identify achievements and gaps, and the findings compiled into a draft assessment report.

6. Presentation of assessment to larger audience of partners in country

All participating countries organised workshops to present the draft assessment to all partners in the country, so that it could be reviewed, verified and a consensus on the assessment achieved.

7.Sharing of findings at the South Asia Forum

The RCO developed a generic format for the presentation of the assessment findings and shared it with the South Asian countries. In October 2005, the results of the assessment were presented at the South Asia Breastfeeding Partners Forum-2, jointly organised by IBFAN Asia Pacific and UNICEF Regional Office for South Asia (ROSA) and hosted by Nepal Breastfeeding Promotion Forum (NEBPROF) at Kathmandu, Nepal. (For more details see the chapter Assessing the Implementation of the *Global Strategy*) Sixty-five participants represented eight countries of South Asia including five governments (Afghanistan, Bangladesh, Bhutan, Maldives and Nepal), UN agencies, WABA, media, professional bodies, NGOs and other international organisations. Based on the gaps identified, all the participating countries formulated a set of recommendations towards action plans. Countries developed plans of action for the next year.

8. Verification of the assessment findings

A team of five members at the RCO checked and verified the findings in consultation with the country coordinators. Findings were then uploaded on WBT*i* website www.worldbreastfeedingtrends.org with the help of the toolkit. The toolkit objectively scored, colour rated and graded the findings for each indicator as well as for each country based on IBFAN Asia Pacific's Guidelines for WBT*i.* WBT*i* also ranked the countries in order of their performance, intending to build some competition among them.

9. Launch of Report Cards

The next step was to generate *The State of the World's Breastfeeding Report Cards* for the individual countries as well as for the region as a whole. These report cards allocate simple and effective visualisation of the status of all 15 indicators nationally as well as regionally, as well as focussing national attention on where immediate action is needed.

National and regional reports were presented to key national decision-makers as well as to potential donors. The reports showed clearly where the country stood in comparison with other countries in the region, where gaps existed in policy and programme, and the direction that planning should take.

10. Ranking, rating, grading and dissemination

The WBT*i* website displays the ranking, rating and grading of the eight countries both nationally and regionally. It scores, grades and rates each indicator, as well as assesses the performance of the country as a whole. Countries were ranked in order of their performance on the implementation of the *Global Strategy*.

11. Review of the assessment findings and action taken

In November 2006, at the South Asia Breastfeeding Partners Forum-3, organised by the Ministry of Health, Government of Afghanistan, actions taken during the year to improve the implementation of the *Global Strategy* was presented. Then country wise plans for 2007 were developed, including plans for conducting re-assessment every few years to track any change in policy and programme. An important impact of WBT*i,* one that IBFAN Asia Pacific had hoped for, was stimulation of national action due to ranking. Countries that stood low in the ranking determined to improve their status. Countries that stood high were determined to improve their performance to maintain their lead. Thus, governments across the region have started a process of detailed planning and implementation of the *Global Strategy* at the country level.

Box 5

Processes followed by Countries

Afghanistan: In Afghanistan, representatives the Ministry of Public Health, UNICEF, Care of Afghan Families (CAF) and Action Contre la Faim (ACF) constituted the core group. On September 14, 2005, the Public Nutrition Department of MoPH organised a workshop at which the key partners discussed all fifteen indicators of the questionnaire and related documents and available data, and came up with recommended actions for improving existing gaps. The recommendations were shared with a wider group consisting of implementing partners - related ministries, donor agencies, UN organisations, and NGOs.

Bangladesh: Bangladesh Breastfeeding Foundation (BBF), an IBFAN Focal Point in Bangladesh along with Government of Bangladesh took up the challenging task of assessment. BBF organised a workshop on August 27, 2005. Thirty-three participants including Director General of Health Services (DGHS), Director General of Family Planning (DGFP), officials of National Nutrition Programme (NNP), Institute of Public Health Nutrition (IPHN), National AIDS/STD Programme (NASP), WHO, UNICEF, Plan Bangladesh, Helen Keller International (HKI) etc attended the workshop. The participants divided themselves into four groups to discuss the indicators, and presented their findings in the plenary, where consensus was reached after more discussion and some modifications.

Bhutan: The Ministry of Health conducted the assessment.

India: Breastfeeding Promotion Network of India (BPNI), together with the government, professional bodies, medical colleges and related institutions, conducted the assessment. The core group consisted of seven **members** representing the Department of Women and Child Development, Government of India; BPNI; National Neonatology Forum of India (NNF); Department of Paediatrics AIIMS; Department of Community Medicine, All India Institute of Medical Sciences (AIIMS); National Institute of Public Cooperation and Child Development (NIPCCD) and Indian Council of Medical Research (ICMR). The core group prepared an initial draft assessment on 30th July 2005. This was shared on 5th August with representatives of 30 different organisations at a workshop. The participants were divided into two groups to verify the draft assessment. The plenary sessions were used to build consensus.

Maldives: The Ministry of Health conducted the assessment.

Nepal: Nepal Breastfeeding Promotion Forum (NEBPROF) in partnership with Government of Nepal conducted the assessment.

Pakistan: The assessment was conducted by the Nutrition Wing of Ministry of Health, Government of Pakistan along with Society for the Protection of the Rights of the Child (SPARC) and Blue Veins (Women Welfare & Relief Services) and prepared a draft of the findings. At a workshop held in Islamabad, 15 participants from diverse backgrounds, including Ministry of Health (Nutrition Wing and Primary Health Care), Ministry of Population Welfare, National Commission for Child Welfare and Development, IBFAN Affiliates, The Network for Consumer Protection and Society for the Protection for the Rights of the Child, reached a consensus on the draft and prioritised areas for action.

Sri Lanka: Family Health Bureau, Ministry of Health, Government of Sri Lanka carried out the assessment.

Assessing the Implementation of the Global Strategy

In this chapter an effort is made to review the existing infant and young child feeding practices, policies and programmes based on findings of the assessments in eight South Asian countries. The report is divided into two parts. Part one deals with five practices related to infant and young child feeding in South Asia and part two deals 10 indicators related to policies and programmes dealing with infant and young child feeding.

Part I: Infant and Young Child Feeding Practices in South Asia

The five practices dealing with IYCF covered in the assessment are:

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

The assessment is based on specific numerical data, which in turn is based on data from random household survey that is national in scope. The level of achievement is given as a percentage for each indicator except for median duration of breastfeeding (indicator-3) for which it is in number of months. For infant and young child feeding practices, the key to rating is from the WHO's *Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes*. Scoring, colour rating and grading are provided according to IBFAN Asia Pacific's Guidelines for WBT*i*. Each indicator was objectively scored out of maximum of ten (10).

Indicator 1: Initiation of Breastfeeding (within 1 hour)

Rationale: As mentioned earlier in the chapter Background, a recent study from rural Ghana concluded that if all women initiated breastfeeding within 1 hour of birth, 22% of the infants would be saved from death. Timely initiation of breastfeeding is beneficial for both the baby and the mother because:

- Colostrum provides the baby with nourishment (the baby needs very little at this time – a few drops are enough) and, more importantly, its first immunisation;
- It helps the production of enough milk for the next feed;
- It provides the skin-to-skin contact and warmth that babies, particularly premature and Low Birth Weight (LBW) babies need;
- It makes use of the baby's sucking reflex (which is present only during the first hour) to establish proper latching;

- It helps prevent blood loss in the mother, a major cause of maternal morbidity and mortality initiation of breastfeeding within the first hour of birth is thus the first and most vital step towards reducing IMR through reducing the overwhelmingly high neonatal mortality rate.

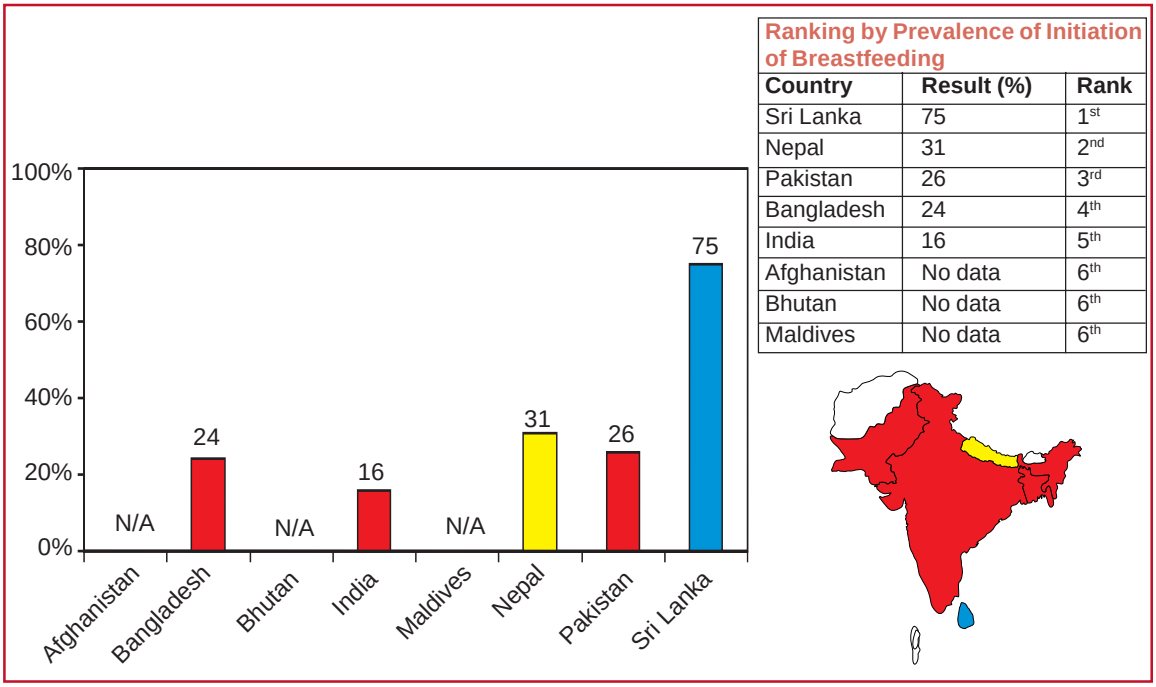
As seen in Figure 5, data on initiation of breastfeeding within one hour in South Asian countries reveals that it varies from 16% to 75% in different countries. The data at national level was not available from Afghanistan, Bhutan and Maldives.

In India, it is dismal 16%, in Bangladesh it is 24% and Pakistan it is 26%, all of them fall in 'Grade D', represented by 'Red' colour. Nepal with 31% stands in 'Yellow' with 'Grade C', where as Sri Lanka, with 75% falls in 'Grade B', with colour 'Blue', which indicates a rating of Good.

There was no data available on the national level in Afghanistan, Bhutan and Maldives. However, the assessment groups provided data based on small studies here and there in Afghanistan and Bhutan. For e.g. in Afghanistan, most of the available data was based on small studies by NGOs in one or two provinces. In Bhutan, a small hospital-based study was conducted; Bhutan has only 24% institutional delivery. In this study, 81% of women initiated breastfeeding within one hour. These findings were not included in the assessment as the study was not national in scope.

☞ **Action needed:** The assessment team suggested that new surveys should be done by a team of experts from the Public Nutrition Department of MOPH in Afghanistan, Ministry of Health in Bhutan and Maldives, to get reliable data at national level. UN Agencies like WHO, UNICEF and other international organisations should help out.

Figure 5: Colour Rating and Ranking of South Asia Countries on Initiation of Breastfeeding



Ranking by Prevalence of Initiation of Breastfeeding

Country	Result (%)	Rank
Sri Lanka	75	1st
Nepal	31	2nd
Pakistan	26	3rd
Bangladesh	24	4th
India	16	5th
Afghanistan	No data	6th
Bhutan	No data	6th
Maldives	No data	6th

All countries, except Sri Lanka ('Grade B', colour rated as 'Blue'), need to put in intensive efforts to universalise timely initiation of breastfeeding. This is particularly true of Bangladesh, India and Pakistan. The National Family Health Survey–2 (1998-99) data of India shows a mere 6.3% increase from the status at the time of NFHS-1 (1992-93). Though NFHS 3, conducted in 2005-06, shows an increase up to 23%, this again falls far short of both the norm for universalisation–90%, as well as the National 10th Plan goals i.e. 80%. The three countries fall in 'Grade D', and are colour rated as 'Red', which indicating poor status of this practice. Nepal**,** at 31% falls in 'Grade C' and is colour rated as 'Yellow'. This indicates that the status in Nepal, is better but there is still a need to intensify the efforts. Sri Lanka is rated as Good, or 'Blue', in 'Grade B', as 75% of the mothers initiate timely breastfeeding. Data revealed that a large majority of Sri Lankan mothers, including those who undergo Caesarean section, breastfeed their babies within one hour of delivery. If Sri Lanka can universalise this practice, it can move from Good to Excellent status and achieve 'Green' colour with 'Grade A'.

Indicator 2: Exclusive Breastfeeding (for first 6 months)

Rationale: Exclusive breastfeeding for the first 6 months is crucial for survival and optimal growth and development of infants and young children. It lowers the risk of illness, particularly from diarrhoeal diseases. It also prolongs lactation amenorrhoea and helps delay the next conception.

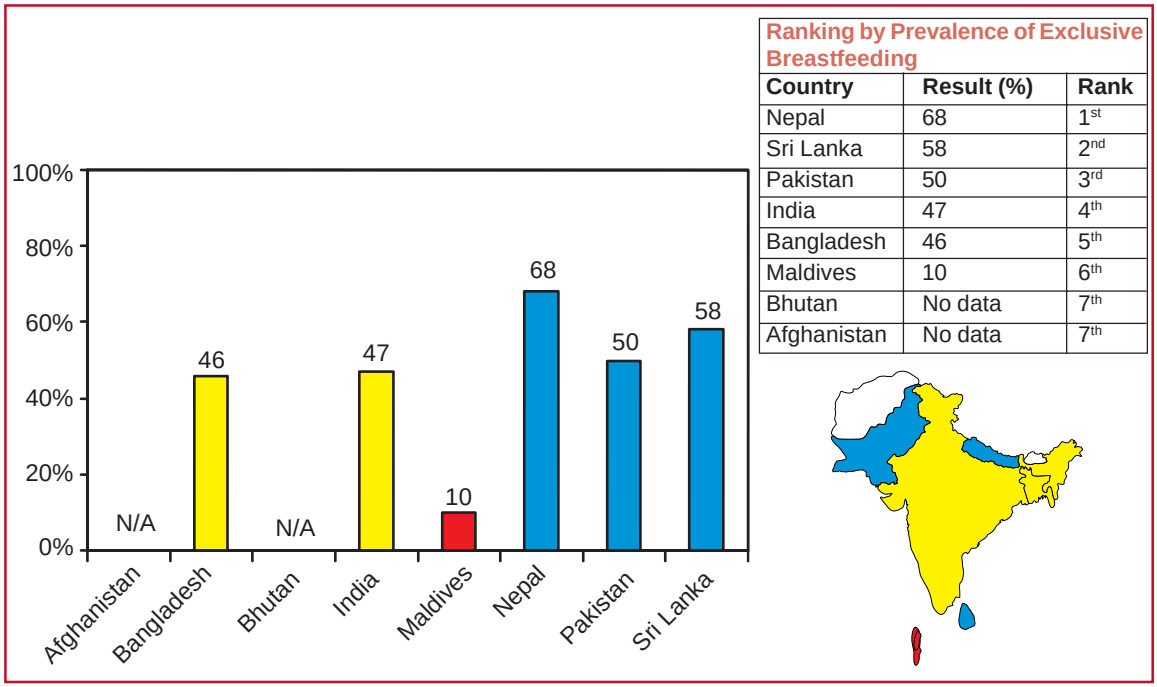
According to the Lancet's child survival series, scaling all preventive interventions to a universal level could prevent 63% of 10.9 million annual child deaths. 'Breastfeeding' (exclusive breastfeeding for the first six months and continued breastfeeding for the next six months) has been identified as the single most effective preventive intervention, cutting 13 to 15% of all childhood deaths and adequate complementary feeding between six months and 24 months could prevent an additional 6% of all such deaths (Jones et al. *Lancet 2003*). Exclusive breastfeeding rates in South Asia have improved between 1990 and 2006 from 43% to 47%, but still there is a wide variation between individual countries. (UNICEF 2006).

The data reveals that the rate for exclusive breastfeeding varies from 10% to 68% in South Asia countries. In Maldives, it is 10%, putting the country in 'Grade D' with 'Red' colour. Bangladesh and India are colour rated as 'Yellow', 'Grade C' with 46% and 47% respectively. Pakistan, Sri Lanka and Nepal fall in Good status with 50%, 58% and 68% and have colour 'Blue' with 'Grade B'.

National level data for exclusive breastfeeding for the first six months was not available in Afghanistan and Bhutan.

☞ **Action needed:** All the countries of the region need to strengthen efforts to increase the rate of exclusive breastfeeding. Actions that need to be taken include creating the necessary infrastructure for this.

Figure 6: Colour Rating and Ranking of South Asia Countries on Exclusive Breastfeeding



Ranking by Prevalence of Exclusive Breastfeeding

Country	Result (%)	Rank
Nepal	68	1st
Sri Lanka	58	2nd
Pakistan	50	3rd
India	47	4th
Bangladesh	46	5th
Maldives	10	6th
Bhutan	No data	7th
Afghanistan	No data	7th

As the majority of women in the South Asian countries are engaged in either farm or other work in the unorganised sector, special policies and programmes need to be designed creatively to ensure that an environment is created where mothers can successfully carryout exclusive breastfeeding. This includes programmes for behaviour change, providing support and skilled counselling to mothers during the antenatal, perinatal and lactation periods and, if needed, provision of resources like financial resources to compensate loss of work, availability of crèches where mothers can keep the babies under their supervision, initiation/ changes in labour laws where needed, etc.

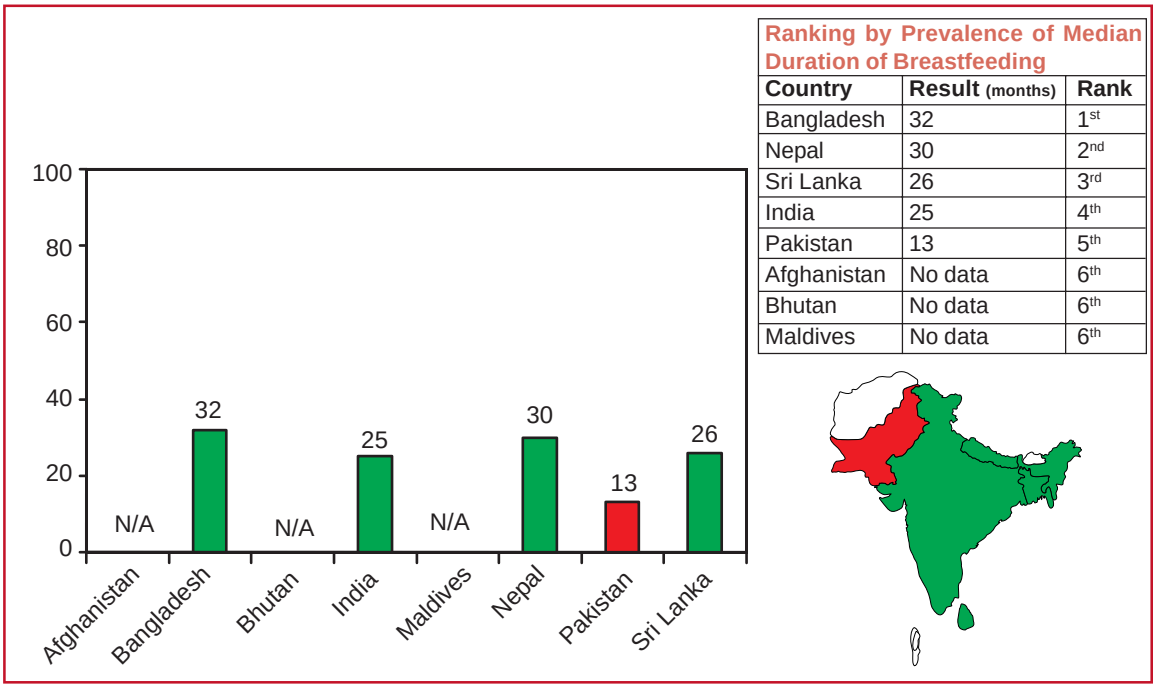
Indicator 3: Median Duration of Breastfeeding

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

The Figure 7, shows median duration of breastfeeding in South Asia. The level of achievement is given in months. Median duration of breastfeeding in Pakistan is 13 months, which is colour-rated as ‘Red’, with ‘Grade D’. Data for Afghanistan, Bhutan and Maldives are not available. Bangladesh (32 months) leads, with Nepal (30 months), Sri Lanka (26 months), and India (25 months) following. All countries falls in ‘Grade A’ an excellent position with ‘Green’ rating.

☞ **Action needed:** Immediate action is needed in countries where data was not available to collect such data at the national level. In Pakistan, action needs to be taken to improve median duration of breastfeeding in keeping with the recommendations of the *Global Strategy.* In other countries, regular tracking should be done to ensure that the period of breastfeeding is not reduced.

Figure 7: Colour Rating and Ranking of South Asia Countries on Median Duration of Breastfeeding



Ranking by Prevalence of Median Duration of Breastfeeding

Country	Result (months)	Rank
Bangladesh	32	1st
Nepal	30	2nd
Sri Lanka	26	3rd
India	25	4th
Pakistan	13	5th
Afghanistan	No data	6th
Bhutan	No data	6th
Maldives	No data	6th

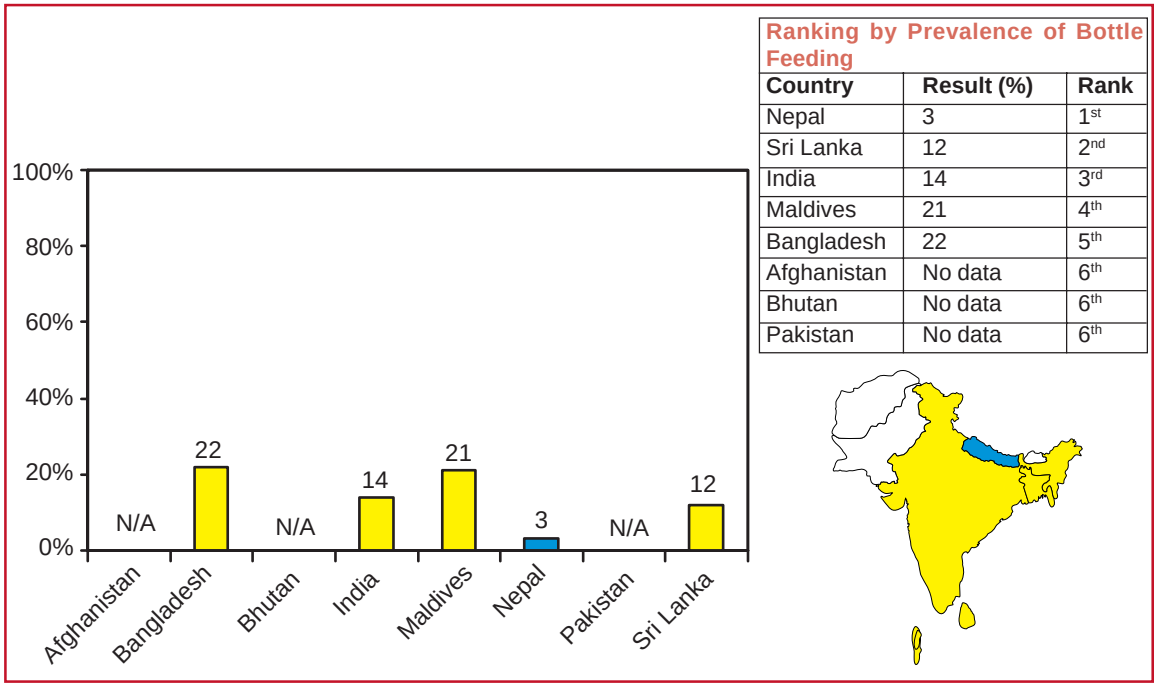
Indicator 4: Bottle Feeding (<6 months)

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

The level of bottle feeding is in percentage. The following Figure 8, shows that Nepal has only 3% of bottle feeding with 'Blue' colour rating and graded as 'Grade B'. Bangladesh, Maldives, India, and Sri Lanka falls in 'Grade C' with 'Yellow' colour with 22%, 21% 14%, and 12% respectively. Data for Afghanistan, Bhutan and Pakistan were not available.

☞ **Action needed:** In countries where data is not available, the first step is to conduct national level surveys. In all other countries, it is essential to emphasise the dangers associated with bottle feeding through special policies and programmes.

Figure 8: Colour Rating and Ranking of South Asia Countries on Bottle Feeding



Ranking by Prevalence of Bottle Feeding

Country	Result (%)	Rank
Nepal	3	1st
Sri Lanka	12	2nd
India	14	3rd
Maldives	21	4th
Bangladesh	22	5th
Afghanistan	No data	6th
Bhutan	No data	6th
Pakistan	No data	6th

Indicator 5: Complementary Feeding (6-9 months)

Rationale: As mentioned earlier, babies require only breastmilk till they are six months old. Thereafter, their nutritional needs must be met through continued breastfeeding, along with the introduction of complementary feeding of adequate and appropriate locally available indigenous foods.

The rate of complementary feeding in South Asian countries varies from 22% to 98%. No data is available for Bhutan. Pakistan has the lowest percentage – 22%, closely followed by Afghanistan (29%), and India (35%). All three fall in 'Grade D' with 'Red' colour. Nepal (66%) and Bangladesh (71%) are in 'Grade C' with 'Yellow' colour. Maldives falls in 'Grade B' with 85% ('Blue') and Sri Lanka falls in 'Grade A' - 'Green' colour, with 98%, which shows an excellent status.

☞ **Action needed:** Bhutan needs to conduct an immediate survey of the status of complementary feeding in the country. Other South Asian countries – Afghanistan, India, Pakistan, Nepal and Bangladesh need to improve their status through well-thought out policies and programmes.

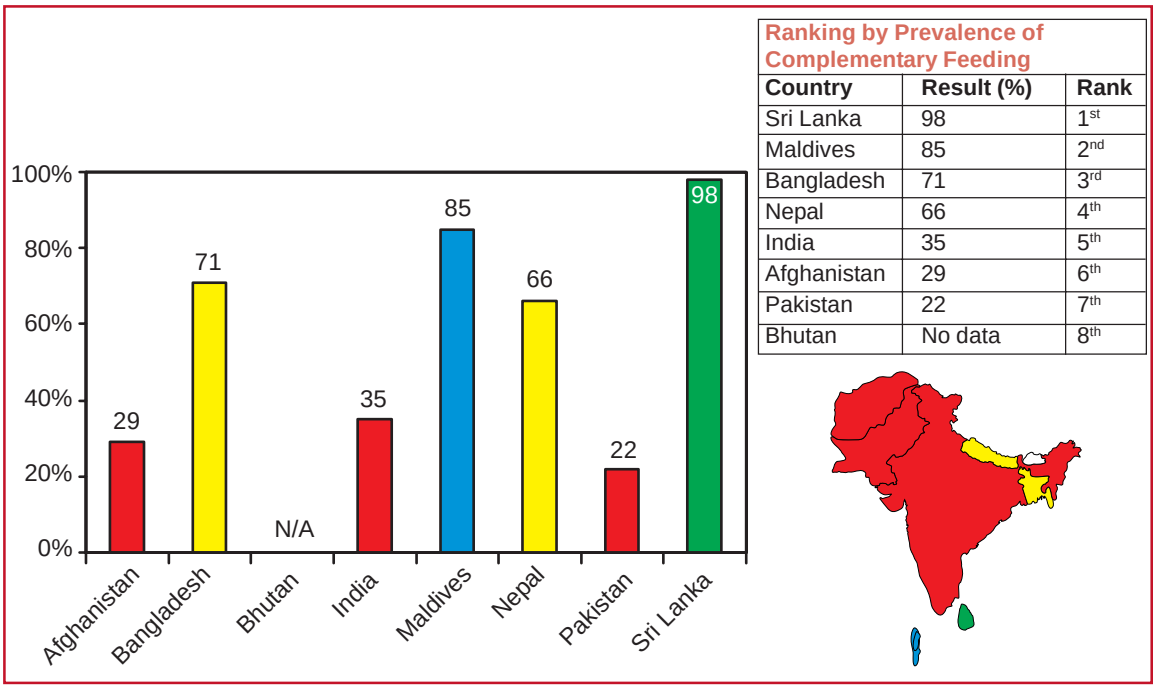
It is important to note that many foods being given as complementary foods are in fact

unnecessary and replace breastfeeding. For example, in addition to some quantity of cooked foods of cereals, pulses, etc., infants are fed with biscuits, soft aerated drinks, teas, diluted juices, etc. These foods are unnecessary; in fact, because they replace breastmilk, they can even become dangerous, as they may firstly introduce infections, and secondly lead to malnutrition.

It is also important to remember that, especially in areas where there is lack of access to potable water and sanitation, freshly cooked foods made with locally available ingredients are often much safer than using commercial foods that need to be mixed with water or other liquids.

Thus policies and programmes must be aimed at not merely improving the status of complementary feeding per se, but improving its quality too. Sri Lanka has already made a start in this direction, with the Family Health Bureau of the Ministry of Health taking steps to improve quality and feeding practices related to complementary foods.

Figure 9: Colour Rating and Ranking of South Asia Countries on Complementary Feeding



Ranking by Prevalence of Complementary Feeding

Country	Result (%)	Rank
Sri Lanka	98	1st
Maldives	85	2nd
Bangladesh	71	3rd
Nepal	66	4th
India	35	5th
Afghanistan	29	6th
Pakistan	22	7th
Bhutan	No data	8th

Summary of Part I

Optimal infant and young child feeding practices in South Asia are summarised below. These findings reveal that Sri Lanka, Nepal and Bangladesh are in good position with scores of 44, 40 and 31 respectively out of 50. These countries fall in ‘Grade B’ with ‘Blue’ colour. India, Maldives and Pakistan are in ‘Grade C’ with ‘Yellow’ colour and their score is 28, 18 and 18 respectively. Afghanistan scores 3 out of 50 where as Bhutan’s score nil as the data for IYCF practices were not available and both these countries fall in ‘Grade D’ with ‘Red’ colour.

☞ **URGENT ACTION:** Those countries where national level data was not available should take URGENT ACTION and conduct a base line study.

Box 6

Facts about the Status of IYCF Practices in South Asia

- Percentage of timely initiation of breastfeeding varies in South Asia: 16% in India and 75% in Sri Lanka.
- Percentage of exclusive breastfeeding varies between 10% in Maldives and 68% in Nepal.
- Percentage of bottle feeding varies between 3% in Nepal to 22% in Bangladesh.
- Percentage of complementary feeding varies from 22% in Pakistan to 98% in Sri Lanka.

Part II: Infant and Young Child Feeding Policies and Programmes in South Asia

Ten indicators (indicators 6-15) deal with infant and young child feeding policies and programmes. The *Global Strategy* reaffirms the *Innocenti Declaration* and lays additional emphasis on some other key aspects of infant and young child feeding. The *Global Strategy for Infant and Young Child Feeding* calls for Revitalisation of the *Innocenti* Goals as well sets additional targets.

The indicators used in assessing the status of policy and programme in South Asia are based on the *Global Strategy* and the *Innocenti Declaration* and include:

- National Policy, Programme and Coordination;
- Baby Friendly Hospital Initiative;
- Implementation of the International Code;
- Maternity Protection;
- Health and Nutrition Care;
- Community Outreach;
- Information Support;
- Infant Feeding and HIV;
- Infant Feeding during Emergencies;
- Monitoring and Evaluation.

A sub set of questions for each indicator was developed to assess key achievements, including how a country is doing in a particular area. Each question has possible score of 0-3 and the indicator has a maximum score of 10.

Indicator 6: National Policy, Programme and Coordination

The *Innocenti Declaration* recommend that all governments have National Breastfeeding Committees and Coordinators as an established mechanisms to protect, promote and support breastfeeding in the country. The World Summit for Children recommends that all governments should develop national breastfeeding policies. The *Global Strategy* calls for an urgent action from all Member States to develop, implement, monitor and evaluate a comprehensive policy on IYCF.

Indicator 6 has eight sub-set of questions which deals with issues related with national policy on IYCF, national plan of action based on the national policy, national breastfeeding committee and financial allocations for infant and young child feeding.

The Figure 10 shows the status of countries on this indicator. Afghanistan, Bangladesh and Bhutan fall in 'Grade D' with colour rating 'Red'; India, Nepal and Pakistan stand in 'Grade C' with 'Yellow' colour and Maldives and Sri Lanka falls in 'Grade B' with 'Blue' colour.

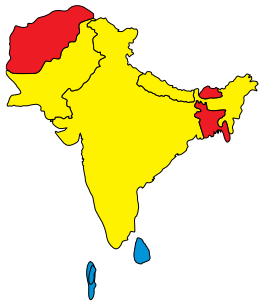
The Table 5, gives the details, highlighting the exact lacunae, and specific areas where action needs to be taken in each country.

Afghanistan: The national health policy of MoPH clearly supports breastfeeding and IYCF through the Basic Package of Health Services, but a practical strategy to implement the policy into action has not yet emerged. Several gaps exist in policies and programmes. For example, there is no national plan of action for IYCF, or a National Breastfeeding Committee.

Figure 10: Colour Rating and Ranking of South Asia Countries on National Policy, Programme and Coordination

Ranking by Prevalence of National Policy, Programme and Coordination

Country	Result (out of 10)	Rank
Maldives	9	1st
Sri Lanka	7	2nd
India	5	3rd
Nepal	5	3rd
Pakistan	5	3rd
Bangladesh	2.5	4th
Afghanistan	2	5th
Bhutan	2	5th



Actions needed:

- Mainstream infant and young child feeding in the child health and development programmes through concrete action plans.
- Develop a plan of action with committed funds, implemented through effective decentralised mechanisms.
- Create a national committee with the authority to monitor and evaluate the

Table 5: Status of National Policy, Programme and Coordination in South Asia

Indicator-6: National Policy, Programme and Coordination	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
A national IYCF policy adopted by the government	NO	NO	YES	YES	YES	YES	NO	YES
The policy consistent with the *Global Strategy*	YES	YES	NO	YES	YES	YES	YES	YES
A national plan of action with the policy	NO	NO	NO	NO	YES	NO	NO	NO
The plan adequately funded	NO	NO	NO	NO	NO	NO	NO	YES
National Breastfeeding Committee (NBC)	NO	NO	NO	YES	YES	YES	YES	YES
NBC meets and reviews on a regular basis	NO	NO	NO	NO	YES	NO	YES	NO
NBC links with all other sectors like health, nutrition, information	NO	YES	NO	NO	YES	NO	YES	YES
NBC is headed by a coordinator with clear terms of reference	NO	NO	NO	NO	YES	NO	YES	YES
Score, Grade and Colour rating	**2/10 Grade-D**	**2.5/10 Grade-D**	**2/10 Grade-D**	**5/10 Grade-C**	**9/10 Grade-B**	**5/10 Grade-C**	**5/10 Grade-C**	**7/10 Grade-B**

programme as well as track the progress in child survival and development on a regular basis.

Bangladesh: Several gaps exist in the Bangladesh policy regarding IYCF. However, it should be noted that a national infant and young child feeding strategy and the national plan of action are in the process of being finalised.

☞ **Action needed:** Establish a clear mechanism for coordination at national level, with clear terms of reference to monitor the progress.

Bhutan: Bhutan has a national IYCF policy; however, this policy needs to be revised to fill the several gaps that exist, such as the absence of a national plan of action and National Breastfeeding Committee.

☞ **Actions needed:**

- Establish a National Breastfeeding Committee, linking infant and young child feeding with all other sectors like health, nutrition, information etc.
- Appoint a Coordinator.

India: India has a good document in the form of *National Guidelines for Infant and Young Child Feeding*, which is consistent with the *Global Strategy for Infant and Young Child Feeding*. It also has a national policy on nutrition, which, should be revised to make it consistent with the global recommendations. Though a National Breastfeeding Committee exists, it is mainly non-functional, and lacks representation of all stakeholders. It is also not linked with other sectors such as health, nutrition, etc. The coordinator's terms of reference should be made clearer and the meetings schedule should be regularised. This has led to the existence of several gaps, which do not allow the policy to the implemented effectively.

☞ **Actions needed:**

- Develop a time-based plan of action with committed funds, implemented through an effective state and national level mechanism.
- Strengthen existing mechanisms with the authority to coordinate, monitor, evaluate the implementation of the plan of action, and to monitor progress at specific time intervals.
- Check policies and programmes of various departments of the Central government and State government for consistency and harmonise with National Guidelines on Infant and Young Child Feeding for impact on infant feeding practices.

Maldives: Maldives has done well in developing national policy, programme and coordination. It falls in 'Grade B' / 'Blue' colour with score 9 out of 10 which is highest among all South Asian countries. However, the national plan needs to be adequately funded.

☞ **Action needed:**

- Commit adequate funding to effectively implement actions on gaps in the national nutrition strategic plans.

Nepal: In Nepal, the IYCF policy is consistent with the *Global Strategy* and has been adopted by the government. There is also a National Breastfeeding Committee but the National Breastfeeding Committee does not meet or review the situation on regular basis.

☞ **Action needed:**

- Develop a national plan of action with adequate funds and appoint a Coordinator for National Breastfeeding Committee to be able to review the progress and track it.

Pakistan: There is no explicit document in the Government of Pakistan that can be termed as 'National Policy on Breastfeeding'. The main achievement is the recent establishment of a National Breastfeeding Committee, which is mandated to meet twice a year. NBC also has links with all other sectors like health, nutrition etc. A coordinator with clear terms or reference heads the NBC. In spite of the lack of a clear and approved policy, programmes and interventions include many IYCF components i.e. BFHI, Breastfeeding Policy, Breastfeeding Ordinance, etc.

☞ **Actions needed:**

- Adopt a clear policy with regard to infant and young child feeding.
- Mainstream infant and young child feeding in the child health and development programmes.

Sri Lanka: Sri Lanka stood second position in among all South Asia countries on indicator – 6 with score 7 out of 10. The current national policy was drafted in 1994 and a committee comprising leading consultants of the country has been appointed by Ministry of Health to draft a new national breastfeeding policy to suit current requirements. There is no national plan developed with the current policy but Family Health Bureau of the Ministry of Health has included IYCF in its 5-year action plan with adequate funding.

☞ **Action needed:**

- Mainstream infant and young child feeding in the child health and development programmes with a clear plan of action.

Indicator 7: Baby Friendly Hospital Initiative

Indicator 7 deals with Baby Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding). It consists of six sub-sets of questions, dealing with quantitative as well as qualitative issues like number of baby friendly hospitals, emphasis on training during the

certification process, and existence of monitoring and reassessment system. Each sub set question carries individual score ranging from 0.5 to 4. The total is out of a maximum of 10.

The data on BFHI reveals that Afghanistan and Nepal falls in 'Grade D' with 'Red' colour, where as Bhutan, India, Pakistan and Sri Lanka stand in 'Grade C' with 'Yellow' colour. Maldives and Bangladesh falls in 'Grade B' with 'Blue' colour.

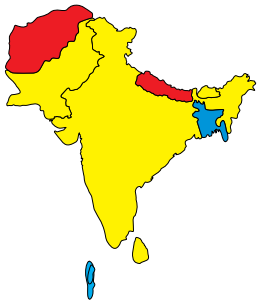
The Table 6 gives more details regarding the situation of Baby Friendly Hospital Initiative in South Asian countries.

Afghanistan: Only 5% of hospitals and maternity facilities have BFHI status. Only 1% of BFHI designated hospitals have staff who have received 18 hour training. There is no standard monitoring system and the assessment system does not rely on interview of mothers.

Figure 11: Colour Rating and Ranking of South Asia Countries on Baby Friendly Hospital Initiative

Ranking by Prevalence of Baby Friendly Hospital Initiative

Country	Result (out of 10)	Rank
Bangladesh	8.5	1st
Maldives	7	2nd
Bhutan	6.5	3rd
Pakistan	6	4th
Sri Lanka	6	4th
India	4.5	5th
Nepal	3.5	6th
Afghanistan	3	7th



☞ **Actions needed:**

- Strengthen efforts to implement BFHI for hospitals and link it with community action to promote and protect breastfeeding.
- Make adequate training of staff as a key criterion of allotting BFHI status.
- Establish review system based on interview of mothers.

Bangladesh: The data reveals that Bangladesh stood first among all South Asian countries on the BFHI initiative. 84% of hospitals and maternity facilities have BFHI status and 88% of BFHI designated hospitals having staff who have received 18 hour training. A standard monitoring system is in place, but needs to be strengthened further. The main gap in Bangladesh is that no reassessment system has been incorporated in national plans.

☞ **Action needed:**

- Incorporate reassessment systems in national plans

Bhutan: Bhutan has the highest percentage of BFHI hospitals and maternity facilities in South Asia – 90%. However, only 30% of them have staff with 18 hours of training. The main gaps in Bhutan are that the BFHI programme does not rely on training of health workers, there is no standard monitoring system, and the reassessment systems have not incorporated in national plans.

Table 6: Status of Baby Friendly Hospital Initiative in South Asia

Indicator 7: BFHI	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Percentage of hospitals and maternity facilities with BFHI Status	5%	84%	90%	10%	70%	7%	43%	80%
Percentage of BFHI designated hospitals having staff with 18 hrs training	1%	88%	30%	30%	50%	0%	43%	60%
BFHI programme relies on training of health workers	YES	YES	NO	NO	YES	YES	YES	YES
A standard monitoring system is in place	NO	YES	NO	NO	YES	NO	YES	NO
An assessment system relies on interviews of mothers	NO	YES	YES	YES	YES	YES	YES	NO
Reassessment systems have been incorporated in national plans	YES	NO	NO	NO	NO	NO	YES	NO
Score, Grade and Colour rating	**3/10 Grade-D**	**8.5/10 Grade-B**	**6.5/10 Grade-C**	**4.5/10 Grade-C**	**7/10 Grade-B**	**3.5/10 Grade-D**	**6/10 Grade-C**	**6/10 Grade-B**

☞ **Actions needed:**

- Revise BFHI to incorporate adequate skill training for staff and link with community action.
- Establish a monitoring system.
- Incorporate reassessment systems in national plans.

India: Only 10% of hospitals and maternity facilities have BFHI status in India. 30% of these hospitals and maternity facilities have staff with 18 hrs training. As in Bhutan, the Indian BFHI programme does not rely on training of health workers, a standard monitoring system does not exist, and national plan is silent on the reassessment system

☞ **Actions needed:**

- Revise BFHI to incorporate adequate training for staff and link with community action.
- Establish a monitoring system.
- Incorporate reassessment systems in national plans.

Maldives: Maldives stood second among all South Asian countries on the BFHI initiative. BFHI was launched in 1995 and 70% of hospitals and maternity facilities have BFHI status; of these, 50% have staff with 18 hrs. training. The main achievements of Maldives are that BFHI programme relies on training of health workers, there is a standard monitoring system existing and the assessment system relies on interviews of mothers.

☞ **Action needed:**

- Link BFHI to community action.

Nepal: Action for achieving baby friendly targets has been stagnating for last 10 years. Only 7% of hospitals and maternity facilities have BFHI status, and none of these have staff with 18 hrs training. There is no standard monitoring system or follow-up assessment system in place. No reassessment system has been incorporated in national plans.

☞ **Actions needed:**

- Assign priority to achieving baby-friendly targets.
- Focus on adequate training of staff as a key criterion for attaining BFHI status.
- Establish standard systems for monitoring and follow-up assessment.
- Incorporate reassessment systems in national plans.
- Link BFHI to community action.

Pakistan: Pakistan set a target of 300 BFHI hospitals and maternity facilities in 2001. Only 130 (43%) hospitals achieved this status by 2003, when the initiative came to a halt. Of

these, only 43% have staff with adequate 18 hours training. However, plans for revitalisation of initiative have been incorporated in the annual nutrition plan. The main achievements of Pakistan are that the BFHI programme relies on training of health workers, there is a standard monitoring system, and the assessment system relies on interviews of mothers.

☞ **Actions needed:**

- Strengthen training component of BFHI.
- Link BFHI initiative with community action.

Sri Lanka: 80% of deliveries in Sri Lank take place in institutions declared as Baby Friendly. At the time of declaring these hospitals as baby friendly, the staff of many hospitals had not undergone the 18-hour training on lactation management. However, currently in 60% of the baby friendly hospitals, staff attached to maternity and neonatal care units have been trained in the 40-hour lactation management course. Lactation management centres have been established in leading hospitals to identify/anticipate breastfeeding problems of infants. Gaps include lack of a standard monitoring system, the assessment system does not rely on interview of mothers, and reassessment systems have not been incorporated in national plans.

☞ **Action needed:**

- There is a need for proper monitoring and reassessment system for BFHI.

Indicator 8: Implementation of the International Code

The aim of the *International Code of Marketing of Breastmilk Substitutes* is an important tool for ensuring safe and adequate nutrition for infants. It protects and promotes breastfeeding by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. Nations are supposed to enact legislations as a follow-up to this. Several relevant subsequent World Health Assembly resolutions, which strengthen the *International Code of Marketing of Breastmilk Substitutes* have been adopted since then and have the same status as the Code. The *Global Strategy* calls for heightened action on this target.

Indicator 8 deals with implementation of the International Code. It addresses issues related with adoption of the international Code as a national legislation, implementation of Code as Law, its monitoring and enforcement. As commercial manufacturers of baby foods are devising new ways to bypass existing laws it is an important step. At the same time, given the pressures of liberalisation, there is a constant threat that these measures will be diluted to allow/attract foreign investment.

Afghanistan and Maldives score 3 out of 10 and are ‘Graded D’ with ‘Red’ colour. Bhutan scored 5 and falls in ‘Grade C’ with ‘Yellow’ colour. Bangladesh, Nepal, Pakistan and Sri Lanka fall in ‘Grade B’ / ‘Blue’ colour and scored as 9, 7, 7 and 7 respectively. The data

reveals that India, with score 10 out of 10, stood first among all South Asian countries and was 'Grade A' with 'Green' colour.

The Table 7 gives more details regarding implementation of the International Code.

Afghanistan: Afghanistan has drafted the Legislation, which is awaiting final approval.

☞ **Action needed:**

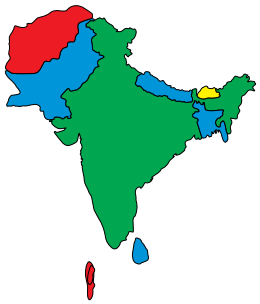
- As a priority, implement all articles of the Code; enact a national legislation with effective enforcement and proper monitoring.

Bangladesh: Bangladesh ranks second on this initiative. All articles of the Code as Law, monitored and additional legislation has been proposed.

Figure 12: Colour Rating and Ranking of South Asia Countries on Implementation of the International Code

Ranking by Prevalence of Implementation of the International Code

Country	Result (out of 10)	Rank
India	10	1st
Bangladesh	9	2nd
Nepal	7	3rd
Pakistan	7	3rd
Sri Lanka	7	3rd
Bhutan	5	4th
Afghanistan	3	5th
Maldives	3	5th



☞ **Action needed:**

- Strengthen national legislation to cover existing loopholes.

Bhutan: The SAARC code has been endorsed by the Government of Bhutan and some articles of the International Code have been accepted a voluntary measure.

☞ **Action needed:**

- Take action to enact national legislation to implement all articles of the Code.

India: The country is the top scorer, having done exceedingly well in the form of enacting and subsequently suitably amending the legislation based on the International Code. The Government of India passed legislation in 1992 to give effect to the *International Code of Marketing of Breastmilk Substitutes*. The *Infant Milk Substitute, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992* (IMS Act), came into effect in 1993 and it was amended in 2003 to include all baby foods. The IMS Act 2003 prohibits promotion of all kinds of baby foods for use less than two years of age. It prohibits advertising, providing gifts and free samples, sponsorship, gifts to health care workers or their associations etc.

In spite of excellent legislation to protect and promote breastfeeding and regulate the marketing of commercial baby foods, effective monitoring of violations and corrective action are yet not up to the mark.

Table 7: Status of Implementation of the International Code in South Asia

Indicator 8: Implementation of the International Code	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
No action taken	NO	NO	NO	NO	NO	NO	NO	NO
The best approach is being studied	NO	NO	NO	NO	NO	NO	NO	NO
Law drafted, awaiting final approval	YES	NO	NO	NO	YES	NO	NO	NO
Some articles of the Code as a voluntary measure	NO	NO	YES	NO	NO	NO	NO	NO
Code as a voluntary measure	NO	NO	NO	NO	NO	NO	NO	YES
Some articles of Code as Law	NO	NO	NO	NO	NO	YES	YES	NO
All articles of the Code as law, monitored	NO	YES	NO	NO	NO	NO	NO	NO
New legislation in addition to the above to give effect to the aims and principles of the Code exist	NO	NO	NO	YES	NO	NO	NO	NO
Score, Grade and Colour rating	**3/10 Grade-D**	**9/10 Grade-B**	**5/10 Grade-C**	**10/10 Grade-A**	**3/10 Grade-D**	**7/10 Grade-B**	**7/10 Grade-B**	**7/10 Grade-B**

☞ **Actions needed:**

- Strengthening the IMS Act to prohibit all interaction between commercial baby food industry and health providers at all levels in any form.
- Effective monitoring.
- Speedy punitive/corrective action taken in case of violation by the industry.

Maldives: The Ministry of Health drafted 'The Code of Marketing of Breastmilk Substitutes for the Maldives', which is awaiting final approval. At the same time, some aspects of the *International Code of Marketing of Breast Milk Substitutes* are being enforced through the food safety regulations and all food products, including milk and milk products, advertised through media are being screened by DPH for its compliance with food safety regulations.

☞ **Action needed:**

- Enact legislation for implementation of the Code.

Nepal: Though the Code is in place, and a few articles have been enacted into law, it is not being implemented.

☞ **Actions needed:**

- Enact the complete Code into law.
- Ensure its speedy and effective implementation.

Pakistan: Only some articles of the International Code are in place as law. The Government of Pakistan passed the 'Protection of Breastfeeding and Young Child Nutrition Ordinance, October 2002'. Baby formula and the breastmilk substitute are the part of law, which is implemented to some extent. Advertisement of baby formula has stopped in media and health facilities. Additional laws and rules have been drafted and being processed.

☞ **Action needed:**

- Strengthen the law to meet the new challenges as well as block existing loopholes.

Sri Lanka: Some articles of International Code exist as law. The existing Code was drafted in 1983 and was amended in 2002. A committee comprising leading consultants of the country has been appointed by Ministry of Health to draft a new Code to suit current requirements.

☞ **Action needed:**

- Implement all articles of the Code as Law with proper monitoring systems in place.

Indicator 9: Maternity Protection

Key international documents call for provision of imaginative legislation to protect the breastfeeding rights of working women and further to monitor its application in consistency with ILO Maternity Protection Convention and recommendations. The ILO's Maternity Protection Convention (MPC) 183 specifies that women should receive:

- At least 14 weeks of paid maternity leave to all women workers;
- One or more paid breastfeeding breaks daily or daily reduction of hours of work to breastfeed;
- Job protection and non-discrimination for breastfeeding workers.

Indicator 9 pertains to maternity protection, which includes duration of maternity leave, inclusion of mother friendly work place in national legislation and country's status on ratifying and enacting ILO MPC 183.

The issue of maternity protection becomes even more complex in South Asian countries, where the majority of the women workers are either in the unorganised sector (in both urban and rural areas) or work as contract workers. Liberalisation and the need to attract foreign investment is also creating a situation where labour laws of many of these countries are being diluted, and special economic zones are being set up where employers are not forced to apply national labour laws. It should also be noted that women's income/labour contribute substantially to the domestic income, and in many cases, their income/labour is critical to the survival of the family.

While the current assessment has taken only ILO MPC as the criterion for grading and ranking, it is evident that if breastfeeding rights of women have to protected, nations, particularly South Asian nations will have to create cross-cutting legislation, policies and programmes that will allow women to exercise this right, while at the same time, their economic status and work status does not become jeopardised.

Bhutan, India and Nepal have taken no action regarding maternity protection with respect to the standards, and these countries score 0 out of 10, falling in 'Grade D' with 'Red' colour. Afghanistan, though in the same category, scores higher at 2 out of 10. Maldives, Pakistan and Sri Lanka fall in 'Grade C' with 'Yellow' colour, scoring 5, 4 and 6 respectively. Bangladesh scored highest - 7 out of 10, and falls in 'Grade B' with 'Blue' colour.

The Table 8 gives more details.

Figure 13: Colour Rating and Ranking of South Asia Countries on Maternity Protection

Ranking by Prevalence of Maternity Protection

Country	Result (out of 10)	Rank
Bangladesh	7	1st
Sri Lanka	6	2nd
Maldives	5	3rd
Pakistan	4	4th
Afghanistan	2	5th
Bhutan	0	6th
India	0	6th
Nepal	0	6th

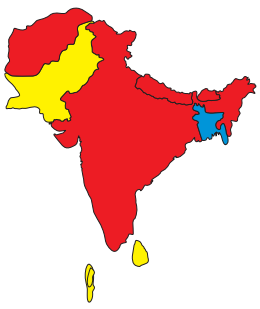


Table 8: Status of Maternity Protection in South Asia

Indicator 9: Maternity Protection	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Women covered by the legislation are allowed at least 14 weeks of paid maternity leave	NO	YES	NO	NO	NO	NO	YES	YES
Women are allowed at least one paid breastfeeding break daily	NO	YES	NO	NO	YES	NO	NO	YES
Private sector employers give at least 14 weeks paid maternity leave and paid nursing breaks	NO	NO	NO	NO	NO	NO	NO	YES
The national legislation encourages worksite accommodation for breastfeeding and/or child care in work places in the formal sector	YES	YES	NO	NO	YES	NO	YES	NO
Women in informal /unorganized sector are provided same protection	NO	NO	NO	NO	YES	NO	NO	NO
Legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period	YES	YES	NO	NO	YES	NO	NO	YES
The ILO MPC No 183 has been ratified or the process initiated	NO	YES	NO	NO	NO	NO	YES	YES
The ILO MPC No 183 has been enacted or the process initiated	NO	YES	NO	NO	NO	NO	NO	NO
Score, Grade and Colour rating	**2/10 Grade-D**	**7/10 Grade-B**	**0/10 Grade-D**	**0/10 Grade-D**	**5/10 Grade-C**	**0/10 Grade-D**	**4/10 Grade-C**	**6/10 Grade-C**

Afghanistan: The national labour legislation of the Ministry of Labour and Social Affairs of Afghanistan is providing maternity leave for only 13 weeks, but there is no article about the private sector. The NGOs working in health and nutrition have differing regulations, most of which do not comply with ILO MPC 183. There is little or no information regarding other organisations and the informal sector. Breastfeeding breaks do not exist, and ILO MPC 183 has not been ratified.

☞ **Action needed:**

- The assessment group recommended that the Public Nutrition Department has to contact with the Ministry of Labour and social affairs to find the fact if there is any progress or work in this regard or not.

Bangladesh: The data reveals that Bangladesh stood first among all South Asian countries and scored as 7 out of 10. The National Legislature allows 14 weeks of paid maternity leave and paid breastfeeding break daily; ILO MPC No 183 has been partially ratified and enacted. The main gaps lie in the lack of coverage of women in informal/unorganised sector and of work side accommodation for breastfeeding and childcare.

☞ **Action needed:**

- Support maternity protection in private as well as informal/unorganised sector.

Bhutan, India and Nepal: There are several partial and complete gaps in these countries which includes, lack of national legislation regarding maternity leave, paid breastfeeding break, paid maternity leave and paid nursing breaks in private sector/unorganised sector. Non-ratification of ILO MPC 183 is another gap. In India, e.g. there is legislation that permits only 12 weeks maternity leave and breastfeeding breaks, but it is not available to all women. However there is a recommendation for 16 weeks maternity leave that applies to central government employees.

☞ **Actions needed:**

- There is a need to address maternity protection through legislation to allow at least 14 weeks of paid maternity leave in all sectors.
- Encourage work site accommodation for breastfeeding and for childcare in work places.
- Devise creative ways to effectively implement maternity protection for all workingwomen, whether in the public, private or informal sector.

Maldives: Maldives stood third among South Asian countries. Main achievements include one hour breastfeeding break till the baby is one year old, worksite accommodation for breastfeeding and strong legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period. One week paternal leave is also

available. The main gaps in Maldives are the lack of national Legislation with 14 weeks paid maternity leave in both public and private sectors - only 60 days were allowed. ILO MPC 183 was not ratified.

☞ **Action needed:**

- Address maternity protection through national legislation to allow at least 14 weeks of paid maternity leave in all sectors.

Pakistan: ILO Convention 183 is ratified and enacted and is being implemented in the government sector. Government and semi-government organisations give 90 days paid maternity leave. But this is not yet fully implemented in the private sector. There is no explicit legislation prohibiting employment discrimination for women workers during breastfeeding. However, in practice, breast feeding and lactating mothers have equal rights in application for jobs.

☞ **Actions needed:**

- There is a need to address maternity protection through legislation to allow at least 14 weeks of paid maternity leave in all sectors.
- Encourage work site accommodation for breastfeeding and for childcare in work places.

Sri Lanka: In the government sector, mothers are given 84 days of full pay maternity leave; another 84 days of half pay maternity leave and another 84 days of leave without pay. In the private sector, mothers are given 84 days of full pay maternity leave for the first 2 childbirths and 42 days full pay maternity leave for subsequent child births. The ILO MPC 183 has been ratified by government and approved by Parliament; it will be enacted in the near future. Sri Lanka stood second among all South Asian countries.

☞ **Actions needed:**

- There is a need to ensure maternity protection in informal/unorganised sector also, aim for 6 months maternity leave.
- All countries in fact should aim for 6 months maternity leave and other benefits to allow women to stay close to babies for first six months to ensure exclusive breastfeeding to benefit the baby and the mothers both and enhance their survival and development.

Indicator 10: Health and Nutrition Care

Health and nutrition care form critical components that ensure survival and optimal growth and development of infants and young children. Ideally, health professionals should be able to promote optimal infant and young child feeding practices. All professionals who interact

with mothers and their young children should attain the basic attitudes, knowledge and skills necessary to integrate breastfeeding counselling, lactation management, and infant and young child feeding into their care.

In spite of the fact that key international documents indicate clearly how to achieve the targets by improving the health and nutrition related services, these subjects are rarely touched by the mainstream education system. In fact, they are not adequately covered in the curricula of health providers. In addition, it is also seen that many of these health and nutrition workers lack adequate skills in counselling for infant and young child feeding which is essential for the success of breastfeeding.

Figure 14: Colour Rating and Ranking of South Asia Countries on Health and Nutrition Care

Ranking by Prevalence of Health and Nutrition Care

Country	Result (out of 10)	Rank
Maldives	8.5	1st
Sri Lanka	8	2nd
Pakistan	6.5	3rd
Bangladesh	4.5	4th
Bhutan	4.5	4th
Afghanistan	4	5th
India	3.5	6th
Nepal	3.5	6th

The indicator 10 deals with health and nutrition. It includes review of schools and pre-service education programmes for the health providers, standards and guidelines for mother-friendly childbirth procedures and support, in-service training programmes providing knowledge and skills related to infant and young child feeding, etc.

India and Nepal scored the lowest – 3.5 or 'Grade D' / 'Red' colour, as they had not completely accomplished inclusion of adequate curricula in training of health providers. Afghanistan, Bangladesh, Bhutan and Pakistan fall in 'Grade C 'with 'Yellow' colour and scored 4, 4.5, 4.5 and 6.5 respectively. Maldives and Sri Lanka fall in 'Grade B' with 'Blue' colour; and scored as 8.5 and 8 correspondingly.

The Table 9 gives more details.

Afghanistan: The assessment group used official documents of MoPH, but the group realised that they are not sufficient and further efforts are needed to include the issue in other training packages, and documents. The main gaps included lack of training of health workers particularly with respect to Code implementation. Child health policies do not allow mothers and babies to stay together when one of them is sick.

☞ **Actions needed:**

- Make infant feeding counselling accessible to all as a key component in 'service delivery', both in health facilities and at family level.
- Provide skill training to all frontline workers.
- Strengthen the pre-service curriculum of all health workers/care providers.

Table 9: Status of Health and Nutrition Care in South Asia

Indicator 10: Health and Nutrition Care	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Pre-service education programmes indicate that IYCF curricula or session plans are adequate / inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Standards and guidelines for mother-friendly childbirth procedures and support developed and disseminated to all facilities and personnel providing maternity care	Inadequate	Inadequate	Inadequate	No reference	Adequate	Inadequate	Inadequate	Inadequate
In-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/ nutrition care providers	Inadequate	Inadequate	No reference	Inadequate	Adequate	No reference	Adequate	Adequate
Health workers are trained with responsibility towards Code implementation as a key input.	No reference	No reference	Inadequate	No reference	Inadequate	No reference	Inadequate	Adequate
Infant feeding related content and skills are integrated into training programmes focusing on relevant topics	Inadequate	Inadequate	Inadequate	Inadequate	Adequate	Inadequate	Adequate	Adequate
In-service training programmes are being provided throughout the country	Inadequate	Inadequate	Inadequate	Inadequate	Adequate	Inadequate	Adequate	Adequate
Child health policies allow mothers and babies to stay together when. one of them is sick	No reference	Inadequate	Adequate	Inadequate	Adequate	Inadequate	Adequate	Adequate
Score, Grade and Colour rating	**4/10 Grade-C**	**4.5/10 Grade-C**	**4.5/10 Grade-C**	**3.5/10 Grade-D**	**8.5/10 Grade-B**	**3.5/10 Grade-D**	**6.5/10 Grade-C**	**8/10 Grade-B**

Bangladesh: There are several gaps in indicator-10. Pre-service education programmes do not indicate IYCF curricula, in-service training programmes do not provide knowledge and skills related to IYCF for relevant health/nutrition care providers, infant feeding related content and skills are not integrated into training programmes focusing on relevant topics etc. The main gaps include health workers are not trained on Code implementation.

☞ **Action needed:**

- Improve/develop guidelines, training and policies from inadequate to adequate or 100% with training monitoring, supervision and advocacy.

Bhutan: The main achievement in Bhutan was child health policies allow mothers and babies to stay together when any one of them is sick. However, in-service training programmes do not provide knowledge and skills related to IYCF; such training is also lacking pre-service education programmes, standard guidelines for mother friendly child birth procedures and in-service training programmes, etc.

☞ **Action needed:**

- Incorporate IYCF knowledge and skill training in pre-service and in-service training of health providers at all levels.

India: The assessment team studied several documents including BPNI's "Study of text books" (BPNI 1999), Annex 4 for WHO Tool for assessing national practices, policies and programmes on Infant and Young Child Feeding, Anganwadi worker training curriculum, a research article titled "Infant feeding – An evaluation of text and taught" (Mathur & Taneja 2004), RCH concept document, IMNCI concept document, etc., to assess the country's status for this indicator:

The assessment team felt that none of the task mentioned in the indicator has been accomplished completely by India. Health workers were not trained in Code implementation and standard guidelines for mother-friendly childbirth procedures were also missing.

☞ **Actions needed:**

- Make infant feeding counselling accessible to all as a key component in 'service delivery', both in health and at family level.
- Skill training of all frontline workers – AWW, ASHA, ANM, doctors and nurses, should back it.
- To sustain this service strengthen the infant feeding component in pre-service curricula.

Maldives: Maldives stood in the first position, scoring 8.5 out of 10. The only gap in the country was that the pre-service education programme does not indicate IYCF curricula or session plans are adequate or inadequate.

☞ **Action needed:**

- Strengthen the infant feeding component in pre-service curricula.

Nepal: Infant feeding is taught in IMCI package but has only covered 25 of 75 districts of Nepal. There is need to revise the curricula of all the health workers in order to include the infant feeding. In service training should be provided to all level of health providers.

☞ **Action needed:**

- Infant feeding counselling should be integrated into over all infant and child health strategy to scale up its coverage to national level.

Pakistan: Very strong components on nutrition and breastfeeding promotion messages related to CDD, ARI, and IMCI have been incorporated in the child health related programmes. However, complementary feeding message needs more attention. In nutrition, component pre-service training does exist but needs to be strengthened and consolidated.

☞ **Action needed:**

- Strengthen and consolidate nutrition component in preservice and in service training.

Sri Lanka: Health workers in Sri Lanka are sensitised about the importance of breastfeeding and basic technical issues but that training is inadequate for them to provide effective counselling services to mothers regarding infant feeding. Family Health Bureau is conducting a 6-day training of trainers programme on lactation management counselling and a 3-day training of trainers on complementary feeding. These trained trainers in turn train the staff in their respective institutions as well as in other institutions in their periphery.

☞ **Action needed:**

- Evaluate training course to ensure it meets current challenges.

Indicator 11: Community Outreach

Outreach and support to women in communities is essential for succeeding in optimal breastfeeding practice. The activities in this include individual or group counselling, home visits or other locally relevant activities that ensure access of infant and young child feeding counselling services to all women. Existing services and community support sub systems need to be looked at, and provision for counselling on infant and young child feeding services built into them. Women who deliver in hospital also need continued support in the community, or they may not be able to maintain exclusive breastfeeding. In fact, community support should be available for all members of the family including the father and the grandmother of the baby, who exert important influence on infant feeding behaviour in the region.

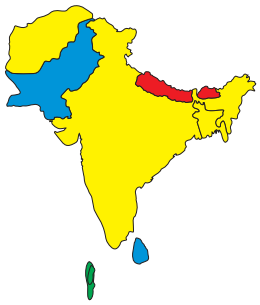
Indicator 11 includes issues like access to counselling services on infant and young child feeding in the community during pregnancy and after birth. It also deals with status of skilled training to the counsellors.

Maldives tops the list of achievers, scoring 10 out of 10, falling in 'Grade A' ('Green'). Pakistan and Sri Lanka falls in 'Grade B' with 'Blue' colour; and scored as 9 and 8 respectively. India, Afghanistan and Bangladesh, fall in 'Grade C' ('Yellow') with scores of 5, 6 and 6 respectively. None of the task mentioned in the indicator has been accomplished completely by Bhutan and Nepal, which scored 3 out of 10, falling in 'Grade D' with 'Red' colour.

The Table 10 gives more details.

Figure 15: Colour Rating and Ranking of South Asia Countries on Community Outreach

Ranking by Prevalence of Community Outreach		
Country	**Result (out of 10)**	**Rank**
Maldives	10	1st
Pakistan	9	2nd
Sri Lanka	8	3rd
Afghanistan	6	4th
Bangladesh	6	4th
India	5	5th
Bhutan	3	6th
Nepal	3	6th



Afghanistan: In Afghanistan, around 77% of the population of the country has been covered by Basic Package of Health Services (BPHS), so women have access to consultation during pregnancy. However, training of health workers in counselling on IYCF has started only recently and was not integrated in the BPHS to cover all population.

☞ **Action needed:**

- The assessment team recommended a rapid extension of the programme in all provinces of the country and proper study of how to integrate the initiative with BPHS and introduce to all implementing partners.

Bangladesh: Women have access to IYCF counselling in the community during pregnancy and after childbirth. However, the coverage is not complete.

☞ **Action needed:**

- The community outreach activities need to be universalised improved through policy formulation for integration, training for skill development, developing awareness and advocacy.

Bhutan and Nepal: There is some degree of access to counselling on infant feeding during and after pregnancy. In Bhutan, the main gaps include non-integration of counselling services into an overall infant and health strategy and lack of skill training for counsellors. In Nepal, there is need to train more counsellors on infant feeding and such a training package should be integrated into national child health strategy.

Table 10: Status of Community Outreach in South Asia

Indicator 11: Community Outreach	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Women have access to IYCF counseling in the community during pregnancy	To some degree	YES	To some degree	To some degree	YES	To some degree	YES	To some degree
Women have access to IYCF counseling after birth	To some degree	YES	To some degree	To some degree	YES	To some degree	YES	YES
The IYCF counseling services have national coverage	To some degree	To some degree	To some degree	To some degree	YES	NO	YES	YES
Counseling services are integrated into an overall infant and child health strategy	YES	NO	NO	To some degree	YES	NO	To some degree	YES
Counselors are trained in skills	To some degree	To some degree	NO	To some degree	YES	To some degree	YES	To some degree
Score, Grade and Colour rating	**6/10 Grade-C**	**6/10 Grade-C**	**3/10 Grade-D**	**5/10 Grade-C**	**10/10 Grade-A**	**3/10 Grade-D**	**9/10 Grade-B**	**8/10 Grade-B**

☞ **Actions needed:**

- Make infant feeding counselling accessible to all women, during pregnancy and after childbirth.
- Infant feeding counselling should be integrated into over all infant and child health strategy to scale up its coverage to national level and it should be backed by skill training of all frontline workers.

India: The assessment team referred several documents including *Status of infant and Young Child Feeding in 49 districts (98 blocks) of India* (BPNI 2003), Report of BFHI study done by BPNI (2000), BPNI/UNICEF/NIPCCD observation visit – Uttaranchal, Report of the project titled BCC campaign for promoting breastfeeding practices in disaster prone Bhuj district of Gujarat – a study done by BPNI, National report of concurrent evaluation of ICDS by National Council of Applied Economic Research (NCAER), 2001. The assessment team felt that there is some progress in this field but a lot more remains to be accomplished.

☞ **Action needed:**

- Strengthening of training and increase in number of trained counsellors at all levels to make it available and accessible to all women.

Maldives: Maldives stood first with a score of 10 out 10, falling in 'Grade A' with 'Green' colour.

☞ **Action needed:**

- Monitor outreach programmes to ensure continued full and effective coverage.

Pakistan: The Lady Health Worker (LHW) programme is an outreach programme providing household services, covering 80% of the total population. Part of their pre-service curriculum and refresher training contained strong component of lactation management. Counseling skills needs to be improved.

☞ **Action needed:**

- Strengthen component on counselling in training.

Sri Lanka: Medical Officers of Health, Public Health Nursing Sisters and Public Health Midwives Island-wide provide maternal and child health services at the grassroot level in Sri Lanka. Counseling services on infant feeding is one of the key areas covered by these field health staff. However, the knowledge, attitudes and skills of these officers on infant feeding counselling need to be improved.

☞ **Action needed:**

- Strengthen community outreach services for breastfeeding and complementary feeding support and counselling.

Indicator 12: Information Support

The key to successful breastfeeding is Information, Education and Communication (IEC) strategies aimed at behaviour change. This is particularly true in the South Asian region, where culture and tradition play extremely significant roles in modulating infant feeding practices. Thus appropriate, adequate and effective IEC strategy needs to become the vital factor in promoting breastfeeding.

IEC strategies are comprehensive when they use a wide variety of media and channels to convey concise, consistent, appropriate, action-oriented messages to targeted audiences at national, facility, community and family levels. IEC approaches include the use of electronic (TV, radio, video), print (posters, counselling cards, flip charts, manuals, newspapers, magazines), interpersonal (counselling, group education, support groups) and community activities to communicate important information and motivational material to mothers, families and the community.

The indicator 12 deals with information support. It asks for a comprehensive national IEC strategy and IEC programmes for improving infant and young child feeding. It also looks at the quality of IEC material being implemented.

Sri Lanka topped the ranking for this indicator with 9 out of 10, falling in 'Grade B' with 'Blue' colour. Afghanistan, Maldives and Pakistan also fall in 'Grade B' with scores of 7, 8 and 7 respectively. Both Bangladesh and Bhutan scored 6 out of 10, falling in 'Grade C' with 'Yellow' colour. India also fell in this grade, but scored only 4 out of 10. Nepal was last, with a score of as 3 out of 10, falling in 'Grade D' with 'Red' colour.

The Table 11 gives more details.

Afghanistan: The assessment team realised that the existing TV, radio and other media channels are not used properly for disseminating the information to the people. Although there are some success stories in Kabul, the capital, there is little happening on this front in other provinces. A monitoring system to assess the success of implementation of the IEC strategy in the field is also lacking.

Action needed:

- Regular national campaigns on IYCF would be a necessary intervention that the assessment team thinks of it.

Figure 16: Colour Rating and Ranking of South Asia Countries on Information Support

Ranking by Prevalence of Information Support

Country	Result (out of 10)	Rank
Sri Lanka	9	1st
Maldives	8	2nd
Afghanistan	7	3rd
Pakistan	7	3rd
Bangladesh	6	4th
Bhutan	6	4th
India	4	5th
Nepal	3	6th

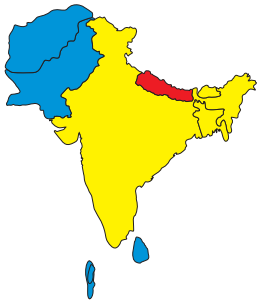


Table 11 Status of Information Support in South Asia

Indicator 12: Information Support	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
There is a comprehensive national IEC strategy for improving IYCF	YES	To some degree	To some degree	NO	To some degree	To some degree	YES	YES
IEC programmes that include IYCF are being actively implemented at local levels	To some degree	To some degree	To some degree	NO	YES	To some degree	To some degree	YES
Individual counseling and group education services related to IYCF available within the health/ nutrition care system or through community outreach	To some degree	To some degree	To some degree	To some degree	To some degree	NO	To some degree	YES
The content of IEC messages is technically correct, sound, based on national or international guidelines	YES	YES	To some degree	YES	YES	NO	YES	YES
A national IEC campaign or programme using electronic and print media and activities has channeled messages on IYCF to targeted audience in the last 12 months	To some degree	To some degree	YES	To some degree	YES	To some degree	To some degree	To some degree
Score, Grade and Colour rating	**7/10 Grade-B**	**6/10 Grade-C**	**6/10 Grade-C**	**4/10 Grade-C**	**8/10 Grade-B**	**3/10 Grade-D**	**7/10 Grade-B**	**9/10 Grade-B**

Bangladesh and Bhutan: The main achieve achievement in Bangladesh was that the contents of IEC message is technically correct, sound, based on national or international guidelines. In Bhutan the main achievement includes a national IEC campaign or programme using electronic and print media and whose activities have channelled messages on IYCF to target audience in the last 12 months.

☞ **Action needed:**

- Effective IEC strategies should be identified and implemented under government out reach setup.

India: While India is a breastfeeding culture, it is evident from all rankings that this does not translate into optimal IYCF for the survival, growth and development of infants. There is an obvious need for behaviour change. The assessment team undertook a general discussion on the subject, as no printed documents were available. The team concluded that there is no IEC policy on infant and young child feeding available in India at present. There are sporadic campaigns on the subject; though the content of such campaigns is by and large technically correct, it does not seem to have made much impact, as the general media still puts out differing messages regarding IYCF.

☞ **Actions needed:**

- Strengthen IEC on early initiation of breastfeeding, exclusive breastfeeding and on timely introduction of appropriate complementary feeding so as not to displace breastfeeding.
- Create a time-bound action plan for IEC, with an adequate budget line for the same.

Maldives: The assessment showed several partial gaps, which includes the lack of a comprehensive national IEC strategy for improving infant and young child feeding.

☞ **Action needed:**

- Develop a comprehensive national IEC strategy for IYCF.

Nepal: Nepal scored the lowest. There is some degree of national IEC materials covering infant and young child feeding. The IMCI programme also covers to some extent on this aspect. But much more needs to be done to improve infant and young child feeding.

☞ **Action needed:**

- There should be a national IEC strategy for infant and young child feeding and this should be implemented from community level. To promote IEC strategy electronic and print media should be utilised.

Pakistan: In Pakistan, nationally prepared IEC material standardised the message. Distribution through the LHW programme has enhanced the coverage. Other community based alternative strategies have to be identified and utilised.

☞ **Action needed:**

- Evaluate the communication strategy as well as the effectiveness of media, and take action to strengthen communication

Sri Lanka: Ministry of Health has taken many initiatives in the field of IEC material on infant feeding. They have prepared five booklets titled- 1) For successful breastfeeding, 2) Common problems and solutions on breastfeeding, 3) Working mother and breastfeeding, 4) How to feed EBM and 5) Caesarean Section and breastfeeding. Steps have been taken to make available these books to all the mothers in Sri Lanka on lending basis. Numerous other booklets, posters, wall charts and leaflets have been published by government agencies on infant and young child feeding. However, the awareness programmes on infant and young child feeding in electronic and print media need to be strengthened.

☞ **Actions needed:**

- Evaluate the effectiveness of various IEC material for improved communication.
- Disseminate messages widely through electronic and print media.
- Encourage local adaptations of message for more effective communication.

Indicator 13: Infant Feeding and HIV

The risk of HIV transmission through breastfeeding presents policy makers, infant feeding counsellors and mothers with a difficult dilemma. They must balance the risk of death due to artificial feeding with the risk of HIV transmission through breastfeeding. These risks are dependent on the age of the infant and household conditions and are not precisely known. Other factors must be considered at the same time, such as the risk of stigmatisation (if not breastfeeding signals the mother's HIV status), the financial costs of replacement feeding and the risk of becoming pregnant again. Policies and programmes to meet this challenge should provide access to voluntary and confidential counselling and testing (VCCT) and, for HIV-positive mothers, counselling on infant feeding options. Safeguards should be in place to protect, promote and support breastfeeding in the rest of the population.

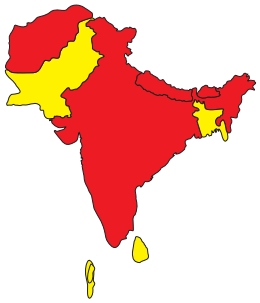
Indicator-13 addresses HIV and infant feeding. It consists nine-sub set of questions, which asks for a comprehensive policy on infant and young child feeding that includes infant feeding and HIV. It also asks for training of health staff and community workers on HIV and infant feeding policies, and various services available to the HIV positive mother dealing with the risks associated with various feeding options. It evaluates that on-going monitoring is in place to determine the effects of interventions to prevent HIV transmission on infant feeding practices.

None of the task mentioned in the indicator 13 have been accomplished completely by Afghanistan and it was scored as 0 out of 10, falls in 'Grade D' with 'Red' colour. Where as Bhutan, India and Nepal was also falls in the same grade i.e. 'Grade D' with the score 2, 3 and 3.5 respectively. The remaining half of the South Asian countries (Bangladesh, Maldives, Pakistan and Sri Lanka) falls in 'Grade C' with 'Yellow' colour.

The Table 12 gives more details.

Figure 17: Colour Rating and Ranking of South Asia Countries on Infant Feeding and HIV

Ranking by Prevalence of Infant Feeding and HIV		
Country	**Result (out of 10)**	**Rank**
Maldives	6	1st
Sri Lanka	6	1st
Bangladesh	4	2nd
Pakistan	4	2nd
Nepal	3.5	3rd
India	3	4th
Bhutan	2	5th
Afghanistan	0	6th



Afghanistan: None of the tasks mentioned in indicator 13, are accomplished in Afghanistan.

☞ **Action needed:**

- Initiate immediate action on infant feeding in HIV programmes.

Bangladesh: The main achievements in Bangladesh are that infant feeding and HIV policy gives effect to national legislation, local appropriate infant feeding counselling in line with current international recommendations are provided to HIV positive mothers and mothers are supported in their infant feeding decisions with further counselling and follow up to make these decisions as safe as possible. There are several partial and complete gaps in Bangladesh, which includes the fact that there is no comprehensive national policy on IYCF and HIV, antenatal VCCT monitoring is not available, limited services for counselling and support for Infant Feeding options for HIV+ve mothers- inline with UNICEF/WHO Guidelines.

☞ **Actions needed:**

- Develop comprehensive national policy on HIV and IYCF.
- Raise awareness among general population regarding PPTCT.
- Routine ANC – HIV community should be included in ANC clinics.

Bhutan: There are several gaps which includes the fact that no ante natal VCCT is available, mothers are not supported in infant feeding decisions, special efforts are not made to counter misinformation on HIV and infant feeding etc.

☞ **Action needed:**

- Initiate action on infant feeding in HIV programmes.

Table 12: Status of Infant Feeding and HIV in South Asia

Indicator 13: Infant Feeding and HIV	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
The country has a comprehensive policy on IYCF that includes infant feeding and HIV	NO	NO	To some degree	To some degree	YES	To some degree	To some degree	YES
The infant feeding and HIV policy gives effect to the National Legislation	NO	YES	To some degree	To some degree	To some degree	To some degree	To some degree	YES
Health staff and community workers receive training on HIV and infant feeding policies, the risk associated with various feeding options for infants of HIV-positive mothers and how to provide counseling and support	NO	To some degree	To some degree	To some degree	To some degree	NO	To some degree	To some degree
Antenatal VCCT is available and offered routinely to couples that are considering pregnancy and to pregnant women and their partners	NO	NO	NO	To some degree	YES	To some degree	To some degree	NO
Locally appropriate infant feeding counseling in line with current international recommendations is provided to HIV positive mothers	NO	YES	NO	To some degree	NO	To some degree	NO	YES
Mothers are supported in their infant feeding decisions with further counseling and follow up to make these decisions as safe as possible	NO	YES	NO	NO	NO	To some degree	To some degree	To some degree
Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support breastfeeding in the general population	NO	To some degree	NO	NO	To some degree	To some degree	To some degree	YES
On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission on infant feeding practices and health outcomes for mothers and infants, including those who are HIV negative or of unknown status	NO	To some degree	NO	NO	To some degree	NO	To some degree	NO
The BFHI provides guidance to hospital administrators and staff in settings with high HIV prevalence on how to assess the needs and provide support for HIV positive mothers	NO	NO	NO	NO	YES	NO	NO	NO
Score, Grade and Colour rating	**0/10 Grade-D**	**4/10 Grade-C**	**2/10 Grade-D**	**3/10 Grade-D**	**6/10 Grade-C**	**3.5/10 Grade-D**	**4/10 Grade-C**	**6/10 Grade-C**

India: The assessment team in India reviewed several documents including Policy document on PPTCT by National AIDS Control Organisation (NACO), and National Guidelines on Infant and Young Child Feeding. The assessment team felt that some positive steps have been taken on the issue but a lot more is yet to be achieved. There are several partial and complete gaps. For example, mothers are not supported in infant feeding decisions, on going monitoring is not in place.

☞ **Action needed:**

- Strengthen actions on infant feeding in HIV programmes.

Maldives and Sri Lanka: The main achievements in Maldives include a comprehensive policy on infant feeding and HIV, ante natal VCCT is available to couples. In Sri Lanka, VCCT is still not available routinely to couples and pregnant mothers and their partners. Counselling services, which include infant feeding counselling, are available for HIV positive mothers but this issue needs improvement.

☞ **Action needed:**

- Strengthen infant feeding and HIV issue in national policy and programmes.

Nepal: National PMCT guideline has just been implemented in few selected hospitals that include HIV and feeding strategy. Most of the health workers have not received training on HIV and feeding policies.

☞ **Actions needed:**

- There is need to implement PMCT in all hospitals and health centres.
- All health workers should be trained in HIV and feeding policies.

Pakistan: Pakistan is a low HIV prevalence country. Although policies, and guidelines exist in the HIV programme, the rate of implementation is still low as it is not a major public health problem.

☞ **Actions needed:**

- Initiate training of health workers on HIV and infant feeding to ensure a pool of trained counsellors if and when needed
- Include training on HIV and infant feeding in pre-service curriculum of health providers, including medical and nursing professions.

Indicator 14: Infant Feeding during Emergencies

Infants and young children are among the most vulnerable groups in emergencies. Interruption of breastfeeding and inappropriate complementary feeding increase the risks of

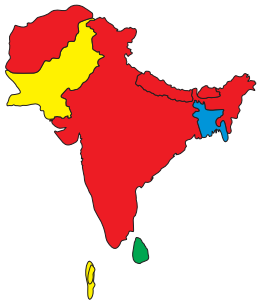
malnutrition, illness and mortality. In emergency and relief situations the responsibility for protecting, promoting and supporting beneficial optimal infant and young child feeding practices and minimising harmful practices should be shared by the emergency-affected host country and responding agencies. Concise guidance on how to facilitate appropriate feeding in emergency situations and comply with international emergency standards has been developed by interagency expert working groups. Practical details on how to implement the guidance are included in companion training materials, also developed through interagency collaboration.

Indicator 14 deals with Infant Feeding during Emergencies. It asks for five sub set of questions which includes policy that addresses key issues related to infant and young child feeding in emergencies, a contingency plan to undertake activities to facilitate exclusive breastfeeding and appropriate complementary feeding and to minimise the risk of artificial feeding, and integration of pre-service and in-service training material on infant and young child feeding in emergencies for emergency management and relevant health care personnel.

Figure 18: Colour Rating and Ranking of South Asia Countries on Infant Feeding During Emergencies

Ranking by Prevalence of Infant Feeding During Emergencies

Country	Result (out of 10)	Rank
Sri Lanka	10	1st
Bangladesh	7	2nd
Maldives	6	3rd
Pakistan	4	4th
Afghanistan	0	5th
Bhutan	0	5th
India	0	5th
Nepal	0	5th



Infant feeding during emergencies is an issue that has neglected in South Asian countries. None of the task mentioned in the indicator 14 have been accomplished completely by Afghanistan, Bhutan, India and Nepal. All these countries have scored 0 out of 10, and fall in 'Grade D' with 'Red' colour. Maldives and Pakistan are graded as 'Grade C' with 'Yellow' colour with scores of 6 and 4 respectively. Bangladesh, scoring 7 out of 10, falls in 'Grade B' with 'Blue' colour. Sri Lanka is the one and only country where all the mentioned tasks were completed; it scores 10 out of 10 and falls in 'Grade A' with 'Green' colour.

The Table 13 gives detailed information.

Afghanistan, Bhutan, India and Nepal: None of these countries has accomplished any of the tasks under this indicator. In Afghanistan, the assessment team found only a strategy on supplementary feeding during emergency but no other documents prepared by the Ministry of Public Health or the other agencies. The group recommended that the emergency and disaster management department of government should be contacted and if they don't have proper strategies, the Public Nutrition Department of MoPH should take the lead and

Table 13: Status of Infant Feeding during Emergencies in South Asia

Indicator 14: Infant Feeding During Emergencies	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
A policy endorsed / developed on key issues related to IYCF in emergencies	NO	To some degree	To some degree	NO	To some degree	NO	To some degree	YES
Person(s) appointed with responsibility for national coordination with the UN, donors, military and NGOs regarding IYCF in emergency situations	NO	To some degree	NO	NO	To some degree	NO	YES	YES
A contingency plan developed to facilitate exclusive breastfeeding and appropriate complementary feeding and to minimize the risk of artificial feeding	NO	To some degree	To some degree	NO	YES	NO	To some degree	YES
Resources identified for implementation of the plan during emergencies	NO	YES	NO	NO	To some degree	NO	NO	YES
Appropriate material on IYCF in emergencies integrated into pre-service and in-service training for emergency management and health care personnel	NO	YES	NO	NO	To some degree	NO	NO	YES
Score, Grade and Colour rating	**0/10 Grade-D**	**7/10 Grade-B**	**0/10 Grade-D**	**0/10 Grade-D**	**6/10 Grade-C**	**0/10 Grade-D**	**4/10 Grade-C**	**10/10 Grade-A**

prepare the required documents. The IYCF group has to back up the initiative and others organisations such as WHO and UNICEF should provide technical and financial support.

In India, the assessment team referred to some documents including NIPCCD report on multi country study on infant and young child feeding, and web prints of disaster management group of GOI. The assessment team analysed that this remains a neglected area and needs prompt attention.

In Nepal, there are no policies that address issues related to infant and young child feeding in emergencies and assessment team emphasised that there is need to develop policies regarding the same during the time of emergencies.

☞ **Actions needed:**

- Develop a Disaster Management Plan/Strategy and build the component of IYCF into it:
- Setting aside space for women to breastfeed in safety and privacy on a priority basis.
- Ensuring that food aid does not violate the Code.
- Provide training on IYCF during disasters to all health care providers as well as workers involved with implementing the Disaster Management Plan/Strategy.
- Include training on IYCF during disaster in pre-service curriculum of health providers, including medical and nursing professions.

Bangladesh: Resources were identified for implementation of the plan during emergencies. Appropriate material on IYCF is integrated into pre-service and in-service trainings. The main gap in Bangladesh is that there is no approved IYCF.

☞ **Actions needed:**

- Have a formal IYCF plan that is approved.
- Strengthen Code implementation and monitoring to prevent violations during disasters and emergencies.
- Ensure that women get enough space and privacy on a priority basis to implement IYCF.

Maldives and Pakistan: Maldives has a contingency plan developed to facilitate exclusive breastfeeding and appropriate complementary feeding to minimise the risk of artificial feeding. In Pakistan, the Nutrition Wing, Ministry of Health is planned to develop a proper policy on infants feeding in emergencies during 2006-2007. After the earthquake of Oct.8th, 2005, the Ministry of Health set guidelines and policies on Breastfeeding in emergencies, especially on donation of breast milk substitute. Nutrition Wing, MoH, co-coordinated with UN agencies and donors. However, there is strong need to prepare a comprehensive document and guidelines for infant feeding in emergencies.

Actions needed:

- Develop Guidelines for infant feeding in emergencies, including the need to set aside space for women to breastfeed in safety and privacy on a priority basis.
- Ensure that food aid does not violate the Code.
- Provide training on IYCF during disasters to all health care providers as well as workers involved with implementing the Disaster Management Plan/Strategy.
- Include training on IYCF during disaster in pre-service curriculum of health providers, including medical and nursing professions.

Sri Lanka: Before December 2004 there was no effective emergency preparedness on infant and young child feeding. The tsunami disaster, which had an adverse effect on existing breastfeeding promotion programmes, highlight the need for concerted and immediate action. Policies and strategies were quickly drafted on feeding of infant and young child feeding during emergencies and rapidly applied in any emergency situation.

Actions needed:

- Based on the experience of IYCF during the tsunami disaster, develop comprehensive guidelines on IYCF during disasters and emergencies.
- Ensure food aid does not violate the Code.
- Provide training on IYCF during disasters to all health care providers as well as workers involved with implementing the Disaster Management Plan/Strategy.
- Include training on IYCF during disaster in pre-service curriculum of health providers, including medical and nursing professions.

Indicator 15: Monitoring and Evaluation

Monitoring and evaluation (M & E) components should be built into all major infant and young child feeding programme activities and collection of data concerning feeding practices integrated into national nutritional surveillance and health monitoring systems or surveys. Monitoring or management information system data should be collected systematically and considered by programme managers as part of the management and planning process.

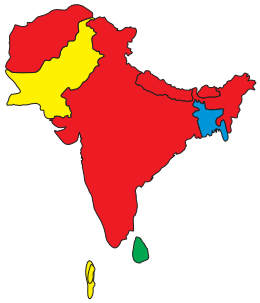
Indicator 15 deals with Monitoring and Evaluation. It analyses whether or not monitoring and evaluation components are built into major infant and young child feeding programme activities. It also looks in to the utilisation of Monitoring and Management Information System (MIS) data by programme managers as part of the planning and management process. Further, it asks for collection of adequate baseline and follow-up data to measure outcomes for major infant and young child feeding programme activities. Finally, it analyses whether or not the evaluation results related to major infant and young child feeding programme activities are reported to key decision-makers, both at national and regional/local levels.

The data on monitoring and evaluation reveals that Afghanistan, Bhutan and Nepal falls in 'Grade D' with 'Red' colour, where as Bangladesh, India, Pakistan and Sri Lanka stand in 'Grade C' with 'Yellow' colour with score 5. Maldives falls in 'Grade B' / 'Blue' colour with score 8 out of 10.

The Table 14 gives more details.

Figure 19: Colour Rating and Ranking of South Asia Countries on Monitoring and Evaluation

Ranking by Prevalence of Monitoring and Evaluation		
Country	**Result (out of 10)**	**Rank**
Maldives	8	1st
Bangladesh	6	2nd
India	5	3rd
Pakistan	5	3rd
Sri Lanka	5	3rd
Nepal	3	4th
Bhutan	1	5th
Afghanistan	0	6th



Afghanistan, Bhutan and Nepal: All these countries fall in 'Grade D' with 'Red' colour and scored as 0, 1 and 3 respectively**.** In Afghanistan (score 0), the assessment team, recognising the weakness of planning and implementation on this issue, recommended developing of tools for regular monitoring, evaluation and mechanisms for using the information at the national level for both advocacy and management purposes. The HMIS department of MoPH has to be supported for collection of proper data and including the required information in the national monitoring, and evaluation programmes.

In Bhutan (score 1), the programme managers considered MIS as a part of planning and management process to a very limited extent only. In Nepal, there are no monitoring and evaluation mechanisms to study the status of infant and young child feeding practices. There is need to develop such strategy to look into the broader aspect of infant and young child feeding.

Action needed:

- Monitor IYCF all five IYCF indicators especially timely initiation (within one hour) and exclusive breastfeeding (0-6 months) and publish on a regular basis under surveillance reports. There is an urgent need to establish baseline data.

Bangladesh: In Bangladesh, MIS data was collected to some extend but there is no intervention.

Actions needed:

- Strengthen the monitoring unit and regularly publish surveillance reports.
- Use data to plan and implement effective intervention strategies.

India, Pakistan and Sri Lanka: In India the assessment team referred to several documents including NIPCCD report on multi country study on infant and young child

Table 14: Status of Monitoring and Evaluation in South Asia

Indicator 15: Monitoring and Evaluation	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Monitoring and evaluation components are built into major IYCF programme activities	NO	To some degree	NO	To some degree	YES	NO	To some degree	To some degree
Monitoring and Management Information System (MIS) data are considered by programme managers as part of the planning and management process	NO	To some degree	To some degree	To some degree	YES	NO	To some degree	YES
Adequate baseline and follow-up data collected to measure outcomes for major IYCF programme activities	NO	To some degree	NO	To some degree	To some degree	To some degree	To some degree	To some degree
Evaluation results related to majorIYCF programme activities reported to key decision-makers, at national and regional/local levels	NO	To some degree	NO	To some degree	YES	To some degree	YES	To some degree
Monitoring of key IYCF practices built into a broader nutritional surveillance and/or health monitoring system or periodic national health surveys	NO	YES	NO	To some degree	To some degree	To some degree	NO	NO
Score, Grade and Colour rating	**0/10 Grade-D**	**6/10 Grade-C**	**1/10 Grade-D**	**5/10 Grade-C**	**8/10 Grade-B**	**3/10 Grade-D**	**5/10 Grade-C**	**5/10 Grade-C**

feeding. Discussion were based on the information provided by the DWCD representative and others. The team felt that some positive steps have been taken on the issue but a definite structured approach is required. In Pakistan, most of the indicators are collected through National Nutritional Survey or House Hold Survey. Right now, it is not the part of Health Management Information System (HMIS), but there are ongoing efforts to incorporate them. Analysis and use of information's by different programme managers at different levels, needs further attention. In Sri Lanka, the monitoring and evaluation component of the infant and young child feeding programme needs improvement. However, the national level managers take into consideration the existing information on infant and young and child feeding in the planning and management process.

☞ **Actions needed:**

- Build targets for each IYCF indicator into surveillance system.
- Use data for effective planning and implementation of intervention strategies at national, state and local levels.

Maldives: Programme managers consider MIS data as a part of planning and management process and evaluation results were reported to key decision makers.

☞ **Actions needed:**

- Build infant and young child indicators clearly into the national and regional systems of monitoring, evaluation and future planning.

Impact of the Assessment

Impact and Action

The impact of the World Breastfeeding Trends Initiative (WBT*i*), in documenting the *State of World's Breastfeeding: South Asia Report,* has been found to be tremendous in all eight countries as well in the region as a whole. The philosophy that if you look at your own problems closely, it is much more likely that you will find solutions to it, worked. Over a nearly two-year period, several countries have already begun taking serious action to bridge the gaps they found in policy and programme. These actions include developing baseline data where it does not exist, legislating the Code, and preparing action plans with national strategy. The process has also resulted in closer and effective networking as well as heightened interest in universalisation of breastfeeding. It has led to stronger partnerships with UNICEF's Regional Office for South Asia and several national UNICEF offices. The work has further enhanced solidarity among several national stakeholders, who were mobilised to work together and build consensus.

1. Country Actions

- Afghanistan has developed and finalised the draft Code that is waiting for approval. The government has constituted a national partnership on breastfeeding – Afghanistan Breastfeeding Promotion Partners (ABPP), which was responsible for organising the South Asia Breastfeeding Partners Forum-3 at Kabul. A National Breastfeeding Promotion Board has been established, BFHI has been revitalized and the government has promised to move breastfeeding up on the priority list of health programmes. Afghanistan will shortly be carrying out a country-level survey to effectively strategise and plan for the future.
- In Bangladesh, there was a country-level revitalisation of the breastfeeding movement and national interest was visible at the National Conference on Breastfeeding and Complementary Feeding in 2006, in which more than 500 persons took part. The National Infant and Young Child Feeding Strategy has been finalised.
- In Bhutan, assessment for BFHI has been carried out, with a view to revitalizing it. The Nutrition Programme plans to implement BFHI in two more hospitals.
- In India, the assessment has led to increased interest by the central and state governments as well as other government institutions. BPNI's (the local group) partnerships with the Government of India and UNICEF have been strengthened further. Strengthening IYCF in the teaching in medical schools has taken off as a new project to bridge gaps in curriculum of medical teaching. A national plan of action with activities and results in 10 areas, with budgets, has been finally developed and submitted for consideration. Serious consideration is being given to

Infant and Young Child Feeding in the 11th Five Year Plan.

- In Maldives, a Consultation Workshop on Breastfeeding Protection and Promotion Regulations was organised; Breastfeeding Coordinating Committee was revised and identified a focal point.
- In Nepal, national capacity has been increased to impart skills training on Infant and Young Child Feeding. The Nepal Breastfeeding Promotion Forum – the local IBFAN group - organised the South Asia Breastfeeding Partners Forum -2. A draft strategy document for IYCF is ready.
- In Sri Lanka, monitoring and evaluation of the Sri Lankan Code has intensified. The country has already started working on the gaps revealed by WBT*i*, focusing also on bottle feeding, BFHI, Maternity Protection and infant feeding and HIV.

2. Developed Action Plans for 2007

The action plans for 2007, which have been developed as a result of the assessment, reiterate the significance of using WBT*i*. They also are evidence that, given the orientation and skills, it is possible to achieve the kind of actions needed to ensure results. The following are some of the key actions included in the plans:

Afghanistan:

- Submission of draft Code to Ministry of Justice for endorsement and further follow up;
- Monitoring Code;
- Establishment of national and provisional breastfeeding promotion committee;
- Development and wide dissemination of breastfeeding IEC materials;
- Conducting sensitisation sessions with central and provincial authorities;
- Baseline surveys.

Bangladesh:

- Curriculum revision in light of IYCF;
- Formation of training committee for establishing Breastfeeding Management Centres;
- Revitalisation of BFHI;
- Implementation of existing legislation;
- Conduct training – TOT;
- Code monitoring - identify violations;
- Identify research agenda, develop grant proposals;
- Monitoring 2nd Child Survival Revolution Targets;
- Initiation within one hour of birth, exclusive breastfeeding for six months, complementary feeding at 6-9 months and continued breastfeeding till 20-23 months;

- HIV and Breastfeeding Policy approval - produce booklets for advocacy.

Bhutan:

- Advocate for maternity leave for 14 weeks and worksite accommodation for breastfeeding;
- Survey on IYCF practices;
- Advocacy for approval of BMS Code by National Assembly;
- Reactivation of National Committee on promotion and protection of breastfeeding as National IYCF Committee.

India:

- Taking breastfeeding to high level political attention;
- Conducting IYCF Counselling training courses;
- Calling for ensuring a budget head for IYCF in 11th plan;
- Campaign on 1st hour breastfeeding to save lives.

Nepal:

- Promote early initiation and exclusive breastfeeding for 6 months through following actions - activate mother groups, develop IEC materials, orientation to pregnant women;
- Reactivation of legislation on BMS Code;
- Reactivation of National Committee on promotion and protection of breastfeeding as National Committee on IYCF;
- Rectification of maternity leave;
- Reactivate BFHI concept;
- Training in integrated IYCF counselling to all level of health manpower.

Sri Lanka:

- Community mobilisation through participatory approaches;
- TOT to safeguard credibility of community leaders as peoples' representatives in interpersonal, organizational and political communication process;
- Formal introduction on the violation of the Sri Lanka Code to the local level leaders through non-formal education programmes;
- Advocacy on identifying issues relating to Code monitoring in rural communities whenever meeting persons of authority;
- Encouraging communities to identify interventions which could be the possible solutions to the problems relating to infant and child well-being;
- Encouraging use of local resources in the process of development;

- Developing a cell in SWM local level centres for data collection and documentation to facilitate the process in relation to infant and maternal health, and nutrition;
- Methods of rapport building with the personnel at macro level to disseminate information / research findings through a participatory process.

3. Strengthened Network

- Capacity of national groups enhanced on dealing with issues both nationally and regionally.
- IBFAN groups in Nepal and Bangladesh organised the South Asia Breastfeeding Partners Forum 1 and 2, in 2004 and 2005 respectively.
- Forum-3 was organised by the Government of Afghanistan, in collaboration with IBFAN, WHO, UNICEF Afghanistan and UNICEF ROSA. The Kabul Declaration on Infant and Young Child Feeding was adopted at Forum 3.

4. Governments and IBFAN are Close Partners

- At the Forum 1, there were two governments, at Forum-2 five governments were represented, and at Forum-3, 4 governments took part.
- Ministry of Public Health, Government of Afghanistan shared their draft Code with IBFAN Asia Pacific for inputs and comments provided.
- MOH, Maldives shared their draft Code with IBFAN Asia and ICDC for valuable inputs. MOH invited IBFAN regional coordinator to facilitate a consultative workshop to finalise the draft Code.

5. Collaboration with UN Agencies

- Over the past three years IBFAN Asia Pacific and UNICEF ROSA have worked in close partnership to organise the Forums 1,2 and 3. Inputs of UNICEF have been in the form of technical and other support.

6. Involvement of media/Media sensitisation

- As a new strategy to sensitise media, several editors were invited to participate in Forum 2 and 3. Media was sensitised to the extent that many of them have started doing very effective stories that help to stimulate national action. For e.g. a young woman journalist, Neelam Raaj, from *Times of India*, a national daily with highest coverage, has done three stories on the role of breastfeeding in tackling malnutrition in the last one year.
- Other media people have also done commendable work in this regard.

In conclusion, the success of WBT*i* is visible action at national level, fulfilling the objective with which it was launched. The next phase of assessments will reveal trends, which is expected to further enhance policy and programme attention to breastfeeding.

Conclusion and Moving Forward

The report reveals where the eight SAARC nations stand on implementation of the *Global Strategy for Infant and Young Child Feeding* and what are they doing about it. The World Breastfeeding Trends initiative (WBT*i*) is an innovative and now, a flagship project of IBFAN Asia that aims at initiating more action worldwide to ensure optimal infant and young child feeding practices. As you would have seen, the three years of work on this project has led not only to countrywide assessments of the state of implementation of the *Global Strategy for Infant and Young Child Feeding*, but also generated huge amount of interest and policy as well as programme development. For instance, the annual South Asia Breastfeeding Partners' Forum, held in Bangladesh, Nepal and then in Kabul, is the result of hard work and keen interest of the regional partners, and have been proof of what can be achieved. The first two Forums resulted in key Calls for Action; the Kabul meeting resulted in the adoption of the "Kabul Declaration on Infant and Young Child Feeding" on 22nd November 2006.

The WBT*i* toolkit helps to colour rate and rank a country by practice. Colour-rating of each nation provides easily understandable format for policy and programmes managers as well as politicians. Colour rating ranges from 'Green', 'Blue', 'Yellow', and 'Red', reflecting 'Excellent' to 'Poor' state of infant feeding. It simply informs us where we stand, as South Asia (which is mostly 'Yellow') and as individual countries. Bangladesh and Maldives are zooming ahead with 'Blue'. A country that moves from 'Reds' to 'Yellows' in several indicators will also zoom ahead of others, reaching 'Green', or 'Excellent'.

Reaching 'Green' will require more than political will – solid action at the ground level; family level; hospitals/ health facility, and policy level. Such action may range from community outreach with accurate information, access to skilled counselling on infant and young child feeding, strengthening BFHI or maternity protection to legislative action as follow up of *International Code of Marketing of Breastmilk Substitutes:* all these contribute to reaching a higher colour rating. All nations with 'Reds'should pledge to get rid of them at least by the next three to five years, earlier if positive change can be effected. This will allow countries to view the trends in their policy and programmes, and in resultant practices. WBT*i* provides a perfect platform to view and analyse the trends. WBT*i* can also assist in documenting case studies, and analyse what works and what does not. As the name suggests World Breastfeeding Trends initiative(WBT*i*) is study of trends, and it goes further by highlighting the direction action should take. To get a true picture of the effectiveness of their national plans and actions, countries should repeat the assessment every three years; that is, the eight nations of South Asia should repeat the exercise in 2008 to track their achievements.

Given the role breastfeeding plays in contributing to all eight MDGs, the WBT*i* provides an excellent opportunity for all nations to get involved tracking their implementation of the *Global Strategy*. The WBT*i* initiative allows building effective partnerships around the mother

and child health and has the potential for effective follow up. The new WFP and UNICEF's Ending Child Hunger and Undernutrition Initiative(*ECHUI 2006)* clearly calls for such an action to scale up optimal infant and young child feeding especially exclusive breastfeeding for 0-6 months to tackle undernutrition, recognising this as an effort to meet the Millennium Development Goals (MDG) 1 and 4.

By tracking and effectively planning action, the WBT*i* would ensure optimal infant and young child feeding, which in turn will help fulfill infant's right to good health and care. It will accomplish many commitments that we have made at World Health Assembly (WHA) including the *Global Strategy*, and the more recent *Innocenti Declaration 2005*. By preventing child malnutrition from setting in, it will reduce poverty and underdevelopment in South Asia.

The WBT*i* process provides increased flow of pertinent information to decision makers and also contributes significantly to capacity building at the country level in analysis to support policy formulation to end undernutrition. The WBT*i* reports provide a quick understanding of the existing gaps and and policies and programmes needed to fill them for the policy makers. This helps nations to advance to a new level of implementation.

For the IBFAN network, the WBT*i* is a significant tool to help develop local and regional databases on policy and programmes as well practices related to infant and young child feeding. The databases, which can be obtained and updated easily, help deepen our understanding of issues, enhance planning skills and provide a strategic edge to our work. WBT*i* allows IBFAN to link with governments and offer technical support after benchmarking and tracking trends.

The coverage of key/critical breastfeeding interventions is very low in the whole of South Asia. There is an urgent need to create a positive environment for optimal breastfeeding in all these countries. This means that national action plans must be developed, including care providers' capacity building in skills, campaigns to promote breastfeeding and legalizing the Code. This in turn requires that budgets be earmarked for such activities. Such budgeting is feasible as cost is just about 5 US$ per woman to enable her to achieve the optimal practices – the cost includes capacity building and incentive of 2 US$ for a skilled person to be available for a couple of hours at birth to help the mothers initiate breastfeeding. For first six months, mothers in poverty situation, may need to be supported with cash assistance or some compensation for staying close to the baby and exclusively breastfeeding him/her. This compensation works out to about 100 US$ for the first six months.

The report reiterates the need for universal action to support and ensure optimal feeding practices for infant survival. It is a critical call for effective resource allocation, starting with allocation for changing the status for indicators that are now in 'Red'. In the region having the most child malnutrition and child mortality, this is no charity or welfare, this is merely the recognition and the fulfilling of women's and children's rights for breastfeeding. The report calls upon all political parties / fora to take stock of the situation and provide necessary

political will to move forward to the next level of achievement. For ensuring infant nutrition for infant survival in this region, a SAARC regional fund could be established, which is a recommendations of the *Kabul Declaration on Infant and Young Child Feeding*. Breastfeeding is a vital national asset and to protect it we need to take deliberate decisions. The sooner we take the better it is!

> If we don't stand up for children, then we don't stand for much.
>
> *Marian W Edelman*

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Annexures

Exclusive Breastfeeding Rate and Bottle Feeding Rate Calculators

Exclusive Breastfeeding Rate (EBR) calculator using DHS data available for two-month intervals

			From the published tables:
1a	EBR, 0–1 mo	%	EBR rate in percentages for children 0–< 2 months
1b	EBR, 2-3 mo	%	EBR rate in percentages for children 2–< 4 months
1c	EBR, 4-5 mo	%	EBR rate in percentages for children 4–< 6 months
1d	EBR, 0-5 mo	%	**Calculated EBR for children 0–< 6 months**
			From the published tables:
2a	Number, 0–1 mo		Total number of children in the age group 0–<2 months
2b	Number, 2-3 mo		Total number of children in the age group 2–<4 months
2c	Number, 4-5 mo		Total number of children in the age group 4–<6 months
2d	Number, 0-5 mo		Calculated total number of children aged 0–< 6 months
			Calculated absolute numbers
3a	Numbers EBF, 0-1 mo		Children 0–<2 months who are exclusively breastfed
3b	Numbers EBF, 2-3 mo		Children 2–<4 months who are exclusively breastfed
3c	Numbers EBF, 4-5 mo		Children 4–<6 months who are exclusively breastfed
3d	Numbers EBF, 0-5 mo		Children 0–<6 months who are exclusively breastfed

Instructions for calculating the exclusive breastfeeding rate for children 0–<6 months of age:

1. Find the table on "breastfeeding status" in the chapter on infant, child and maternal nutrition in the most recent *Demographic and Health Survey* (*DHS*) www.measuredhs.com for the selected country.
2. Locate the data on percentage of breastfeeding children "exclusively breastfed" and the data on the "number of living children" for the same age groups – usually the second and last columns in the table.
3. List the exclusive breastfeeding rates (EBR) in percentages for children ages 0–1, 2–3, and 4–5 in rows 1a–1c in the table above. (Use figures with one decimal point e.g. 15.6%).
4. List the total number of living children ages 0–1, 2–3, and 4–5 in rows 2a–2c in the table above.
5. Calculate the number of children in the survey aged 0–5 months by adding the numbers in rows 2a–2c and insert this number in row 2d above.
6. Calculate the number of children exclusively breastfed for each age group by multiplying the total number in each age group by the percentage exclusively breastfed in that age group and insert in the appropriate rows above (1a x 2a = 3a; 1b x 2b = 3b; 1c x 2c = 3c). Round each number to the nearest whole number.
7. Calculate the number of children exclusively breastfed 0–5 months of age by adding up the numbers of exclusively breastfed children in each age group, and insert this number in row 3d above (3a + 3b + 3c = 3d).
8. Calculate the exclusive breastfeeding rate for children 0–5 months by dividing the number of children 0–5 months exclusively breastfed by the total number of children for these same ages, and insert the percentage in row 1d above (3d /2d = 1d).

Source: Adapted from the EBR Calculator developed by Nadra Franklin, LINKAGES Project, 1999.

Bottle Feeding rate (BOT) calculator using DHS data available for two-month intervals

			From the published tables:
1a	BOT, 0-1 mo	%	BOT rate in percentages for BF children 0-< 2 months
1b	BOT, 2-3 mo	%	BOT rate in percentages for BF children 2-< 4 months
1c	BOT, 4-5 mo	%	BOT rate in percentages for BF children 4-< 6 months
1d	BOT, 6-7 mo	%	BOT rate in percentages for BF children 6-< 8 months
1e	BOT, 8-9 mo	%	BOT rate in percentages for BF children 8-< 10 months
1f	BOT, 10-11 mo	%	BOT rate in percentages for BF children 10-< 12 months
1g	BOT, 0-11 mo	%	Calculated BOT rate for BF children 0-< 12 months
			From the published tables:
2a	Number, 0-1 mo		Total number of BF children in the age group 0-<2 months
2b	Number, 2-3 mo		Total number of BF children in the age group 2-<4 months
2c	Number, 4-5 mo		Total number of BF children in the age group 4-<6 months
2d	Number, 6-7 mo		Total number of BF children in the age group 6-<8 months
2e	Number, 8-9 mo		Total number of BF children in the age group 8-<10 months
2f	Number, 10-11 mo		Total number of BF children in the age group 10-<12 months
2g	Number, 0-11 mo		Calculated total number of children aged 0-< 12 months
			Calculated absolute numbers
3a	Numbers BOT, 0-1 mo		BF children 0-<2 months who are bottle-fed
3b	Numbers BOT, 2-3 mo		BF children 2-<4 months who are bottle-fed
3c	Numbers BOT, 4-5 mo		BF children 4-<6 months who are bottle-fed
3d	Numbers BOT, 6-7 mo		BF children 6-<8 months who are bottle-fed
3E	Numbers BOT, 8-9 mo		BF children 8-<10 months who are bottle-fed
3F	Numbers BOT, 10-11mo		BF children 10-<12 months who are bottle-fed
3G	Numbers BOT, 0-11 mo		BF children 0-<12 months who are bottle-fed

Instructions for calculating the bottle-feeding rate for children 0-<12 months of age:

1. Find the table on "types of food received by children in preceding 24 hours" in the chapter on infant, child and maternal nutrition in the most recent Demographic and Health Survey (DHS) www.measuredhs.com for the selected country.
2. Locate the data on percentage of breastfeeding (BF) children "using bottle with a nipple" And the data on the "number of children" for the same age groups - usually the last two columns in the table.
3. List the bottle-feeding rates (BOT) in percentages for children ages 0-1, 2-3, 4-5, 6-7, 8- 9, and 10-11 in rows 1a-1f in the table above. (Use figures with one decimal point e.g. 15.6%).
4. List the total number of children ages 0-1, 2-3, 4-5, 6-7, 8-9, and 10-11 in rows 2a-2f in the table above.
5. 5. Calculate the numbers of children in the survey aged 0-11 months by adding the numbers in rows 2a-2f and insert this number in row 2g above.
6. Calculate the numbers of BF children who are bottle-fed for each age group by multiplying the total number in each age group by the ercentage bottle-fed in that age group, and insert in the appropriate rows above (1a x 2a = 3a; 1b x 2b = 3b; 1c x 2c = 3c; 1d x 2d = 3d;1e x 2e = 3e and 1f x 2f = 3f). Round each number to the nearest whole number.

7. Calculate the number of BF children who are bottle-fed 0-11 months of age by adding up the numbers of BF children who are bottle-fed in each age group, and insert this number in row 3g above (3a + 3b + 3c +3d + 3e + 3f = 3g).
8. Calculate the bottle-feeding rate for BF children 0-5 months by dividing the number of BF children 0-11 months who are bottle-fed by the total number of BF children for these same ages and insert the percentage in row 1g above (3g /2g = 1g).

Source: Adapted from the EBR Calculator developed by Nadra Franklin, LINKAGES Project, 1999.

Guiding Principles for Complementary Feeding of the Breastfed Child

1. Practise exclusive breastfeeding from birth to six months of age, and introduce complementary foods at six months of age (180 days) while continuing to breastfeed.
2. Continue frequent, on-demand breastfeeding until two years of age or beyond.
3. Practise responsive feeding applying the principles of psychosocial care, specifically:
   - Feed infants directly and assist older children when they feed themselves, being sensitive to their hunger and satiety clues. Feed slowly and patiently, and encourage children to eat, but do not force them. If children refuse many foods, experiment with different food combinations, tastes, textures, and methods of encouragement. Minimize distractions during meal times if the child loses interest easily. Remember that feeding times are periods of learning and love. Talk to children during feeding, with eye-to-eye contact.
4. Practise good hygiene and proper food handling.
5. Start at six months with small amounts of food and increase the quantity as the child gets older, while maintaining frequent breastfeeding.
   - The energy needs from complementary foods for infants with average breastmilk intake in developing countries are approximately 200 kcal/day at 6–8 months of age; 300 kcal/day at 9–11 months; and 550 kcal/day at 12–23 months.
6. Gradually increase food consistency and variety as the infant gets older, adapting to the infant's requirements and abilities.
   - Infants can eat pureed, mashed and semi-solid foods beginning at 6 months. By 8 months most infants can also eat 'finger foods'. By 12 months, most children can eat the same types of food as consumed by the rest of the family.
7. Increase the number of times that the child is fed complementary foods as he/she gets older.
   - For the average healthy breastfed infant, meals of complementary foods should be provided 2–3 times per day at 6–8 months of age and 3–4 times per day at 9–11 and 12–24 months of age, with additional nutritious snacks offered 1–2 times per day, as desired.
8. Feed a variety of foods to ensure that nutrient needs are met.
   - Meat, poultry, fish, or eggs should be eaten daily, or as often as possible.
   - Vitamin A-rich fruits and vegetables should be eaten daily. Provide diets with adequate fat content.
9. Use fortified complementary foods or vitamin–mineral supplements for the infant, as needed. In some populations, breastfeeding mothers may also need vitamin–mineral supplements or fortified products.
10. Increase fluid intake during illness, including more frequent breastfeeding, and encourage the child to eat soft, varied, appetizing, favourite foods. After illness, give food more often than usual and encourage the child to eat more.

Source: PAHO/WHO, Guiding principles for complementary feeding of the breastfed child

Education Checklist - *Infant and Young Child Feeding Topics*

Objectives (to be achieved by all health students and trainees who will care for infants, young children and mothers)	**Content/skills** (to achieve objectives)
1. Identify factors that influence breastfeeding and complementary feeding.	National/local breastfeeding and complementary feeding rates and demographic trends; cultural and psychosocial influences; common barriers and concerns; local influences.
2. Provide care and support during the antenatal period.	Breastfeeding history (previous experience), breast examination, information targeted to mother's needs, support.
3. Provide intra-partum and immediate postpartum care that supports and promotes successful lactation.	The Baby-friendly Hospital Initiative (BFHI), Ten steps to successful breastfeeding; supportive practices for mother and baby; potentially negative practices.
4. Assess the diets and nutritional needs of pregnant and lactating women and provide counselling, as necessary.	Nutritional needs of pregnant and lactating women, dietary recommendations (foods and liquids) taking account of local availability and costs; micronutrient supplementation; routine intervention and counselling.
5. Describe the process of milk production and removal.	Breast anatomy; lactation and breastfeeding Physiology
6. Inform women about the benefits of optimal infant feeding.	Benefits of breastfeeding for infant, mother,family, and community; benefits of exclusive breastfeeding for 0–6 months; options and risks when unable to breastfeed.
7. Provide mothers with the guidance needed to successfully breastfeed.	Positioning/ attachment; assessing effective milk removal; signs of adequate intake; practise observing and assessing breastfeeding and suggesting improvements.
8. Help mothers prevent and manage common breastfeeding problems. Manage uncomplicated feeding difficulties in the infant and mother.	Normal physical, behavioural and developmental changes in mother and child (prenatal through weaning stages); feeding history; observation of breastfeeding; suckling difficulties; causes and management of common infant feeding difficulties; causes and management of common maternal feeding difficulties.

9. Facilitate breastfeeding for infants with special health needs, including premature infants.	Risk/benefit of breastfeeding/breast milk; needs of premature infants; modifications; counseling mothers.
10. Facilitate successful lactation in the event of maternal medical conditions or treatments.	Risk/benefit; modifications; pharmacological Choices; treatment choices.
11. Inform lactating women about contraceptive options.	Advantages and disadvantages of various child spacing methods during lactation; counseling about LAM; cultural considerations for counselling.
12. Prescribe/recommend medications, contraceptives and treatment options compatible with lactation.	Compatibility of drugs with lactation; effects of various contraceptives during lactation.
13. Assist mothers to sustain lactation during separation from their infants, including during hospitalization or illness of mother or child and when returning to work or school.	Milk expression, handling and storage; alternative feeding methods; cup-feeding; cause, prevention and management of common associated difficulties such as low milk supply; coordinating out-of-home activities with breastfeeding; workplace support.
14. Explain the International Code of Marketing of Breastmilk Substitutes and World Health Assembly esolutions,current violations, and health worker responsibilities under the Code.	Main provisions of the Code and WHA resolutions, including responsibilities of health workers and the breastmilk substitute, bottles and teats industries; violations by infant food companies; monitoring and enforcement of the Code.
15. Describe what foods are appropriate to introduce to children at various ages and which foods are available and affordable to the general population.	Developmental approach to introducing complementary foods; foods appropriate at various ages; available foods and their costs; incomes of local families and how income levels affect their abilities to afford various foods.
16. Ask appropriate questions to mothers and other caregivers to identify sub-optimal feeding practices with young children between 6 and 24 months of age.	Growth patterns of breastfed infants; complementary foods: when, what, how, how much; micronutrient eficiencies/supplements; young child feeding history; typical problems.
17. Provide mothers and other caregivers with information on how to initiate complementary feeding, using the local staple.	Local staples and nutritious recipes for first foods; practise counselling mothers; common difficulties and solutions.
18. Counsel mothers and other caregivers on how to gradually increase consistency, quantity, and frequency of foods, using locally available foods.	Guidelines for feeding young children at various ages and stages of development; potential difficulties and solutions regarding feeding and weaning; Essential Nutrition Actions.
19. Help mothers and other caregivers to continue feeding during illness and ensure adequate recuperative feeding after illness.	Energy and nutrient needs; appropriate foods and liquids during and after illness; strategies for encouraging child to eat and drink; local beliefs about feeding during illness; appropriate feeding support during hospitalization; relactation.

20. Help mothers of malnourished children to increase appropriate food intake to regain correct weight and growth pattern.	Feeding recommendations for malnourished children; micronutrient supplements for malnourished children.
21. Inform mothers of the micronutrient needs of infants and young children and how tomeet them through food and, when necessary, supplementation.	Micronutrient needs of infants and young children (iron, vitamin A, iodine, others); meeting these needs with food (breastfeeding and omplementary foods); supplementation needs.
22. Demonstrate good interpersonal communication and counselling skills.	Listening and counselling skills, use of simple language, providing praise and support, considering mother's viewpoint, trials of new practices.
23. Facilitate group education sessions related to infant and young child nutrition and maternal nutrition.	Adult education methods; strategies for preparing and facilitating competency-based, participatory sessions.
24. Counsel mothers about prevention and reduction of mother-to-child-transmission of HIV/AIDS; options and risks of various feeding methods to consider when HIV positive.	Modes of mother-to-child-transmission of HIV and how to prevent or reduce them; counseling confirmed HIV-positive mothers about feeding options and risks.
25. Provide guidance on feeding of infants and young children in emergencies and appropriate protection, promotion and support in these circumstances.	Policies and guidelines on feeding inemergencies; appropriate promotion and support; compliance with the International Code of Marketing of Breastmilk Substitutes and WHA resolutions.

HIV and Infant Feeding Recommendations

Situation	Guidelines for health workers
Mother's HIV status isunknown	– Promote availability and use of HIV testing and counseling. – Promote breastfeeding as safest infant feeding method (exclusive breastfeeding for first 6 months, introduction of appropriate complementary foods at about 6 months, and continued breastfeeding to 24 months and beyond)· – Counsel the mother and her partner on how to avoid exposure to HIV.
HIV-negative mother	– Promote breastfeeding as safest infant feeding method (exclusive breastfeeding for first 6 months, introduction of appropriate complementary foods at about 6 months, and continued breastfeeding to 24 months and beyond)· – Counsel the mother and her partner on how to avoid exposure to HIV.
All HIV-positive mothers	– Provide anti-retroviral drugs to prevent MTCT· – Counsel mother on the risks and benefits of various infant-feeding options, including the acceptability, feasibility, affordability, sustainability and safety of the various options· – Guide the mother to choose the most appropriate infant-feeding option, according to her own situation· – Counsel mother on infant feeding after six months· – Refer the mother to family planning and child care services, as appropriate.

HIV-positive mother who chooses to breastfeed	– Promote safer breastfeeding (exclusive breastfeeding with early cessation when replacement feeding is acceptable, feasible, affordable, sustainable and safe)· – Support the mother in planning and carrying out a safe transition from exclusive breastfeeding to replacement feeding· – Prevent and treat breast conditions of mothers. Treat thrush in infants.
HIV-positive mother who chooses other breast milk option	– Provide support to the mother to carry-out her option as safely as possible.
HIV-positive mother whochooses replacement feeding	– Provide the mother with the skills to carry out her choice· – Support her in her choice (including cup-feeding, hygienic preparation and storage, health care, family planning services).

Key to Scoring, Colour-Rating, Grading and Ranking

Part I: IYCF Practices (Indicator 1-5)

In the case of indicators 1 to 5 on practices, key to rating is used from WHO's 'Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". Scoring, color-rating and grading are provided according to IBFAN Asia Pacific's guidelines for WBT*i*. Each indicator is scored out of maximum of 10.

Practices (Indicator 1-5)	**WHO's Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes**	**IBFAN Asia Pacific guideline guideline for WBT*i***		
	Key to rating	***Score***	***Colour***	***Grade***
Initiation of Breastfeeding (within 1 hour)	0-29%	3	Red	D
	30-49%	6	Yellow	C
	50-89%	9	Blue	B
	90-100%	10	Green	A
Exclusive Breastfeeding (for first 6 months)	0-11%	3	Red	D
	12-49%	6	Yellow	C
	50-89%	9	Blue	B
	90-100%	10	Green	A
Median Duration of Breastfeeding	0-17 months	3	Red	D
	18-20 months	6	Yellow	C
	21-22 months	9	Blue	B
	23-24 months or beyond	10	Green	A
Bottle Feeding (<6 months)	30-100%	3	Red	D
	5-29%	6	Yellow	C
	3-4%	9	Blue	B
	0-2%	10	Green	A
Complementary Feeding (6-9 months)	0-59%	3	Red	D
	60-79%	6	Yellow	C
	80-94%	9	Blue	B
	95-100%	10	Green	A

Total Score of Indicators 1 to 5

Total score of infant and young child feeding practices (indicators 1-5) are calculated out of 50.

Score	Colour	Grade
0 - 15	Red	D
16 - 30	Yellow	C
31 - 45	Blue	B
46 - 50	Green	A

Part II: IYCF Policies and Programme (Indicator 6-15)

For indicator 6 to15 on policies and programmes, there is a sub set of questions leading to key achievement, indicating how a country is doing in a particular area. Each question has possible score of 0-3 and the indicator has a maximum score of 10.

Score	Colour	Grade
0 - 3	Red	D
4 - 6	Yellow	C
7 - 9	Blue	B
More than 9	Green	A

Total Score of Indicators 6 to 15

Total score of infant and young child feeding policies and programmes (indicators 6-15) are calculated out of 100.

Score	Colour	Grade
0 - 30	Red	D
31 - 60	Yellow	C
61 - 90	Blue	B
91 - 100	Green	A

Total Score of Indicators 1 to 15

Total score of infant and young child feeding practices; policies and programmes (indicators 1-15) are calculated out of 150. Countries are then graded as:

Score	Colour	Grade
0 - 45	Red	D
46 - 90	Yellow	C
91 - 135	Blue	B
136 - 150	Green	A

Policy Issues

National governments should adopt comprehensive policies on infant and young child feeding that:

- Promote infant and young child feeding practices consistent with international guidelines.
- Ensure functioning of a strong national committee and coordinator.
- Monitor trends and assess interventions and promotional activities to improve feeding practices.
- Provide technically sound and consistent messages through appropriate media and educational channels.
- Strengthen and sustain the Baby Friendly Hospital Initiative (BFHI) and fully integrate it within the health system.
- Provide health workers in health services and communities with the skills and knowledge necessary to provide counselling and support related to breastfeeding,complementary feeding, and HIV and infant feeding, and to fulfill their responsibilities under the *International Code of Marketing on Breastmilk Substitutes.*
- Strengthen pre-service education for health workers.
- Promote the development of community-based support networks to help ensure optimal infant and young child feeding to which hospitals can refer mothers on discharge.
- Formulate plans for ensuring appropriate feeding for infants and young children in emergency situations and other exceptionally difficult circumstances.
- Ensure that the *International Code of Marketing on Breastmilk Substitutes* and subsequent World Health Assembly resolutions are implemented within the country's legal framework and enforced.
- Promote maternity protection legislation that includes breastfeeding support measures for working mothers, including those employed both in the formal and informal economy.

Policies on infant and young child feeding should be:

- Officially adopted/approved by the government.
- Routinely distributed and communicated to those managing and implementing relevant programmes.
- Integrated into other relevant national policies (nutrition, family planning, integrated child health policies, etc.).

Source: Summarized from the WHO Global Strategy for Infant and Young Child Feeding

Community Outreach

Contact points that can be used for community outreach and support

- Maternity services
- Health centres
- Growth monitoring and promotion programmes
- Immunization clinics or campaigns
- Mother-support groups
- Women's groups
- Home visits
- Workplaces
- Community meetings
- Schools
- Agricultural extension programmes
- Credit or microenterprise programmes
- Family planning programmes
- Health fairs.

Channels that can be used for community outreach and support

- Health service personnel
- Home-birth attendants
- Traditional healers
- Staff or volunteers from nongovernmental organizations (NGOs)
- Lay or peer counsellors
- Teachers
- Agricultural extension agents
- Family planning staff.

Some activities for infant and young child feeding community outreach and Support

- Individual counselling
- Group counselling
- Community education
- Cooking demonstrations
- Promotion of production of food that can fill gaps in local diets
- Micronutrient campaigns
- Mother-to-mother support
- Trials of new infant or young child feeding practices
- Baby shows or contests featuring optimal infant and young child feeding
- Organization of workplace nurseries for breastfeeding infants, breastfeeding rooms or areas
- Social mobilization activities – planned actions that reach, influence and involve all relevant segments of society, such as World Breastfeeding Week activities, World Walk for Breastfeeding.

Community support strategies should focus on protection, promotion and support of both breastfeeding and complementary feeding.