World Breastfeeding Trends Initiative (WBTi)

SIERRA LEONE

JANUARY 2014

IBFAN

SIERRA LEONE REPORT

TABLE OF CONTENTS

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
DHS	Demographic and Health Survey
GLOPAR	Global Participatory Action Research
GSIYCF	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
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)
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	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 Sierra Leone

Various sectors were invited to participate in the 4-days training workshop. The Nutrition Unit and the Child Health Programme of the Ministry of Health coordinated the WBTi training and assessment.

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 scope[1]. 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.

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	**6/10**

Information Sources

- National Food and Nutrition Policy (2012);
- National Food and Nutrition Security Implementation Plan (revised) 2013 – 2017, (2012);
- Draft IYCF Strategy (2013);
- Minutes of Code Committee meetings (2011 – onwards); and
- Technical Working Group minutes (Standing Working Group).

Conclusion

A National Food and Nutrition Policy was available; however the multi-sectoral Food and Nutrition Security Implementation Plan (2013 – 2017) was still in draft form as well as the Infant and Young Child Feeding (IYCF) strategy. Whilst there was no national breastfeeding Committee there was however a technical Breastfeeding Working Group and a Code Committee which coordinated breastfeeding promotion, Protection and support. The Code Committee comprised of multi-sectoral members while the Breastfeeding Working Group comprised only of Nutrition, MoHS (Ministry of Health and Sanitation), UN Partners and NGOs.

Gaps

- The national Food and Nutrition Security Implementation Plan and IYCF Strategy were still in draft form and needed to be finalised; however certain activities were being implemented. There was inadequate funding for the implementation of the Nutrition Implementation Plan. There was need for more actors to support the implementation of the strategy and for Government to scale up its funding; and
- The relevant committees and Working group needed to schedule regular /review meetings.

Recommendations

The Committees/working groups should schedule quarterly meetings and advocate more with Government and development partners to scale up their funding allocation towards implementation of IYCF. In terms of funding for implementing the plan, advocacy through stakeholders meetings would be undertaken to disseminate the assessment report and seek more support.

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

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 centres 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.

---

[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

Guidelines – Quantitative Criteria

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	**0.5/5**
Total Score	**0.5/10**

[3] IYCF training programmes such as IBFAN Asia's '4 in1' 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

- MoHS (Nutrition) BFHI Training reports (2009);
- UNICEF Status country reports (2009);
- BFHI Cascade Reports; and
- (The BFHI Facilitators report 2009).

Conclusion

A training of trainers on BFHI was conducted in 2009 and cascade training also done covering all districts, but there had been no follow up on the implementation. The 10 steps for Successful Breastfeeding posters were reproduced and disseminated to all maternities nationwide.

Gaps

There was a big gap in BFHI implementation as well as training of health workers.

Recommendations

- The BFHI Guidelines should be adapted and implemented;
- Pilot facilities should be identified in order to kick start the process;
- National training of health workers should be identified and training cascaded to all maternity facilities;
- A periodic review and assessment of the process should be conducted; and
- Resource mobilization for training and sustaining the programme should be done.

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 are 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

Guidelines for scoring	
Criteria (Legal Measures that are in Place in the Country)	**Scoring**
3.8 All articles of the Code as law	5
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 b. Provisions based on all 4 of the WHA resolutions as listed below are included	 5.5 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
3.12The 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)	**0.5/10**

Information Sources

- International Code of Marketing of Breastmilk Substitutes training Report, (May 2011);
- Minutes of the Code Committee (2011 – to date); and
- Draft Cabinet Paper on the Code (2013).

Conclusion

Code issues were part of the Minister Flagship project. Code training was conducted in 2011 and a draft Cabinet paper was developed but awaiting submission and approval. A sensitization meeting was held with Parliamentary Committee on Health for drafting and implementation of the National legislation on the BMS Code in 2013. The Law Reform Commission was to work with the Code Committee for the drafting of a National BMS Code. A Concurrence on the draft cabinet paper needed to be sent out and lobbing of other cabinet ministers done prior to presentation in Cabinet for approval.

Gap: There was no national legislation on the code for Marketing of breastmilk Substitutes.

Recommendations

- Develop a lobbing strategy for the relevant committees including resource mobilisation; and
- Train and lobby the Health Parliamentary Committee on the cost benefits of breastfeeding

[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 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. a) Unpaid break	

Guidelines for scoring	
Criteria	**Tick one which is applicable**
b) Paid break	0.5 1
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 *(more than one may be applicable)* a) Space for Breastfeeding/Breastmilk expression b) Crèche	 1 0.5
4.5) Women in informal/unorganized and agriculture sector are: a) accorded some protective measures b) accorded the same protection as women working in the formal sector	 √0.5 1
4.6) . *(more than one may be applicable)* a) Information about maternity protection laws, regulations, or policies is made available to workers. b) There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	 √0.5 √0.5
4.7) Paternity leave is granted in public sector for at least 3 days.	0.5
4.8) Paternity leave is granted in the private sector for at least 3 days.	0.5
4.9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	0.5
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	√1
Total Score:	**4/10**

Information Sources

- Regulations of Wages and Industrial Relations Act (no 18 of 1971);
- Employment Act (1971);
- Factories Act 1974; and
- Sierra Leone Gazette Vol CXLII (2 September 2011).

Conclusion

The laws on maternity protection were found to be inadequate, as they did not make provision for breastfeeding breaks or facilities at work places. Government was however in the process of reviewing all Labour Laws.

Gaps

- Women in the informal/unorganised sector were difficult to reach;
- The ILO Maternity Protection Convention 183 (2000) and Domestic Workers Convention 189 (2012) had not been ratified;
- The law was silent on provisions for senior staff in the private sector (Regulations of Wages and Industrial Relations Act (no 18 of 1971); and
- There was no provision for breastfeeding facilities and crèches in the work place.

Recommendations:

- The ILO MPC 183 should be ratified and domesticated as well as Convention 189 on domestic workers. The Labour laws should be reviewed to include emerging issues such as duration, breastfeeding facilities and crèches at places of work; and
- There is need to harmonise maternity leave for the period of six months covering all sectors to effectively enhance 6 months of exclusive breastfeeding.

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 - √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	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	√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]	√2	1	0
5.4) Health workers are trained on their responsibility under the Code implementation / national regulation throughout the country.	1	√0.5	0
5.5) Infant feeding and young 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.)	√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 - √Check that apply**		
	Adequate	**Inadequate**	**No Reference**
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country.[9]	√1	0.5	0
5.7) Child health policies provide for mothers and babies to stay together when one of them is sick.	1	√0.5	0
Total Score:	**7/10**		

Information Sources

- Reproductive, New Born and Child Health Policy (2011);
- National Protocol for Management of Acute Malnutrition (2011);
- c-IYCF –Counselling Package (UNICEF) 2010; and
- National Nutrition Syllabus for Allied Health Science Training Institutions (2013).

Conclusion

Health Training Institutions were well catered for, however medical school still needed attention. Community IYCF counselling training was provided for in-service training. A core group of trainers from District Health Management Team (DHMT) were trained to cascade to Peripheral Health Unit (PHU) staff. Pre-service training courses in schools included IYCF component.

Gaps

The revised nutrition syllabus had not yet been integrated into the medical school curriculum. There was no Code component in the in-service c-IYCF training.

Recommendation

- There is need to adapt a module on the International Code from the WHO Integrated IYCF Counselling Course for inclusion into the in-service training programme;
- The National Nutrition Syllabus should be integrated into the Medical School Curriculum; and
- There should be more in-service training throughout the country.

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 counselling 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 counselling support for Infant and young child feeding counselling and support services have national coverage.	√2	1	0

Guidelines for scoring			
Criteria	**Scoring**		
	Yes	To some degree	No
6.4) Community-based counselling 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 counselling skills for infant and young child feeding.	2	√1	0
Total Score:	**6/10**		

Information Sources

- c-IYCF Training reports for Mother Support Groups (2011); and
- Community Health Workers manual (2012)

Conclusion

Not all pregnant mothers had access to community-based support systems for IYCF after birth as scaling up was on-going. Coverage was also not adequate; not all communities had mother support groups. Support was more available at the institutional level. Community-based support services for pregnant and breastfeeding woman were integrated within the Health Sector but still needed to be integrated into other sectors particularly Agriculture and Social Welfare.

Gap

There were inadequate trained personnel with counselling and listening skills to support mothers.

Recommendations

- There was need to scale up Community health workers (volunteers) and health workers training in counselling and listening skills; and
- There was need to establish more mother support groups in all communities.

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

Guidelines for scoring			
Criteria	**Scoring - √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]	√2	0	0
Total Score:	**9/10**		

Information Sources

- World Breastfeeding Week Celebrations reports: previous to date;
- National Food and Nutrition Policy (Draft) (2012); and
- National Food and Nutrition Security Policy Implementation Plan 2013- 2017, (2012).

Conclusion

There was no standalone IEC strategy on IYCF but integrated into the National Food and Nutrition Security Policy Implementation Plan. World Breastfeeding week was celebrated in the country at all levels; however government funding support needed to be scaled up even though partners generally provided such support. The media was comprehensively used for IYCF messages.

Gaps

- There was inadequate funding from government and development partners for support towards IEC/BCC material production;
- There was untimely disbursement of government funds, which negatively affected programme implementation; and
- There was weak coordination and harmonization for production of IEC/BCC materials.

Recommendations

- Greater coordination was needed in order to maximise on other annual events such as International Women's Day, Labour Day, International Day of the African Child, World Food Day etc with input on IYCF messages. There was need to strengthen networks amongst partners in terms of activity implementation; and
- There was need for early budgetary submissions in order to get timely disbursements. Government and development partners needed to scale up funding support towards IEC/BCC. The Nutrition Directorate should strengthen coordination and harmonization of IEC/BCC materials that were being produced.

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 action[11] 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.

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

Policies and programmes to implement this effectively will require HIV Testing and Counselling (HTC) to be available and offered routinely to all mothers. Furthermore support should be provided to ensure ARVs are made accessible to all breastfeeding mothers as per the national recommendations and support and follow up is provided to all 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:		**9/10**	

Information Sources

- National HIV Policy (2008);
- HIV Policy Guidelines (2008);
- National Nutrition Policy Guidelines for People living with HIV and AIDS, (2008);
- Strategic Plan towards Elimination of Mother to child transmission of HIV and Aids and for paediatric and HIV Care in Sierra Leone, 2013 – 2015, (2012);
- Revised National Guidelines for the Preventions of Mother to Child Transmission of HIV and Aids (2012); and
- Revised Infant Feeding Counselling Guidelines in the context of HIV and AIDS, 2013.

Conclusion

Sierra Leone had stabilised a prevalence rate of 1.5% over the last 4 years for which the country was awarded a medal in 2010 at Geneva (UN Development Corporation). All selected sites provided PMTCT and the message on infant feeding and the risks associated with various feeding options for infants born to HIV positive mothers had been well disseminated in the country. Mothers were therefore educated and sensitised accordingly. There was a training manual available, which included infant and young child feeding counselling for health workers.

The HIV Unit had a strong monitoring programme and had moved to the level of elimination of Mother to Child Transmission of HIV and AIDS. The country was moving from option A (prophylaxis) to option B+ (treatment for life) and strategy was being piloted in 7 hospitals at the time of the assessment.

Gap

The challenge of stigma was still high within the community, thus requiring a lot more work in terms of effecting much more change in attitude among members in the community towards Persons Living with HIV.

Recommendations

- All nutritionists should be trained on HIV and infant feeding counselling;
- Peripheral Health Unit workers should counsel the mothers on the importance of follow up so that they could comply; and
- PMTCT should be scaled up to all sites in the country.

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.ennonline.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.ennonline.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 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 1	 0.5 0.5	 0 0

Guidelines for scoring			
Criteria	**Scoring**		
	Yes	**To some degree**	**No**
9.4) Resources have been allocated for implementation of the emergency preparedness and response plan	2	1	0
9.5) a) Appropriate orientation and training material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel. b) Orientation and training is taking place as per the national emergency preparedness and response plan	1 1	0.5 0.5	0 0
Total Score:	**1/10**		

Information Sources

- Draft Disaster Management Policy; and
- National Nutrition and Food Security Implementation Plan 2013 -2016, (2012).

Conclusion

The Office of National Security had a disaster management unit, which was responsible for all Sierra Leoneans during emergencies. The Food and Nutrition Implementation Plan had a component that covered infant and young child feeding during emergencies. Initial meetings were held to come up with an operational plan for IYCF during emergencies; however, this needed to be revived. There was a draft policy on disaster management for the country.

Gaps

There was no policy on infant and young child feeding during emergencies neither a preparedness plan nor materials for training. There was no designated national coordinator for IYCF in emergencies at the office of the National Security.

Recommendations

- The preparedness plan for IYCF should be shared with all relevant sectors;
- A package for training IYCF in emergencies should be developed and implemented;
- Training of a core team on emergency preparedness using the available human resource in country should be done; and
- The Director of Nutrition in the Ministry of Health should coordinate IYCF activities in emergencies.

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

Information Sources

- Decentralised Monitoring and Evaluation system report;
- SMART Report 2010;
- Demographic Health survey 2008;
- Multiple Indicator Cluster Survey 2010;

[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.

- Health Management Information System (ongoing);
- District Health Management Information System (on-going); and
- Use of BMS in Sierra Leone Report (2013)

Conclusion

The Health Information System and the Decentralised Monitoring and Evaluation system includes not only IYCF but Community based Management of Acute Malnutrition (CMAM) and Water Sanitation and Hygiene (WASH). Several National Health Surveys had been conducted on Infant and Young Child Feeding practices using Standardised Monitoring and Assessment in Relief and Transition (SMART), Multiple Indicator Cluster Survey (MICS), Demographic Health Survey (DHS), The Use of BMS in Sierra Leone (2013) and the National Micronutrient Survey conducted in 2013 for which a report was yet to be available.

Gap

The Health Management Information System (HMIS) and District Health Management Information System (DHMIS) were a challenge due to late reporting, heavy workload, inadequate training, and logistics required for reporting as well as inadequate staffing at facility level and IT breakdown of the DHMIS etc.

Recommendations

- There is need for equitable distribution of trained health staff on IYCF to health facilities;
- There is need to ensure continuity of implementation of the decentralised monitoring and evaluation (M&E);
- There is need to ensure that actions are taken on the recommendations on monitoring and supervision reports;
- There should be constant maintenance of the HMIS & DHMIS;
- There should be timely and adequate provision of logistical support to enhance reporting; and
- There should be continued strengthening of Nutrition Surveillance for informed decision for action.

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%**[51%]**	√9	**Blue**
	89.1 - 100%	10	**Green**

Data Source

- Demographic Health Survey 2008
- Multiple Indicator Cluster Survey 2005
- Multiple Indicator Cluster Survey 2010

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

Conclusion

According to MICS, early initiation of breastfeeding showed an increasing trend from 33% in 2005 to 45% in 2010. However, SLDHS 2008, showed a rate of 51%. The DHS report further showed that 49% of **urban** children were likely to receive breastmilk in the first hour compared to 51% of **rural** children. Whilst this difference may not be significant, there was a more pronounced difference amongst the regions. The proportion of women who breastfed within the first hour of birth was highest in the Northern region with 61% and lowest in the Eastern region where only 38% of new born received the same attention. Lower maternal educational levels and rural locations were associated with high levels of timely initiation as shown by figures in the North (MICS4). Furthermore, interventions by partners were also having an impact on the higher figures. A second DHS 2013 had been conducted but the results were not yet available.

Gaps

Weak BFHI implementation at maternity hospitals. Inadequate nationwide coverage of birth waiting homes. There were still on-going home deliveries with no information to support early initiation of breastfeeding.

Recommendations

- There is need for raising more awareness in the other regions on the merits of early initiation of breastfeeding amongst mothers and caregivers;
- The need to continue strengthening institutional deliveries is crucial;
- There is need to make more use of mother support groups and sensitize the communities on the need for promotion, protection and support for appropriate feeding practices;
- There is need to increase the number of birth waiting homes and sensitize the community on their availability;
- The need for communities to produce bye-laws against home deliveries should be done; and
- The implementation of the BFHI programme needs to be strengthened in order to impact on step 3 of the 10 steps to successful breastfeeding.

Indicator 12: Exclusive Breastfeeding for the First Six Months

Key question: *What is the percentage of babies 0<6 months of age exclusively breastfed[14] 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 Lancet[15] 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% (32%)	√6	**Yellow**
	49.1 - 89%	9	**Blue**
	89.1 - 100%	10	Green

Data Source

- Multiple Indicator Cluster Survey 2005;
- Demographic Health Survey 2008; and
- Multiple Indicator Cluster Survey 2010.

Conclusion

The MICS 2005, SLDHS 2008, and MICS 2010 reports revealed a progressive increase in exclusive breastfeeding rates at 8%, 11% and 32% respectively. This showed a very encouraging trend and

[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)

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

needed to be sustained. The increase from 8% to 32% could be attributed to increase in support from government and partners for the implementation of IYCF programmes. The establishment of mother-mother support groups in all chiefdoms and in selected sections in western Area as well as training in community IYCF had also contributed to the positive impact on exclusive breastfeeding trends.

Gaps

- About 70% of babies in Sierra Leone were not benefiting from exclusive breastfeeding;
- Inadequate Mother Support Groups in the country; and
- Non implementation of BFHI.

Recommendations

- Need for more support from government and partners for the implementation of BFHI and BFCI is required to increase the rates of exclusive breastfeeding;
- Efforts are needed for improved conditions for working mothers to ensure that their children also benefit maximally from exclusive breastfeeding;
- Labour regulations need to be reviewed to provide for the corresponding period of leave to allow for 6 months exclusive breastfeeding;
- Capacity building for health worker on optimal infant feeding practices is required by implementing the BFHI; and
- Male involvement in both rural and urban areas is also critical for improved breastfeeding practices.

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	
Median Duration of Breastfeeding		***Scores***	***Colour-rating***
	0.1 – 18 Months	3	**Red**
	18.1 – 20 Months (20 months)	√6	Yellow
	20.1 – 22 Months	9	**Blue**
	22.1- 24 or beyond Months	10	Green

Data Source

- Demographic Health Survey 2008; and
- Multiple Indicator Cluster Survey 2010

Conclusion

The DHS 2008 and MICS 2010 figures on median duration of breastfeeding were about the same at 20 and 21 months respectively. This was very encouraging as this shows that most babies were being breastfed. The major problem could be the duration of exclusive breastfeeding.

Gap

Lack of enabling environment (male involvement, policy documents, family and community support, laws for Maternity Protection, BMS Code, etc) to support continued breastfeeding.

Recommendations

Median breastfeeding status needs to be increased to 24months and beyond through rigorous awareness raising. It is also critical to involve males to get them to appreciate the benefits of continued breastfeeding so that they could give adequate support to their partners by creating an enabling environment.

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% (10%)	√6	Yellow
	2.1 - 4%	9	Blue
	0.1 - 2%	10	Green

Data Source:

- Multiple Indicator Cluster Survey 2010; and Demographic Health Survey 2008.

Conclusions

The 2008 DHS reported 16% rate for bottle feeding for infants 0-1months and 14.4% for infants ages 4-5months. Compared to the 2010 MICS figure of 12%, even though the survey methodologies were different, this still showed some substantial improvement in better infant feeding patterns. With 12% of babies being bottle-fed and 32% being exclusively breastfed, there were a large number of infants who could have been receiving mixed feeding at an early age.

Gaps: Significant proportion of infants still receives mixed feeding at an early age.

Recommendations

There is need to target all health workers as well as mothers and/or caregivers on the demerits of bottle-feeding given the need to reduce the rate of bottle-feeding. Future assessment needs to address breastfeeding practices amongst HIV+ lactating mothers.

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	
	Key to rating	***Scores***	***Colour-rating***
Complementary Feeding (6-9 months)	0.1 - 59% (25%)	√3	**Red**
	59.1 - 79%	6	Yellow
	79.1 - 94% (68%)	9	**Blue**
	94.1 - 100%	10	Green

Data Source

- Demographic Health Survey 2008;
- Multiple Indicator Cluster Survey 2005; and
- Multiple Indicator Cluster Survey 2010.

Conclusion

According to the MICS report of 2010, 25% of infants were receiving complementary foods at the right age of between (6 - 9 months). This was a decline from 52% in 2005 (MICS). This may mean that close to 60% of babies were being mixed fed even from an early age. The use of glucose biscuit, ORS and glucose, powered milk in small sachets was very common practice. These unhealthy feeding practices needed to be stopped. However at all PHU levels, food demonstrations were carried using locally available foods as well as the promotion of backyard gardens. Whilst the Nutrition Strategy was still in draft form, it became difficult to address some of the identified inappropriate feeding practices particularly among mothers and caregivers.

Gap:

Inappropriate feeding practices was still high amongst mothers and caregivers.

Recommendations:

- There is need to finalise, disseminate and implement the National IYCF Strategy and Guidelines;
- The development of national recipes for complementary feeding from 6 – 23 months using locally available foods is critical;
- It was also critical to enact the national legislation on the Marketing of Breastmilk Substitutes in order to regulate the marketing of baby foods;
- Strengthen Nutrition Food demonstrations at PHU level; and
- Strengthen linkages with MAFFS and other relevant MDAs to enhance food preservation, processing and proper storage to ensure local food availability throughout the year.

Summary Part I: IYCF Policies and Programmes

Targets	Score (Out of 10) 2015
1. National Policy, Programme and Coordination	6
2. Baby Friendly Hospital Initiative	0.5
3. Implementation of the International Code	0.5
4. Maternity Protection	4
5. Health and Nutrition Care Systems	7
6. Mother Support and Community Outreach	6
7. Information Support	9
8. Infant Feeding and HIV	9
9. Infant Feeding during Emergencies	1
10. Monitoring and Evaluation	10
Total	**53/100**

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

Summary Part II: Infant and young child feeding (IYCF) practices

IYCF Practice	Result	Score
Indicator 11 Starting Breastfeeding (Initiation)	51%	9
Indicator 12 Exclusive Breastfeeding for first 6 months	32%	6
Indicator 13 Median duration of Breastfeeding	20 months	6
Indicator 14 Bottle-feeding	10%	6
Indicator 15 Complementary Feeding	25%	3
Score Part II (Total)		30/50

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**

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√ (83)	**Yellow**
91 – 135.5	**Blue**
136 – 150	**Green**

CONCLUSIONS

Key Gaps

- The National Food and Nutrition Security Implementation Plan and Strategy were still in a draft form and needed to be finalised;
- There was inadequate funding for the Implementation of the Plan and Strategy;
- There were irregular coordination meetings by the IYCF Working group;
- There were no guidelines for BFHI implementation and training of health workers;
- A national Code on the Marketing of Breastmilk Substitutes was not in place;
- The labour law did not make provision for exclusive breastfeeding (0-6 months) in the work place and there were no breastfeeding breaks for lactating working women in line with the ILO Maternity Protection Convention 183 (2000);
- The Country had not ratified ILO Convention 189 which covered working conditions for Domestic workers;
- There was no revised nutrition Syllabus for the medical school;
- There was no module on the Code of Marketing of Breastmilk Substitutes in the in-service c-IYCF training;
- There were inadequate trained personnel with counselling and listening skills to counsel mothers on IYCF;
- There were inadequate IEC materials on IYCF (posters, Bill boards, flip charts, flyers, brochures etc) in facilities and communities;
- Follow up support for HIV positive women was difficult due to misinformation and mixed messages;
- The component on IYCF during emergencies was absent from the Food and Nutrition Policy, draft Implementation Plan and IYCF Strategy;
- Inadequate practice of early initiation of breastfeeding;
- About 70% of babies did not benefit from exclusive breastfeeding; and
- There were no compiled national recipes on complementary foods for infants 6 – 23 months.

RECOMMENDATIONS

KEY Overall Recommendations:

- Need for other actors and government to increase resource allocated for Infant and Young Child Feeding implementation;
- Regular quarterly meetings to be held by the National Infant and Young Child Feeding Committee;
- Need for continued capacity development in IYCF implementation for health parliamentary committee, the Judiciary, health workers and community support groups;
- The need for a national BFHI training and identification of hospitals as pilot sites for effective implementation of the guidelines;
- Approval is required from Cabinet to draft and implementation of a national Code for Marketing of Breastmilk Substitutes for Sierra Leone;
- The Labour laws need to be reviewed to increase maternity leave unto 6 months in order to promote, protect and support exclusive breastfeeding for the first 6 months after birth;
- The ratification of ILO convention on Maternity Protection (183) is required;
- Scaling up the Mother Support Groups (MSGs) nationwide to enhance appropriate Infant and Young Child Feeding practices;
- Need for inter-sectoral collaboration and integration to help strengthen networks amongst partners for programme implementation;
- All Nutritionist needs to be trained on HIV (IYCF) counselling;
- PMTCT sites needs scaling-up nationwide;
- A component on IYCF during emergencies needs to be developed and included into the Nutrition Implementation plan;
- The need for a focal person at the office of national security to oversee nutrition in Emergencies;
- A functional and updated DHMIS and HMIS System is required for sustained source of data information;
- Increase sensitization on IYCF recommended practices;

- IEC material on the risk of not breastfeeding should be developed and disseminated;
- Awareness raising on the demerits of bottle feeding is strongly required;
- Development of a National Standardized recipe for Complementary Foods for infants age 6 – 23 months is required; and
- Finalization of the National Food and Nutrition Security Implementation Plan and IYCF Strategy.

SOURCE DOCUMENTS

1. National Food and Nutrition Security Policy Implementation Plan (revised) 2013 – 2017, (2012);
2. Draft IYCF Strategy (2013);
3. Draft Implementation Plan 2012 – 2017, (revised Feb2013);
4. Minutes of Code Committee meetings (2011 – onwards);
5. Technical Working Group minutes (Standing Working Group);
6. MoHS (Nutrition) BFHI Training reports (2009);
7. UNICEF Status country reports (2009);
8. (The BFHI Facilitators report 2009);
9. International Code of Marketing of Breastmilk Substitutes training Report, (May 2011);
10. Minutes of the Code Committee (2011 – to date);
11. Draft Cabinet Paper on the Code (2013);
12. Regulations of Wages and Industrial Relations Act (no 18 of 1971);
13. Employment Act (1971);
14. Factories Act 1974;
15. Sierra Leone Gazette Vol CXLII (2 September 2011) ;
16. Reproductive, New Born and Child Health Policy (2011);
17. National Protocol for Management of Acute Malnutrition (2011);
18. c-IYCF –Counselling Package (UNICEF) 2010 ;
19. National Nutrition Syllabus for Allied Health Science Training Institutions (2013);
20. World Breastfeeding Week Celebrations reports: previous to date;
21. National Food and Nutrition Security Policy Implementation Plan 2013- 2017, (2012);
22. National HIV Policy (2008);
23. HIV Policy Guidelines (2008);
24. National Nutrition Policy Guidelines for People living with HIV and AIDS, (2008);

25. Strategic Plan towards Elimination of Mother to child transmission of HIV and Aids and for paediatric and HIV Care in Sierra Leone, 2013 – 2015, (2012);
26. Revised National Guidelines for the Preventions of Mother to Child Transmission of HIV and Aids (2012);
27. Revised Infant Feeding Counselling Guidelines in the context of HIV and AIDS, 2013;
28. Draft Disaster Management Policy;
29. National Nutrition and Food Security Implementation Plan 2013 -2016, (2012);
30. Decentralised Monitoring and Evaluation system report;
31. SMART Report 2010;
32. Demographic Health Survey 2008;
33. Multiple Indicator Cluster Survey 2010;
34. DHIS & HMIS Reporting System (ongoing); and
35. Multiple Indicator Cluster Survey 2005.

ANNEXES

Annex 1: Policy Issues

Policy issues[16]

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.).

[16] 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)
▪ 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.
▪ Provide care and support during the antenatal period.	Breastfeeding history (previous experience), breast examination, information targeted to mother's needs and support.
▪ 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.
▪ 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.
▪ Describe the process of milk production and removal.	Breast anatomy; lactation and breastfeeding physiology
▪ 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.
▪ 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.
▪ 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.
▪ Facilitate breastfeeding for infants with special health needs, including premature infants.	Risk/benefit of breastfeeding/breast milk; needs of premature infants; modifications; counselling mothers.
▪ Facilitate successful lactation in the event of maternal medical conditions or treatments.	Risk/benefit; modifications; pharmacological choices; treatment choices.
▪ Inform lactating women about contraceptive options.	Advantages and disadvantages of various child spacing methods during lactation; counselling about LAM; cultural considerations for counselling.
▪ Prescribe/recommend medications, contraceptives and treatment options compatible with lactation.	Compatibility of drugs with lactation; effects of various contraceptives during lactation.
▪ 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.
▪ 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.
▪ Describe what foods are appropriate to introduce to children at various ages and which foods are available and affordable to the general population.	Developmental approach to introduce complementary foods; foods appropriate at various ages; available foods and their costs; incomes of local families and how income levels affect their abilities to afford various foods.
▪ Ask appropriate questions of mothers and other caregivers to	Growth patterns of breastfed infants; complementary foods: when,

Objectives (to be achieved by all health students and trainees who will care for infants, young children and mothers)	Content/skills (to achieve objectives)
identify sub-optimal feeding practices with young children between 6 and 24 months of age.	what, how, how much; micronutrient deficiencies/supplements; young child feeding history; typical problems.
▪ 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.
▪ 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.
▪ 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; relactation.
▪ 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.
▪ 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.
▪ 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.
▪ 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.
▪ 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.
▪ 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 care[17]

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.

[17] 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 environement 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 unsollicited 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.ennonline.net/resources/126
- Model joint statement on IFE http://www.ennonline.net/resources/237

- Key messages on IFE - for mothers and caregivers. English and French http://www.ennonline.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.ennonline.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.ennonline.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.ennonline.net/resources/722.
- Integration of Infant and Young Child Feeding into Community based Management of Acute Malnutrition. October 2009. English and French http://www.ennonline.net/resources/722

- IASC Nutrition. Harmonized Training Package, Cluster Module 17 on Infant and young child feeding in emergencies. http://www.ennonline.net/resources/761

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

Annex 12: Exclusive breastfeeding rate calculator [18]

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 x 2a = 3a; 1b x 2b = 3b; 1c x 2c = 3c). Round each number to the nearest whole number.
7. Calculate the number of children exclusively breastfed 0–5 months of age by adding up the numbers of exclusively breastfed children in each age group, and insert this number in row 3d above (3a + 3b + 3c = 3d).

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).

[18] 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 [19]

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.

[19] 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

.

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