

NaNA

National Nutrition Agency



World Breastfeeding Trends Initiative (WBTi)

The Gambia Report

June 2015





The Gambia Report



WBTi Assessment Report – The Gambia

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BFHI	Baby Friendly Hospital Initiative
BPNI	Breastfeeding Promotion Network of India
CRC	Committee on the Rights of the Child
DHS	Demographic and Health Survey
EBR	Exclusive Breastfeeding Rates
GDHS	Gambia Demographic and Health Survey
GLOPAR	Global Participatory Action Research
GSİYCF	Global Strategy for Infant and Young Child Feeding
HIV	Human Immune Virus
IBFAN	International Baby Food Action Network
ICDC	International Code Documentation Centre
ICMBS	International Code of Marketing of Breast-milk Substitutes
IEC	Information Education Communication
IFE	Infant and Young Child Feeding in Emergencies
ILO	International Labour Organization
IYCF	Infant and Young Child Feeding
LAM	Lactation Amenorrhoea Method
LLLI	La Leche League International
MICS	Multiple Indicator Cluster Survey
MPC	Maternity Protection Convention
MSG	Mother Support Groups
NaNA	National Nutrition Agency
NCD	Non Communicable Disease
NGO	Non Governmental Organization
NTAC	National Technical Advisory Committee
PEM	Protein Energy Malnutrition
PMTCT	Prevention of Mother to Child Transmission of HIV
UNICEF	United Nations Children's Fund
WABA	World Alliance for Breastfeeding Action
WBCi	World Breastfeeding Costing Initiative
WBTi	World Breastfeeding Trends Initiative
WHO	World Health Organization

INTRODUCTION

Background

The World Breastfeeding Trends Initiative (WBTi) is an initiative developed by IBFAN Asia, to assess the status and benchmark the progress of the implementation of the Global Strategy for Infant and Young Child Feeding at national level. The tool is based on two global initiatives; the first is WABA's Global Participatory Action Research (GLOPAR) and the second the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". The WBTi is designed to assist countries in assessing the strengths and weaknesses of their policies and programmes aimed at protecting, promoting and supporting optimal infant and young child feeding practices. The WBTi has identified 15 indicators in two parts, each indicator having specific significance.

Part I: Policy and Programmes (Indicators 1-10)	Part II: Infant feeding practices (Indicators 11-15)
<ol style="list-style-type: none"> 1. National Policy, Programme and Coordination 2. Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding) 3. Implementation of the International Code of Marketing of Breastmilk Substitutes 4. Maternity Protection 5. Health and Nutrition Care Systems (in support of breastfeeding & IYCF) 6. Mother Support and Community Outreach 7. Information Support 8. Infant Feeding and HIV 9. Infant Feeding during Emergencies 10. Mechanisms of Monitoring and Evaluation System 	<ol style="list-style-type: none"> 1. Early Initiation of Breastfeeding 2. Exclusive breastfeeding 3. Median duration of breastfeeding 4. Bottle feeding 5. Complementary feeding

A set of criteria has been developed for each indicator based on Global Strategy for Infant and Young Child Feeding (2002) and the Innocenti Declaration on Infant and Young Child Feeding (2005). For each indicator, there is a subset of questions. Answers to these can lead to identify achievements and gaps in national policies and programmes and therefore shows how a country is doing in a particular area of action on Infant and Young Child Feeding.

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. 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.

WBTi Assessment in The Gambia

The WBTi Assessment was a desk review of existing literature. The whole exercise lasted for three (3) days (1st to 3rd June 2015). On the last day, a draft report was produced that was validated on the 5th of June 2015. The process was at 2 levels: (a) Assessment of Policy and programmes; (b) Assessment of Infant and Young Child Feeding Practices.

Part 1: Policy and Programmes

Each indicator used for assessment had following components:

- Key question that needed to be investigated;
- Background on why the practice, policy or programme component was important; and
- A list of key criteria as subset of questions to be considered in identifying achievements and areas needing improvement, with guidelines for scoring, colour-rating and ranking how well the country was doing.

Part II: Infant and Young Child Feeding Practices

Specific numerical data on each practice was assessed based on data from random household survey that was national in scope¹. The data thus collected was entered into the web- based printed toolkit. The achievement on a particular indicator was then rated i.e. Red, Yellow, Blue and Green. The cut off points for each of these levels of achievement were then selected systematically based on an analysis of past achievements on these indicators in developing countries. These were incorporated from the WHO's tool. Definition of various quantitative indicators were taken from “ WHO's Indicators for assessing infant and young child feeding practices - 2008” [<http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/>].

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.

METHOD OF WORK

The coordination of the WBTi reassessment was undertaken by the National Nutrition Agency (NaNA), the government Agency mandated by the Food Act of 2005 to coordinate all nutrition and related activities in the country. Mr. Malang N. Fofana Ag. Deputy Executive Director and Programme Manager responsible for Nutrition Programme Implementation of the Agency was assigned the overall coordination of the assessment assisted by Mr. Bakary Jallow, Programme Manager responsible for Policy and Resource Mobilization.

A Core Group of assessors was formed comprising of the following: Mrs. Halimatou Jesuorobo – National AIDS Control Programme, Mr. Labbo Bah – Directorate of Health Promotion and Education and Mrs. Phebian Sagnia – Reproductive and Child Health Unit, all of the Ministry of Health and Social Welfare, Mrs. Horeja Dibba of the Child Fund (an NGO), Mr. Malang Ceesay of The Gambia Food and Nutrition Association (an NGO), Ms. Awa Nagib of The Gambia Bureau of Statistics, Mr. Stanley Mwase and Mrs. Aminata Sarr of UNICEF and Mr. Abdou Aziz Ceesay – Programme Manager, Mr. Alieu Kujabi - Principal Programme Officer, Mrs Fatou Drammeh – Senior Programme Officer, Mr. Musa B. Dahaba – Programme Officer, Ms Fatou Jankey Jawara – Programme Officer and Ms. Haddy Crookes – Programme Officer of the National Nutrition Agency. Also in attendance was Ms. Elise Hill, a Medical Student from the University of Iowa on internship at the National Nutrition Agency.

The process began by presentations on the objectives of the assessment, the current situation of IYCF in The Gambia and the overview of the WBTi process. After the presentations and discussions that followed, the assessors were divided into three (3) groups each assigned a set of indicators as shown in the Table 1.

Upon completion of the group tasks, the different groups presented their findings at a plenary where discussions, comments and suggestions ensued which led to the Final Draft Report that was reviewed and approved by stakeholders.

Table 1: Indicator Assignments

Group	Indicator	Members
One	1) National Policy, Programme and Coordination 2) Baby Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding) 3) Implementation of the International Code	Mr. Labbo Bah Ms. Fatou Jankey Jawara Ms. Elise Hill Mrs. Horeja Dibba Mr. Alieu Kujabi Mrs. Halimatou Bah
Two	4) Maternity Protection 5) Health and Nutrition Care Systems 6) Mother Support and Community Outreach – Community Based Support for the pregnant and breastfeeding mother 7) Information Support	Mr. Malang Ceesay Mrs. Phebian Sagnia Mr. Abdou Aziz Ceesay Ms. Haddy Crookes
Three	8) Infant Feeding and HIV 9) Infant Feeding in Emergencies 10) Mechanisms of monitoring and evaluation system	Mrs. Fatou Drammeh Mrs. Halimatou Jesuorobo Mr. Stanley Mwase Ms. Awa Nagib Mr. Musa B. Dahaba Mrs. Aminata Sarr
All	11) Early Initiation of Breastfeeding 12) Exclusive breastfeeding 13) Median duration of breastfeeding 14) Bottle feeding 15) Complementary feeding	Everyone

FINDINGS

Indicator 1: National Policy, Programme and Coordination

Key question: *Is there a national infant and young child feeding or breastfeeding policy that protects, promotes and supports optimal infant and young child feeding? Is the policy supported by a government programme? Is there a mechanism for coordination of infant and young child feeding such as a committee and/or coordinator? (Refer to Annex 1)*

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 (2002) calls for an urgent action from all member states to develop, implement, monitor and evaluate a comprehensive policy on IYCF. The Innocenti Declaration on Infant and Young Child Feeding (2005) captures the renewed commitments made at this historic anniversary meeting and records the additional five operational targets that were identified as part of the on-going global strategy on Infant and Young Child feeding including the WHA resolutions regarding IYCF. The Planning Guide for national implementation of the Global Strategy for Infant and Young Child Feeding (2007) calls for translation of the Global Strategy for Infant and Young Child Feeding into concrete focused national strategy, policy and action plans.

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

Information Sources

1. National Nutrition Policy (2010-2020);
2. National Health Policy (2012-2020);
3. Strategic Plan (2011-2015) for the Implementation of the National Nutrition Programme;
4. Food Act 2005; and
5. Scheme of Service and Service Rules (2007).

Conclusions

The National Nutrition Agency (NaNA) promotes appropriate policies and programmes as well as coordinates the promotion of Infant and Young Child Feeding Practices. This is done through supporting the promotion of infant and young child feeding practices; creating an enabling environment for mothers and care givers to be able to make and implement informed feeding choices; and raising public awareness on the main problems affecting infant and young child feeding.

Following the assessment, the exclusive breastfeeding rates of 48% were still below the international standards of 90% (Demographic Health Survey, 2013). Therefore, further strengthening of technically sound and consistent messages through appropriate media and educational channels would improve on optimal infant and young child feeding practices.

With regards to funding of the IYCF plan, all critical and major activities were funded although other activities were still very important for continued progress and improvement of IYCF practices in The Gambia, they required additional funding.

These national policies, programmes and their coordination fall under the delegation of the National Nutrition Agency. In order to adequately achieve these goals, a formally structured committee was established called the National Technical Advisory Committee (NTAC), which meets on a quarterly basis. This committee, together with adequate funding and review of the policy has led to the improvement of the IYCF rates.

Recommendations

1. Mobilize additional funds to implement other important activities that will improve and sustain IYCF practices; and
2. Update the strategic plan before its expiration in 2015.

Indicator 2: Baby Friendly Care and Baby-Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding²)

Key questions:

- What percentage of hospitals and maternity facilities that provides maternity services have been designated as “Baby Friendly” based on the global or national criteria?
- What is the quality of BFHI program implementation? (Refer to Annex 2.1, 2.2, 2.3)

Background

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

The ten steps to successful breastfeeding established, became the cornerstone of the global Baby-friendly Hospital Initiative launched in 1992 by both agencies. Several countries initiated action on BFHI and progress made so far has been in numbers. Reports suggest that fall back happens if the skills of health workers are not sufficiently enhanced. The Global Strategy for Infant and Young Child Feeding indicates the need for implementation of BFHI, monitoring and re-assessment of already designated facilities (materials developed in 1998) and expanding the Initiative to include clinics, health centers and paediatric hospitals. The Global Criteria continue to be the minimum requirement for all baby-friendly facilities. The Global Criteria were revised in 2005, both to update them to take account of new evidence regarding best practices and to ensure that the needs of non-breastfeeding mothers were fully met, as well as to provide new criteria for HIV and infant feeding and mother-friendly care, which could be included at the discretion of the national authority for BFHI.

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

The assessment focused on both quantitative and qualitative aspects. It looked at the percentages of hospitals and maternity facilities designated as BFHI and how it was monitored and evaluated and the expansion of the programme.

Guidelines – Quantitative Criteria

² The Ten Steps To Successful Breastfeeding: The BFHI promotes, protects, and supports breastfeeding through The Ten Steps to Successful Breastfeeding for Hospitals, as outlined by UNICEF/WHO. The steps for the United States are:

1. Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breastmilk, unless medically indicated.
7. Practice “rooming in”- allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

2.1) 0 out of 60 total hospitals (both public & private) and maternity facilities offering maternity services have been designated or reassessed as “Baby Friendly” in the last 5 years 0%

Guidelines for scoring	
Criteria	√ Check only one which is applicable
0	√0
0.1 - 20%	1
20.1 - 49%	2
49.1 - 69%	3
69.1-89 %	4
89.1 - 100%	5
Total rating	0/5

Guidelines – Qualitative Criteria

Quality of BFHI programme implementation:

Guidelines for scoring	
Criteria	√ Check that apply
2.2) BFHI programme relies on training of health workers using at least 20 hours training programme ³	1.0
2.3) A standard monitoring ⁴ system is in place	0.5
2.4) An assessment system includes interviews of health care personnel in maternity and post natal facilities	√0.5
2.5) An assessment system relies on interviews of mothers.	√0.5
2.6) Reassessment ⁵ systems have been incorporated in national plans with a time bound implementation	1.0
2.7) There is/was a time-bound program to increase the number of BFHI institutions in the country	√0.5
2.8) HIV is integrated to BFHI programme	√0.5
2.9) National criteria are fully implementing Global BFHI criteria (Refer to Annex 2.1)	√0.5
Total rating	2.5/5
Total Score	2.5/10

³ IYCF training programmes such as IBFAN Asia's '4 in 1' IYCF counseling training programme, WHO's Breastfeeding counseling course etc. may be used.

⁴ **Monitoring** is a dynamic system for data collection and review that can provide information on implementation of the *Ten Steps* to assist with on-going management of the *Initiative*. It can be organized by the hospitals themselves or at a higher level in the system. Data should be collected either on an on-going basis or periodically, for example on a semi-annual or yearly basis, to measure both breastfeeding support provided by the hospitals and mothers' feeding practices.

⁵ **Reassessment** can be described as a "re-evaluation" of already designated baby-friendly hospitals to determine if they continue to adhere to the *Ten Steps* and other baby friendly criteria. It is usually planned and scheduled by the national authority responsible for BFHI for the purpose of evaluating on-going compliance with the *Global Criteria* and includes a reassessment visit by an outside team. Because of the human and financial resources required, in many countries it may be feasible to reassess hospitals only once every three years, but the final decision concerning how often reassessment is required should be left to the national authority.

Information Sources

- Infant and young child feeding counseling: An Integrated Course (2006); and
- Strategic Plan (2011-2015) for the implementation of the National Nutrition Programme.

Conclusion

Since its inception in The Gambia in 1993, the BFHI protects, promotes and supports breastfeeding, especially initiation, exclusive breastfeeding for six months and continued breastfeeding up to 2 years and beyond. It is focused on health care facilities offering maternity services. As of now, none of these facilities are currently designated as baby friendly. One of the major challenges of the successful implementation of the BFHI is the high attrition rate of the health care staff, which hinders continued progress. In addition, the training currently in use is out-dated. In order to improve upon this, efforts should be made to address the high attrition rate and an updated training manual should be adopted that includes at least 20 hours of training, standard monitoring, and a structured reassessment process. When this is achieved, health care facilities can be designated as baby friendly hospitals.

Gaps

- o Outdated training manual;
- o The health facilities are not being assessed on BFHI;
- o Inadequate implementation of BFHI policy;
- o Human resource (staff turn over & attrition rate); and
- o Inadequate Monitoring and Evaluation within health care facilities.

Recommendations

- Updated training manual must be adopted that includes at least 20 hours of training;
- Strengthen Information Education Communication;
- Assessment of health facilities needs to be carried out;
- Strengthen implementation of BFHI policy; and
- Strengthen monitoring and evaluation.

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

Key question: *Is the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions in effect and implemented? Has any new action been taken to give effect to the provisions of the Code? (Refer to Annex 3.1 and 3.2)*

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 International Code Documentation Center (ICDC) on countries’ progress in implementing the Code provides sufficient information on the action taken.

Nations are supposed to enact legislations as a follow-up to the International Code. Several relevant subsequent World Health Assembly resolutions, which strengthen the International Code have been adopted since then and have the same status as the Code and should also be considered. The Global Strategy for infant and young child feeding calls for heightened action on this target. According to WHO 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.

A report by WHO (2013) “Country implementation of the international code of marketing of breast-milk substitutes: status report 2011” has also highlighted dismal status of the global implementation of the International Code. http://apps.who.int/iris/bitstream/10665/85621/1/9789241505987_eng.pdf

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

Guidelines for scoring	
Criteria (Legal Measures that are in Place in the Country)	Scoring
3a: Status of the International Code of Marketing	
√ (Check that apply. If more than one is applicable, record the highest score.)	
3.1 No action taken	0
3.2 The best approach is being considered	0.5
3.3 National Measures awaiting approval (for not more than three years)	1
3.4 Few Code provisions as voluntary measure	1.5
3.5 All Code provisions as a voluntary measure	2
3.6 Administrative directive/circular implementing the code in full or in part in health facilities with administrative sanctions	3
3.7 Some articles of the Code as law	4
3.8 All articles of the Code as law	5

Guidelines for scoring	
Criteria (Legal Measures that are in Place in the Country)	Scoring
3.9 Relevant provisions of WHA resolutions subsequent to the Code are included in the national legislation ⁶	
a. Provisions based on at least 2 of the WHA resolutions as listed below are included	√5.5
b. Provisions based on all 4 of the WHA resolutions as listed below are included	6
3b: Implementation of the Code/National legislation	
3.10 The measure/law provides for a monitoring system	√1
3.11 The measure provides for penalties and fines to be imposed to violators	√1
3.12 The compliance with the measure is monitored and violations reported to concerned agencies	√1
3.13 Violators of the law have been sanctioned during the last three years	√1
Total Score (3a + 3b)	9.5/10

Information Sources

FOOD ACT, 2005 (2005 No. 9) Breastfeeding Promotion Regulations 2006

Conclusion

The Breastfeeding Promotion Regulations of 2006, enacted under the Food Act of 2005, successfully implement the International Code of Marketing of Breast-milk Substitutes (ICMBS). The regulations cover all of the articles presented in the ICMBS, to include implementation of the code in health facilities with administrative sanctions. In addition, the law also allows for a monitoring system and penalties as well as fines and reporting. However, since the Breastfeeding Promotion Regulations were adopted, additional resolutions have been added to the ICMBS, specifically addressing conflicts of interest. In order to reflect the changes made to the ICMBS, updated Breastfeeding Promotion Regulations must be adopted. In 2008, The Gambia scored 10/10 on this indicator as compared to 9.5/10 in 2015 because the Breastfeeding Promoting Regulations of 2006 do not take into account the WHA resolutions of 2008. The improved grading system of 2015 has revealed this gap.

Gaps

The law has not been updated to take account of WHA resolutions past after 2006 including conflicts of interest

Recommendations

Update the regulation to capture the recent World Health Assembly Resolutions including conflicts of interest

⁶ Following WHA resolutions should be included in the national legislation/enforced through legal orders to tick this score.

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

Indicator 4: 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? (Refer Annex 4)*

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 workingwomen 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; and
- 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.

Guidelines for scoring	
Criteria	Tick one which is applicable
4.1) Women covered by the national legislation are allowed the following weeks of paid maternity leave <ul style="list-style-type: none"> a) Any leave less than 14 weeks b) 14 to 17weeks c) 18 to 25 weeks d) 26 weeks or more 	0.5 1 √1.5 2
4.2) Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily. <ul style="list-style-type: none"> a) Unpaid break b) Paid break 	0.5 1

Guidelines for scoring	
Criteria	Tick one which is applicable
4.3) Legislation obliges private sector employers of women in the country to give a) at least 14 weeks paid maternity leave b) paid nursing breaks	√0.5 0.5
4.4) There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector (<i>more than one may be applicable</i>) a) Space for Breastfeeding/Breastmilk expression b) Crèche	√1 0.5
4.5) Women in informal/unorganized and agriculture sector are: a) accorded some protective measures b) accorded the same protection as women working in the formal sector	0.5 √1
4.6). (<i>more than one may be applicable</i>) a) Information about maternity protection laws, regulations, or policies is made available to workers. b) There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	√0.5 √0.5
4.7) Paternity leave is granted in public sector for at least 3 days.	√0.5
4.8) Paternity leave is granted in the private sector for at least 3 days.	√0.5
4.9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	√0.5
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	√1
Total Score:	7.5/10

Information Sources

1. Women's Act 2010;
2. National Nutrition Policy 2010-2020; and
3. Nutrition Strategic Plan 2011 – 2015.

Conclusion

This assessment has shown a marked improvement when compared to the first assessment conducted in 2008 that had a score of 2.5. This can be attributed to the enactment of the Women's Act 2010 and the development of the National Nutrition Policy (2010 – 2020). The Women's Act has incorporated some of the ILO Maternity Protection Conventions that recommend a maternity leave of at least 14 weeks and paternity leave. This act provides women with 6 months (24 weeks) of paid leave and their partners are also entitled to a paid leave of 10 working day (paternity leave).

The Nutrition Strategic Plan (2011 – 2015) has clearly indicated strategies that promote maternity protection. Examples of these strategies are (i) advocating for the domestication of the ILO Maternity Protection Convention 183 and (ii) advocating for the provision of an enabling environment to facilitate breastfeeding at workplaces.

Both national policies does not clearly specify the number of break hours to be accorded to lactating mothers during working hours; however, many institutions are flexible in giving time to these mothers in addition to the paid break.

Gaps

National policies and the Women’s Act do not provide for breastfeeding breaks or shorter working hours for breastfeeding mothers.

Recommendations

The National Nutrition Policy should promote the provision of breastfeeding breaks or shortened working hours for breastfeeding mothers or promote the creation of crèches at work places like the construction of rest houses in the farms.

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

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? (Refer to Annex 5.1 and 5.2)*

Background

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

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

Guidelines for scoring			
Criteria	Scoring - \checkmark Check that apply		
	Adequate	Inadequate	No Reference
5.1) A review of health provider schools and pre-service education programmes for health professionals, social and community workers in the country ⁷ indicates that infant and young child feeding curricula or session plans are adequate/inadequate	$\sqrt{2}$	1	0
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care. (See Annex 5b Example of criteria for mother-friendly care)	2	$\sqrt{1}$	0
5.3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers. ⁸	$\sqrt{2}$	1	0
5.4) Health workers are trained on their responsibility under the Code implementation / national regulation throughout the country.	1	$\sqrt{0.5}$	0
5.5) Infant feeding and young feeding information and skills are integrated, as appropriate, into training programmes focusing on (diarrheal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, breast cancer, women's health, NCDs etc.)	$\sqrt{1}$	0.5	0

⁷ 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.

⁸ 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.

Guidelines for scoring			
Criteria	Scoring - $\sqrt{\text{Check that apply}}$		
	Adequate	Inadequate	No Reference
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country. ⁹	$\sqrt{1}$	0.5	0
5.7) Child health policies provide for mothers and babies to stay together when one of them is sick.	$\sqrt{1}$	0.5	0
Total Score:	8.5/10		

Information Sources

1. National Nutrition Policy 2010-2020;
2. Infant and Young Child Feeding Counselling Cards for Community Workers 2014;
3. National Maternity Care Guidelines and Service Delivery Standards 2014;
4. Breastfeeding Promotion Regulations 2006;
5. Integrated Management of Acute Malnutrition Protocol 2012;
6. Nutrition Education for Lower Basic Schools Pupils Book 6, 2012; and
7. IMCI 1999.

Conclusion

The findings of this assessment have shown an improvement on this indicator compared to the results of the 2008 assessment. This may be attributed to the inclusion of IYCF in the curricula of health training institutions as well as their teaching complemented with in-service training of health providers. Though there exists many mother-baby friendly guidelines, gaps still remain that should be filled in order to fully incorporate all mother-baby friendly care procedures, including choice of position during birth.

Gap

Inadequate mother and baby friendly guidelines

Recommendation

Develop adequate mother and child friendly guidelines that are disseminated to all health facilities and health workers that include all guidelines, to include freedom to choose position during birth.

⁹ 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 6: 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 (Refer to Annex 6)*

Background

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

Women need the support of evidence-based public health policies, health providers, employers, friends, family, the community, and particularly of other women and mothers in regards to preparation for breastfeeding. Such support could come during pregnancy and postpartum as well as after delivery. Community volunteers at community level or health workers under the health care system can offer and ensure sustained support is given to mothers. The knowledge and skills of such structures have to be of the highest quality. Such knowledge and skills could be acquired through training.

In addition, it is necessary to have appropriate counseling in the community for motivation and increasing confidence in breastfeeding and home based complementary feeding. The support to mothers can be provided at doorsteps by women’s groups for example mother support group (MSG) who are composed of some successful mothers and others of the same community. Mother support group is a core component of empowerment of the women. With correct knowledge at community and outreach levels, mothers can practice exclusive breastfeeding up to six months and continued breastfeeding for two years or beyond and start home based appropriate complementary food.

Other important area is to consider the people living in remote areas where services are difficult to access. Support by peers in community and mothers support groups have shown increasing Exclusive breastfeeding and appropriate Complementary feeding rates even in large-scale interventions. The quality of interaction and counselling are critical issues. Community counselling and services on IYCF should be focused to new mothers, and various vulnerable groups.

Guidelines for scoring			
Criteria	Scoring		
	Yes	To some degree	No
6.1) All pregnant women have access to community-based ante-natal and post -natal support systems with counseling services on infant and young child feeding.	√2	1	0
6.2) All women receive support for infant and young child feeding at birth for breastfeeding initiation.	√2	1	0
6.3) All women have access to counseling support for Infant and young child feeding counseling and support services have national coverage.	√2	1	0

Guidelines for scoring			
Criteria	Scoring		
	Yes	To some degree	No
6.4) Community-based counseling through Mother Support Groups (MSG) and support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development policy IYCF/Health/Nutrition Policy.	√2	1	0
6.5) Community-based volunteers and health workers are trained in counseling skills for infant and young child feeding.	√2	1	0
Total Score:	10/10		

Information Sources

1. National Maternity Care Guidelines and Service Delivery Standards 2014;
2. Infant and Young Child Feeding Counseling Cards for Community Workers 2014;
3. National Nutrition Policy 2010-2020; and
4. NaNA Annual Report 2013.

Conclusion

There is an extensive community based support system that provides up to date information to pregnant women and mothers. This system is based on existing structures within the health sector as well as in the community. Community support is provided nationally since it relies on both the antenatal and infant welfare clinics for which there is a very high coverage. The assessment has shown an improvement in this indicator compared to the 2008 assessment findings.

Recommendation

The Agency (NaNA) has registered the highest score under the mother support and community outreach indicator; it is therefore crucial for the Agency to sustain the gains registered

Indicator 7: 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? (Refer to Annex 7.1 and 7.2)*

Background

Women and/or carers having the right to appropriate and objective information, education and communication (IEC) strategies which are important aspects of a comprehensive programme to improve infant and young child feeding practices. However, because such programmes are expensive and often take place within a commercial context, they tend to attract inappropriate funding, for example, from the baby feeding industry. This can undermine the effectiveness of any campaign and lead to unwise decision-making. The first crucial step in an information strategy should be to ensure that baby feeding industry influence of such messaging is kept to an absolute minimum. IEC approaches may 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.

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

Guidelines for scoring			
Criteria	Scoring - $\sqrt{\text{Check that apply}}$		
	Yes	To some degree	No
7.1) There is a national IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence/ potential conflicts or interest are avoided.	$\sqrt{2}$	0	0
7.2a) National health/nutrition systems include individual counselling on infant and young child feeding	$\sqrt{1}$.5	0
7.2b) National health/nutrition systems include group education and counselling services on infant and young child feeding	$\sqrt{1}$.5	0
7.3) IYCF IEC materials are objective, consistent and in line with national and/or international recommendations and include information on the risks of artificial feeding	$\sqrt{2}$	1	0
7.4. IEC programmes (eg World Breastfeeding Week) that include infant and young child feeding are being implemented at local level and are free from commercial influence	$\sqrt{2}$	1	0

Guidelines for scoring			
Criteria	Scoring - \sqrt Check that apply		
	Yes	To some degree	No
7.5 IEC materials/messages to include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF). ¹⁰	\sqrt 2	0	0
Total Score:	10/10		

Information Sources

- Nutrition Communication Strategy 2012- 2015;
- Infant and Young Child Feeding counseling cards for community workers 2014;
- National Nutrition Policy 2010-2020;
- NaNA Annual Report “NaNA working with the communities for better Health and Nutrition” December 2013; and
- Community Based Nutrition and Health Education Messages Booklet February 2015.

Conclusion

The existence of a national IEC strategy for improving IYCF practices in The Gambia incorporated in the Nutrition Communication Strategy and the accompanying IEC materials helped ensure that the results of the assessment for this indicator were the same as those recorded in 2008. The Gambia made it a tradition to celebrate the World Breastfeeding Week at both health facility and community levels, which gave it more prominence. The WBW celebrations were extended to the whole month of August. Both the print and electronic media were used to channel messages, which were technically correct, sound and based on both national and international guidelines to the general public. The development and dissemination of messages on IYCF were done without commercial influence.

Recommendation

The Agency managed to registered the highest score under comprehensive information, education and communication strategies for improving IYCF (breast feeding and complementary feeding). It is therefore of paramount importance that the Agency sustains the gains registered.

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

Indicator 8: Infant Feeding and HIV

Key question: *Are policies and programmes in place to ensure that HIV - positive mothers are supported to carry out the national recommended Infant feeding practice? (Refer to Annex 8.1& 8.2)*

Background

The HIV and infant feeding 2010: an updated framework for priority action¹¹ has suggested following activities to achieve HIV free survival for children.

- Develop or revise (as appropriate) a comprehensive evidence-based national infant and young child feeding policy which includes HIV and infant feeding;
- Promote and support appropriate infant and young child feeding practices, taking advantage of the opportunity of implementing the revised guidelines on HIV and infant feeding;
- Provide adequate support to HIV-positive women to enable them to successfully carry out the recommended infant feeding practice, including ensuring access to antiretroviral treatment or prophylaxis;
- Develop and implement a communication strategy to promote appropriate feeding practices aimed at decision-makers, health workers, civil society, community workers, mothers and their families; and
- Implement and enforce the International Code Marketing of Breastmilk substitutes and subsequent WHA resolutions

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

Optimal replacement feeding is rarely possible in resource-limited settings. Formula feeding is expensive and unreliable and consistent supplies of infant formula are difficult to maintain in countries with limited infrastructure for transport and storage. Even when formula is freely provided it may not be culturally acceptable and often puts the mother at risk of having her HIV status disclosed involuntarily to her family and community. In view of this, breastfeeding has remained the best feeding practice regardless of HIV status in most settings especially in the developing countries where HIV prevalence is high. Furthermore, evidence has shown that antiretroviral drugs (ARVs), either lifelong antiretroviral therapy (ART) or antiretroviral drug prophylaxis, that is given to the breastfeeding mother and the infant can reduce the risk of breastfeeding transmission to as low as one percent. The 2010 WHO Guidelines thus stipulate that national health authorities, or even sub-national authorities where appropriate, should decide whether health services will principally counsel and support mothers known to be HIV-infected to either breastfeed and receive ARV interventions (for themselves or for their infants), or, avoid all breastfeeding, as the strategy that will most likely give infants the greatest chance of remaining HIV uninfected and alive.

Policies and programmes to implement this effectively will require HIV Testing and Counselling (HTC) to be available and offered routinely to all mothers. Furthermore support should be provided

11 WHO 2010. WHO Guidelines on HIV and Infant Feeding: An updated framework for priority action. Available at: http://apps.who.int/iris/bitstream/10665/75152/1/FW_C_MCA_12.1_eng.pdf

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

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

In countries that recommend formula feeding for HIV-infected mothers, great care should be taken to ensure that Code-compliant infant formula is available only for those infants who need it. National authorities and/or the authority managing the emergency should establish whether the recommendation for formula feeding is still appropriate given the circumstances. Health staff dealing with mothers and infants requires preparation to be able to face circumstances they are likely to encounter in emergency situations, including supporting HIV-infected women.

Guidelines for scoring			
Criteria	Results		
	Yes	To some degree	No
8.1) The country has a comprehensive updated policy in line with international Guidelines on infant and young child feeding that includes infant feeding and HIV	√2	1	0
8.2) The infant feeding and HIV policy gives effect to the International Code/ National Legislation	√1	0.5	0
8.3) Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	√1	0.5	0
8.4) HIV Testing and Counselling (HTC)/ Provide Initiated HIV Testing and Counselling (PIHTC)/ Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	√1	0.5	0
8.5) Infant feeding counselling in line with current international recommendations and appropriate to local circumstances is provided to HIV positive mothers.	√1	0.5	0
8.6) Mothers are supported in carrying out the recommended national infant feeding practices with further counselling and follow-up to make implementation of these practices feasible.	√1	0.5	0
8.7) HIV positive breastfeeding mothers, who are supported through provision of ARVs in line with the national recommendations, are followed up and supported to ensure their adherence to ARVs uptake.	√1	0.5	0
8.8) Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	√1	0.5	0
8.9) On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	√1	0.5	0
Total Score:		10/10	

Information Sources

- Gambia National Nutrition Policy (2010-2020);

- PMTCT Guidelines 2010;
- Breast Feeding Promotion Regulation 2006;
- PMTCT Training Manual 2008 revised 2013; and
- Nutrition Communication Strategy 2012.

Conclusion

There was an improvement from the score of 9 in the 2008 assessment to 10 in 2015 due to full integration of infant feeding into the PMTCT policy. In addition, in 2015, antibody testing was done for all exposed infants at the age of 16 to 18 months. The country had started Polymerase Chain Reaction (PCR) testing for exposed infants in November 2014 and this test identified that the viral DNA could be done as early as six weeks of the infant's age.

At the time of the 2015 assessment, counsellors had been trained in almost all MTCT sites (34 of 48) on IYCF in both private and public facilities. Mothers were also counselled on HIV and infant feeding at every appointment and during follow-up visits and their chosen method of feeding was also supported. Counselling support on IYCF was given when HIV positive mothers were in stress or wanted to change an option. Assistance was also provided to a couple or partners and/or family members to counteract stigma associated with stopping breastfeeding at 6 months for mothers living with HIV.

Gaps

- IYCF (including IYCF in relation to HIV/AIDS) is not comprehensively captured within the nutrition policy and strategy; and
- Inadequate funding to scale up interventions in IYCF/HIV.

Recommendations

- Strengthen IYCF/HIV in the development of the national nutrition strategy; and
- Mobilise more resources to support IYCF/HIV interventions.

Indicator 9: Infant and Young Child Feeding During Emergencies

Key question: *Are appropriate policies and programmes in place to ensure that mothers, infants and young children will be provided adequate protection and support for appropriate feeding during emergencies? (Refer to Annex 9)*

Background

Infants and young children are among the most vulnerable groups in emergencies. Absence of or inadequate breastfeeding and inappropriate complementary feeding increase the risks of undernutrition, illness and mortality. In emergency and humanitarian relief situations, the emergency-affected host country and responding agencies share the responsibility for protecting, promoting and supporting optimal infant and young child feeding practices and minimizing harmful practices. Concise Operational guidance on how to ensure appropriate feeding in emergency situations and comply with international emergency standards has been developed by an interagency Infant Feeding in Emergencies Core Group and was adopted at WHA 63.23 in 2010 (Infant and Young Child Feeding in Emergencies. Operational Guidance for emergency and relief staff and program managers, version 2.1, 2007, IFE Core group <http://www.enonline.net/resources/6>). Practical details on how to implement the guidance summarized in the Operational Guidance are included in companion training materials, also developed through interagency collaboration as well as part of the UN Nutrition Cluster capacity building materials. All these resources are available at www.enonline.net/IFE

Guidelines for scoring			
Criteria	Scoring		
	Yes	To some degree	No
9.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance	2	√1	0
9.2) Person(s) tasked with responsibility for national coordination with all relevant partners such as the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed	2	√1	0
9.3) An emergency preparedness and response plan based on the practical steps listed in the Operational Guidance has been developed and put into effect in most recent emergency situations, and covers:			
a) basic and technical interventions to create an enabling environment for breastfeeding, including counselling by appropriately trained counsellors, support for re-lactation and wet-nursing, and protected spaces for breastfeeding; and	1	√0.5	0
b) measures to minimize the risks of artificial feeding, including an endorsed statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsolicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions	1	√0.5	0
9.4) Resources have been allocated for implementation of the emergency preparedness and response plan	2	√1	0

Guidelines for scoring			
Criteria	Scoring		
	Yes	To some degree	No
9.5)			
a) Appropriate orientation and training material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.	1	√0.5	0
b) Orientation and training is taking place as per the national emergency preparedness and response plan	1	√0.5	0
Total Score:	5/10		

Information Sources

- National Nutrition Policy (2010-2020); and
- Strategic Plan for the Implementation of the National Nutrition Programme 2011 -2015

Conclusion

The 2008 assessment score for The Gambia was 0 and 5 in 2015 and the change was as a result of inclusion of IFE in the National Nutrition Policy and Strategic Plan; however not all the elements of the WHO guidelines on IFE were included. There were no resources mobilized to fund IFE related activities in the National Nutrition Strategic Plan. There were resources allocated to emergency preparedness but not specific to IFE. NaNA, as the Agency responsible for nutrition, had a focal person for IYCF but there was no one specifically appointed for IFE.

Gaps

- o No nutrition or IYCF in the national disaster management policy and programme;
- o IFE not integrated in pre service and in service trainings; and
- o No national guideline available on nutrition in emergencies.

Recommendations

- Include nutrition and IYFC in the national disaster management policy and strategic plan;
- Advocate for resource mobilization for emergency preparedness for nutrition and IYFC;
- Integrate IFE in the pre and in service trainings;
- Develop guidelines for nutrition in emergencies; and
- There is need for the NTAC to form a sub group mandated with coordinating IYCF activities in general, which will include IFE.

Indicator 10: Mechanisms of Monitoring and Evaluation System

Key question: *Are monitoring and evaluation systems in place that routinely collect, analyze and use data to improve infant and young child feeding practices? (Refer to Annex 10.1)*

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.

Periodic monitoring or management information system data should be collected systematically, analysed and considered by programme managers as part of the planning, management and implementation process. When appropriate, both baseline and follow-up data should be collected to measure outcomes. Unified criteria on the use of internationally agreed-upon indicators and data collection strategies should be considered, in an effort to increase availability of comparable data.¹² It is important to devise strategies to assure that results of important evaluation are used to assure evidence-based decision-making.

Guidelines for scoring			
Criteria	Scoring - $\sqrt{}$ Check that apply		
	Yes	To some degree	No
10.1) Monitoring and evaluation components are built into major infant and young child feeding programme activities.	$\sqrt{2}$	1	0
10.2) Data/information on progress made in implementing the IYCF programme are used by programme managers to guide planning and investments decisions	$\sqrt{2}$	1	0
10.3) Data on progress made in implementing IYCF programme activities routinely collected at the sub national and national levels	$\sqrt{2}$	1	0
10.4) Data/Information related to infant and young child feeding programme progress are reported to key decision-makers	$\sqrt{2}$	1	0
10.5) Monitoring of key infant and young child feeding practices is integrated into the national nutritional surveillance system, and/or health information system or national health surveys.	$\sqrt{2}$	1	0
Total Score:	10/10		

¹² See the WHO Indicators for assessing infant and young child feeding practices for suggestions concerning Infant and Young Child Feeding indicators and data collection strategies.

Information Sources

- National Nutrition Policy 2010 – 2020;
- Policy Guidelines for the Prevention of Mother to Child Transmission in The Gambia 2010;
- Strategic plan for implementation of the national nutrition programme 2011 – 2015;
- National Nutrition and HIV programme reports;
- Gambia Demographic Health Survey (GDHS) 2013; and
- Multiple Indicator Cluster Survey (MICS) 4 (2010).

Conclusions

Compared to the 2008 assessment score of 8, the 2015 score was 10 due to the inclusion of IYCF in the 2013 Gambia Demographic Health Survey (GDHS) and the District Health Information System (DHIS 2).

Recommendations

Maintain good coordination at the central level and strengthen monitoring at the regional level

Indicator 11: Early Initiation of Breastfeeding

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

Definition of the indicator: *Proportion of children born in the last 24 months who were put to the breast 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 rural areas. Breastfeeding is started late in many of these settings due to cultural or other beliefs. According to the new guidelines on Baby Friendly Hospital Initiative (BFHI) “Step” 4 of the Ten Steps to Successful Breastfeeding, “the baby should be placed “skin-to-skin” with the mother in the first half an hour following delivery and offered the breast within the first hour in all normal deliveries. If the mother has had a caesarean section the baby should be offered breast when mother is able to respond and it happens within few hours of the general anaesthesia”. Mothers who have undergone caesarean 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 trial has shown that early initiation of breastfeeding could reduce neonatal mortality by 22%.¹³

Guideline:

Indicator 11	Key to rating adapted from WHO tool (Refer to Annex 11.1)	IBFAN Asia Guideline for WBTi	
		Scores	Colour-rating
Initiation of Breastfeeding (within 1 hour)	0.1 - 29%	3	Red
	29.1 - 49%	6	Yellow
	49.1 - 89% [52%]	9	Blue
	89.1 - 100%	10	Green

Data Source

- Demographic Health Survey, 2013

Summary Comments

Breast Feeding Initiation has improved from 48% in 2008 to 52% in 2015, resulting in a score increase of 6 to 9.

¹³ Edmond KM, Zandoh C, Quigley MA et al. Delayed breastfeeding initiation increases risk of neonatal mortality. *Pediatrics* 2006; 117: 380-386

Indicator 12: Exclusive Breastfeeding for the First Six Months

Key question: *What is the percentage of babies 0<6 months of age exclusively breastfed¹⁴ in the last 24 hours?*

Definition of the indicator: *Exclusive breastfeeding under 6 months: Proportion of infants 0–5 months of age who are fed exclusively with breast milk*

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. An analysis published in Lancet¹⁵ clearly points to the role of exclusive breastfeeding during first six months for Infant survival and development.

Guideline

Indicator 12	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
		Scores	Colour-rating
Exclusive Breastfeeding (for first 6 months)	0.1 - 11%	3	Red
	11.1 - 49% [48%]	√6	Yellow
	49.1 - 89%	9	Blue
	89.1 - 100%	10	Green

Data Source

Demographic Health Survey, 2013

Summary Comments

Exclusive Breastfeeding for 6 months has increased by 7percentage points in 2008 to 48% in 2015, but remains at a score of 6.

¹⁴ 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)

¹⁵Robert E Black, Saul S Morris, Jennifer Bryce. Where and why are 10 million children dying every year? THE LANCET 2003; 361 : 2226-34.

Indicator 13: 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 13	Key to rating adapted from WHO tool (Refer to Annex 11.1)	IBFAN Asia Guideline for WBTi	
		Scores	Colour-rating
Median Duration of Breastfeeding	0.1 – 18 Months	3	Red
	18.1 – 20 Months [20months]	√6	Yellow
	20.1 – 22 Months	9	Blue
	22.1- 24 or beyond Months	10	Green

Data Source:

Demographic Health Survey, 2013

Summary Comments

Because of new data on the Median Duration of Breastfeeding of 20 months, a score of 6 was recorded for this area.

Indicator 14: Bottle feeding

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

Definition of the indicator: *Proportion of children 0–23 months of age who are fed with a bottle*

Background

Babies should be breastfed exclusively for the first six months of age and they need not be given any other fluids, fresh or tinned milk formula as this would cause more harm to babies and replace the breastmilk. Similarly, after six months babies should ideally receive mother's milk plus solid complementary foods. If a baby cannot be fed the breastmilk from his/her mother's breast, s/he should be fed with a cup (if unable to swallow, breastmilk can be given by means of an infant feeding tube).

Bottle-feeding means the proportion of children 0–23 months of age who are fed with a bottle having nipple/teat. Information on bottle-feeding is useful because of the potential interference of bottle-feeding with optimal breastfeeding practices and the association between bottle-feeding and increased morbidity and mortality due to diarrhoea, which is a common complication due to bottle-feeding. Bottles with a nipple are particularly prone to contamination.

Guideline:

Indicator 14	Key to rating adapted from WHO tool (Refer to Annex 11.1)	IBFAN Asia Guideline for WBTi	
		Scores	Colour-rating
Bottle Feeding (<6 months)	29.1 - 100%	3	Red
	4.1 - 29% [7%]	√6	Yellow
	2.1 - 4%	9	Blue
	0.1 - 2%	10	Green

Data Source:

Demographic Health Survey, 2013

Summary Comments

Bottle-Feeding data is now also available, giving a score of 6 at 7%.

Indicator 15: Complementary feeding [Introduction of solid, semi-solid or soft foods]

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

Definition of the indicator: *Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods*

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-breast-feeding babies are receiving replacement foods in a timely manner. 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 15	WHO's	IBFAN Asia Guideline for WBTi	
Complementary Feeding (6-9 months)	Key to rating	Scores	Colour-rating
	0.1 - 59% [55%]	√3	Red
	59.1 - 79%	6	Yellow
	79.1 - 94%	9	Blue
	94.1 - 100%	10	Green

Data Source: Demographic Health Survey, 2013

Summary Comments

Complementary Feeding should be a focus area. Although up to 55% (2015) from 33% (2008), the score remains at 3.

Summary Part I: IYCF Policies and Programmes

Targets:	Score (Out of 10)	
	2015	2008
1. National Policy, Programme and Coordination	10	6
2. Baby Friendly Hospital Initiative	2.5	2.5
3. Implementation of the International Code	9.5	10
4. Maternity Protection	7.5	2.5
5. Health and Nutrition Care Systems	8.5	6
6. Mother Support and Community Outreach	10	8
7. Information Support	10	10
8. Infant Feeding and HIV	10	9
9. Infant Feeding during Emergencies	5	0
10. Monitoring and Evaluation	10	8
Total	83	62

Total score of infant and young child feeding policies and programmes (indicators 1-10) are calculated out of 100 based on the IBFAN Asia Guidelines for WBTi.

Scores	Colour- rating
0 – 30.9	Red
31 – 60.9	Yellow
61 – 90.9 ✓	Blue
91 – 100	Green

Conclusions¹⁶:

The Gambia has improved its overall Part I score from 62 to 83. This is partly due to the development of policies and regulations that culminated in the implementation of programmes.

¹⁶ 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: Infant and young child feeding (IYCF) practices

IYCF Practice	Result		Score	
	2015	2008	2015	2008
Indicator 11 Starting Breastfeeding (Initiation)	52%	48%	9	6
Indicator 12 Exclusive Breastfeeding for first 6 months	48%	41%	6	6
Indicator 13 Median duration of Breastfeeding	20mo	N/A	6	0
Indicator 14 Bottle-feeding	7%	N/A	6	0
Indicator 15 Complementary Feeding	55%	33%	3	3
Score Part II (Total)			30	15

Total score of infant and young child feeding Practice (indicators 11-15) are calculated out of 50 based on the IBFAN Asia Guidelines for WBTi.

Scores	Colour-rating
0 – 15	Red
16 - 30 [√]	Yellow
31 – 45	Blue
46 – 50	Green

Conclusions ¹⁷ :

The Gambia has increased its Part II score from 15 in 2008 to 30 in 2015. Although The Gambia's score for Part II remains in yellow, the progress is still significant as it brings The Gambia closer to its goal of optimal infant and young child feeding. This is partly due to improvements in programme implementation.

¹⁷ 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.

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 rated as:

Scores	Colour- rating
0 – 45.5	Red
46 – 90.5	Yellow
91 – 135.5√(113)	Blue
136 – 150	Green

CONCLUSIONS

The Gambia has improved its IYCF practices, policies, and programs. Since the 2008 assessment, the total score has increased from 77 to 113, and the color has improved from yellow to blue accordingly. The successes seen in this assessment are due to the development of policies and subsequent implementation of programmes addressing the 10 indicators, resulting in a positive impact on the 5 practice indicators. Great advancements have been made in the areas of national policy, programs, and coordination; maternity protection; infant feeding during emergencies; breastfeeding initiation; and median duration of breastfeeding, in addition to modest improvements elsewhere. However, there are still gaps that must be bridged, and more work should be done to ensure that all of these gaps are addressed in order to optimize IYCF practices in The Gambia. Indicators that should be specifically focused on include the Baby Friendly Hospital Initiative, complementary feeding, and, although it has improved since 2008, Infant Feeding During Emergencies. Many conclusions were reached as a result of this assessment, gaps were identified, and recommendations were proposed.

Indicator 1: National Policy, Programmes, and Coordination, has improved from 6 to 10. The National Nutrition Agency is responsible for these tasks and since 2008 has made strides to improve, most notably in the development of the Strategic and Business Plan for better nutrition. This led to the adoption of the National Technical Advisory Committee that meets on a quarterly basis, policy review, and an increase in funding of 24%. Although all critical and major activities are funded, additional funding would support other important initiatives that would improve and sustain proper IYCF practices.

Indicator 2: Baby Friendly Hospital Initiative has remained at 2.5 and should be a major focus area in the coming years. Major challenges to progress include the high rate of attrition in the healthcare system and the current use of out-dated training materials. These challenges should be overcome to ensure future progress.

Indicator 3: Implementation of the International Code has decreased slightly from 10 to 9.5 due to revised grading methods. The action that should be taken in this area is to update the Breastfeeding Promotion Regulations to reflect WHA resolutions to the International Code made after 2006, especially protection against conflicts of interest.

Indicator 4: Maternity Protection has improved from 2.5 to 7.5 due to the enactment of the Women's Act 2010, which provides 6 months of maternity leave and 10 days of paternity leave for all workers. Also, the development of the National Nutrition Policy (2010 – 2020) created an enabling environment for optimal IYCF practices. These actions also promote the establishment of breastfeeding facilities within the workplace. To further advance in this area, a breastfeeding break of 1 hour should be promoted for all new mothers.

Indicator 5: Health and Nutrition Care Systems has improved from 6 to 8.5 mostly because of the inclusion of IYCF in the curricula of health training institutions. The next step will be to also incorporate mother and baby friendly guidelines into the curricula of health training institutions.

Indicator 6: Mother Support and Community outreach is up from 8 to 10. The support system is based on existing structures within the health sector and the community, and is present nationally.

Indicator 7: Information support has been excellent since 2008, and remains at 10. The implementation of the Nutrition Communication Strategy is partly responsible for this

performance. The tradition of celebrating World Breastfeeding Week all through August has given this area prominence and will help sustain the high level of achievement.

Indicator 8: Infant Feeding and HIV is up to 10 from 9 because of the full integration of infant feeding into the PMTCT Policy. Antibody testing and newly introduced PCR testing help to support this mission. In addition, counselling is provided to those who may be affected by HIV.

Indicator 9: Infant Feeding During Emergencies is a main area for improvement, though it is up to 5 from 0. The advancements are due to the inclusion of IFE into the National Nutrition Policy and Strategy, but all elements of the WHO Operational Guidance on IFE should be adhered to in order to ensure progress.

Indicator 10: Monitoring and Evaluation has increased from 8 to 10 because of the inclusion of IYCF in the 2013 GDHS.

Indicators 11-15: These indicators have all shown improvements partly due to the creation of appropriate policies and legislations as well as scaling up of programmes to reach more of the population. This has led to an overall increase from red to yellow in this area. Breast Feeding Initiation (Indicator 11) has improved from 48% to 52%, resulting in a score increase of 6 to 9. Exclusive Breastfeeding for 6 months (Indicator 12) has increased by 7 percentage points to 48%, but remains at a score of 6. Because of new data on the Median Duration of Breastfeeding (Indicator 13) of 20 months, a score of 6 was recorded for this area. Bottle-Feeding (Indicator 14) data is now also available, giving a score of 6 at 7%. Complementary Feeding (Indicator 15) should be a focus area. Although up to 55% (2015) from 33% (2008), the score remains at 3.

Many improvements have been made since the 2008 assessment. The advancements that still need to be accomplished will be focused on with targeted policies and programmes. The Gambia is committed to continued improvement in the problem areas, as well as sustenance of its current successes.

OVERALL GAPS:

- Outdated BFHI training materials;
- Health facilities are not being assessed for BFHI;
- Inadequate implementation of BFHI policy;
- Inadequate human resources due to staff turnover & attrition rate;
- Inadequate monitoring and Evaluation within health care facilities;
- The Breastfeeding Promotion Regulations have not been updated to take into account WHA resolutions made after 2006, specifically conflicts of interest;
- National policies and the Women's Act do not provide for breastfeeding breaks or shorter working hours for breastfeeding mothers;
- Non-existence of the mother and baby friendly guidelines;
- IYCF in relation to HIV/AIDS is not comprehensively captured within the nutrition policy and strategy;
- Inadequate funding to scale up interventions in IYCF;
- No nutrition or IYCF component in the national disaster management policy and programme;
- IFE not integrated in pre service and in service trainings; and
- No national implementation guideline available on nutrition in emergencies.

RECOMMENDATIONS

Based on the assessment, the following recommendations were made:

- Mobilize additional funds to implement other important activities that will improve and sustain IYCF practices, such as BFHI, HIV and emergency preparedness;
- Review and update the National Nutrition Policy and Strategy Plan before its expiration;
- Updated training materials should be adopted that includes the 20 hours BFHI training materials;
- Strengthen Social and Behavior Change Communication regarding IYCF;
- Revitalize BFHI and carry out an assessment of the implementing facilities;
- Strengthen monitoring and evaluation of IYCF programmes;
- Update the Breastfeeding Promotion Regulations 2006 to capture the recent World Health Assembly Resolutions including conflicts of interest;
- The National Nutrition Policy should promote the provision of breastfeeding breaks, shortened working hours for breastfeeding mothers, or the creation of crèches at work places;
- Develop mother and child friendly guidelines that are disseminated to all health facilities and health workers;
- Include nutrition and IYCF in the National Disaster Management Policy and Strategic Plan;
- Integrate IFE in the pre and in service trainings;
- Develop implementation guidelines for nutrition in emergencies;
- Maintain good coordination of IYCF practices at the central level and strengthen monitoring at the regional level; and
- Sustain practices that are currently effective.

SOURCE DOCUMENTS

- 1. Food Act 2005
 - 2. Food Act 2005 (2005 NO. 9) Breastfeeding promotion regulations 2006
 - 3. Gambia Demographic Health Survey (GDHS) 2013
 - 4. IMCI 1999
 - 5. Infant and Young Child Feeding Counseling: An Integrated Course (2006)
 - 6. Infant and Young Child Feeding Counselling Cards for Community Workers 2014
 - 7. Integrated Management of Acute Malnutrition Protocol 2012
 - 8. Multiple Indicator Cluster Survey (MICS) 4 (2010)
 - 9. NaNA Annual Report “NaNA working with the communities for better Health and Nutrition” December 2013
 - 10. National Health Policy (2012-2020)
 - 11. National Maternity Care Guidelines and Service Delivery Standards 2014
 - 12. National nutrition and HIV programme reports
 - 13. National Nutrition Policy (2010-2020)
 - 14. Nutrition Communication Strategy 2012- 2015
 - 15. Nutrition Education for Lower Basic Schools Pupils Book 6 , 2012
 - 16. PMTCT Training Manual 2008 revised 2013
 - 17. Policy Guidelines for the Prevention of Mother to Child Transmission in The Gambia 2010
 - 18. Scheme of Service and Service Rules (2007)
 - 19. Strategic Plan (2011-2015) for the Implementation of the National Nutrition Programme
 - 20. Women’s Act 2010
-

ANNEXES

Annex 1: Policy Issues

Policy issues¹⁸

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 fulfil their responsibilities under the International Code of Marketing on Breast-milk 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 Breast-milk 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.).

¹⁸ Summarized from the *WHO Global Strategy for Infant and Young Child Feeding (1)*, pages 13–15.

Annex 5.1: 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)
<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Provide care and support during the antenatal period. 	Breastfeeding history (previous experience), breast examination, information targeted to mother's needs and support.
<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Describe the process of milk production and removal. 	Breast anatomy; lactation and breastfeeding physiology
<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> 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 lactation stages); feeding history; observation of breastfeeding; suckling difficulties; causes and management of common infant feeding difficulties; causes and management of common maternal feeding difficulties.
<ul style="list-style-type: none"> Facilitate breastfeeding for infants with special health needs, including premature infants. 	Risk/benefit of breastfeeding/breast milk; needs of premature infants; modifications; counselling mothers.
<ul style="list-style-type: none"> Facilitate successful lactation in the event of maternal medical conditions or treatments. 	Risk/benefit; modifications; pharmacological choices; treatment choices.
<ul style="list-style-type: none"> Inform lactating women about contraceptive options. 	Advantages and disadvantages of various child spacing methods during lactation; counselling about LAM; cultural considerations for counselling.
<ul style="list-style-type: none"> Prescribe/recommend medications, contraceptives and treatment options compatible with lactation. 	Compatibility of drugs with lactation; effects of various contraceptives during lactation.
<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Explain the International Code of Marketing of Breast-milk Substitutes and World Health Assembly resolutions, current violations, and health worker responsibilities under the Code. 	Main provisions of the Code and WHA resolutions, including responsibilities of health workers and the breast-milk substitute, bottles and teats industries; violations by infant food companies; monitoring and enforcement of the Code.
<ul style="list-style-type: none"> Describe what foods are appropriate to introduce to children at various ages and which foods are available and affordable 	Developmental approach to introduce complementary foods; foods appropriate at various ages; available foods and their

Objectives (to be achieved by all health students and trainees who will care for infants, young children and mothers)	Content/skills (to achieve objectives)
to the general population.	costs; incomes of local families and how income levels affect their abilities to afford various foods.
<ul style="list-style-type: none"> ▪ Ask appropriate questions of 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 deficiencies/supplements; young child feeding history; typical problems.
<ul style="list-style-type: none"> ▪ 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.
<ul style="list-style-type: none"> ▪ 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.
<ul style="list-style-type: none"> ▪ Help mothers and other caregivers to continue feeding during illness and assure 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; relaxation.
<ul style="list-style-type: none"> ▪ 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.
<ul style="list-style-type: none"> ▪ Inform mothers of the micronutrient needs of infants and young children and how to meet 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 complementary foods); supplementation needs.
<ul style="list-style-type: none"> ▪ 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.
<ul style="list-style-type: none"> ▪ 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.
<ul style="list-style-type: none"> ▪ 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; counselling confirmed HIV-positive mothers about feeding options and risks.
<ul style="list-style-type: none"> ▪ 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 in emergencies; appropriate promotion and support; compliance with the International Code of Marketing of Breast-milk Substitutes and WHA resolutions.

Annex 5.2: Example of criteria for mother-friendly care¹⁹

A woman in labour, regardless of birth setting, should have:

- Access to care that is sensitive and responsive to the specific beliefs, values, and customs of the mother's culture, ethnicity and religion.
- Access to birth companions of her choice who provide emotional and physical support throughout labour and delivery.
- Freedom to walk, move about, and assume the positions of her choice during labour and birth (unless restriction is specifically required to correct a complication). The use of the lithotomy position (flat on back with legs elevated) is discouraged.
- Care that minimizes routine practices and procedures that are not supported by scientific evidence (e.g. withholding nourishment; early rupture of membranes; IVs (intravenous drip); routine electronic fetal monitoring; enemas; shaving).
- Care that minimizes invasive procedures (such as rupture of membranes or episiotomies) and involves no unnecessary acceleration or induction of labour, and no medically unnecessary caesarean sections or instrumental deliveries.
- Care by staff trained in non-drug methods of pain relief and who do not promote the use of analgesic or anaesthetic drugs unless required by a medical condition.

A health facility that provides delivery services should have:

- Supportive policies that encourage mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions.
- Clearly-defined policies and procedures for collaborating and consulting throughout the perinatal period with other maternity services, including communicating with the original caregiver when transfer from one birth site to another is necessary; and linking the mother and baby to appropriate community resources, including prenatal and post-discharge followup and breastfeeding support.
- A policy on mother-baby-friendly services (as outlined above) and staff who are trained to understand that the health and well-being of the mother, her fetus, her newborn, and the successful initiation of breastfeeding, are all part of a continuum of care.

¹⁹ WHO's " Infant and Young Child Feeding-A tool for assessing national practices, policies and programmes". Available at <http://whqlibdoc.who.int/publications/2003/9241562544.pdf>

Annex 6: Community outreach and support for infant and young child feeding

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
- Demonstration of cooking Complementary foods
- Promotion of production of food that can fill gaps in local diets
- Mother-to-mother support
- Trials of new infant or young child feeding practices
- Baby shows or contests focusing on 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.

Annex 9: Infant and Young Child Feeding in Emergencies

Criteria for appropriate emergency preparedness policies and programmatic measures at the national level

- 1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance

Essential items to address in a national policy are included in:

Infant and young child feeding in emergencies: operational guidance for emergency relief staff and programme managers. Interagency Working Group on Infant and Young Child Feeding in Emergencies, version 2.1, February 2007 (adopted WHA 63.23) – <http://www.ennonline.net/resources/6> (available in 13 languages)

Key points from the Operational Guidance (see full text for listed practical steps)

1. Appropriate and timely support of infant and young child feeding in emergencies (IFE) saves lives.
2. Every agency should endorse or develop a policy on IFE. The policy should be widely disseminated to all staff, agency procedures adapted accordingly and policy implementation enforced (Section 1).
3. Agencies should ensure the training and orientation of their technical and non-technical staff in IFE, using available training materials (Section 2).
4. Within the United Nations (UN) Inter-agency Standing Committee (IASC) cluster approach to humanitarian response, UNICEF is likely the UN agency responsible for co-ordination of IFE in the field. Also, other UN agencies and NGOs have key roles to play in close collaboration with the government (Section 3).
5. Key information on infant and young child feeding needs to be integrated into routine rapid assessment procedures. If necessary, more systematic assessment using recommended methodologies could be conducted (Section 4).
6. Simple measures should be put in place to ensure the needs of mothers, infants and young children are addressed in the early stages of an emergency.
 1. Support for other caregivers and those with special needs, e.g. orphans and unaccompanied children, must also be established at the outset (Section 5).
 7. Breastfeeding and infant and young child feeding support should be integrated into other services for mothers, infants and young children (Section 5).
 8. Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food aid dependent populations (Section 5).
 9. Donated (free) or subsidised supplies of breastmilk substitutes (e.g. infant formula) should be avoided. Donations of bottles and teats should be refused in emergency situations. Any well-meant but ill-advised donations of breastmilk substitutes, bottles and teats should be placed under the control of a single designated agency (Section 6).
 10. The decision to accept, procure, use or distribute infant formula in an emergency must be made by informed, technical personnel in consultation with the co-ordinating agency, lead technical agencies and governed by strict criteria (Section 6).
 11. Breastmilk substitutes, other milk products, bottles and teats must never be included in a general ration distribution. Breastmilk substitutes and other milk products must only be distributed according to recognised strict criteria and only provided to mothers or caregivers for those infants who need them. The use of bottles and teats in emergency contexts should be actively avoided (Section 6).

2) A person or team responsible for national response and coordination with all relevant partners such as the United Nations, donors, the military and nongovernmental organizations (NGOs) on issues related to infant and young child feeding in emergencies has been appointed.

Responsibilities will include:

- Development of a national contingency plan based on the existing national policy and the IFE Operational Guidance;
- Representation of the national government during an emergency response in the following coordination activities: policy development; intersectoral coordination; development of an action plan that identifies agency responsibilities and mechanisms for accountability; dissemination of the policy and action plan to operational and non-operational agencies, including donors; monitoring of the implementation of the action plan; and
- Involvement of affected communities in the planning process.

3) An emergency preparedness and response plan based on the practical steps listed in the Operational Guidance has been developed and put into effect in most recent emergency situations , that covers:

- basic and technical interventions to create an enabling environment for breastfeeding, including counseling by appropriately trained counselors, support for relactation and wet-nursing, and protected spaces for breastfeeding
- measures to minimize the risks of artificial feeding, including an endorsed statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsolicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the Operational Guidance, and the International Code and subsequent relevant WHA resolutions

The plan should include the following requirements in an emergency:

- Assessment and ongoing monitoring activities will include demographic data disaggregated by age, and data on infant and young child feeding practices and support to determine priorities for action and response.
- Conditions will be created to support early exclusive and continued breastfeeding and appropriate complementary feeding (including general conditions and supportive care for all mothers and caregivers, basic aid, and skilled help for mothers/caregivers experiencing problems with feeding, relactation, and wetnursing).
- Guidelines that comply with the International Code of Marketing on Breast-milk Substitutes and subsequent World Health Assembly resolutions will be provided on the appropriate procurement, management, distribution, targeting and use of breast-milk substitutes and other milks, bottles and teats; adherence to these guidelines will be monitored and enforced.
- Current contact information on national infant feeding expert groups that can be consulted in an emergency situation will be available.

Useful Resources include:

- Media guide on Infant and young child feeding in emergencies. English, French, German, Spanish, Italian, Arabic. <http://www.enonline.net/resources/126>
- Model joint statement on IFE <http://www.enonline.net/resources/237>
- Key messages on IFE - for mothers and caregivers. English and French <http://www.enonline.net/resources/735>
- World Breastfeeding Week, 2009. 'Breastfeeding, a vital emergency response: are you ready?' <http://www.worldbreastfeedingweek.net/wbw2009/index.htm>
- Many more resources can be found at: <http://www.enonline.net/resources/tag/121>

4) Resources have been allocated for implementation of the emergency preparedness and response plan

Check if any preparedness activities are/have been carried out (development of policy, identification of coordination person or team, orientation and training) and with what funds; check if any funds have been set aside for an eventual emergency, and if any emergencies have taken place, if any funds/what funds were allocated to infant and young child feeding

5) Appropriate orientation and training material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.

Materials include:

- Policies and guidelines relevant to infant and young child feeding in emergencies.
- Appropriate knowledge and skills to support caregivers in feeding infants and young children in the special circumstances of emergencies.

Note: Basic information on infant and young child feeding in emergencies should be provided to all who may be involved in humanitarian assistance work, including policy-makers and decision-makers who will act in an emergency, agency staff (headquarters, regional, desk and field staff) and national breastfeeding specialists.

Useful training materials include:

For orientation:

Core group in Infant feeding in Emergencies, Module 1, Orientation Package on IFE, v2.1, 2010. English. <http://www.enonline.net/ife/orientation>

- This is a package of resources to help in orientation on infant and young child feeding in emergencies (IFE). These resources are targeted at emergency relief staff, programme managers, and technical staff involved in planning and responding to emergencies, at national and international level.
- The IFE Orientation Package, an update of Module 1 on IFE (essential orientation), a print content first produced in 2001, uses the Operational Guidance on IFE as a guiding framework to support its implementation. This package supports the content of HTP Module 17 on Infant and Young Child Feeding, v2.0, 2010.
- The IFE orientation package comprises e-learning lessons, training resources, technical notes, key resources, and an evaluation guide.

For technical training:

- Module 2. Infant and young child feeding. For health and nutrition staff, v1.1, 2007. English, French, Bahasa (Indonesia) and Arabic <http://www.enonline.net/resources/722>.
- Integration of Infant and Young Child Feeding into Community based Management of Acute Malnutrition. October 2009. English and French <http://www.enonline.net/resources/722>
- IASC Nutrition. Harmonized Training Package, Cluster Module 17 on Infant and young child feeding in emergencies. <http://www.enonline.net/resources/761>

Other key useful orientation and training materials developed by the IFE core group see <http://www.enonline.net/resources/tag/128>

Annex 12: Exclusive breastfeeding rate calculator ²⁰

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) 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 ($1a \times 2a = 3a$; $1b \times 2b = 3b$; $1c \times 2c = 3c$). 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 ($3a + 3b + 3c = 3d$).

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 ($3d / 2d = 1d$).

²⁰ WHO (2003). Infant and Young Child Feeding - A tool for assessing national practices, policies and programmes. Available at <http://whqlibdoc.who.int/publications/2003/9241562544.pdf>

Annex 14: Bottle-feeding rate (BOT) calculator ²¹

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 BF 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) 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. 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.

²¹ WHO (2013). Infant and Young Child Feeding-A tool for assessing national practices, policies and programmes. Available at <http://whqlibdoc.who.int/publications/2003/9241562544.pdf>

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 percentage bottle-fed in that age group, and insert in the appropriate rows above ($1a \times 2a = 3a$; $1b \times 2b = 3b$; $1c \times 2c = 3c$; $1d \times 2d = 3d$; $1e \times 2e = 3e$ and $1f \times 2f = 3f$). 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 ($3g / 2g = 1g$).

