WORLD BREASTFEEDING TRENDS INITIATIVE

Assessment Tool

IBFAN defending breastfeeding

bpni putting child nutrition at the forefront of social change

Version 4
(March 2024)

Assessment Tool

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(March 2024)

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WBT*i* Assessment Tool

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Version 4: 2024

Design & Layout: Amit Dahiya

Revision and updating the WBT*i* Assessment Tool 2019 followed by minor updates in March 2024

This revision in 2019 is based on the new information available after the last revision in 2013.

The present updating was undertaken after receiving feedback from countries to seek clarity and to update information on some of the indicators. The WBTi global secretariat constituted a Technical Working Group (TWG) of experts (See below) from several countries. The TWG included experts on breastfeeding and infant and young child feeding issues and those involved in the development and implementation of this tool. The TWG was to relook and suggest any changes in contents based on availability of new information and feedback.

The global secretariat sought individuals' concurrence and choice of the indicator to work on. Eleven sub-groups were constituted; one for each indicator of policy and programmes, and one group for the indicators on the IYCF practices.

The WBTi Secretariat shared the feedback on earlier tools and new information with each group, and followed up for clarifications with the groups and individuals. Finally, the WBTi Secretariat shared the revised draft tool with the TWG to review and provide feedback. This led to its finalization and the version- 3 (2019) of the tool is now available.

All this process took 4 months. The tool now has updated background information of each indicator and at places change in some questions, as well as the process for scoring make the assessment more objective yet simple to carry out.

Technical Working Group

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The tool was further updated with minor changes based on feedback from European region and United Kingdom.

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Acronyms

BFHI	Baby Friendly Hospital Initiative
BPNI	Breastfeeding Promotion Network of India
DHS	Demographic and Health Survey
FAO	Food and Agriculture Organization
GLOPAR	Global Participatory Action Research
GSIYCF	Global Strategy for Infant and Young Child Feeding
IBFAN	International Baby Food Action Network
ICDC	International Code Documentation Centre
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
PMTCT	Prevention of Mother-to-Child Transmission
WABA	World Alliance for Breastfeeding Action
WBC*i*	World Breastfeeding Costing Initiative
WBT*i*	World Breastfeeding Trends Initiative
WHO	World Health Organization
WHA	World Health Assembly

The World Breastfeeding Trends Initiative (WBT*i*)

About WBT*i*

The Breastfeeding Promotion Network of India (BPNI)/International Baby Food Action Network (IBFAN) South Asia and the World Breastfeeding Trends Initiative (WBTi) Global Secretariat launched the innovative tool in 2004 at a South Asia Partners Forum.

The WBTi assists countries to assess the status and benchmark the progress in implementation of the *Global Strategy for Infant and Young Child Feeding* in a standard way. It is based on the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". The WBTi programme calls on countries to conduct their assessment to measure strengths and weaknesses on the ten parameters of policy and programmes that protect, promote and support optimal infant and young child feeding (IYCF) practices. It maintains a Global Data Repository of these policies and programmes in the form of scores, color codes, report and report card for each country The WBTi assessment process brings people together and encourages collaboration, networking and local action. Organisations such as government departments, UN, health professionals, academics and other civil society partners (without Conflicts of Interest) participate in the assessment process by forming a core group with an objective to build consensus. With every assessment countries identify gaps and provide recommendations to their policy makers for affirmative action and change. The WBTi Global Secretariat encourages countries to conduct a re-assessment every 3-5 years for tracking trends in IYCF policies and programme.

Vision & Mission

The WBTi envisages that all countries create an enabling environment for women to be successful in breastfeeding their babies optimally at home, health facilities or at work places. The WBTi aspires to be a trusted leader to motivate policy makers and programme managers in countries, to use the global data repository of information on breastfeeding and IYCF policies and programmes. WBTi envisions serving as a knowledge platform for programme managers, researchers, policy makers and breastfeeding advocates across the globe. WBTi's mission is to reach all countries to facilitate assessment and tracking of IYCF policies and programmes through mobilising local partnerships without conflicts of interest and building a data repository for advocacy.

Ethical Policy

The WBTi works on 7 principles of IBFAN and does not seek or accept funds donation, grants or sponsorship from manufacturers or distributors and the front organisations of breastmilk substitutes, complementary foods, infant and young child feeding related products like breast pumps, or any such organization that has conflicts of interest.

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

Part-I deals with policy and programmes (indicator 1-10)	Part –II deals with infant feeding practices (indicator 11-15)
1. National Policy, Governance and Funding 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. Counselling services for the pregnant and breastfeeding mothers 7. Accurate and Unbiased Information Support 8. Infant Feeding and HIV 9. Infant and Young Child Feeding during Emergencies 10. Monitoring and Evaluation	1. Timely Initiation of Breastfeeding within one hour of birth 2. Exclusive Breastfeeding for the first six months 3. Median duration of Breastfeeding 4. Bottle-Feeding 5. Complementary Feeding-Introduction of solid, semi-solid or soft foods

Each indicator used for assessment has following components;

- The key question that needs to be investigated.
- Background on why the practice, policy or programme component is important.
- A list of key criteria for assessment as subset of questions to be considered in identifying strengths and weaknesses to document gaps.
- Annexes for related information

Part I: Policies and Programmes: The criteria of assessment has been developed for each of the ten indicators, based on the *Global Strategy for Infant and Young Child Feeding* (2002) and the Innocenti Declaration on Infant and Young Child Feeding (2005) as well as updated with most recent developments in this field. For each indicator, there is a subset of questions. Answers to these can lead to identification of the gaps in policies and programmes required to implement the *Global Strategy*. Assessment can reveal how a country is performing in a particular area of action on Breastfeeding /Infant and Young Child Feeding. Additional information is also sought in these indicators, which is mostly qualitative. Such information is used in the elaborate report, however, is not taken into account for scoring or colour coding.

Part II: Infant and Young Child Feeding Practices in Part II ask for specific numerical data on each practice based on data from random national household surveys. These five indicators are based on the WHO's tool for keeping it uniform. However, additional information on some other practice indicators such as 'continued breastfeeding' and 'adequacy of complementary feeding' is also sought.

Scoring and Colour-Coding

Policy and Programmes Indicator 1-10

Once the information on the 'WBTi Questionnaire 'is gathered and analysed, it is then entered into the web-tool. The tool provides *scoring* of each individual sub set of questions as per their weight age in the indicators 1-10 (policies and programmes). Each indicator has a maximum score of 10. Total score of ten indicators has a maximum score of 100.

The web tool also assigns *Colour-Coding* (Red/Yellow/Blue/Green) of each indicator as per the *WBTi Guidelines for Colour-Coding* based on the scores achieved.

In the part II (IYCF practices)

Indicators of part II are expressed as percentages or absolute number. Once the data is entered, the tool assigns *Colour coding* as per the *Guidelines*.

The WBTi Tool provides details of each indicator in sub-set of questions, and weight age of each.

Global acceptance of the WBT*i*

The WBTi met with success South Asia during 2004-2008 and based on this, the WBTi was introduced to other regions. By now more than 100 countries have been trained in the use of WBTi tools and 97 have completed and reported. Many of them repeated assessments during these years.

WBTi has been published as BMJ published news in the year 2011, when 33 country WBTi report was launched[1]. Two peer reviewed publications in the international journals add value to the impact of WBTi, in Health Policy and Planning in 2012 when 40 countries had completed[2], and in the Journal of Public Health Policy in 2019[3] when 84 countries completed it.

The WBTi has been accepted globally as a credible source of information on IYCF polices and programmes and has been cited in global guidelines and other policy documents e.g. WHO National Implementation of BFHI 2017[4] and IFE Core group's Operational Guidance on Infant Feeding in Emergencies, 2017[5].

Accomplishment of the WBTi assessment is one of the seven policy asks in the Global Breastfeeding Collective (GBC), a joint initiative by UNICEF & WHO to accelerate progress towards achieving the WHA target of exclusive breastfeeding to 50% by 2030. The Global Breastfeeding Scorecard for tracking progress for breastfeeding policies and programmes developed by the Collective has

[1] BMJ 2011;342:d18doi: https://doi.org/10.1136/bmj.d18 (Published 04 January 2011)
[2] https://academic.oup.com/heapol/article/28/3/279/553219
[3] https://link.springer.com/article/10.1057/s41271-018-0153-9
[4] https://www.who.int/nutrition/publications/infantfeeding/bfhi-national-implementation2017/en/
[5] https://www.ennonline.net/attachments/3028/Ops-Guidance-on-IFE_v3-2018_English.pdf

identified a target that at least three-quarters of the countries of the world should be able to conduct a WBTi assessment every five years by 2030.[6] The report on implementation of the International Code of Marketing for Breastmilk Substitutes also used WBTi as a source. The Global database on the Implementation of Nutrition Action (GINA) of WHO has used WBTi as a source.[7] Global researchers have used WBTi findings to predict possible increase in exclusive breastfeeding with increasing scores and found it valid for measuring inputs into global strategy.[8] Other than this PhD students have used WBTi for their research work, and New Zealand used WBTi for developing their National Strategic Plan of Action on breastfeeding 2008-2012.

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[6] https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2017.pdf?ua=1
[7] https://extranet.who.int/nutrition/gina/
[8] https://academic.oup.com/advances/article/4/2/213/4591629

The WBT*i* Guidelines for Colour-Coding (Part I and II)

Table 1: WBT*i* Guidelines for Colour-Coding for Individual indicators1-10

Scores	*Colour-coding*
0 – 3.5	**Red**
4 – 6.5	**Yellow**
7 – 9	**Blue**
> 9	**Green**

Table 2: WBT*i* Guidelines for Colour-Coding 1-10 indicators **(**policy and programmes)

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

Table 3: WBT*i* Guidelines for Colour-Coding Individual indicators 11-15 (Practices)

WBTi Guidelines for Indicator 11 (Initiation of breastfeeding {within 1 hour})

Percentage (WHO's key)	*Colour-coding*
0.1-29%	**Red**
29.1-49%	**Yellow**
49.1%-89%	**Blue**
89.1-100%	**Green**

WBTi Guidelines for Indicator 12 (Exclusive Breastfeeding {for first 6 months})

Percentage (WHO's key)	*Colour-coding*
0.1-11%	**Red**
11.1-49%	**Yellow**
49.1-89%	**Blue**
89.1-100%	**Green**

WBTi Guidelines for Indicator 13 (Median Duration of Breastfeeding)

Months (WHO's key)	*Colour-coding*
0.1-18 months	**Red**
18.1-20 months	**Yellow**
20.1-22 months	**Blue**
22.1-24 months	**Green**

WBTi Guidelines for Indicator 14 (Bottle-feeding {0-12 months})

Percentage (WHO's key)	*Colour-coding*
29.1-100%	**Red**
4.1-29%	**Yellow**
2.1-4%	**Blue**
0.1-2%	**Green**

WBTi Guidelines for Indicator 15 (Complementary Feeding {6-8 months})

Percentage (WHO's key)	*Colour-coding*
0.1-59%	**Red**
59.1-79%	**Yellow**
79.1%-94%	**Blue**
94.1-100%	**Green**

Part I: IYCF Policies and Programmes

In Part I, each question has possible score of 0-3 and each indicator has a maximum score of 10. Once information about the indicators is entered, the achievement on the particular target indicator is then rated i.e. Red, Yellow, Blue and Green based on the guidelines.

Indicator 1: National Policy, Governance and Funding

Key question/s: *Is there a national breastfeeding/ infant and young child feeding policy that protects, promotes and supports optimal breastfeeding and infant and young child feeding (IYCF) practices? Is the policy supported by a government programme? Is there a plan to implement this policy? Is sufficient funding provided? Is there a mechanism to coordinate like e.g. National breastfeeding committee and a coordinator for the committee? (See Annex 1)*

Background

The "Innocenti Declaration" adopted in 1990, recommended all governments to have national breastfeeding committees and coordinators as established mechanisms to protect, promote and support breastfeeding in the country along with Code, BFHI and maternity protection policies. The *Global Strategy for Infant and Young Child Feeding (2002)* incorporated all these actions, and calls for urgent action by all Member States to develop, implement, monitor and evaluate a comprehensive policy and plan of action on breastfeeding / infant and young child feeding to achieve reduction in child malnutrition and mortality. In 2005, the Innocenti Declaration on Infant and Young Child Feeding provided five additional targets. In 2005, the World Health Assembly adopted a resolution 58.32 that calls upon member states to assure resources for plan of action to improve optimal practices. In 2007 WHO launched a 'Planning Guide for implementation of Global Strategy' that helps to develop a concrete national strategy, policy and action plans. The Global Breastfeeding Collective led by UNICEF and WHO (2017), recommended seven policy actions to increase breastfeeding rates with emphasis on funding. The World Bank **'An Investment Framework for Nutrition (2017)'** estimated financing required to scale up a core set of interventions across allow- and middle-income countries to achieve the World Health Assembly target for exclusive breastfeeding by 2025 is $5.7 billion, or approximately $4.70 for every newborn.

Possible Sources of Information

- National Plans of Action on Nutrition
- National Plan of Action for the Child or similar document
- National Nutrition or Health Policy
- Terms of reference of the national breastfeeding / IYCF committee/s and /or its' coordinator
- Minutes of the National Breastfeeding/IYCF Committee/s
- CRC country reports
- Interviews with the National Breastfeeding Coordinator, officials from the Ministries of Health, Ministry of Women and Children, Ministry of Nutrition, Planning, and Labour, WHO, UNICEF, and country breastfeeding promotion groups.

Having looked at these resources, do try to get hold of copies of national policy/programmes that refer to breastfeeding and infant and young child feeding.

Criteria for Assessment –Policy and Funding	✔*Check all that apply*	
1.1) A national breastfeeding/infant and young child feeding policy/guideline (stand alone or integrated) has been officially approved by the government	❑Yes = 1	❑No=0
1.2) The policy recommends initiation of breastfeeding within one hour of birth and exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	❑Yes = 1	❑No=0
1.3) A national plan of action is approved with goals, objectives, indicators and timelines (stand alone or integrated)	❑Yes = 2	❑No = 0
1.4) The country (government and others) is spending on breastfeeding and IYCF interventions[9] a. no funding b. < $1 per birth c. $1-2 per birth d. $2-5 per birth e. =or >$5 per birth	√ Check one which is applicable ❑ 0 ❑ 0.5 ❑ 1 ❑ 1.5 ❑ 2.0	
Governance		
1.5) There is a National Breastfeeding/IYCF Committee	❑Yes =1	❑No = 0
1.6) The committee meets, monitors and reviews the plans and progress made on a regular basis	❑Yes = 2	❑No = 0
1.7) The committee links effectively with all other sectors like finance, health, nutrition, information, labor, disaster management, agriculture, social services etc.	❑Yes = 0.5	❑No = 0
1.8) The committee is headed by a coordinator with clear terms of reference, regularly coordinating action at national and sub national level and communicating the policy and plans.	❑Yes = 0.5	❑No = 0
Total Score	**____/10**	

Additional useful information

1. What is the amount of money currently being spent annually on the breastfeeding and IYCF interventions?
2. How many babies are born each year?
3. Is the food industry/representative a part of the breastfeeding/IYCF committee?

[9] Global Breastfeeding Scorecard, 2023 (Unicef) https://www.unicef.org/documents/global-breastfeeding-scorecard-2023

Information Sources Used *(please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Conclusions *(Summarize which aspects ofIndicator-1 i.e. IYCF policy, plan and funding are appropriate; which need improvement and why; and any further analysis needed)***:**

Gaps *(List gaps identified in the implementation of this indicator)***:**

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Recommendations *(List actions recommended to bridge the gaps):*

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Policy issues[10]

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

- Promote infant and young child feeding practices consistent with international guidelines.
- Ensure functioning of a strong national committee and coordinator.
- Monitor trends and assess interventions and promotional activities to improve feeding practices.
- Provide technically sound and consistent messages through appropriate media and educational channels.
- Strengthen and sustain the Baby-friendly Hospital Initiative (BFHI) and fully integrate it within the health system.
- Provide health workers in health services and communities with the skills and knowledge necessary to provide counselling and support related to breastfeeding, complementary feeding, and HIV and infant feeding, and to fulfill their responsibilities under the *International Code of Marketing on 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.
- Adopt safeguards against conflicts of Interest and industry interference.

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, labor, disaster, HIV, information etc.).

[10] Summarized and adapted from the WHO Global Strategy for Infant and Young Child Feeding (1), pages 13–15.

Indicator 2: Baby Friendly Hospital Initiative / Ten Steps to Successful Breastfeeding

Key questions

- *What percentage of hospitals/maternity facilities are designated/ accredited/awarded OR what % of new mothers have received maternity care as per the 'Ten Steps' within the past 5 years?*
- *What is the quality of implementation of BFHI? (see annex 2.1,2.2,2.3,2.4,2.5,2.6,2.7)*

Background

The Joint WHO/UNICEF Statement: *Protecting, promoting and supporting breastfeeding: the special role of maternity services*, in 1989 came up with the *'Ten Steps to Successful Breastfeeding'*. The *Innocenti Declaration* of 1990 called upon governments to ensure that all maternity services fully implement all the *Ten Steps*.

The Ten Steps became the cornerstone of the Baby-friendly Hospital Initiative (BFHI) launched in 1992 with the aim to protect, promote and support breastfeeding in the health facilities, and included among other steps having a written policy, competence training of the staff and implementing the International Code of Marketing for Breastmilk Substitutes. BFHI designation process was introduced to reflect changes in health policy and care practices. Several countries initiated action on BFHI and made progress demonstrating change. The *Global Strategy for Infant and Young Child Feeding* emphasized the need for implementation monitoring and reassessment of already designated facilities. In 2020 WHO and Unicef, revised, updated and expanded for integrated care material for implementation of the BFHI.[11] The course is divided into sessions that vary in length according to the sessions selected. It can be conducted over three days or can be spread in other ways depending on the needs of the specific context. The sessions use a variety of teaching methods, including lectures, demonstrations and work in smaller groups, with classroom-based exercises, and clinical practice sessions in clinical facilities providing maternity and newborn baby services.

In 2018, WHO using updated evidence, developed the implementation guidance for the revised Baby-friendly Hospital Initiative and revised the *Ten steps*.[12] According to WHO only 10% births have been taking place in BFHI designated facilities and new guidance addressed this to expand to many more hospitals. The revised ten Steps include all the earlier concepts except that it categorized these into *Critical management procedures* (Step 1 and 2) and *Key clinical practices* (Step 3-10). Implementation of the *International Code of Marketing of Breastmilk Substitutes* is explicit under Step 1. While the new guidance lays emphasis on integration of the Ten Steps into the national or hospital standards of care with nine principles (Annex-2.1) for implementing it, it also guides the countries that currently have a well-functioning designation programme. The new guidance *"..should not be viewed as a reason to discontinue a successful programme…"*Annex-2.4)

The present version of the WBTi tool indicator 2 has used both the old and the revised Ten Steps

[11] https://iris.who.int/bitstream/handle/10665/333673/9789240008915-eng.pdf?sequence=1 (Accessed on 23 March 2024)
[12] https://www.who.int/publications/i/item/9789241513807 (Accessed on 23 March 2024)

(2018) in order to reach out to every country at whatever state of implementation they are.

Table 4 below depicts the Ten Steps from 2009 and revised in 2018

Ten Steps 2009	Ten Steps 2018
Every facility providing maternity services and care for newborn infants should:	***Critical management procedures***
1. Have a written breastfeeding policy that is routinely communicated to all health care staff.	1.a. Comply fully with the *International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly resolutions. 1.b. Have a written infant feeding policy that is routinely communicated to staff and parents. 1.c. Establish ongoing monitoring and data-management systems.
2. Train all health care staff in skills necessary to implement this policy.	2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.
	Key clinical practices
3. Inform all pregnant women about the benefits and management of breastfeeding.	3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Help mothers initiate breastfeeding within a half-hour of birth. (Interpreted since 2009 as: Place babies in skin-to-skin contact with their mother immediately following birth for at last an hour and encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.)	4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.	5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Give newborn infants no food or drink other than breastmilk unless medically indicated.	6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
7. Practise rooming in - allow mothers and infants to remain together - 24 hours a day.	7. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
8. Encourage breastfeeding on demand.	8. Support mothers to recognize and respond to their infants' cues for feeding.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.	9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.	10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

Annex 2.3 compares the old and new Ten steps in operational terms and 2.2 explains them in lay terms. For skill training and counselling one can refer to the WHO or other courses and guidelines given in the Annexes or wait for the WHO/UNICEF revised training material being actually pilot tested and published End of 2019.

Possible Sources of Information:

- Interviews with the national BFHI coordinator/the BFHI committee members, the Ministry of Health, UNICEF and WHO officials
- Minutes of the meetings of coordination committee, summary reports of the status of the BFHI
- Reports/research studies on the BFHI/implementation of the 10 steps
- Global BFHI reports
- Interviews of mothers delivering in these hospitals to generate additional information on the quality of care can be planned.
- Interviews with breastfeeding support groups or postpartum caregivers.

Quantitative Criteria for assessment

2.1) out of total hospitals (both public &private) offering maternity services that have been designated/accredited/awarded/measured for implementing 10 steps within the past 5 years.

Criteria for assessment	√ Check 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 score 2.1	**_____/5**

Qualitative Criteria for assessment

Criteria for assessment	√ Check that apply	
2.2) There is a national coordination body/mechanism for BFHI / to implement Ten Steps with a clearly identified focal person.	❑ Yes = 1	❑ No=0
2.3) The Ten Steps have been integrated into national/ regional/hospital policy and standards for all involved health professionals.	❑ Yes = 0.5	❑ No=0
2.4) An external assessment mechanism is used for accreditation /designation/awarding/evaluate the health facility.	❑ Yes = 0.5	❑ No=0

Criteria for assessment	√ Check that apply	
2.5) Provision for the reassessment[13] have been incorporated in national plans to implement Ten Steps.	❑ Yes = 0.5	❑ No=0
2.6) The accreditation/designation/awarding/measuring process for BFHI/implementing the Ten Steps includes assessment of knowledge and competence of the nursing and medical staff.	❑ Yes = 1	❑ No=0
2.7) The external assessment process relies on interviews of mothers.	❑ Yes = 0.5	❑ No=0
2.8) The International Code of Marketing of Breastmilk Substitutes is an integral part of external assessment.	❑ Yes = 0.5	❑ No=0
2.9) Training on the Ten Steps and standard of care are included in the pre-service curriculum for nurses, midwives and doctors and other involved health care professionals.	❑ Yes = 0.5	❑ No=0
Total Score (2.2 to 2.9)	**____/5**	

Total Score (2.1 to 2.9)	**_______/10**

Additional information: Can you explain the process in the country and how it is aligned to the earlier or revised ten Steps and if it relies on national or international criteria (see Appendix: indicators for monitoring.

Please describe the deviations from the international criteria.

Information Sources Used *(please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Conclusions *(Summarize how the country is doing in achieving Baby Friendly Hospital Initiative targets (implementing ten steps to successful breastfeeding) in quantity and quality both. List any aspects of the initiative needing improvement and why and any further analysis needed):*

[13] ***Reassessment*** can be described as a "re-evaluation" of already designated baby-friendly hospitals to determine if they continue to adhere to the *TenSteps* and other baby friendly criteria. It is usually planned and scheduled by the national authority responsible for BFHI for the purpose of evaluatingon-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.

Gaps *(List gaps identified in the implementation of this indicator)***:**

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________

Recommendations *(List action recommended to bridge the gaps):*

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________

Nine key responsibilities of a national BFHI programme

1. Establish or strengthen a national breastfeeding coordination body.
2. Integrate the Ten Steps into relevant national policy documents and professional standards of care.
3. Ensure the competency of health professionals and managers in implementation of the Ten Steps.
4. Utilize external assessment systems to regularly evaluate adherence to the Ten Steps.
5. Develop and implement incentives for compliance and/or sanctions for non-compliance with the Ten Steps.
6. Provide technical assistance to facilities that are making changes to adopt the Ten Steps.
7. Monitor implementation of the initiative.
8. Advocate for the BFHI to relevant audiences.
9. Identify and allocate sufficient resources to ensure the ongoing funding of the initiative.

Source: *Implementation Guidance Protecting, Promoting and Supporting Breastfeeding In Facilities Providing Maternity And Newborn Services: The Revised Baby-Friendly Hospital Initiative 2018. UNICEF-WHO*

Ten Steps to Successful Breastfeeding in lay terms

	Hospitals support mothers to breastfeed by…	Because…
a. Hospital policies	• Not promoting infant formula, bottles or teats • Making breastfeeding care standard practice • Keeping track of support for breastfeeding	Hospital policies help make sure that all mothers and babies receive the best care
b. Staff competency	• Training staff on supporting mothers to breastfeed • Assessing health workers' knowledge and skills	Well-trained health workersprovide the best support forbreastfeeding
c. Antenatal care	• Discussing the importance of breastfeedingfor babies and mothers • Preparing women in how to feed their baby	Most women are able to breastfeed with the right support
d. Care right after birth	• Encouraging skin-to-skin contact betweenmother and baby soon after birth • Helping mothers to put their baby to the breast right away	Snuggling skin-to-skin helps breastfeeding get started
e. Support mothers with breastfeeding	• Checking positioning, attachment andsuckling • Giving practical breastfeeding support • Helping mothers with common breastfeeding problems	Breastfeeding is natural, but most mothers need help at first
f. Supplementing	• Giving only breast milk unless there aremedical reasons • Prioritizing donor human milk when asupplement is needed • Helping mothers who want to formula feed do so safely	Giving babies formula in the hospital makes it hard to get breastfeeding going
g. Rooming-in	• Letting mothers and babies stay togetherday and night • Making sure that mothers of sick babies canstay near their baby	Mothers need to be near their babies to notice and respond to feeding cues
h. Responsive feeding	• Helping mothers know when their baby ishungry • Not limiting breastfeeding times	Breastfeeding babies wheneverthey are ready helps everybody
i. Bottles, teats, and pacifiers	• Counselling mothers about the use and risksof feeding bottles and pacifiers	Everything that goes in the baby's mouth needs to be clean
j. Discharge	• Referring mothers to community resourcesfor breastfeeding support • Working with communities to improve breastfeeding support services	Learning to breastfeed takes time

Source: *Implementation Guidance Protecting, Promoting and Supporting Breastfeeding In Facilities Providing Maternity and Newborn Services: The Revised Baby-Friendly Hospital Initiative 2018. UNICEF-WHO*

Annex-2.3

Ten Steps to Successful Breastfeeding – revised 2018 version: comparison to the original Ten Steps and the new 2017 WHO guideline

Ten Steps to Successful Breastfeeding – revised 2018	Corresponding recommendations from WHO Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services (2017)	Ten Steps in Protecting, promoting and supporting breast-feeding: the special role of maternity services (1989)
Critical management procedures		
1a. The International Code of Marketing of Breast-milk Substitutes(25–27): Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.	N/A	N/A (incorporated in the hospital self-appraisal and monitoring guidelines and the external assessment)
1b. Infant feeding policy: Have a written infant feeding policy that is routinely communicated to staff and parents.	**Recommendation 12:** Facilities providing maternity and newborn services should have a clearly written breastfeeding policy that is routinely communicated to staff and parents.	**Step 1:** Have a written breastfeeding policy that is routinely communicatedto all health-care staff.
1c. Monitoring and data-management systems: Establish ongoing monitoring and data-management systems.	N/A	N/A
2. Staff competency: Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.	**Recommendation 13:** Health facility staff who provide infant feeding services, including breastfeeding support, should have sufficient knowledge, competence and skills to support women to breastfeed.	**Step 2:** Train all health-care staff in the skills necessary to implement thispolicy.
Key clinical practices		
3. Antenatal information: Discussthe importance and management of breastfeeding with pregnant womenand their families.	**Recommendation 14:** Where facilities provide antenatal care, pregnant women and their familiesshould be counselled about the benefits and management of breastfeeding.	**Step 3:** Inform all pregnant women about the benefits and management of breastfeeding.
4. Immediate postnatal care: Facilitate immediate and uninterrupted skin-to-skin contact andsupport mothers to initiate breastfeeding as soon as possible afterbirth.	**Recommendation 1:** Early and uninterrupted skin-to-skin contact between mothers and infants should be facilitated and encouraged as soon as possible after birth. **Recommendation 2:** All mothers should be supported to initiate breastfeeding as soon as possible after birth, within the first hour afterdelivery.	**Step 4:** Help mothers initiate breastfeeding within a half-hour ofbirth.
5. Support with breastfeeding: Support mothers to initiate and maintain breastfeeding and managecommon difficulties.	**Recommendation 3:** Mothers should receive practical support to enable them to initiate and maintain breastfeeding and manage common breastfeeding difficulties.	**Step 5:** Show mothers how to breastfeed and maintain lactation, even if they should be separated fromtheir infants.
	Recommendation 4: Mothers shouldbe coached on how to express breast milk as a means of maintaining lactation in the event of their being separated	

Ten Steps to Successful Breastfeeding – revised 2018	Corresponding recommendations from WHO Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services (2017)	Ten Steps in Protecting, promoting and supporting breast-feeding: the special role of maternity services (1989)
	temporarily from their infants.	
6. Supplementation: Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.	**Recommendation 7:** Mothers should be discouraged from giving any food or fluids other than breast milk, unless medically indicated.	**Step 6:** Give newborn infants no foodor drink other than breastmilk, unless medically indicated.
7. Rooming-in: Enable mothers and their infants to remain together and to practise rooming-in throughout the day and night.	**Recommendation 5:** Facilities providing maternity and newborn services should enable mothers and their infants to remain together and to practise rooming-in throughout the day and night. This may not apply in circumstances when infants need to be moved for specialized medical care.	**Step 7:** Practise rooming in – allow mothers and infants to remain together – 24 hours a day.
8. Responsive feeding: Support mothers to recognize and respond to their infants' cues for feeding.	**Recommendation 6:** Mothers should be supported to practise responsive feeding as part of nurturing care. **Recommendation 8:** Mothers shouldbe supported to recognize their infants' cues for feeding, closeness and comfort, and enabled to respond accordingly to these cues with a variety of options, during their stay atthe facility providing maternity and newborn services.	**Step 8:** Encourage breastfeeding on demand.
Feeding bottles, teats and pacifiers: Counsel mothers on the useand risks of feeding bottles, teats and pacifiers.	**Recommendation 9:** For preterm infants who are unable to breastfeed directly, non-nutritive sucking and oral stimulation may be beneficial until breastfeeding is established. **Recommendation 10:** If expressed breast milk or other feeds are medically indicated for term infants, feeding methods such as cups, spoons or feeding bottles and teats may be used during their stay at the facility. **Recommendation 11:** If expressed breast milk or other feeds are medically indicated for preterm infants, feeding methods such as cupsor spoons are preferable to feeding bottles and teats.	**Step 9:** Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Care at discharge: Coordinate discharge so that parents and their infants have timely access to ongoing support and care.	**Recommendation 15:** As part of protecting, promoting and supporting breastfeeding, discharge from facilities providing maternity and newborn services should be planned for and coordinated, so that parents and their infants have access to ongoing support and appropriate care.	**Step 10:** Foster the establishment of breastfeeding support groups and refer mothers to them on discharge fromthe hospital or clinic.

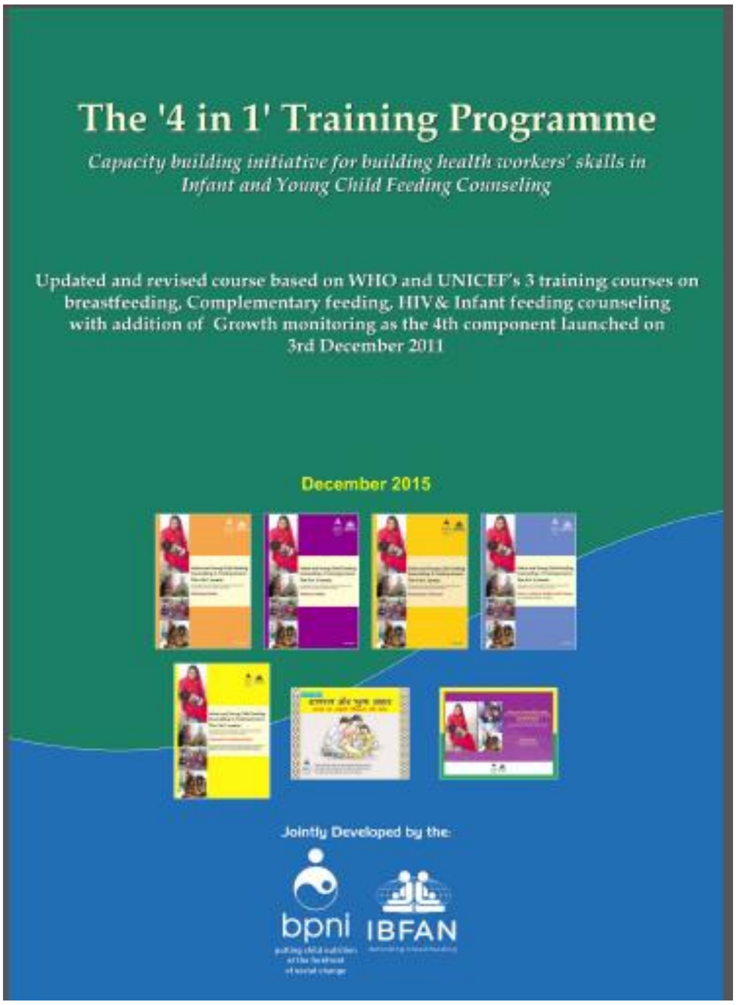
Source: *Implementation Guidance Protecting, Promoting and Supporting Breastfeeding In Facilities Providing Maternity and Newborn Services: The Revised Baby-Friendly Hospital Initiative 2018. UNICEF-WHO*

Protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative 2018:Implementation guidance
Link: https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation/en/

(Please see the web link for the complete document) and Appendix: Indicators for monitoring
https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018-appendix.pdf?ua=1

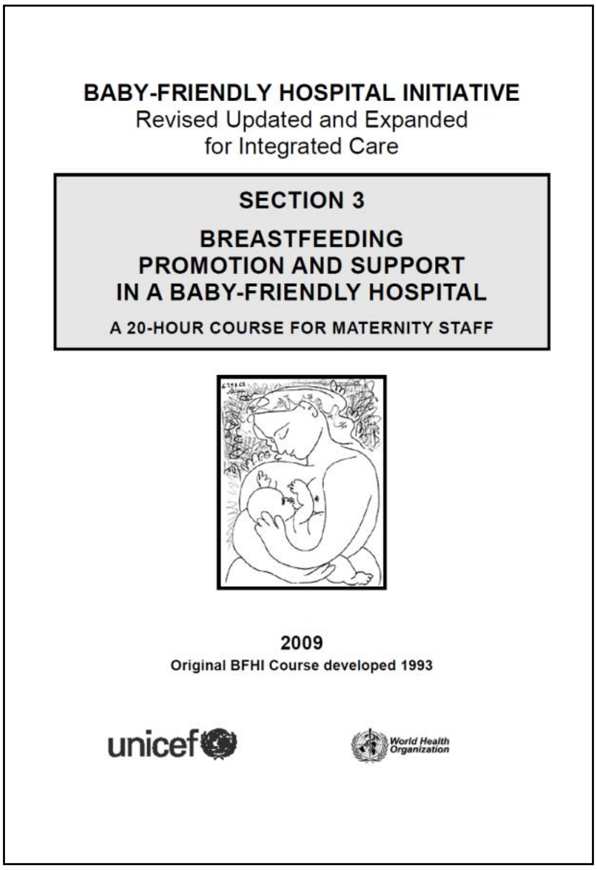
Authors:
World Health Organization, UNICEF

Infant and Young Child Feeding Counselling: A Training Course 'The 4 in 1' Course
(An integrated course on Breastfeeding, Complementary feeding, Infant Feeding & HIV and Growth monitoring) (BPNI-International Baby Food Action Network (IBFAN)



http://bpni.org/Training/4-in-1-brochure.pdf

WHO UNICEF Breastfeeding Promotion and Support in A Baby-friendly Hospital (20 hours course for maternity staff)



BABY-FRIENDLY HOSPITAL INITIATIVE
Revised Updated and Expanded
for Integrated Care

SECTION 3

BREASTFEEDING
PROMOTION AND SUPPORT
IN A BABY-FRIENDLY HOSPITAL

A 20-HOUR COURSE FOR MATERNITY STAFF

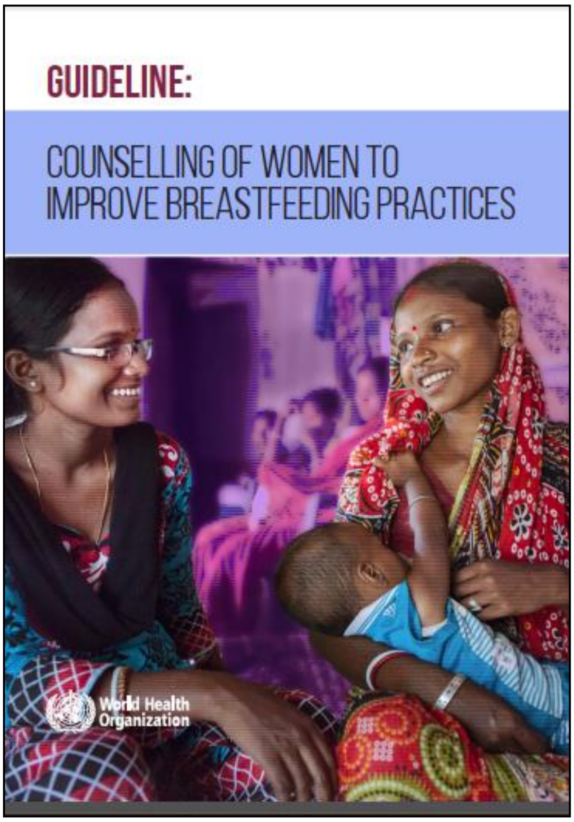
2009
Original BFHI Course developed 1993

unicef

World Health Organization

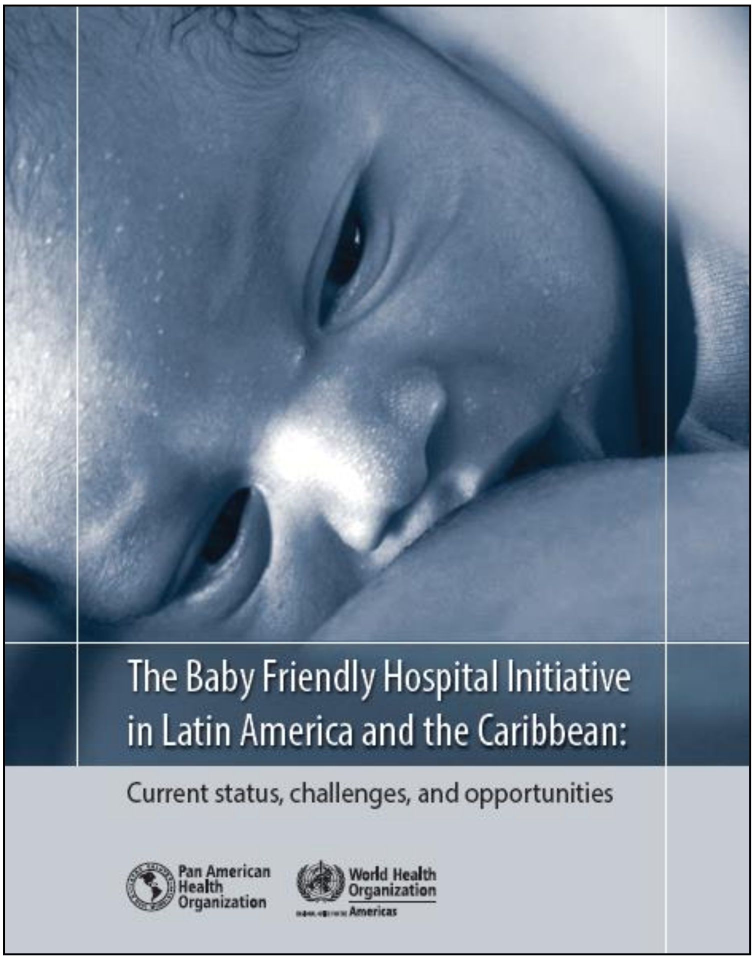
https://www.unicef.org/nutrition/files/BFHI_2009_s3.1and2.pdf

WHO Guidelines on counselling of women to improve breastfeeding practices (2018)
https://www.who.int/nutrition/publications/guidelines/counselling-women-improve-bf-practices/en/



The Baby Friendly Hospital Initiative in Latin America and the Caribbean: Current status, challenges, and opportunities

http://iris.paho.org/xmlui/bitstream/handle/123456789/18830/9789275118771_eng.pdf?sequence=1&isAllowed=y



Author: PAHO and WHO

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

Key questions: *Are the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions in effect and implemented in the country? Has any action been taken to monitor and enforce the above?* (See Annex 3.1, 3.2)

Background

The World Health Assembly (WHA), the forum that governs the World Health Organization (WHO) and sets its health policies, adopted the International Code of Marketing of Breastmilk Substitutes as a recommendation in 1981 through resolution WHA 34.22. The resolution stresses that the adoption of and adherence to the Code is a minimum requirement, and countries are expected to give effect to the principles and aim of the Code in their entirety. For the Code to take legal effect at the national level, it must first be translated into legislation, regulations or other suitable measures as appropriate to the social and legislative framework of the implementing country. 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. These resolutions keep the Code up-to-date with evolving marketing trends and the latest scientific knowledge. When implementing the Code nationally, legislators must ensure that the subsequent WHA resolutions are also incorporated into law.

The "Innocenti Declaration" 1990calls 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. An important aim of the Code is to bring an end to misleading information about infant and young child feeding and contribute to the provision of safe and adequate nutrition for infants. It calls on Member States to protect, promote and support breastfeeding, ensure the proper use of breastmilk substitutes, when these are necessary, while ensuring full, frank and independent information and appropriate marketing and distribution. The "State of the Code by Country" by the ICDC documents countries' progress in implementing the Code and provides important and relevant information on the type of action taken.

According to WHO 136 out of 194 Member States have adopted code related legal measures, however just 35 countries incorporate all or most of the provisions of the Code in law.[14]

Possible Sources of Information:

- Interviews of the officials of Ministry of Health, WHO and UNICEF.
- Current data on Code implementation by country can be obtained from:
  - The International Code Documentation Centre (ICDC) of the International Baby Food Action Network (IBFAN), which publishes the "State of the Code by Country" report periodically See: https://www.ibfan-icdc.org

[14] The 2018 joint report by WHO-UNICEF-IBFAN "Marketing of Breast-milk Substitutes-National implementation of the International Code: Status Report 2018

- Mother support groups /IBFAN Focal Points' office
- Other groups that have conducted national surveys on Code compliance.
- WHO, UNICEF, IBFAN Code monitoring reports published in 2016 and 2018

Criteria for Assessment (*Legal Measures that are in Place in the Country*)	
	Score
3a: Status of the International Code of Marketing √ *Check that applies upto the questions 3.9. If it is more than one, tick the higher one.*	
3.1 No action taken	❑0
3.2 The best approach is being considered	❑0.5
3.3 Draft measure awaiting approval (for not more than three years)	❑1
3.4 Few Code provisions as voluntary measure	❑1.5
3.5 All Code provisions as a voluntary measure	❑2
3.6 Administrative directive/circular implementing the code in full or in part in health facilities with administrative sanctions	❑3
3.7 Some articles of the Code as law	❑4
3.8 All articles of the Code as law	❑5
3.9 Relevant provisions of World Health Assembly (WHA) resolutions subsequent to the Code are included in the national legislation[15] a) Provisions based on 1 to3 of the WHA resolutions as listed below are included b) Provisions based on more than 3 of the WHA resolutions as listed below are included	 ❑5.5 ❑6
Total score 3a	

3b: Implementation of the Code/National legislation *Check that applies. It adds up to the 3a scores.*	
3.10 The measure/law provides for a monitoring system independent from the industry	❑1
3.11 The measure provides for penalties and fines to be imposed to violators	❑1
3.12 The compliance with the measure is monitored and violations reported to concerned agencies	❑1
3.13 Violators of the law have been sanctioned during the last three years	❑1
Total Score 3b	

Total Score (3a + 3b)	**__/10**

[15] Following WHA resolutions should be included in the national legislation/enforced through legal orders to tick this score.
1. Donation of free or subsidized supplies of breastmilk substitutes are not allowed (WHA 47.5)
2. Labeling of complementary foods recommended, marketed or represented for use from 6 months onward (WHA 49.15)
3. Health and nutrition claims for products for infants and young children are prohibited (WHA 58.32) are prohibited
4. Labels of covered products have warnings on the risks of intrinsic contamination and reflect the FAO/WHO recommendations for safe preparation of powder infant formula (WHA 58.32, 61.20)
5. Ending inappropriate promotion of foods for infants and young children (WHA 69.9)

Additional Information

1. How often you see the violations of the Code or National law?(Attach some examples)
2. Has your country taken any steps that strengthen the Code implementation?
3. How is the Code information disseminated among the health workers? (List some examples)

Information Sources Used *(please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Conclusions *(Summarize which aspects of Code implementation have been achieved, and which aspects need improvement and why. Identify areas needing further analysis)*

Gaps *(List gaps identified in the implementation of this indicator)***:**

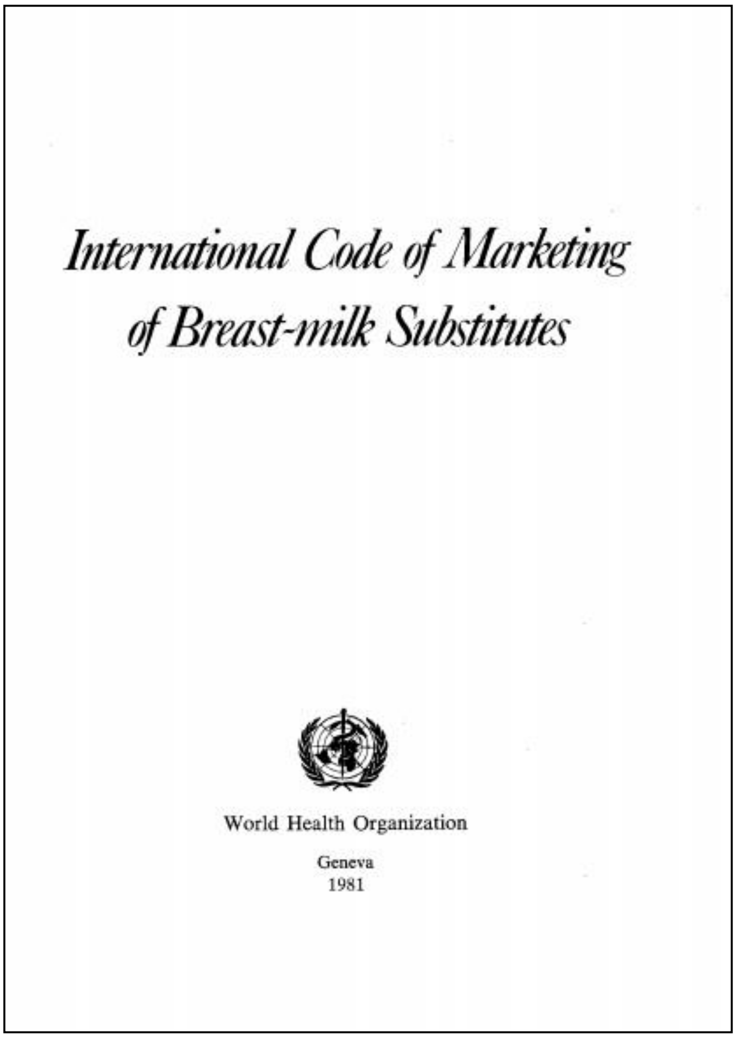
1. ______________________
2. ______________________
3. ______________________
4. ______________________

Recommendations *(List action recommended to bridge the gaps):*

1. ______________________
2. ______________________
3. ______________________
4. ______________________

International Code of Marketing of Breast-milk Substitutes

See complete document at:
https://iris.who.int/bitstream/handle/10665/40382/9241541601.pdf?sequence=1
(Accessed on 23 March 2024)



International Code of Marketing of Breast-milk Substitutes

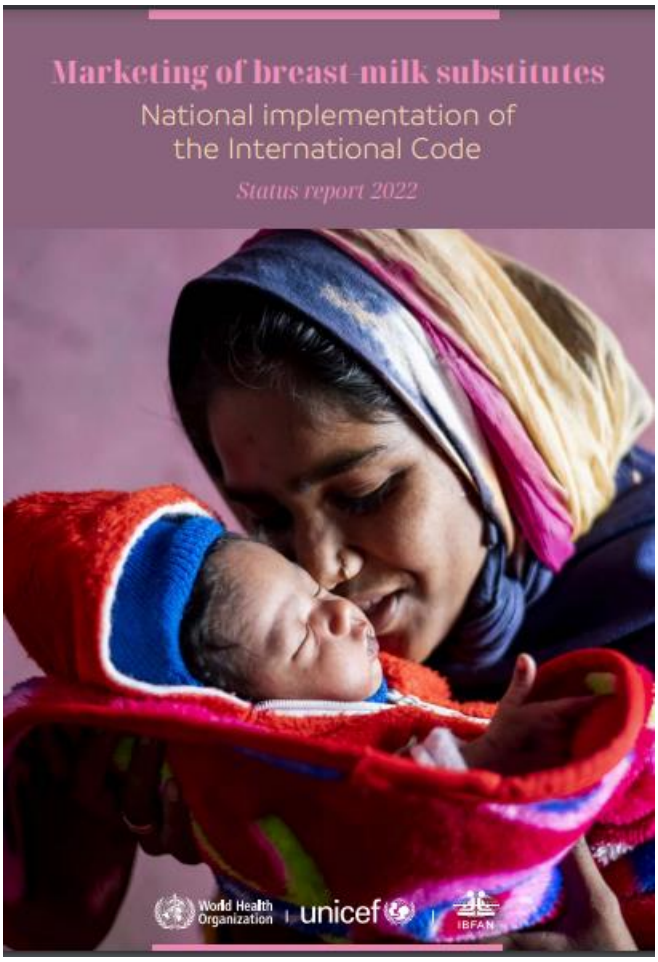
World Health Organization

Geneva
1981

Marketing of breast-milk substitutes: national implementation of the international code, status report 2022

https://iris.who.int/bitstream/handle/10665/354221/9789240048799-eng.pdf?sequence=1

Accessed on 23 March 2024



Indicator 4: Maternity Protection

Key question: *Is there a legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labor Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including mothers working in the informal sector? (See Annex 4)*

Background

Women have the right to adequate support to be able to breastfeed their babies. Convention of Rights of the Child and The Convention on the Elimination of all Forms of Discrimination Against Women (**CEDAW**), an international treaty adopted in 1979 by the United Nations General Assembly protect these rights of women. The Innocenti Declarations (1999, 2005) and WHO Global Strategy for IYCF (2002) call for provision of imaginative legislation to protect the breastfeeding rights of working women and further monitoring of its application consistent with ILO Maternity Protection Convention No 183, 2000 and Recommendation 191. The ILO's Maternity Protection Convention (MPC) 183 specifies that women workers should receive:

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

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

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

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

Maternity protection for all women implies that women working in the informal economy should also be protected too. The 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. Paternity leave policies should prioritise women's access to paid maternity leave for the first 6 months. Policies should prevent marketing of milk formula as the counterpart to paternity leave and equality in infant care work.

Possible Sources of Information

- Interviews can be held with officials of the Ministry of Health, Labour, Welfare, or Women's Affairs and staff of NGOs such as IBFAN.
- Data on the ILO conventions and progress in ratifying them in various countries can be found on the ILO website.
- WABA documents a country profile on the status of Maternity Protection. http://www.waba.org.my/whatwedo/womenandwork/pdf/mpchart2015.pdf. It lists the length of maternity leave and paternity leave as well as who pays for these, breastfeeding breaks provided or not and if these are paid or unpaid.

Criteria for Assessment	Scores
4.1) Women covered by the national legislation are protected with 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	✓*Tick one which is applicable* ❑0.5 ❑1 ❑1.5 ❑2
4.2) Does the national legislation provide at least one breastfeeding break or reduction of work hours? a. Unpaid break b. Paid break c. No break	*Tick one which is applicable* ❑0.5 ❑1 ❑0
4.3) The national legislation obliges private sector employers to a. Give at least 14 weeks paid maternity leave b. Paid nursing breaks.	*Tick one or both* ❑YES (0.5)❑NO (0) ❑ YES (0.5) ❑ NO (0)
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. a. Space for Breastfeeding/Breastmilk expression b. Crèche	*Tick one or both* ❑ YES (1) ❑ NO (0) ❑ YES (0.5) ❑ NO (0)
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 c. No measures	*Tick one which is applicable* ❑0.5 ❑1 ❑0
4.6) a. Accurate and complete information about maternity protection laws, regulations or policies is made available to workers by their employers on commencement. b. There is a system for monitoring compliance and a way for	*Tick one or both* ❑ YES (0.5) ❑ NO (0) ❑ YES (0.5) ❑ NO (0)

Criteria for Assessment	**Scores**
workers to complain if their entitlements are not provided.	
4.7) Paternity leave is granted in public sector for at least 3 days.	*Tick one which is applicable* ❑YES (0.5) ❑NO (0)
4.8) Paternity leave is granted in the private sector for at least 3 days.	*Tick one which is applicable* ❑YES (0.5) ❑NO (0)
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.	*Tick one which is applicable* ❑YES (0.5) ❑NO (0)
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	*Tick one which is applicable* ❑YES (1) ❑NO (0)
Total Score	**____/10**

Any additional information

1. Please provide information on the current situation regarding paternity leave and its relation to maternity leave.
2. Does the financial allocation for paternity leave affect the maternity leave?
3. How best maternity leave is positioned in the context of optimal breastfeeding protection?

Information Sources Used *(please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Conclusions *(Summarize which aspects of the legislation are appropriate, and which aspects need improvement and why. Identify areas needing further analysis)***:**

Gaps *(List gaps identified in the implementation of this indicator)***:**

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________

Recommendations *(List action recommended to bridge the gaps):*

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________

Human Rights Related to Breastfeeding

Infants have the right to …

- Enjoyment of the highest attainable standard of health (Art. 24(1) CRC, Art. 12(1) ICESCR)
- Adequate nutritious food (Art.24 (2)(c) CRC, Art. 11(1) ICESCR)
- Primary health care (Art. 24(2)(b) CRC)
- A standard of living adequate for the child's physical, mental, spiritual, moral and social development (Art. 27(1) CRC)

Mothers have the right to…

- Health care services and appropriate post-natal care (CEDAW 12.2, CRC 24)
- Education and support in the use of basic knowledge of child health and nutrition, the advantages of Breastfeeding (CRC 24.2(e))
- Appropriate assistance in their child-rearing responsibilities (CRC 18)
- Adequate nutrition during pregnancy and lactation (CEDAW 12.2)
- Paid maternity leave or other equivalent, including job protection (ICESCR 10, CEDAW 11.2(b))
- Safeguarding of the function of reproduction in working conditions (CEDAW 11.1(f))
- Decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights (CEDAW 16.1(e))

States Parties are obliged to…

- Ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff, as well as competent supervision (Art. 3(3) CRC)
- Ensure to the maximum extent possible the survival and development of the child (Art. 6(2) CRC)
- Take appropriate measures to diminish infant and child mortality (Art.24 (2)(a) CRC)
- Ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care (Art. 24(2)(b) CRC)
- Combat disease and malnutrition, including within the framework of primary health care (Art. 24(2)(c) CRC)
- Take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children (Art. 24(3) CRC)
- Take [in accordance with national conditions and within their means] appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programs, particularly with regard to nutrition.(Art.27 (3) CRC)

Source: *Kaia Engesveen. (2005). Strategies for Realizing Human Rights to Food, Health and Care for Infants and Young Children in Support of the Millennium Development Goals: Role and Capacity Analysis of Responsible Actors in Relation to Breastfeeding in the Maldives.SCN News (United Nations System Standing Committee on Nutrition). 30: 56-66.*

General Survey (2023): Achieving gender equality at work

https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_norm/@relconf/documents/meetingdocument/wcms_870823.pdf (Accessed on 23 March 2024)

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

Key question: *Do care providers in the health and nutrition care systems undergo training in knowledge and skills, and do their pre-service education curricula support optimal infant and young child feeding; do these services support mother-friendly and breastfeeding-friendly birth practices, do the policies of health care services support mothers and children, and are health workers trained on their responsibilities under the Code? (See Annex 5.1, 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, as well as lacking knowledge in IYCF.

Ideally, new graduates of health provider programmes are able to support optimal IYCF practices from the outset of their careers. All providers who interact with mothers and their young children need to acquire the basic attitudes, knowledge and skills necessary to integrate breastfeeding counselling, lactation management, and other aspects of IYCF into the care they give. The topics can be covered at various levels during education and employment. In addition, the policies of the institutions in which the providers work need to be supportive.

Possible Sources of Information

- Educational institutions, Ministries of Health and Nutrition or other relevant sectors, human resource personnel, trainers in counselling on IYCF, UNICEF, WHO, donors or other projects involved in curriculum review and reform, administrators and graduates.
- Standards and guidelines for institutions, such as hospital maternity departments, may be available nationally or regionally. To review them, see Annex 5.2, Examples of criteria for mother-friendly care, which is used to judge whether they are adequate.

To review standards, curricula or session plans for medical, nursing and nutrition courses see the ***WHO Education Checklist*** (Annex 5.1) for the list of 25 objectives and corresponding content, which is used to judge if IYCF courses are adequate.

Criteria for assessment	√ *Check **ONE** that applies in each question*		
5.1) A review of health provider schools and pre-service education programmes for healthcare professionals,[16] indicates that IYCF curricula or session plans are adequate/ inadequate (See Annex 5.1)	> 20 out of 25 content/skills are included ❑ 2	5-20 out of 25 content/ skills are included ❑ 1	Fewer than 5 content/skills are included ❑ 0
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been disseminated to all facilities and personnel providing maternity care. (See Annex 5.2)	Disseminate to> 50% facilities ❑ 2	Disseminate to 20-50% facilities ❑ 1	No guideline, or disseminated to < 20% facilities ❑ 0
5.3) There are in-service training programmes available providing knowledge and skills related to IYCF for relevant health/nutrition care providers.[17]	Available for all relevant workers ❑ 2	Limited Availability ❑ 1	Not available ❑0
5.4) Health workers are trained on their responsibilities under the Code and national regulations, throughout the country.	Throughout the country ❑1	Partial Coverage ❑ 0.5	Not trained ❑ 0
5.5) Infant and young child feeding information and skills are integrated, as appropriate, into training programmes not covered in 5.1 but where the care providers may have some contact with families with infants and young children.(Training programmes such as diarrhea control, HIV, NCDs, Women's Health etc.)	Integrated in > 2 training programmes ❑ 1	1-2 training programmes ❑ 0.5	Not integrated ❑ 0
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country.[18]	Throughout the country ❑ 1	Partial Coverage ❑ 0.5	Not provided ❑ 0
5.7) Health policies provide for mothers and babies to stay together when one of them is hospitalised.	Provision for staying together for both ❑ 1	Provision for only to one of them: mothers or babies ❑ 0.5	No provision ❑ 0
Total Score	**______/10**		

[16] 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.

[17] The types of health providers that should receive training may vary from country to country, but should include providers who care for mothers and children in fields such as pediatrics, OB-Gynae, nursing, midwifery, nutrition and public health.

[18] 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. Partial could mean more than 1 provinces covered.

Information Sources Used *(please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each).*

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Conclusions: (Summarize which aspects of health and nutrition care system are appropriate and which need improvement and why. Identify areas needing further analysis.)

Gaps: *(List gaps identified in the implementation of this indicator)*

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Recommendations: *(List action recommended to bridge the gaps):*

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Education checklist Infant and young child feeding topics

Objectives (*to be achieved by all health students and trainees who will care for infants, young children and mothers*)	***Content/skills*** (*to achieve objectives*)
1. Identify factors that influence breastfeeding and complementary feeding.	National/local breastfeeding and complementary feeding rates and demographic trends; cultural andpsychosocial influences; common barriers and concerns; local influences.
2. Provide care and support during the antenatalperiod.	Breastfeeding history (previous experience), breast examination, information targeted to mother's needs and support.
3. Provide intra-partum and immediate postpartumcare that supports and promotes successful lactation.	The Baby-friendly Hospital Initiative (BFHI), *Ten steps to successful breastfeeding*; supportive practices for mother and baby; potentially negativepractices.
4. Assess the diets and nutritional needs of pregnantand lactating women and provide counselling, as necessary.	Nutritional needs of pregnant and lactating women,dietary recommendations (foods and liquids) takingaccount of local availability and costs; micronutrient supplementation; routine intervention and counselling.
5. Describe the process of milk production andremoval.	Breast anatomy; lactation and breastfeedingphysiology
6. Inform women about the benefits of optimalinfant feeding.	Benefits of breastfeeding for infant, mother, family, and community; benefits of exclusive breastfeeding for 0–6 months; options and riskswhen unable to breastfeed.
7. Provide mothers with the guidance needed tosuccessfully breastfeed.	Positioning/ attachment; assessing effective milkremoval; signs of adequate intake; practise observing and assessing breastfeeding and suggesting improvements.
8. Help mothers prevent and manage common breastfeeding problems. Manage uncomplicatedfeeding 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.
9. Facilitate breastfeeding for infants with specialhealth needs, including premature infants.	Risk/benefit of breastfeeding/breast milk; needs of premature infants; modifications; counselling mothers.
10. Facilitate successful lactation in the event ofmaternal medical conditions or treatments.	Risk/benefit; modifications; pharmacologicalchoices; treatment choices.
11. Inform lactating women about contraceptiveoptions.	Advantages and disadvantages of various childspacing methods during lactation; counselling about LAM; cultural considerations for counselling.
12. Prescribe/recommend medications, contraceptivesand treatment options compatible with lactation.	Compatibility of drugs with lactation; effects ofvarious contraceptives during lactation.
13. Assist mothers to sustain lactation during separation from their infants, including during hospitalization or illness of mother or child andwhen returning to work or school.	Milk expression, handling and storage; alternative feeding methods; cup-feeding; cause, prevention and management of common associated difficultiessuch as low milk supply; coordinating out-of-homeactivities with breastfeeding; workplace support.
14. Explain the *International Code of Marketing of Breast-milk Substitutes* and World Health Assembly resolutions,	Main provisions of the *Code* and WHA resolutions, including responsibilities of health workers and thebreast-

Objectives (*to be achieved by all health students and trainees who will care for infants, young children and mothers*)	***Content/skills*** (*to achieve objectives*)
current violations, and health worker responsibilities under the *Code*.	milk substitute, bottles and teats industries; violations by infant food companies; monitoring and enforcement of the *Code*.
15. Describe what foods are appropriate to introduce to children at various ages and which foods are available and affordable to the general population.	Developmental approach to introduce complementary foods; foods appropriate at variousages; available foods and their costs; incomes of local families and how income levels affect their abilities to afford various foods.
16. Ask appropriate questions of mothers and othercaregivers to identify sub-optimal feeding practices with young children between 6 and 24months of age.	Growth patterns of breastfed infants; complementary foods: when, what, how, how much; micronutrient deficiencies/supplements;young child feeding history; typical problems.
17. Provide mothers and other caregivers with information on how to initiate complementaryfeeding, using the local staple.	Local staples and nutritious recipes for first foods;practise counselling mothers; common difficultiesand solutions.
18. Counsel mothers and other caregivers on how to gradually increase consistency, quantity, and frequency of foods, using locally available foods.	Guidelines for feeding young children at variousages and stages of development; potential difficulties and solutions regarding feeding and weaning; Essential Nutrition Actions.
19. Help mothers and other caregivers to continuefeeding during illness and assure adequate recuperative feeding after illness.	Energy and nutrient needs; appropriate foods andliquids during and after illness; strategies for encouraging child to eat and drink; local beliefs about feeding during illness; appropriate feeding support during hospitalization; re-lactation.
20. Help mothers of malnourished children to increase appropriate food intake to regain correctweight and growth pattern.	Feeding recommendations for malnourishedchildren; micronutrient supplements for malnourished children.
21. Inform mothers of the micronutrient needs of infants and young children and how to meet themthrough food and, when necessary, supplementation.	Micronutrient needs of infants and young children (iron, vitamin A, iodine, others); meeting these needs with food (breastfeeding and complementaryfoods); supplementation needs.
22. Demonstrate good interpersonal communicationand counselling skills.	Listening and counselling skills, use of simplelanguage, providing praise and support, considering mother's viewpoint, trials of new practices.
23. Facilitate group education sessions related to infant and young child nutrition and maternalnutrition.	Adult education methods; strategies for preparingand facilitating competency-based, participatory sessions.
24. Counsel mothers about prevention and reductionof 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 andhow to prevent or reduce them; counselling confirmed HIV-positive mothers about feeding options and risks.
25. Provide guidance on feeding of infants and youngchildren 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.

Criteria for mother-friendly care[19]

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

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

A health facility that provides delivery services should have:

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

[19] WHO's "Infant and Young Child Feeding-A tool for assessing national practices, policies and programmes". Available at https://iris.who.int/bitstream/handle/10665/42794/9241562544.pdf?sequence=1 (accessed on 23 March 2024)

Indicator 6: Counselling Services for the Pregnant and Breastfeeding Mothers

Key question: *Are there counselling services in place to protect, promote and support breastfeeding and optimal infant and young child feeding practices both at facility and community level (See Annex 6.1)*

Background

Key interventions to improve feeding practices include implementing "Ten Steps" of the BFHI, skilled counselling of women and community mobilisation. Removing barriers to optimal practices, that women face at home, hospitals or at work place is the key to success.

Counselling to improve breastfeeding and infant and young child feeding practices and related support for women is essential for success in optimal breastfeeding practices. Support by peers in community and mothers support groups have shown positive results. The quality of interaction and counseling are critical issues.

Women need counselling services and support during pregnancy, at birth and postpartum. At the community level appropriate support from community volunteers or health workers under the health systems can offer and ensure sustained support to mothers. Community support workers must have adequate training to acquire the optimal knowledge and skills for giving support. It is necessary to have appropriate counseling in the community to motivate and increasing a mother's confidence to breastfeed and provide home based complementary feeding. Sometimes, the mother support group (MSG) composed of few successful mothers and others of the same community is helpful and so is the support from health professionals and health care workers.

Other important area is to consider the people living in remote areas where services are difficult to provide and receive. There is also need to provide adequate information to support maternal nutrition without which IYCF action by mothers may be suboptimal. The principle of "feed the mother so she can feed the child" is an important policy principle.

The activities in these contexts include woman-to-woman support, individual or group counselling, home visits or other locally relevant support measures and activities that ensure woman have access to adequate, supportive and respectful information, assistance and counselling services for improving breastfeeding and optimal infant and young child feeding practices. Provision of counselling services on breastfeeding and infant and young child feeding within the health care system needs a review.

Possible Sources of Information:

- Discussions held with representatives of the Ministry of Health, Nutrition, Ministry of Social Welfare, Ministry of Women's Affairs or any government organization involved in social welfare, the National Breastfeeding (or Infant and Young Child Feeding) Coordinator, Mother support groups, Breastfeeding groups or representatives from NGOs, such as IBFAN, World

Alliance for Breastfeeding Action (WABA) and La Leche League International (LLLI) involved in infant and young child feeding.

- Relevant government circulars/orders/Child health or nutrition programme document.
- Information on counselling services from the health surveys / internal health management data.

Criteria of assessment	√ *Check **ONE** that applies in each question*		
6.1) Pregnant women receive counselling services for breastfeeding during ANC.	>90% ❑ 2	50-89% ❑ 1	<50% ❑ 0
6.2) Women receive counselling and support for initiation breastfeeding and skin to contact within an hour birth.	>90% ❑ 2	50-89% ❑ 1	<50% ❑ 0
6.3) Women receive post-natal counselling for exclusive breastfeeding at hospital or home.	>90% ❑ 2	50-89% ❑ 1	<50% ❑ 0
6.4) Women/families receive breastfeeding and infant and young child feeding counselling at community level.	>90% ❑ 2	50-89% ❑ 1	<50% ❑ 0
6.5) Community-based health workers are trained in counselling skills for infant and young child feeding.	>50% ❑ 2	<50% ❑ 1	No Training ❑ 0
Total Score:	**_____/10**		

Additional Information: *If pre-lacteal feeding is going on, please give examples, share some challenges to providing counselling at community level.*

***Information Sources Used** (please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Conclusions *(Summarize which aspects of a health and nutrition care system are adequate and which need improvement and why. Identify areas needing further analysis)***:**

Gaps *(List gaps identified in the implementation of this indicator)***:**

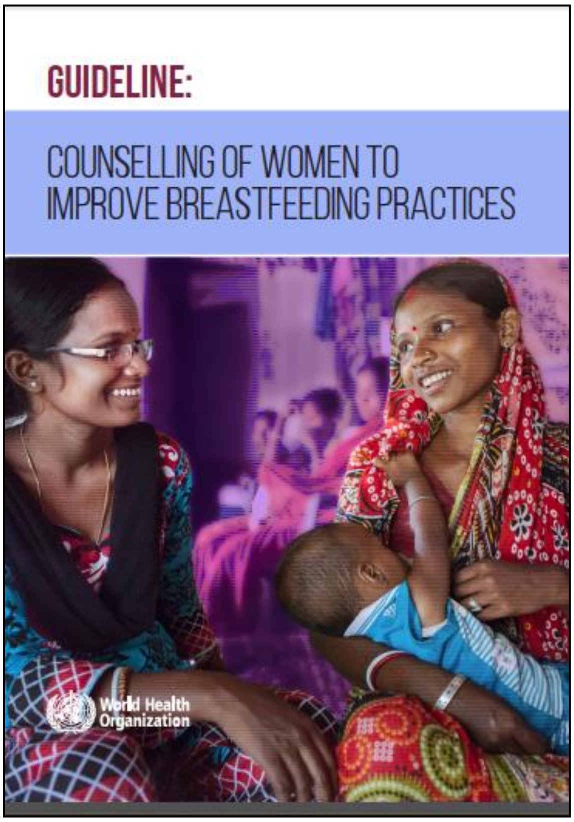
1. ______________________
2. ______________________
3. ______________________
4. ______________________

Recommendations *(List action recommended to bridge the gaps):*

1. ________________________
2. ________________________
3. ________________________
4. ________________________

WHO's Guideline Counselling of Women to Improve Breastfeeding Practices (2018) lend credible support to organise counselling services in order to enhance early and exclusive breastfeeding rates through protecting, promoting and supporting breastfeeding through the health systems.

Definition of Counselling: The 2009 WHO publication on Infant and young child feeding. Model chapter for textbooks for medical students and allied health professionals states that "Infant and young child feeding counselling is the process by which a health worker can support mothers and babies to implement good feeding practices and help them overcome difficulties". This was used as the operational definition for breastfeeding counselling used to gather and synthesize evidence that informed the recommendations. This definition excludes mass education or non-facilitated groups.



https://iris.who.int/bitstream/handle/10665/280133/9789241550468-eng.pdf?sequence=1
(Accessed on 23 March 2024)

Indicator 7: Accurate and Unbiased 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?(See: Annex 7.1, 7.2, 7.3)*

Background:

Women and care givers having the right to appropriate and objective support and information, education and communication (IEC) strategies are important aspects of a comprehensive programme to improve infant and young child feeding practices.

Information strategies are more likely to lead to positive behavior change if they are supported by 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.

The World Health Assembly has adopted eight resolutions to safeguard infant and young child feeding practices from commercial interests. When programmes take place within a commercial context (influenced or funded by the baby feeding industry), they can undermine the effectiveness of any campaign and lead to unwise decision making. Thus, it is important to keep the IEC free from any conflicts of interest. IEC approaches may include the use of electronic (TV, radio, video), print (posters, counselling cards, flip charts, manuals, newspapers, magazines), interpersonal (counseling, group education, support groups) and community activities to communicate important information and motivational material to mothers, families and the community. Since counselling is dealt in Indicator 6, the indicator 7 is focused on type and frequency of information.

Possible Sources of Information:

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

Criteria for assessment	√ *Check that apply*	
7.1) There is a national IEC strategy for improving infant and young child feeding.	YES ❑ 2	NO ❑ 0
7.2) Messages are communicated to people through different channels and in local context.	YES ❑ 1	No ❑ 0
7.3) IEC strategy, programmes and campaigns like WBW and are free from commercial influence.	YES ❑ 1	No ❑ 0
7.4) Breastfeeding/IYCF IEC materials and messages are objective, consistent and in line with national and/or international recommendations.	YES ❑ 2	No ❑ 0
7.5) IEC programmes (eg World Breastfeeding Week) that include infant and young child feeding are being implemented at national and local level.	YES ❑ 2	No ❑ 0
7.6) IEC materials/messages include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF).[20]	YES ❑ 2	No ❑ 0
Total Score:	**_____/10**	

Information Sources Used *(please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ________________________
2. ________________________
3. ________________________

Conclusions *(Summarize which aspects of the IEC programme are appropriate and which need improvement and why. Identify areas needing further analysis)***:**

Gaps *(List gaps identified in the implementation of this indicator)***:**

1. ________________________
2. ________________________
3. ________________________
4. ________________________

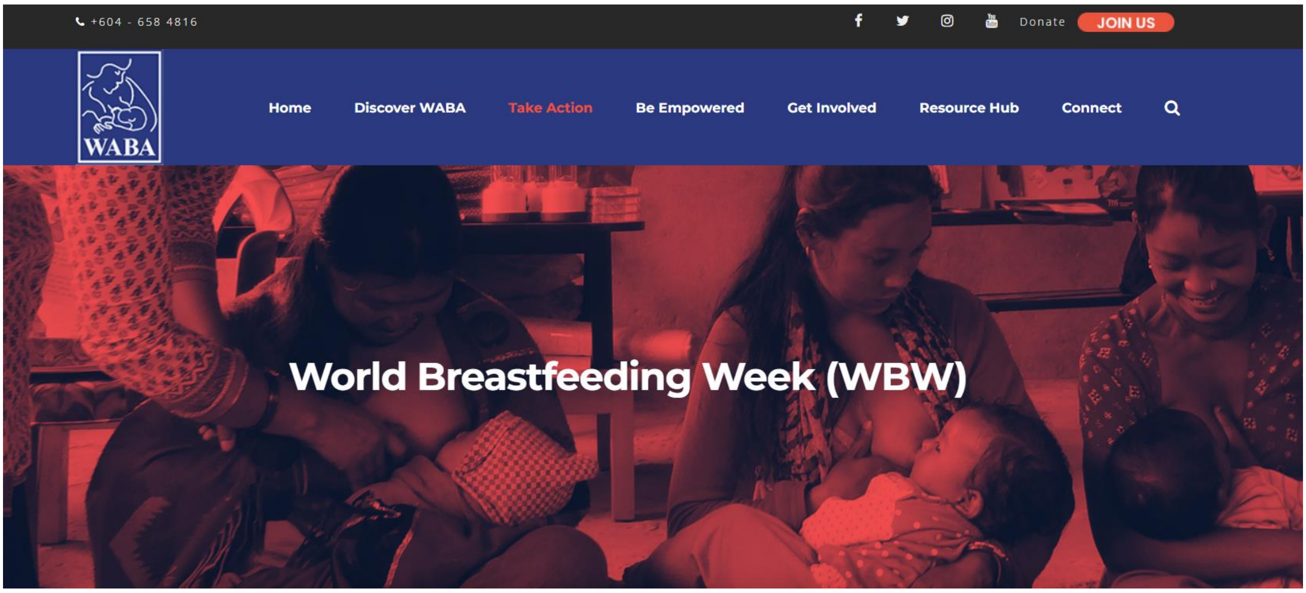
[20] To ensure that clinicians and other health-care personnel, community health workers and families, parents and other caregivers, particularly of infants at high risk, are provided with enough information and training by health-care providers, in a timely manner on the preparation, use and handling of powdered infant formula. This is to minimize health hazards. Parents 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.

Recommendations *(List action recommended to bridge the gaps):*

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________

World Breastfeeding Week Page (WABA)

See the lates theme and action here:
https://waba.org.my/wbw/

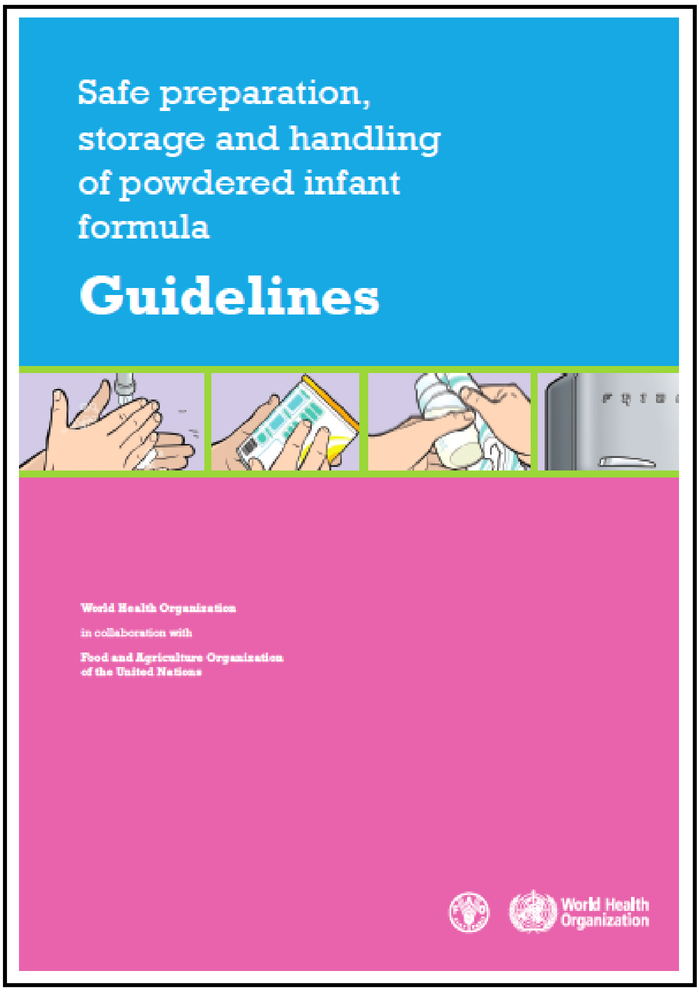


WHO and FAO Guidelines on safe preparation, storage and handling of powdered infant formula (2007)

See full document at:

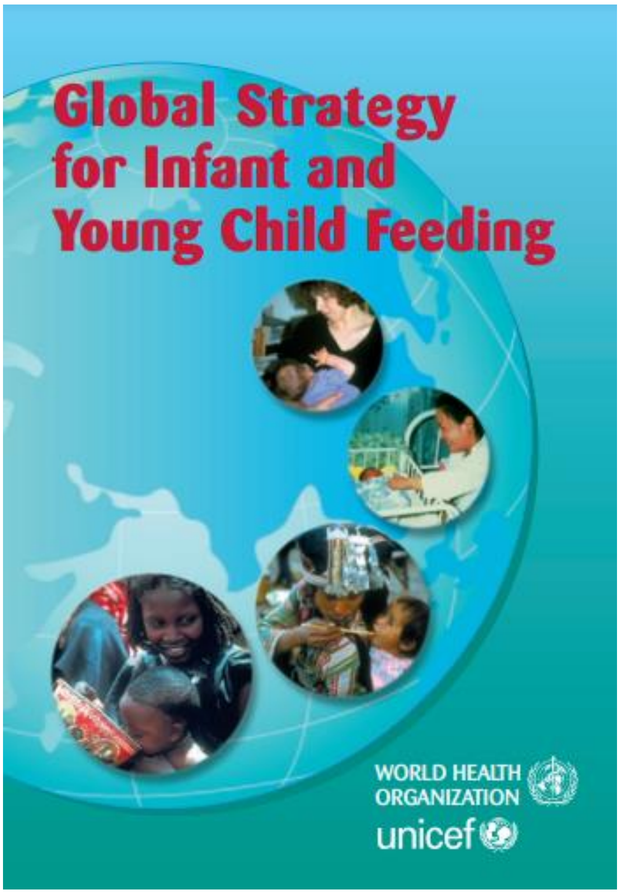
https://iris.who.int/bitstream/handle/10665/43659/9789241595414_eng.pdf?sequence=1

(Accessed on 23 March 2024)



Unicef's document on Protecting Infant and Young Child Nutrition from Industry Interference and Conflicts of Interest (2023)
https://www.globalbreastfeedingcollective.org/media/2126/file
(Accessed on 23 March 2024)

The Global Strategy for Infant and Young Child Feeding in 2003 outlines the two clear roles for industry
https://iris.who.int/bitstream/handle/10665/42590/9241562218.pdf?sequence=1
(Accessed on 23 March 2024)



Indicator 8: Infant Feeding and HIV

Key question: *Are policies and programmes in place to ensure that mothers living with HIV are supported to carry out the global/national recommended Infant feeding practice?(See Annex 8.1, 8.2)*

Background

In 2010, WHO for the first time recommended ARV drug interventions to prevent postnatal transmission of HIV through breastfeeding. WHO adopted a public health approach, recommending that national authorities should promote and support one feeding practice for all women living with HIV accessing care in the health facilities. WHO advised countries to choose a national approach for their ARV option for PMTCT based on operational consideration. WHO also recommended that countries while deciding upon the feeding option should avoid harm to infant feeding practices in the general population by counseling and support to mothers known to be HIV-infected and health message to the general population should be carefully delivered so as not to undermine optimal breastfeeding practices among the general population.[21]

The 2013 WHO consolidated guidelines on the use of ARV drugs recommended one of two approaches: (a) providing ART during pregnancy and counseling for breastfeeding to women living with HIV who are otherwise not eligible for ART (Option B); or (b) providing lifelong ART for all pregnant and breastfeeding mothers living with HIV regardless of their CD4 count or clinical stage (Option B+).

In the past few years, a significant amount of new research evidence and programmatic experience on infant feeding in the women living with HIV have emerged, which has led to a major shift in the policies on infant feeding counseling to the women and their families. Infant feeding recommendations to mothers living with HIV now aim for greater likelihood of HIV free survival of their children and not just prevention of transmission of HIV to the offspring. WHO has updated its infant feeding recommendations for HIV settings in 2016[22] which says, "practicing mixed feeding is not a reason to stop breastfeeding in the presence of Anti-retroviral (ARV) drugs", though all efforts should be made to counsel mother to do exclusive breastfeeding." Updated guidelines also recommend "mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence."

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

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[21] Consolidated Guidelines On The Use Of Antiretroviral Drugs For Treating And Preventing Hiv Infection (Recommendations For A Public Health Approach) 2016 https://iris.who.int/bitstream/handle/10665/208825/9789241549684_eng.pdf?sequence=1 (Accessed on 30 Nov 2023) Check: Page xxxiii, 4.4.8 Infant feeding in the context of HIV

[22] World Health Organization (2016). Guideline: updates on HIV and infant feeding: the duration of breastfeeding, support from health services to improve feeding practices among mothers living with HIV. Available at: https://iris.who.int/bitstream/handle/10665/246260/9789241549707-eng.pdf?sequence=1 (Accessed on 23 March 2024)

recommendations, with support and follow up being provided to all mothers, regardless of HIV status.

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

In countries that recommend formula feeding for mothers living with HIV, 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 require preparation to face the circumstances they are likely to encounter in emergency situations, including supporting the women living with HIV.

Possible Sources of Information:

1. Latest documents on global recommendations on HIV and Infant feeding (Check for inclusion of the global recommendation in the national policy) such as
    a. World Health Organization (2016). Guideline: updates on HIV and infant feeding: the duration of breastfeeding, support from health services to improve feeding practices among mothers living with HIV. Available at: http://apps.who.int/iris/bitstream/handle/10665/246260/9789241549707-eng.pdf?sequence=1 (Accessed on 23 March 2024)
2. Reports of national HIV/AIDS control organization.
3. Interview officials of Ministry of Health, Department dealing with HIV/AIDS control, UNICEF, WHO etc.

Criteria for Assessment[23]	√ *Check that apply*	
8.1) The country has an updated policy on Infant feeding and HIV, which is in line with the international guidelines on infant and young child feeding and HIV[24].	YES ❑ 2	NO ❑ 0
8.2) The infant feeding and HIV policy gives effect to the International Code/ National Legislation.	YES ❑ 1	NO ❑ 0
8.3) Health staff and community workers of HIV programme have received training on HIV and infant feeding counselling in past 5 years.	YES ❑ 1	NO ❑ 0
8.4) HIV Testing and Counselling (HTC)/ Provider-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.	YES ❑ 1	NO ❑ 0
8.5) The breastfeeding mothers living with HIV are provided ARVs in line with the national recommendations.	YES ❑ 1	NO ❑ 0
8.6) Infant feeding counselling is provided to all mothers living with HIV appropriate to national circumstances.	YES ❑ 1	NO ❑ 0
8.7) Mothers are supported and followed up in carrying out the recommended national infant feeding	YES ❑ 1	NO ❑ 0
8.8) Country is making efforts 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.	YES ❑ 1	NO ❑ 0
8.9) Research on Infant feeding and HIV is carried out 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.	YES ❑ 1	NO ❑ 0
Total Score:	**____/10**	

Information Sources Used *(please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ____________________
2. ____________________
3. ____________________
4. ____________________

[23] Some of the questions may need discussion among the core group, and based on information sources the Core group may decide about the strengths.
[24] Updated guidance on this issue is available from WHO as of 2016. Countries who may be using the earlier guidance and are on way to use the new guidance if not completely may be included here.

Conclusions *(Summarize which aspects of HIV and infant feeding programming are appropriate, and which aspects need improvement and why. Identify areas needing further analysis)***:**

Gaps *(List gaps identified in the implementation of this indicator)***:**

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________

Recommendations *(List action recommended to bridge the gaps):*

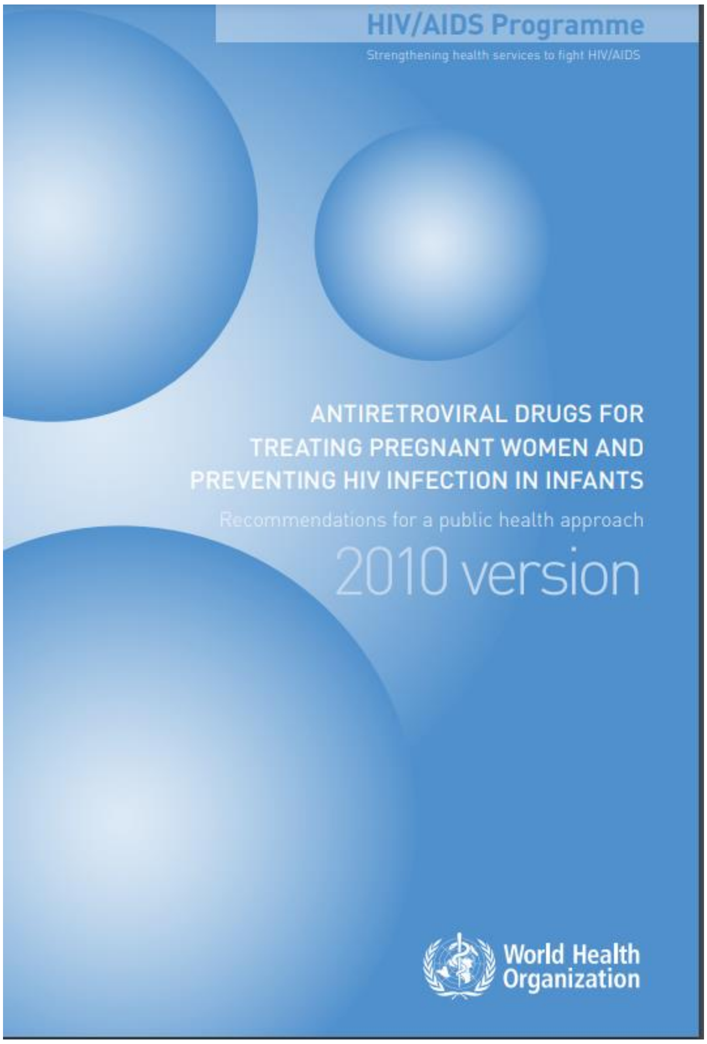
1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________

World Health Organization (2016)

Guideline: updates on HIV and infant feeding: the duration of breastfeeding, support from health services to improve feeding practices among mothers living with HIV.
https://iris.who.int/bitstream/handle/10665/246260/9789241549707-%20eng.pdf?sequence=1
(accessed on 23 March 2024)

WHO 2009 (revised 2010). Rapid Advice

Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Recommendations for a public health approach.
https://iris.who.int/bitstream/handle/10665/75236/9789241599818_eng.pdf?sequence=1
(Accessed on 23 March 2024)



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?* (See 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 for all women and children affected by emergencies. 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). In 2018 the World Health Assembly Resolution called for all governments to ensure IYCF-E is part of their policy and plans and that their staff have the capacity needed to protect, promote and support IYCF practices during emergencies. 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

Possible Sources of Information:

Interviews and discussion with the national authorities officials (or equivalent) responsible for emergency preparedness and response.

National policy or programme and other relevant documents

Criteria for assessment	√ Check that apply	
9.1) The country has a comprehensive Policy/Strategy/ Guidance on infant and young child feeding during emergencies as per the global recommendations with measurable indicators.	YES ❑ 2	NO ❑ 0
9.2) Person(s) tasked to coordinate and implement the above policy/ strategy/guidance have been appointed at the national and sub national levels	YES ❑ 2	NO ❑ 0
9.3) The health and nutrition emergency preparedness and response (stand alone or integrated) recommendation includes: a. Basic and technical interventions to create an enabling environment for breastfeeding, including counselling by appropriately skill trained counsellors, and support for relactation and wet-nursing.	YES ❑ 0.5	NO ❑ 0
b. Measures to protect, promote and support appropriate and complementary feeding practices	YES ❑ 0.5	NO ❑ 0
c. Measures to protect and support the non breast-fed infants	YES ❑ 0.5	NO ❑ 0
d. Space for IYCF counselling support services.	YES ❑ 0.5	NO ❑ 0
e. Measures to minimize the risks of artificial feeding, including an endorsed Joint statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsolicited donations, and minimize the risk of formula feeding, procurement management and use of any infant formula and BMS, in accordance with the global recommendations on emergencies	YES ❑ 0.5	NO ❑ 0
f. Indicators, and recording and reporting tools exist to closely monitor and evaluate the emergency response in the context of feeding of infants and young children.	YES ❑ 0.5	NO ❑ 0
9.4) Adequate financial and human resources have been allocated for implementation of the emergency preparedness and response plan on IYCF	YES ❑2	NO ❑0
9.5) 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.	YES ❑0.5	NO ❑0
9.6) Orientation and training is taking place as per the national plan on emergency preparedness and response is aligned with the global recommendations (at the national and sub-national levels)	Yes ❑ 0.5	NO ❑ 0
Total Score:	**_____/10**	

Additional Information: Please share any stories of implementing the IFE in your country during a disaster

Information Sources Used *(please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Conclusions *(Summarize which aspects of emergency preparedness and response are appropriate and which need improvement and why. Identify areas needing further analysis)**:***

Gaps *(List gaps identified in the implementation of this indicator)***:**

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Recommendations *(List actions recommended to bridge the gaps):*

1. ________________________
2. ________________________
3. ________________________
4. ________________________

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 3, 2017.* https://www.ennonline.net/operationalguidance-v3-2017 (Accessed on 23 March 2024)

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.
7. Support for other caregivers and those with special needs, e.g. orphans and unaccompanied children, must also be established at the outset (Section 5).
8. Breastfeeding and infant and young child feeding support should be integrated into other sectors and services for mothers, infants and young children (Section 5).
9. 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).
10. Donated (free) or subsidized supplies of breastmilk substitutes (e.g. infant formula) or commercial complementary foods 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).
11. The decision to accept, procure, use or distribute infant formula in an emergency must be made by informed, technical personnel in consultation with the coordinating agency, lead technical agencies and governed by strict criteria (Section 6).
12. 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 recognized 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) 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; inter-sectoral 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
- 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:…….

Following is a summary of preparedness actions contained in Sections 1-6 of the OG-IFE.
https://www.ennonline.net/attachments/3127/Ops-G_English_04Mar2019_WEB.pdf
(Accessed on 23 March 2024)

Endorse or develop policies

1. Ensure IFE is adequately reflected in relevant national policies, guidelines and procedures.
2. Ensure there is adequate policy provision for IFE regarding IDPs and refugees.
3. Develop national/sub-national preparedness plans on IFE.
4. Draft context-specific joint statements on IFE to enable rapid release.
5. Develop legally enforceable national regulations on the Code. Monitor and report Code violations.
6. Enact legislation and adopt policies in line with the WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children.
7. Develop national legally binding policies regarding private sector engagement in emergency response by UN, civil society and government policy-makers to enable constructive collaboration and avoid undue influence and conflicts of interest.
8. Update policies, guidelines and procedures based on lessons learned from previous emergencies.

Train staff

1. dentify and sensitise key personnel involved in planning and delivering emergency response regarding IFE.
2. Forecast capacity needs based on emergency scenarios.
3. Identify national capacity development needs on IYCF. Integrate context-specific training content into existing curricula and delivery mechanisms.
4. Orientate and train relevant staff on IYCF support. Include key components of IFE and the Code in pre-service training of health professionals.
5. Map existing capacities for key areas, e.g. skilled breastfeeding support and translators, and develop key contact lists of existing national expertise.
6. Prepare orientation material for use in early emergency response.
7. Update training content based on lessons learned from emergency response.

Coordinate operations

1. Identify government leadership and coordination authority on IFE and support capacity development to strengthen this responsibility as necessary.
2. Where government capacity is constrained, identify options for coordinated IFE response and leadership.
3. Develop terms of reference for IFE coordination in a response.
4. Raise public and professional awareness regarding recommended IYCF practices and benefits. Develop an IFE communication strategy and plan for rapid implementation in an emergency. Prepare easily adapted media briefs.
5. Engage development agencies and donors in preparedness planning that includes adaptation of existing programmes to meet emergency needs, negotiating funder flexibility to meet new needs and priming sources of surge funding to accommodate increased demands.
6. Allocate funding to support monitoring, evaluation and learning.
7. Establish links with other sector focal points and coordination mechanisms, especially food security, health and WASH.

Assess and monitor

1. Develop a profile on IYCF practices and maternal and child nutrition to inform early decision- making in an emergency.
2. Ensure disaggregated data and recent reports are readily accessible.
3. Calculate the prevalence of non-breastfed infants less than six months old and at one year and two years old from existing data.
4. Prepare key questions to include in early needs assessment.
5. Identify existing and/or potential national/sub-national capacity to undertake IYCF assessment and surveys.
6. Support government to develop policies and procedures to monitor for and act on Code violations. Monitor and report Code violations to relevant authorities.
7. Identify what existing monitoring and evaluation tools and systems can be applied in an emergency context and agree any necessary adaptations.

Protect, promote and support optimal infant and young child feeding with integrated multi-sector interventions

1. Actively promote and support recommended IYCF practices in the population.
2. Integrate the Ten Steps to Successful Breastfeeding of the WHO/UNICEF Baby-friendly Hospital Initiative into maternity services.
3. Develop preparedness plans for interventions on breastfeeding support, complementary feeding, artificial feeding and identification and management of particularly vulnerable children.
4. Identify key sector focal points in ministries and agencies to engage on programming.
5. Profile complementary foods and feeding practices, including existing nutrient gaps and culturally-sensitive response options, and mechanisms for scale-up and response in an emergency context.
6. Identify supply chain for an appropriate BMS (if needed) and complementary foods.
7. Work to ensure that local/commercially produced complementary foods meet minimum standards.
8. Examine national legislation related to food and drugs, particularly importation.
9. Anticipate likely need for and mechanisms to provide micronutrient supplementation to PLW and children.
10. Develop plans for response and for transition post-emergency regarding IYCF interventions.
11. Identify existing or potential public health issues of nutrition concern and plan accordingly.

Minimise the risks of artificial feeding

1. Develop plans for prevention and management of donations of BMS, other milk products and feeding equipment in an emergency.
2. Communicate government position on not seeking or accepting donations to key actors, including country embassies, donors, development partners and civil society groups, among others.
3. Use scenarios to forecast potential artificial feeding needs in an emergency-affected population and develop preparedness plans accordingly.
4. Establish systems for management of artificial feeding, including coordination authority (or at least terms of reference), BMS supply chain and monitoring mechanisms.

Note: Programme preparedness actions (as well as response and recovery) are detailed in UNICEF Core Commitments for Children in Humanitarian Action. UNICEF 2010.

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 Resources:

- Media guide on Infant and young child feeding in emergencies. English, French, German, Spanish, Italian, Arabic. https://www.ennonline.net/iycfmediaguide
    - The recently updated joint statement can be found here https://www.ennonline.net/modelifejointstatement
    - Key messages on IFE - for mothers and caregivershttps://www.ennonline.net//ifekeymessagesmothers
- World Breastfeeding Week, 2009. 'Breastfeeding, a vital emergency response: are you ready?' http://www.worldbreastfeedingweek.net/wbw2009/index.htm

- Save the Children, IYCF E Tool Kit: https://resourcecentre.savethechildren.net/toolkits/iycf-e-toolkit/

Useful training materials:

For orientation:

Core group in Infant feeding in Emergencies, Module 1, Orientation Package on IFE, v2.1, 2010. English. https://www.ennonline.net//ourwork/capacitydevelopment/iycfeorientation
https://www.ennonline.net//iycfeorientationpackage

- 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. (working link: https://www.ennonline.net/ourwork/capacitydevelopment/iycfemodule2)
- Integration of Infant and Young Child Feeding into Community based Management of Acute Malnutrition. October 2009. English and French https://www.ennonline.net/ourwork/capacitydevelopment/iycfcmam
- IASC Nutrition. Harmonized Training Package, Cluster Module 17 on Infant and young child feeding in emergencies. https://www.ennonline.net/ourwork/capacitydevelopment/htpversion2

For other key useful orientation and training materials developed by the IFE core group see (Accessed on 23 March 2024)

- https://database.ennonline.net/resources/tag/128
- https://www.ennonline.net/ourwork/capacitydevelopment/iycfeorientation (here you can find all the relevant and available IFE training package)

Indicator 10: Monitoring and Evaluation

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

Background:

Monitoring and evaluation (M & E) components should be built into all infant and young child feeding programme activities and collection of data concerning feeding practices should be integrated into national nutritional surveillance and health information systems and surveys.

Periodic monitoring and 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.26It is important to devise strategies to assure that results of important evaluation are used to assure evidence-based decision making.

Possible Sources of Information:

- Interviews with officials, programme managers, and/or evaluation specialists overseeing or conducting monitoring and evaluation activities within the national infant and young child feeding programme.
- Survey reports of National Governments, such as the Demographic and Health Survey and MICS (or a similar national survey), can also provide information.
- Relevant evaluation reports.
- Discussions with key decision-makers utilizing M & E results.
- Discussion or interviews of Country breastfeeding groups or child rights advocates.

Criteria for assessment and scoring

The table shows the five criteria for assessing countries. The maximum total score for the indicator is 10.

Criteria for assessment	√ Check that apply	
10.1) Monitoring and evaluation of the IYCF programmes or activities (national and sub national levels) include IYCF indicators (early breastfeeding within an hour, exclusive breastfeeding 0-6 months, continued breastfeeding, complementary feeding and adequacy of complementary feeding)	YES ❑ 2	NO ❑ 0
10.2) Data/information on progress made in implementing the IYCF programme are used by programme managers to guide planning and investment decisions.	YES ❑ 1	NO ❑ 0
10.3) Data on progress made in implementing IYCF programme and activities are routinely or periodically collected at the sub national and national levels.	YES ❑ 3	NO ❑ 0
10.4) Data/information related to IYCF programme progress are reported to key decision-makers.	YES ❑ 1	NO ❑ 0
10.5) Infant and young child feeding practices data is generated at least annually by the national health and nutrition surveillance system, and/or health information system.	YES ❑ 3	NO ❑ 0
Total Score	**____/10**	

Additional Information

Please share challenges being faced at national level, and solutions offered for monitoring the infant and young child feeding practices.

***Information Sources Used** (please provide web-links or references for each of the information used above in answering the questions. To be acceptable, there has to be a source for each.*

1. ________________________
2. ________________________
3. ________________________
4.

Conclusions *(Summarize which aspects of monitoring and evaluation are appropriate and which need improvement and why. Identify areas needing further analysis)**:***

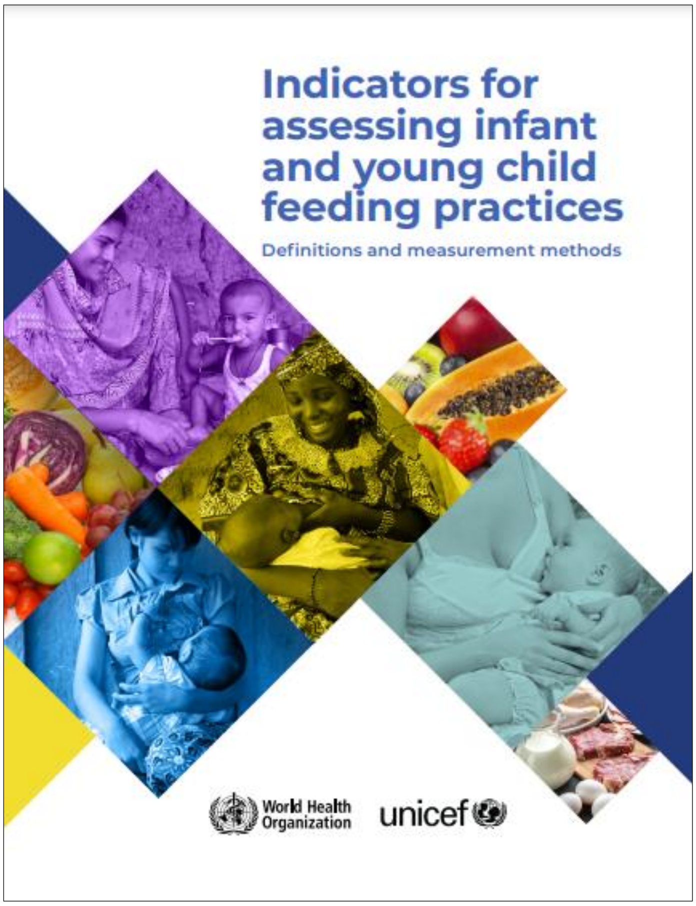
Gaps *(List gaps identified in the implementation of this indicator)***:**

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Recommendations *(List actions recommended to bridge the gaps):*

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Indicators for assessing infant and young child feeding practices (2021)
Available at: https://www.who.int/publications/i/item/9789240018389
(Accessed on 23 March 2024)



Part II – IYCF Practices

In Part II ask for specific numerical data on each infant and young child feeding practice. Those involved in this assessment are advised to use data from a random household survey that is national in scope[25]. The data thus collected is entered into the web- based printed toolkit. The achievement on the particular target indicator is then rated i.e. **Red, Yellow, Blue and Green**. The cut off points for each of these levels of achievement were selected systematically, based on an analysis of past achievements on these indicators in developing countries. These are incorporated from the WHO's tool.

Definition of various quantitative indicators have been taken from "WHO's Indicators for assessing infant and young child feeding practices - 2008" Available at: http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/ (Annex 10.1)

Preferably, data should have been collected in past five years. Most recent data should be used, which is national in scope.

[25] 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.

Indicator 11: Initiation of Breastfeeding (within 1 hour)

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

Definition of the indicator: Proportion of children born in '0-23' 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 low income 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 for the Baby Friendly Hospital Initiative (BFHI),Step 4 of the Ten Steps to Successful Breastfeeding recommends placing all babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encouraging mothers who have chosen to breastfeed to recognize when their babies are ready to breastfeed, offering help if needed.

If the mother has had a cesarean section, the baby should be offered the breast when the mother is able to respond; this happens within few hours even if general anesthesia was used. Mothers who have undergone a cesarean section need extra help with breastfeeding otherwise they may initiate breastfeeding much later. Ideally, 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 contributes to better temperature control of the newborn baby, enhances bonding between the mother and the baby, and also increases the chances of establishing exclusive breastfeeding early and its success. Evidence shows that early initiation of breastfeeding could reduce neonatal mortality by 22% in low income countries.[26]

Source of data: Demographic and Health Surveys, MICS surveys, national and sub-national surveys, national health information systems.

Assessment

	Key to rating adapted from WHO tool (see Annex 11.1)	***Please enter your country data in %***	***Colour-rating***
Indicator 11: Initiation of Breastfeeding (within 1 hour)	0.1-29%		**Red**
	29.1-49%		**Yellow**
	49.1-89%		**Blue**
	89.1-100%		**Green**

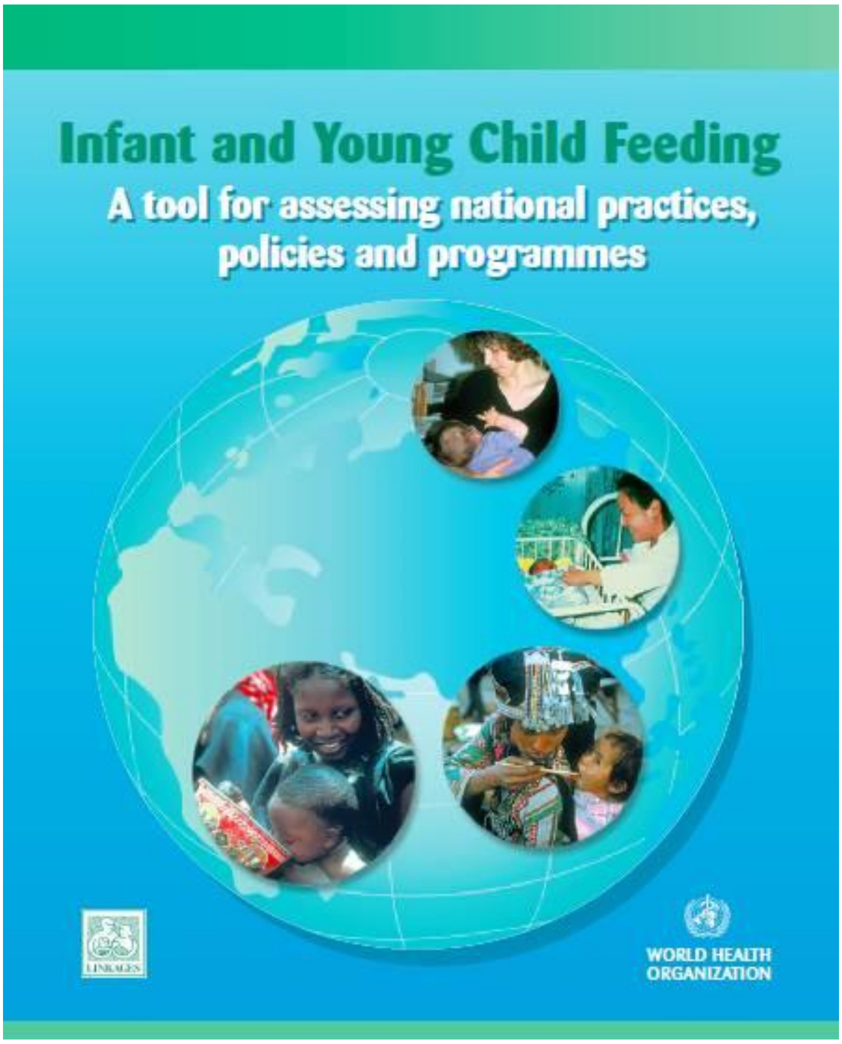
Data Source (including year):

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

Additional Information

Please provide information on use of pre-lacteal feeds, use of formula during stay in health facility, with specific challenges in cesarean section delivery, or any other relevant information you want to share in the report.

WHO (2003). Infant and young child feeding - A tool for assessing national practices, policies and programmes. Available at:
https://www.who.int/publications/i/item/9241562218
(Accessed on 23 March 2024)



See page 5-14

Indicator 12: Exclusive Breastfeeding under 6 months

Key question: *What is the percentage of infants less than 6 months of age who were exclusively breastfed[27] in the last 24 hours?*

Definition of the indicator: Proportion of infants 0–5 months of age who received only breastmilk during the previous 24 hours. (0-5 months means 5 months and 29 days as per research guidance)

Technical note: this indicator can be calculated if data are available for the whole population of infants less than 6 months of age or, more often, it can be estimated from a random sample of infants. The sample must be random so that it reflects the distribution of infants by month of age of the whole population. If the sample is not random, it may over- or under-represent an age group, thus over- or under-estimating the rate of exclusive breastfeeding under 6 months.

Background

Exclusive breastfeeding for the first six months is crucial for survival, growth and development of infants and young children. It lowers the risk of illness, particularly diarrheal diseases and acute respiratory infections. It also prolongs lactation amenorrhea in mothers who breastfeed frequently, also at night. WHO commissioned a systematic review of the published scientific literature about the optimal duration of exclusive breastfeeding and in March 2001the 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 4-6 months. The World Health Assembly (WHA) formally adopted this recommendation in May 2001 through Resolution 54.2/2001. In 2002, the WHA approved Resolution 55.25 that adopted the Global Strategy for Infant and Young Child Feeding. Later on, in September 2002, the UNICEF Executive Board also adopted this Resolution and the Global Strategy for Infant and Young Child Feeding, bringing a unique consensus on this health recommendation. Analyses published in the Lancet in 2003[28] and 2016[29]clearly point to the role of exclusive breastfeeding during first six months for infant survival and development.

Source of data: Demographic and Health Surveys[30], MICS surveys, national and sub-national surveys, national health information systems.

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[27] 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)

[28] Black RE, Morris SS, Bryce J. Where and why are 10 million children dying every year? Lancet 2003;361:2226-34

[29] Victora CG, Bahl R, Barros AJD et al. Breastfeeding in the 21st century: epidemiology, mechanisms and lifelongeffect. Lancet 2016;387:475-90 32

[30] Exclusive breastfeeding rate (EBR) calculator may be used, if required, to calculate data for exclusive breastfeeding for babies <6 months. The calculator may be seen at: 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

Assessment

Indicator 12: Exclusive Breastfeeding under 6 months	***Key to rating adapted from WHO tool (see Annex 11.1)***	***Please enter your country data in %***	***Colour-rating***
	0.1-11%		**Red**
	11.1-49%		**Yellow**
	49.1-89%		**Blue**
	89.1-100%		**Green**

Data Source (including year):

Additional Information

Please provide information on cultural use supplements during this period, challenges to achieve exclusivity, or any other relevant information you want to share in the report.

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.

Source of data: Demographic and Health Surveys, MICS survey, national and sub-national survey, national health information systems.

Assessment

	Key to rating adapted from WHO tool (see Annex 11.1)	***Please enter your country data in months***	***Colour-rating***
Indicator 13: Median Duration of Breastfeeding	0.1-18 **Months**		**Red**
	18.1-20 ”		**Yellow**
	20.1-22 ”		**Blue**
	22.1-24 or beyond ”		**Green**

Data Source (including year):

Additional Information

If the data for this indicator is not available, please provide information on the "continued breastfeeding" at 1 and 2 years.

Indicator 14: Bottle-feeding

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

Definition of the indicator: *Proportion of children 0–12 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 precious breastmilk. Similarly, after six months babies should ideally receive mother's milk plus solid complementary foods. If a baby cannot be fed the breastmilk from his/her mother's breast, s/he should be fed with a cup (if unable to swallow, breastmilk can be given by means of an infant feeding tube). Bottle feeding means the proportion of children 0–12 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 diarrhoeal disease morbidity and mortality. Bottles with a nipple are particularly prone to contamination.

Source of data: Demographic and Health Surveys[31], MICS survey, national and sub-national survey, national health information systems

Assessment

Indicator 14: Bottle-feeding (0-12 months)	***Key to rating adapted from WHO tool (see Annex 11.1)***	***Please enter your country data in %***	***Colour-rating***
	29.1-100%		**Red**
	4.1-29%		**Yellow**
	2.1-4%		**Blue**
	0.1-2%		**Green**

Data Source (including year):

Additional Information

Please provide information if bottle feeding is on the rise and is that related to advertising etc or any other relevant information on bottle –feeding may be useful.

[31] Bottle feeding rate (BOT) calculator may be used, if required, to calculate data for bottle feeding for babies 0-<12 months. The calculator may be seen at: 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

Indicator 15: Complementary Feeding (6-8 months)

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

Definition of the indicator: *According to WHO around the age of 6 months, an infant's need for energy and nutrients starts to exceed what is provided by breast milk, and complementary foods are necessary to meet those needs. An infant of this age is also developmentally ready for other foods. This transition is referred to as complementary feeding. If complementary foods are not introduced around the age of 6 months, or if they are given inappropriately, an infant's growth may falter.*

Background

As babies need additional nutrients, along with continued breastfeeding, after 6 months of age, complementary feeding should begin with locally available foods that are affordable and sustainable, in addition to safe and nutritious. Infants should be offered a variety of 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 proposed indicator measures only whether complementary foods are added in a timely manner, after 6 months of age along with breastfeeding.

Source of data: Demographic and Health Surveys, MICS surveys, national and sub-national surveys, national health information systems

Assessment

	Key to rating adapted from WHO tool (see Annex 11.1)	***Please enter your country data in %***	***Colour-rating***
Indicator 15: Complementary Feeding (6-8 months)	0.1-59%		**Red**
	59.1-79%		**Yellow**
	79.1-94%		**Blue**
	94.1-100%		**Green**

Data Source (including year):

Additional Information

Please provide information on the adequacy and quality of complementary feeding e.g. minimum acceptable diet of children 6-23 months, dietary diversity or consumption of iron-rich foods? This will be useful addition to the report to advocate from improved feeding practices.

Summary Part I: IYCF Policies and Programmes

Targets:	Score **(Out of 10)**
1. National Policy, Governance and Funding	
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. Counselling Services for the Pregnant and Breastfeeding Mothers	
7. Accurate and Unbiased Information Support	
8. Infant Feeding and HIV	
9. Infant and Young Child Feeding during Emergencies	
10. Monitoring and Evaluation	
Total Country Score	

Guidelines for WBT*i*

Total score of infant and young child feeding policies and programmes (indicators 1-10) are calculated out of 100.

Scores	**Total Country Score**	**Colour-coding**
0 – 30.9		**Red**
31 – 60.9		**Yellow**
61 – 90.9		**Blue**
91 – 100		**Green**

Conclusions *(Summarize the achievements on the various programme components, what areas still need further work)*[32] **:**

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

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

IYCF Practice	**Result**	**Colour-coding**
Indicator 11: Initiation of Breastfeeding (within 1 hour)	______ %	
Indicator 12: Exclusive Breastfeeding under 6 months	______ %	
Indicator 13: Median Duration of Breastfeeding	___ months	
Indicator 14: Bottle-feeding (0-12 months)	______ %	
Indicator 15: Complementary Feeding (6-8 months)	______ %	

Conclusions

Summarise the achievement on policy and programme and identify key gaps. Here analyse the gaps with the core group and provide a summary of what needs to be done to bridge the gaps. Also include analysis of the 5 IYCF practices and its colour coding. Summarise which infant and young child feeding practices are good and which need improvement and why, any further analysis needed.

Draw a list of recommendations for your health and nutrition managers and policy makers, keeping in mind the gaps you have on policy & programmes.

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