

World Breastfeeding Trends Initiative (WBTi) Indicators 1 to 15

The WBTi has identified 15 indicators in two parts, each indicator having specific significance.

Source : WBTi Assessment 2008

1. *Part-I deals with infant feeding practices (indicator 1-5)*
2. *Part –II deals with policy and programmes (indicator 6-15)*

Once assessment of gaps is carried out, the data on 15 indicators is fed into the questionnaire using the WBTi web based toolkit© which is specifically designed to meet this need. The toolkit objectively quantifies the data to provide a colour- coded Rating in Red, Yellow, Blue or Green representing grade 'D' to 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 used for assessment has following components;

- Background on why the practice, policy or programme component is important.
- 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, colour-rating, grading and ranking how well the country is doing.

Part 1: Infant and Young Child Feeding Practices

In Part I ask for specific numerical data on each infant and young child feeding practice. Those involved in this assessment are advised to use data from a random household survey that is national in scope¹. The data thus collected is entered into the web-based printed toolkit. The achievement on the particular target indicator is then rated and graded i.e. **Red or grade ‘D’, Yellow or grade ‘C’, Blue or grade ‘B’ and Green or grade ‘A’**. The cut off points for each of these levels of achievement were selected systematically, based on an analysis of past achievements on these indicators in developing countries². These are incorporated from the WHO’s tool.

¹ One source of data that is usually high in quality is the Demographic and Health Survey (DHS)(4) conducted in collaboration with Macro International and national research organizations, with support from USAID. If this source of data is used the data are likely to be comparable across countries. Other sources of data include UNICEF’s Multiple Indicator Cluster Surveys (MICS) (5) and the WHO Global Data Bank on Breastfeeding (6). In some countries recent national surveys may have been conducted. It is important to assess the scope and quality of any data sources being considered for use.

² The ratings were developed based on an analysis of percentages achieved by countries on the various indicators, as evidenced by results from the Demographic and Health Surveys (4) and other selected national studies presented in Breastfeeding Patterns in the Developing World (7). The results from each country were rated from lowest to highest, using MS Excel. The results were then divided into three parts. The first two-fifths of the scores were used to determine the rating for “Poor”, the second two-fifths for “Fair” and the last one-fifth for “Good”. The category of “Excellent” was reserved for the rating which would indicate practices in the country were almost “optimal” – for example 90% to 100% attainment of exclusive breastfeeding for 0<6 months. This rating system allows the country to see how it is doing relative to other countries on the various indicators while reserving the highest rating only for optimal practices.

Indicator 1: Early Initiation of Breastfeeding

Key question: Percentage of babies breastfed within one hour of birth

Background

Many mothers, in the world, deliver their babies at home, particularly in the developing countries and more so in the rural areas. Breastfeeding is started late in many of these settings due to cultural or other beliefs. According to the new guidelines in Baby Friendly Hospital Initiative (BFHI) “Step” 4 of the *Ten Steps to Successful Breastfeeding*, the baby should be placed “skin-to-skin” with the mother in the first half an hour following delivery and offered the breast within the first hour in all normal deliveries. If the mother has had a cesarean section the baby should be offered breast when mother is able to respond and it happens within few hours of the general anesthesia also. Mothers who have undergone cesarean sections need extra help with breastfeeding otherwise they initiate breastfeeding much later. Optimally, the baby should start to breastfeed before any routine procedure (such as bathing, weighing, umbilical cord care, administration of eye medications) is performed. Early breastfeeding helps better temperature control of the newborn baby, enhances bonding between the mother and the baby, and also increases chances of establishing exclusive breastfeeding early and its success. Evidence from a large community study has established early initiation as a major intervention to prevent neonatal mortality.

Guideline:

| Indicator 1 | WHO's | IBFAN Asia Guideline for WBTi | | |
|---|----------------------|-------------------------------|----------------------|----------------|
| | <i>Key to rating</i> | <i>Scores</i> | <i>Colour-rating</i> | <i>Grading</i> |
| Initiation of Breastfeeding (within 1 hour) | 0.1-29% | 3 | Red | D |
| | 30-49% | 6 | Yellow | C |
| | 50-89% | 9 | Blue | B |
| | 90-100% | 10 | Green | A |

Mention Data Source (including year):

Indicator 2: Exclusive breastfeeding for the first six months

Key question: *Percentage of babies 0<6 months of age exclusively breastfed in the last 24 hours³?*

Background

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

Guideline:

| Indicator 2 | WHO's | IBFAN Asia Guideline for WBTi | | |
|--|----------------------|-------------------------------|----------------------|----------------|
| | <i>Key to rating</i> | <i>Scores</i> | <i>Colour-rating</i> | <i>Grading</i> |
| Exclusive Breastfeeding (for first 6 months) | 0.1-11% | 3 | Red | D |
| | 12-49% | 6 | Yellow | C |
| | 50-89% | 9 | Blue | B |
| | 90-100% | 10 | Green | A |

Data Source (including year):

³ Exclusive breastfeeding means the infant has received only breastmilk (from his/her mother or a wet nurse, or expressed breastmilk) and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines (2)

Indicator 3: Median duration of breastfeeding

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

Background

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

Guideline:

| Indicator 3 | WHO's | IBFAN Asia Guideline for WBTi | | |
|----------------------------------|----------------------|-------------------------------|----------------------|----------------|
| | <i>Key to rating</i> | <i>Scores</i> | <i>Colour-rating</i> | <i>Grading</i> |
| Median Duration of Breastfeeding | 0.1-17 Months | 3 | Red | D |
| | 18-20 ” | 6 | Yellow | C |
| | 21-22 ” | 9 | Blue | B |
| | 23-24 ” | 10 | Green | A |

Data Source (including date):

Indicator 4: Bottle feeding

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

Background

Babies should be breastfed exclusively for first 6 months of age and they need not be given any other fluids, fresh or tinned milk formulas as this would cause more harm to babies and replace precious breastmilk. Similarly after six months babies should ideally receive mother's milk plus solid complementary foods. If a baby cannot be fed the breastmilk from 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 6 months of age, any liquids given should be fed by cup, rather than by bottle. Feeding bottles with artificial nipples and pacifiers (teats or dummies) may cause 'nipple confusion' and infants' refusal of the breast after their use. Feeding bottles are more difficult to keep clean than cups and the ingestion of pathogens can lead to illness and even death. Pacifiers also can easily become contaminated and cause illness.

Guideline:

| Indicator 4 | WHO's | IBFAN Asia Guideline for WBTi | | |
|--------------------------------------|---------------|-------------------------------|---------------|----------|
| | Key to rating | Scores | Colour-rating | Grading |
| Bottle Feeding (<6 months) | 30-100% | 3 | Red | D |
| | 5-29% | 6 | Yellow | C |
| | 3-4% | 9 | Blue | B |
| | 0.1-2% | 10 | Green | A |

Data Source (including date):

Indicator 5: Complementary feeding

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

Background

As babies grow continuously and need additional nutrition along with continued breastfeeding, after they are 6 months of age, complementary feeding should begin with locally available indigenous foods being affordable and sustainable. They should be offered soft or mashed foods in small quantities, 3-5 times a day. Complementary feeding should gradually increase in amount and frequency as the baby grows. Breastfeeding, on demand, should continue for 2 years or beyond. Complementary feeding is also important from the care point of view, the caregiver should continuously interact with the baby and take care of hygiene to keep it safe.

The indicator proposed here measures only whether complementary foods are provided in a timely manner, after 6 months of age along with breastfeeding. Complementary feeds should also be adequate, safe and appropriately fed, but indicators for these criteria are not included because data on these aspects of complementary feeding are not yet available in many countries. It is useful to know the median age for introduction of complementary foods, what percentage of babies are not breastfeeding at 6-9 months and also how many non-breastfeeding babies are receiving replacement foods in a timely manner. These figures can help in determining whether it is important to promote longer breastfeeding and/or later or earlier introduction of complementary foods. This information should be noted, if available, although it is not scored. It is also possible to generate more information as additional and help guide local program.

Guideline:

| Indicator 5 | WHO's | IBFAN Asia Guideline for WBTi | | |
|------------------------------------|----------------------|-------------------------------|----------------------|----------------|
| | <i>Key to rating</i> | <i>Scores</i> | <i>Colour-rating</i> | <i>Grading</i> |
| Complementary Feeding (6-9 months) | 0.1-59% | 3 | Red | D |
| | 60-79% | 6 | Yellow | C |
| | 80-94% | 9 | Blue | B |
| | 95-100% | 10 | Green | A |

Data Source (including date):

Part II: IYCF Policies and Programmes

In 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*. For each indicator 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. Once information about the indicators is entered, The achievement on the particular target indicator is then rated and graded i.e. Red or grade ‘D’, Yellow or grade ‘C’, Blue or grade ‘B’ and Green or grade ‘A’

IBFAN Asia Guidelines for WBTi

| <i>Scores</i> | <i>Colour- rating</i> | <i>Grading</i> |
|---------------|-----------------------|----------------|
| 0 - 3 | Red | D |
| 4 - 6 | Yellow | C |
| 7 - 9 | Blue | B |
| 9.1-10 | Green | A |

This part of the Toolkit will cover “*Innocenti and beyond*” targets looking at policies and programmes. The Score will be assigned again as a color-coded rating for easy understanding of the current situation with regard to the Global Strategy for Infant and Young Child Feeding.

Indicator 6: National Policy, Programme and Coordination

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

Background

The “*Innocenti Declaration*” was adopted in 1990. It recommended all governments to have national breastfeeding committees and coordinators as established mechanisms to protect, promote and support breastfeeding in the country. World Summit for Children (2000) recommended all governments to develop national breastfeeding policies. The Global Strategy for Infant and Young Child Feeding calls for an urgent action form all member states to develop, implement, monitor and evaluate a comprehensive policy on IYCF.

Possible Sources of Information

Most countries would have their National Plans of Action on Nutrition, National Plan of Action for the Child as a follow up to the UN Summit for Children. Apart from this National Nutrition Policies and National Health Policies should accommodate infant and young child feeding. Many countries have taken action and already have national breastfeeding committees. Minutes of this committee as well terms of reference of the committee would be quite useful, These documents could give possible source for detailed information on this particular section. Many countries have also CRC meetings. Minutes and reports of these meetings could be used.

Discussions on implementation of the Global Strategy for Infant and Young Child Feeding can be held at national level with the National Breastfeeding Coordinator, officials from the Ministries of Health, Planning, and/or Labour, government regulatory representatives, WHO, UNICEF, and country breastfeeding promotion groups like IBFAN. Find out and get written copies of whatever national policies cover infant and young child feeding.

Other sources could be BFHI policy and programme, national legislation as a follow up to the *International Code of Marketing of Breastmilk Substitutes* (The Code) and its implementation process, or reports of community based organizations on nutrition and health.

Information Sources Used:

Criteria of Indicator 6

| | Scoring √ <i>Check that apply</i> |
|---|--|
| 6.1) A national infant and young child feeding/breastfeeding policy has been officially adopted/approved by the government | 2 |
| 6.2) The policy promotes exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond. | 2 |
| 6.3) A national plan of action developed with the policy | 2 |
| 6.4) The plan is adequately funded | 1 |
| 6.5) There is a National Breastfeeding Committee | 1 |
| 6.6) The national breastfeeding (infant and young child feeding) committee meets and reviews on a regular basis | 1 |
| 6.7) The national breastfeeding (infant and young child feeding) committee links with all other sectors like health, nutrition, information etc. effectively | 0.5 |
| 6.8) Breastfeeding Committee is headed by a coordinator with clear terms of reference | 0.5 |
| Total Score | __/10 |
| Conclusions and Recommendations | |
| Summarize which aspects of IYCF policy, program and coordination are good and which need improvement and why, any further analysis needed and recommendations for action. | |

Indicator 7: Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding)

Key questions:

7A) What percentage of hospitals and maternity facilities that provide maternity services have been designated “Baby Friendly” based on the global or national criteria?

7B) What is the skilled training inputs and sustainability of BFHI?

7C) What is the quality of BFHI program implementation?

Background:

The *Innocenti Declaration* calls for that all maternity services fully practice all the *Ten Steps to Successful Breastfeeding* set out in *Protecting, promoting and supporting breastfeeding: the special role of maternity services, a Joint WHO/UNICEF Statement*. UNICEF’s 1999 Progress Report on BFHI lists the total number of hospitals/maternalities in each country and the total number designated “Baby Friendly”. According to the Step 2 of ten steps all staff in maternity services should be trained in lactation management. UNICEF and WHO recommend that all staff should receive at least 18 hours of training and higher level of training is more desirable. Several countries initiated action on BFHI and progress made so far has been in numbers mostly and reports suggest that fall back happens if the skills of health workers are not sufficiently enhanced. The Global Strategy for Infant and Young Child Feeding indicates that revitalization of BFHI is necessary and its assessment is also carried out periodically to sustain this programme and contribute to increase in exclusive breastfeeding.

The *Toolkit* will focus on quantitative and qualitative aspects both. It looks at the percentages of hospitals and maternity facilities designated BFHI and also at the programme quality e.g. skilled training inputs in BFHI, which is key to sustaining it, and how it is monitored and evaluated.

Possible Sources of Information:

Interviews can be held with the national Baby Friendly Hospital Initiative (BFHI) committee members in the Ministry of Health, and UNICEF and WHO officials. Review any summary reports on the status of the BFHI, numbers (and percentages) of hospitals declared Baby Friendly, etc. Refer to the latest status report on BFHI prepared by UNICEF/NY for official figures reported by the country. Find out from the IBFAN/other breastfeeding groups in the country on such information on quantity and quality of BFHI. Find out how many hospitals that are certified BFHI have trained their staff with minimum level of training of 18 hours recommended. To find out the quality of services, interviews of mothers delivering in these hospitals. Use any studies done on BFHI within country may be recorded.

Information Sources Used:

Guidelines 7A Quantitative

7.1) ___ out of ___ total hospitals (both public & private)and maternity facilities offering maternity services have been designated “Baby Friendly” ___ %

| Criteria | √ Check only “one” |
|--|--------------------|
| 0 | 0 |
| 0.1 - 7% | 1 |
| 8 - 49% | 2 |
| 50 - 89% | 3 |
| 90 - 100% | 4 |
| Rating on BFHI quantitative achievements: | ___/4___ |

Guidelines:**Indicator 7B Qualitative**

Skilled training input in BFHI programme ___ out of ___ BFHI designated hospitals that have been certified after a minimum recommended training of 18 hours for all its staff working in maternity services. ___ %

| Criteria | Check only “one” |
|--------------------|------------------|
| 0 | 0 |
| 0.1-25% | 1 |
| 26-50% | 1.5 |
| 51 –75% | 2.5 |
| 75% and more | 3.5 |
| Total Score | ___/3.5___ |

Guidelines:**Indicator 7C Qualitative**

Quality of BFHI programme implementation:

| Criteria | √ Check that apply |
|---|--------------------|
| 7.3) BFHI programme relies on training of health workers | .5 |
| 7.4) A standard monitoring system is in place | .5 |
| 7.5) An assessment system relies on interviews of mothers | .5 |
| 7.6) Reassessment systems have been incorporated in national plans | .5 |
| 7.7) There is a time-bound program to increase the number of BFHI institutions in the country | .5 |
| Total Score | ___/2.5___ |

| | |
|--|-------|
| Total Score 7A, 7B and 7C | _____ |
| Conclusions and Recommendations | |
| Summarize how the country is doing in achieving Baby Friendly Hospital Initiative targets (implementing Ten Steps to successful breastfeeding) in quantity and quality both. List any aspects of the Initiative needing improvement and why, any further analysis needed and | |

| |
|-----------------------------|
| recommendations for action: |
|-----------------------------|

Indicator 8: Implementation of the International Code

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

Background:

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

Nations are supposed to enact legislations as a follow-up to 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 and should also be considered. The Global Strategy for infant and young child feeding calls for heightened action on this target. According to WHO 162 out of 191 Member States have taken action to give effect to it but the ICDC’s report brings out the fact that only 32 countries have so far brought national legislations that fully covers the Code. The ICDC uses criteria to evaluate the type of action.

The Code has been reaffirmed by the World Health Assembly several times while undertaking resolutions regarding various issues related with infant and young child feeding.

Possible Sources of Information:

Current data on Code implementation by country can be obtained from the International Code Documentation Centre (ICDC) of the International Baby Food Action Network (IBFAN), which publishes the “State of the Code by Country” report periodically www.ibfan.org/english/pdfs/btr04/soccountry04.pdf, the local Breastfeeding groups /IBFAN Focal Points’ office, or other groups that have conducted national surveys on Code compliance. Other key informants may include MOH, WHO and UNICEF officials.

Information Sources Used:

Guidelines

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

| Criteria | Scoring <i>√ Check those apply. If more than one is applicable, record the highest score.</i> |
|--|---|
| 8.1) No action taken | 0 |
| 8.2) The best approach is being studied | 1 |
| 8.3) National breastfeeding policy incorporating the Code in full or in part but not legally binding and therefore unenforceable | 2 |
| 8.4) National measures (to take into account measures other than law), awaiting final approval | 3 |
| 8.5) Administrative directive/circular implementing the Code in full or in part in health facilities with administrative sanctions | 4 |
| 8.6) Some articles of the Code as a voluntary measure | 5 |
| 8.7) Code as a voluntary measure | 6 |
| 8.8) Some articles of the Code as law | 7 |
| 8.9) All articles of the Code as law | 8 |
| 8.10) All articles of the Code as law, monitored and enforced | 10 |
| Total Score: | ___/10___ |

Conclusions and Recommendations

Summarize which aspects of Code compliance have been achieved and which need improvement and why, any further analysis needed and recommendations for action:

Indicator 9: Maternity Protection

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

Background:

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

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

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

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

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

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

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

Possible Sources of Information:

Interviews can be held with officials of the Ministry of Health, Labour, Welfare, or Women's Affairs and staff of NGOs such as IBFAN. Data on the ILO conventions and progress in ratifying them in various countries can be found on the ILO website. WABA also documents a country profile on the status of Maternity Protection www.waba.org.my/womenwork/mpc19nov04.pdf. It lists the length of maternity leave and paternity leave as well as who pays for these, breastfeeding breaks provided or not and if these are paid or unpaid.

Information Sources Used:

Guidelines for Indicator 9

Maternity Protection legislation, other policies and practices that protect and support breastfeeding: _____ points

| Criteria | Check \checkmark that apply |
|--|---|
| 9.1) Women covered by the national legislation are allowed the following weeks of paid maternity leave a. Any leave less than 14 weeks – 0.5 (score) b. 14 to 17weeks – 1 (score) c. 18 to 25 weeks– 1.5 (score) d. 26 weeks or more – 2 (score) | 2 |
| 9.2) Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily. a. Unpaid break – 0.5 (score) b. Paid break - 1 (score) | 1 |
| 9.3) Legislation obliges private sector employers of women in the country to give at least 14 weeks paid maternity leave and paid nursing breaks. | 1 |
| 9.4) There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector. | 1 |
| 9.5) Women in informal/unorganized and agriculture sector are: a. accorded some protective measures – 0.5 (score) b. accorded the same protection as women working in the formal sector – 1 (score) | 1 |
| 9.6) a. Information about maternity protection laws, regulations, or policies is made available to workers. – 0.5 (score) b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided. – 0.5 (score) | 1 |
| 9.7) Paternity leave is granted in public sector for at least 3 days. | 0.5 |
| 9.8) Paternity leave is granted in the private sector for at least 3 days. | 0.5 |
| 9.9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding. | 0.5 |
| 9.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period. | 0.5 |
| 9.11) ILO MPC No 183 has been ratified, or the country has a national law equal to or stronger than C183. | 0.5 |
| 9.12) The ILO MPC No 183 has been enacted, or the country has enacted provisions equal to or stronger than C183. | 0.5 |
| Total Score: | ___/10__ |

Indicator 10: Health and Nutrition Care Systems

Optimal infant and young child feeding includes exclusive breastfeeding for first six months and continued breastfeeding along with adequate and appropriate complementary feeding after six months to two years or beyond.

Key question: Do care providers in these systems undergo skills training, and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place? (See Annexure 1 - Education checklist)

Backgrounds:

The Global Strategy for Infant and Young Child Feeding indicates clearly how to achieve its targets and improving these services is critical for this. It has been documented that curriculum of providers is weak on this issue. And it is also seen that many of these health and nutrition workers lack adequate skills in counseling for infant and young child feeding which is essential for the success of breastfeeding.

Ideally, new graduates of health provider programmes should be able to promote optimal infant and young child feeding practices from the outset of their careers. All providers who interact with mothers and their young children should attain the basic attitudes, knowledge and skills necessary to integrate breastfeeding counseling, lactation management, and infant and young child feeding into their care. The topics can be integrated at various levels during education and job. Therefore the total programme should be reviewed to assess this.

Possible Sources of Information:

Interviews can be held with Ministry of Health and Nutrition or other relevant sectors, human resource personnel, trainers in counseling on infant and young child feeding, UNICEF, WHO, donors or other projects involved in curriculum review and reform, administrators and graduates. Review curricula or session plans for appropriate departments. Ask for written curricula. *See Education Checklist* for a list, which can be used to judge if infant and young child feeding learning objectives and content are adequate.)

Information Sources Used:

Guidelines

Health provider (pre-service) education: _____ points

| Criteria | Scoring <i>√ Check that apply</i> | | |
|--|--------------------------------------|------------|--------------|
| | Adequate | Inadequate | No Reference |
| 10.1) A review of health provider schools and pre-service education programmes in the country ⁴ indicates that infant and young child feeding curricula or session plans are adequate/inadequate | 2 | 1 | 0 |
| 10.2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care. | 2 | 1 | 0 |
| 10.3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers. ⁵ | 2 | 1 | 0 |
| 10.4) Health workers are trained with responsibility towards Code implementation as a key input. | 1 | 0.5 | 0 |
| 10.5) Infant feeding-related content and skills are integrated, as appropriate, into training programmes focusing on relevant topics (diarrheal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, etc.) | 1 | 0.5 | 0 |
| 10.6) These in-service training programmes are being provided throughout the country. ⁶ | 1 | 0.5 | 0 |
| 10.7) Child health policies provide for mothers and babies to stay together when one of them is sick | 1 | 0.5 | 0 |
| Total Score: | /10 | | |

Conclusions and Recommendations

Summarize which aspects of health and nutrition care system are good and which need improvement and why. Identify areas needing further analysis and recommendations for action.

⁴ Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. Which departments within various schools are responsible for teaching various topics may also vary. The assessment team should decide which schools and departments are most essential to include in the review, with guidance from educational experts on infant and young child feeding, as necessary.

⁵ The types of health providers that should receive training may vary from country to country, but should include providers that care for mothers and children in fields such as medicine, nursing, midwifery, nutrition and public health.

⁶ Training programmes can be considered to be provided "throughout the country" if there is at least one training programme in each region or province or similar jurisdiction.

Indicator 11: Mother Support and Community Outreach - Community-based Support for the pregnant and breastfeeding mother

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

Backgrounds:

Community-based support for women is essential for succeeding in optimal breastfeeding practices. Step 10 of BFHI and the Global Strategy for IYCF, which includes mother support and peer support, recognizes this need. Mother Support, as defined by the Global Initiative for Mother Support (GIMS) is

“any support provided to mothers for the purpose of improving breastfeeding practices for both mother and infant and young child.” Women need the support of evidence-based public health policies, health providers, employers, friends, family, the community, and particularly of other women and mothers.

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

The activities in these contexts include woman-to-woman support, individual or group counseling, home visits or other locally relevant support measures and activities that ensure women have access to adequate, supportive and respectful information, assistance and counseling services on infant and young child feeding. Mother support enhanced by community outreach or community-based support has been found to be useful in all settings to ensure exclusive breastfeeding for the first six months and continued breastfeeding with appropriate and local complementary foods for 2 years or more. There needs to be a review and evaluation of existing community support systems, especially for the provision of counseling in infant and young child feeding. Women who deliver in a hospital need continued support in the home and in the community, with support for all members of the family, including the father and grandmother of the baby.

Possible Sources of Information:

Discussions can be held with representatives of the Ministry of Health, Nutrition, Ministry of Social Welfare, Ministry of Women’s Affairs or any government organization involved in social welfare, the National Breastfeeding (or Infant and Young Child Feeding) Coordinator, Mother support groups, Breastfeeding groups or representatives from NGOs, such as IBFAN, WABA and LLLI involved in infant and young child feeding.

Information Sources Used:**Guidelines**

Community based initiatives: _____ points

| Criteria | Scoring | | |
|--|---------------------------|----------------|----|
| | <i>√ Check that apply</i> | | |
| | Yes | To some degree | No |
| 11.1) All pregnant women have access to community-based support systems and services on infant and young child feeding. | 2 | 1 | 0 |
| 11.2) All women have access to support for infant and young child feeding after birth. | 2 | 1 | 0 |
| 11.3) Infant and young child feeding support services have national coverage. | 2 | 1 | 0 |
| 11.4) Community-based support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development strategy (inter-sectoral and intra-sectoral). | 2 | 1 | 0 |
| 11.5) Community-based volunteers and health workers possess correct information and are trained in counseling and listening skills for infant and young child feeding. | 2 | 1 | 0 |
| Total Score: | /10 | | |
| Conclusions and Recommendations | | | |
| Summarize which aspects of a health and nutrition care system are adequate and which need improvement and why. Identify areas needing further analysis and recommendations for action. | | | |

Indicator 12: Information Support

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

Background:

Information, education and communication (IEC) strategies are critical aspects of a comprehensive programme to improve infant and young child feeding practices. IEC approaches may include the use of electronic (TV, radio, video), print (posters, counseling cards, flip charts, manuals, newspapers, magazines), interpersonal (counseling, group education, support groups) and community activities to communicate important information and motivational material to mothers, families and the community.

Behavior change is an important strategy, often used in counseling sessions, home visits, action-oriented group discussions and dramas focused on problem solving. 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.

Possible Sources of Information:

Interviews can be held with representatives of national communication or information agencies, national TV and radio stations, officials of the Ministry of Health such as the National Breastfeeding (or Infant and Young Child Feeding) Coordinator/Committees, nutrition and health education officers, Ministry of Women and Child development /Social Welfare officials, and representatives of UNICEF, WHO and NGOs. Consider reviewing samples of electronic media spots and printed material, and observing counseling, education and community media events.

Information Sources Used:

Guidelines

Are comprehensive Information, education and communication (IEC) strategies for improving infant and young child feeding practices (breastfeeding and complementary feeding) being implemented?

| Criteria | Scoring | | |
|---|---------------------------|----------------|----|
| | <i>√ Check that apply</i> | | |
| | Yes | To some degree | No |
| 12.1) There is a comprehensive national IEC strategy for improving infant and young child feeding. | 2 | 1 | 0 |
| 12.2) IEC programmes (eg World Breastfeeding Week) that include infant and young child feeding are being actively implemented at local levels | 2 | 1 | 0 |
| 12.3) Individual counseling and group education services related to infant and young child feeding are available within the health/nutrition care system or through community outreach. | 2 | 1 | 0 |
| 12.4) The content of IEC messages is technically correct, sound, based on national or international guidelines. | 2 | 1 | 0 |
| 12.5) A national IEC campaign or programme ⁷ using electronic and print media and activities has channeled messages on infant and young child feeding to targeted audiences in the last 12 months. | 2 | 1 | 0 |
| Total Score: | /10 | | |
| Conclusions and Recommendations | | | |
| Summarize which aspects of the IEC programme are good and which need improvement and why. Identify areas needing further analysis and recommendations for action. | | | |

⁷ An IEC campaign or programme is considered “national” if its messages can be received by the target audience in all major geographic or political units in the country (e.g., regions or districts).

Indicator 13: Infant Feeding and HIV

Key question: Are policies and programmes in place to ensure that HIV - positive mothers are informed about the risks and benefits of different infant feeding options and supported in carrying out their infant feeding decisions? (See Annexure 2 - WHO HIV and infant feeding technical consultation consensus statement).

Background:

The Global Strategy for IYCF highlights the importance of correct policy and programme work in this area for achieving the targets. The UN Framework for priority action on infant feeding and HIV activities lists:

1. Develop or revise (as appropriate) a comprehensive national infant and young child feeding policy, which includes HIV and infant feeding.
2. Implement and enforce the International Code of Marketing of Breastmilk substitutes and subsequent relevant WHA resolutions
3. Intensify efforts to protect, promote and support appropriate infant and young child feeding practices in general, while recognizing HIV as one of a number of exceptionally difficult circumstances.
4. Provide adequate support to HIV-positive women to enable them to select the best feeding option for themselves and their babies, and to successfully carry out their infant feeding decisions.
5. Support research on HIV and infant feeding, including operations research, learning, monitoring and evaluation at all levels, and disseminate findings.

The risk of HIV transmission through breastfeeding presents policy makers, infant feeding counselors 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 stigmatization (e.g. if not breastfeeding may signal the mother's HIV status), the financial costs of replacement feeding⁸ and the risk of becoming pregnant again. Policies and programmes to meet this challenge should provide access to HIV voluntary and confidential counseling and testing (VCCT) and, for HIV-positive mothers, counseling and support for the chosen method of feeding, such as safe exclusive breastfeeding or exclusive artificial feeding. Safeguards should be in place to protect, promote and support breastfeeding in the rest of the population.

Possible Sources of Information:

The National AIDS Control Programme (or equivalent) and Department of Nutrition or Child Health within the Ministry of Health should be able to provide information on the availability

⁸ feeding infants who are receiving no breastmilk with a diet that provides all the nutrients infants need until the age at which they can be fully fed on family foods. During the first 6 months of life, replacement feeding should be with a suitable breastmilk substitute. After 6 months the suitable breastmilk substitute should be complemented with other foods

and uptake of VCCT among pregnant women and on the content and availability of infant feeding counseling. International recommendations related to HIV and infant feeding are available from UNAIDS, UNICEF and WHO, WHO HIV and Infant Feeding Technical Consultation and other sources.

Information Sources Used:

Guidelines

Are policies and programmes in place to ensure that HIV – positive mothers are informed about risks and benefits of different infant feeding options and supported in carrying out their infant feeding decisions?

| Criteria | Scoring | | |
|--|---------------------------|----------------|----|
| | √ <i>Check that apply</i> | | |
| | Yes | To some degree | No |
| 13.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding and HIV | 2 | 1 | 0 |
| 13.2) The infant feeding and HIV policy gives effect to the International Code/ National Legislation | 1 | 0.5 | 0 |
| 13.3) Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counseling and support. | 1 | 0.5 | 0 |
| 13.4) Voluntary and Confidential Counseling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners. | 1 | 0.5 | 0 |
| 13.5) Infant feeding counseling in line with current international recommendations and locally appropriate is provided to HIV positive mothers. | 1 | 0.5 | 0 |
| 13.6) Mothers are supported in making their infant feeding decisions with further counseling and follow-up to make implementation of these decisions as safe as possible. | 1 | 0.5 | 0 |
| 13.7) Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population. | 1 | 0.5 | 0 |
| 13.8) On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding | 1 | 0.5 | 0 |

Indicators

| | | | |
|---|------------|-----|---|
| on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status. | | | |
| 13.9) The Baby-friendly Hospital Initiative incorporates provision of guidance to hospital administrators and staff in settings with high HIV prevalence on how to assess the needs and provide support for HIV positive mothers. | 1 | 0.5 | 0 |
| Total Score: | /10 | | |
| Conclusions and Recommendations | | | |
| Summarize which aspects of HIV and infant feeding programming are good and which need improvement and why. Identify areas needing further analysis and recommendations for action. | | | |

Indicator 14: Infant Feeding during Emergencies

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

Backgrounds:

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 optimal infant and young child feeding practices and minimizing harmful practices should be shared by the emergency-affected host country and responding agencies. Concise Operational guidance on how to ensure appropriate feeding in emergency situations and comply with international emergency standards has been developed by interagency Infant Feeding in Emergencies Core Group. Practical details on how to implement the guidance are included in companion training materials, also developed through interagency collaboration. All these resources are available at www.enonline.net.

Possible Sources of Information:

The national authorities (or equivalent) responsible for emergency preparedness and response and designated staff in national health and nutrition programmes should be contacted for information on policy and guideline development and the implementation of preparedness activities for a detailed list of the criteria necessary to protect, promote and provide support for appropriate infant and young child feeding practices during emergencies. This list provides useful references and information to assist in scoring the criteria presented below.

Information Sources Used:

Guidelines

Are appropriate policies and programmes in place to ensure that mothers, infants and children will be provided adequate protection and support for appropriate feeding during emergencies?

| Criteria | Scoring | | |
|--|--------------------|----------------|----|
| | √ Check that apply | | |
| | Yes | To some degree | No |
| 14.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies | 2 | 1 | 0 |
| 14.2) Person(s) tasked with responsibility for national coordination with the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed | 2 | 1 | 0 |
| 14.3) An emergency preparedness plan to undertake activities to ensure exclusive breastfeeding and appropriate complementary feeding and to minimize the risk of artificial feeding has been developed | 2 | 1 | 0 |
| 14.4) Resources identified for implementation of the plan during emergencies | 2 | 1 | 0 |
| 14.5) Appropriate teaching material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel. | 2 | 1 | 0 |
| Total Score: | /10 | | |
| Conclusions and Recommendations | | | |
| Summarize which aspects of emergency preparedness are good and which need improvement and why. Identify areas needing further analysis and recommendations for action. | | | |

Indicator 15: Mechanisms of Monitoring and Evaluation System

Key question: Are monitoring and evaluation data routinely collected and used to improve infant and young child feeding practices?

Background:

Monitoring and evaluation (M & E) components should be built into all major infant and young child feeding programme activities and collection of data concerning feeding practices integrated into national nutritional surveillance and health monitoring systems or surveys. Monitoring or management information system data should be collected systematically and considered by programme managers as part of the management and planning process. When appropriate, both baseline and follow-up data should be collected to measure outcomes. Use of internationally agreed-upon indicators and data collection strategies should be considered, in an effort to increase availability of comparable data.⁹ It is important that strategies be devised to help insure that key decision-makers receive important evaluation results and are encouraged to use them.

Possible Sources of Information:

Interviews can be held with officials, programme managers, and/or evaluation specialists overseeing or conducting monitoring and evaluation activities within the national infant and young child-feeding programme. National Government that conducts surveys such as the Demographic and Health Survey (or a similar national survey) can provide information as well. Review any major evaluation reports that are available. Talk with key decision-makers who should receive and use M & E results. Country breastfeeding groups may also have information on this aspect.

Information Sources Used:

⁹ See the WHO report on indicators for assessing breastfeeding practices for suggestions concerning breastfeeding indicators and data collection strategies. The WHO is in the process of considering appropriate indicators for measuring complementary feeding practices.

Guidelines

Are monitoring and evaluation data routinely collected and used to improve infant and young child feeding practices?

| Criteria | Scoring | | |
|--|--------------------|----------------|----|
| | √ Check that apply | | |
| | Yes | To some degree | No |
| 15.1) Monitoring and evaluation components are built into major infant and young child feeding programme activities. | 2 | 1 | 0 |
| 15.2) Monitoring or Management Information System (MIS) data are considered by programme managers in the integrated management process. | 2 | 1 | 0 |
| 15.3) Adequate baseline and follow-up data are collected to measure outcomes for major infant and young child feeding programme activities. | 2 | 1 | 0 |
| 15.4) Evaluation results related to major infant and young child feeding programme activities are reported to key decision-makers | 2 | 1 | 0 |
| 15.5) Monitoring of key infant and young child feeding practices is built into a broader nutritional surveillance and/or health monitoring system or periodic national health surveys. | 2 | 1 | 0 |
| Total Score: | /10 | | |
| Conclusions and Recommendations | | | |
| Summarize which aspects of monitoring and evaluation are good and which need improvement and why. Identify areas needing further analysis and recommendations for action. | | | |

Summary part 1: Infant and young child feeding (IYCF) practices

| IYCF Practice | Result | Score |
|--|---------|-------|
| Indicator 1 Starting Breastfeeding (Initiation) | _____ % | |
| Indicator 2 Exclusive Breastfeeding for first 6 months | _____ % | |
| Indicator 3 Median duration of Breastfeeding | _____ % | |
| Indicator 4 Bottle-feeding | _____ % | |
| Indicator 5 Complementary Feeding | _____ % | |
| Score Part 1 (Total) | | |

Guideline:

| Scores (Total) Part-I | Colour-rating | Grading |
|-----------------------|---------------|---------|
| 0 - 15 | Red | D |
| 16 - 30 | Yellow | C |
| 31 - 45 | Blue | B |
| 46 – 50 | Green | A |

Summary of Results and Recommendations

Summarize which infant and young child feeding practices are good and which need improvement and why, any further analysis needed and recommendations for action:

In this summary sheet analysis is done based on what are the SCORES and where your country or region stands in terms of Infant and young child feeding practices individually or combined. It is good to analyze this with team of stakeholders. Find out reasons and draw a list of recommendations for your health and nutrition managers and policy makers.

Summary Part II: IYCF Polices and Programmes

| Targets: | Score (Out of 10) |
|--|-------------------|
| 1. National Policy, Programme and Coordination | |
| 2. Baby Friendly Hospital Initiative | |
| 3. Implementation of the International Code | |
| 4. Maternity Protection | |
| 5. Health and Nutrition Care | |
| 6. Community Outreach | |
| 7. Information Support | |
| 8. Infant Feeding and HIV | |
| 9. Infant Feeding during Emergencies | |
| 10. Monitoring and Evaluation | |

Summary of Conclusions and Recommendations

Summarize the achievements on the various programme components, what areas still need further work, and recommendations for action:

IBFAN Asia Guidelines for WBTi

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

| Scores | Colour- rating | Grading |
|----------|----------------|---------|
| 0 - 30 | Red | D |
| 31 - 60 | Yellow | C |
| 61 - 90 | Blue | B |
| 91 – 100 | Green | A |

Total of Part I and Part II (indicator 1-15): IYCF Practices and Policies and Programmes

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:

| Scores | Colour- rating | Grading |
|-----------|----------------|---------|
| 0 - 45 | Red | D |
| 46 – 90 | Yellow | C |
| 91 - 135 | Blue | B |
| 136 - 150 | Green | A |

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