Infant and Young Child Feeding

A tool for assessing national practices, policies and programmes

LINKAGES

WORLD HEALTH ORGANIZATION

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Preface

This tool is designed to help users assess the strengths and weaknesses of policies and programmes for protecting, promoting and supporting optimal feeding practices, and determine where improvements may be needed to meet the aim and objectives of the Global Strategy for Infant and Young Child Feeding.

WHO and LINKAGES were jointly responsible for developing the tool. A large number of experts provided a variety of technical inputs, or served as reviewers; these included staff of or individuals affiliated with WHO, LINKAGES/Academy for Educational Development (AED), Wellstart International (WSI), the United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), the World Alliance for Breastfeeding Action (WABA), and a number of nongovernmental organizations and individuals from various countries.

Funding for the development of the *Tool* was provided by USAID through the LINKAGES Project, under Cooperative Agreement No. HRN-A-00-97-00007-00. USAID and WHO co-funded the tool's field-testing, and its publication and distribution.

The material presented does not necessarily reflect the official position of any of the organizations listed.

Acknowledgements

Many people from numerous countries contributed their valuable time and expertise to the development and field-testing of this national assessment tool. However, several individuals deserve special recognition for the roles they played.

- Randa Saadeh, Technical Officer, Department of Nutrition, WHO who coordinated the tool's development, publication and dissemination as a companion to the Global Strategy for Infant and Young Child Feeding;

- Carmen Casanovas, Medical Officer, Department of Child and Adolescent Health and Development, WHO who served as a technical consultant;

- Ann Brownlee, Consultant, LINKAGES and WSI who was the primary author;

- Linda Sanei, Deputy Director, LINKAGES/AED who was the originator of the national assessment tool and its development;

- Mary Kroeger, Consultant, LINKAGES and WSI who acted as technical liaison for the tool's development, while serving as the WSI Maternal and Child Health Coordinator at LINKAGES;

Other contributors include staff of LINKAGES/AED, WHO, WSI, USAID, UNICEF, WABA, International Baby Food Action Network (IBFAN), Catholic Relief Services, COTALMA (Technical Committee for Breastfeeding Support), Project Concern International, the Australian Breastfeeding Association, and many individuals from various countries.

Special thanks are due to the country coordinators and assessment teams – in Bolivia, Chile, Ghana, India, Indonesia, the Russian Federation, Sri Lanka, Thailand, and the United Kingdom of Great Britain and Northern Ireland – who field-tested the tool and provided valuable feedback that contributed to its completion.

CONTENTS

Introduction and instructions

This *Tool* is designed to assist users in assessing the status of infant and young child feeding practices, policies, and programmes in their country. The purpose of such an assessment is to identify strengths and possible weaknesses, with a view to improving the protection, promotion, and support of optimal infant and young child feeding.

The *Tool* is designed to be a flexible instrument. It can be used in its entirety, which is preferred, or in part, and can be employed by a range of users for various purposes. The approach taken may depend on:

- the stage of policy and programme development in the country concerned;
- the commitment of key decision-makers to undertake the assessment and to use the results; and
- the human and financial resources available.

The *Tool* can be used as a companion piece to the *Global Strategy for Infant and Young Child Feeding* (*1*) as an assessment tool to help determine where improvements might be needed to meet the *Global Strategy* targets. Consideration should be given to using the *Tool* periodically, every several years, to track trends on the various indicators, report on progress, identify areas still needing improvement, and assist in the planning process.

Parts of the tool

Part one, Infant and young child feeding practices can be used to assess progress made on key practices in infant and young child feeding and to help identify background data which interact with these practices. Practice indicators are based on those recommended by WHO for global use (*2,3*).

Part two, National infant and young child feeding policies and targets is focused on the key actions and targets identified by the *Innocenti Declaration* (*4*) which governments have been encouraged to achieve, as well as additional targets identified in the *Global Strategy for Infant and Young Child Feeding.* This part of the *Tool* provides a mechanism for assisting countries in assessing their progress in meeting these key targets.

Part three, National infant and young child feeding programme is focused on other important aspects of a comprehensive national programme that take more time to evaluate. These include, for example, up-to-date pre-service education, community outreach activities, and contraceptive support for breastfeeding women. The material in this section will help to guide an initial assessment of progress in the development and implementation of key components of a national programme. The key components included here have been shown to play an integral role in the overall approach needed to protect, promote, and support optimal infant feeding practices.

These three parts of the *Tool* will help to provide assessment data that can assist planners and decision-makers at various levels in identifying the strengths and weaknesses of their current policies and programmes. This, in turn, will enable them to plan effectively for any needed improvements.

Scoring and rating of achievements

Each indicator or component has been designed to be user-friendly. Clear directions are provided to the user about how to undertake the assessment for each indicator including:

- the ***key question*** that needs to be investigated;
- ***background*** on why the practice, policy or programme component is important, with key references, when relevant;
- suggestions concerning possible ***sources of information*** or data, with a blank space for recording which data sources are actually used – when available, URLs for web sites containing useful information have been embedded in the text of the electronic version; and
- a list of ***key criteria*** to consider in identifying achievements and areas needing improvement, with guidelines for scoring and rating progress.

Sources of data. A usually high-quality source of data is the *Demographic and Health Survey* (*DHS*)(*5*) conducted in collaboration with Macro International and national research organizations, with support from USAID. If this source is used, the data are likely to be comparable across countries. Other sources include the UNICEF *Multiple Indicator Cluster Survey (MICS)* (*6*) and the *WHO Global Data Bank on Breastfeeding and Complementary Feeding* (*7*). 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.

Because local sources may have the most recent information, these should be identified at the beginning of the process. Possible local sources include departments where national statistics and/or censuses are kept, *DHS* focal points where available, universities, and WHO collaborating centres.

In ***Part one***, the section on ***Infant and young child feeding practices*** asks for specific numerical data on each indicator. Whenever possible, assessors are encouraged to use data from a random household survey that is national in scope or that covers the local area or region being assessed. The level of achievement on each indicator is rated on a scale including “poor”, “fair”, “good”, and “very good”. The cut-off points for each level were selected systematically, based on an analysis of past achievements on these indicators in developing countries.

The ratings were developed based on an analysis of percentages achieved by countries on the various indicators, as evidenced by results from the *DHS* (*5*) and other selected national studies presented in *Breastfeeding patterns in the developing world* (*8*). The results from each country were rated from lowest to highest, using the Excel software programme. The results were then divided into five parts. The first two-fifths of the scores were used to determine the rating for “poor”, the second two-fifths for “fair” and the last one-fifth for “good”. The rating “very good” was reserved to indicate practices that were close to ‘optimal’ – for example 90–100% attainment of exclusive breastfeeding for 0–<6 months. The rating system allows a country to compare its progress on the various indicators with that of other countries, reserving the highest rating only for optimal practices.

For many reasons including access to food, availability of food types, working patterns, and cultural norms, practices may differ between rural and urban areas. It is therefore recommended that information about practices be disaggregated by urban/rural area. If the country has the capacity to make such an analysis, assessment results for each practice should be provided for each area. Using the suggested sources of data, the assessment team can consider each indicator for urban/rural areas, integrating this information into the corresponding practice page. The inclusion of this information may help stakeholders – during analysis and planning – to target the most vulnerable groups.

Background data in Part one is not to be scored. It should be used to provide a better understanding of the context which influences and is influenced by infant and young child feeding practices and programming. It is recommended that the information be separated by rural/urban area for as many as possible of the background data indicators.

In ***Parts two and three*** a set of criteria has been developed for each component. In most cases these criteria summarize the key achievements that would, in total, indicate a country's progress in a particular area. Each criterion is given a possible score of 1–3 points. The scores are weighted, depending on the importance of good performance attached to each criterion. A score of 10 points is the maximum total possible for each component. Achievement on each component is then rated "poor", "fair" "good" or "very good". Guidelines are provided on the number of points needed for each rating.

To help in scoring the criteria, the collection of ***additional information*** is suggested for some components. Definitions of key terms and additional technical information on some of the policy and programme components are provided in the attached Annexes.

The criteria for the programme components in ***Part three*** are often qualitative in nature. In some cases they may be difficult to score. The scoring system therefore offers three alternatives for each criterion:

- a full score if the criterion is fully met;
- half of the number of points if the criterion is met "to some degree"; and
- zero (0) points, if the criterion is not met at all.

An alternative ***Checklist*** version of ***Part three*** is also provided. Some users may find this alternative preferable as it gives countries the option of assessing strengths and weaknesses without quantitative scoring. It allows users to indicate whether the country (or local area or region within it) being assessed meets the various critieria for each programme component fully ("yes"), partially, ("to some degree"), or not at all ("no").

Potential users

The *Tool* can be used by a team composed of key national policy-makers, programme managers or staff, and leaders of local nongovernmental organizations (NGOs) who wish to undertake an assessment of their country's progress in the area of infant and young child feeding. Such an assessment could be a first step in formulating a plan of action for strengthening policies and programmes.

Countries developing plans to implement the *Global Strategy for Infant and Young Child Feeding* can use the *Tool* as a companion document for needs assessment and planning purposes. It has often been shown that if key decision-makers are engaged in assessing their own policies and programmes, they are much more likely to accept the results and take the actions needed to remedy any deficiencies identified.

The *Tool* can be used separately by donor agencies to assist in assessing the situation related to infant and young child feeding, in order to determine where their support might best be targeted. It

can also be used by advocacy groups for assessing progress, in order to identify areas for improvement which their members can advocate or support. However, if key representatives of government, NGOs, donor agencies and advocacy groups are all involved in a joint assessment process, it is much more likely that all those who can potentially provide programme and financial support will reach a consensus as regards an understanding of the situation, the actions needed, and how to work together to achieve them.

The *Tool* can also be used at the regional/local levels to help in assessing the need for improvements at those levels. Consideration should be given to designing a process that engages local and regional teams in assessment, analysis, and planning for action at the local/regional level – while feeding the results into a larger national planning process. The importance of a process that provides an opportunity for input from the community and gains the commitment of those who must eventually implement the recommendations at various levels cannot be over-emphasized.

Using the assessment tool

The process for conducting an assessment may vary from country to country. The choice of strategy that will both yield the most accurate results and best motivate decision-makers to make improvements will depend on who is using the *Tool* and for what purpose, as well as the particular national context. As mentioned above, although the potential users may vary, it is recommended that representatives from the national government, NGOs, donor agencies and advocacy groups be involved in a joint assessment, whenever possible.

The *Tool* was field tested in nine countries. The experience of the teams who participated in the field tests was helpful in providing guidance on the key steps involved, alternative strategies for collecting data, and methods of scoring and rating. That experience was also useful in developing recommendations for action in a joint assessment involving key decision-makers. The suggestions which emerged are summarized below.

Step 1. Identify a key coordinator and any support needed. The person responsible for initiating the assessment process should identify the organization and key individual within it who will be the primary coordinator of the assessment team. This could be a staff member of an organization that is central to planning and implementation of the country's national infant and young child feeding programme. For example, it could be the national breastfeeding (or infant and young child feeding) coordinator within the Ministry of Health. If the key coordinator has only a limited amount of time available, a senior consultant might be identified to coordinate the work of the assessment team.

The initiator of the process and the key coordinator should review the *Tool*, and decide generally how the assessment should be conducted. They should at the same time determine whether any financial support is needed; if so, they should identify the amount that can be made available and by whom. For example, funding may be needed for transportation and other expenses involved in the arrangement of meetings, photocopying, and other costs, depending on the country.

Step 2. Identify the assessment team. The composition and size of the team may vary, depending on which organizations are represented in the assessment. The team could include representatives of:

- the department or unit within the Ministry of Health responsible for infant and young child feeding,
- NGOs and advocacy groups working in the field of infant and young child feeding;
- key professional organizations;
- international agencies such as WHO and UNICEF, and donor and bilateral aid agencies that may provide financial or technical support for programme activities.

It is useful to have a core team of between four and seven members who have primary responsibilities for data collection and who are active throughout the entire process. If it is necessary to involve a wider group of representatives, consideration could be given to their participation in key meetings where data is reviewed, results are agreed upon, and recommendations for action are developed.[1]

Step 3. Plan and undertake the assessment. When deciding on the assessment process, the assessment team should establish a timetable for completing the assessment, as well as operating rules for the team. Operating rules should define what individual team members will do to contribute to the overall effort, how they will work together, how they will communicate with one another, and how they will consolidate feedback and make recommendations. Any support that will be provided for expenses involved in data collection or team meetings should be clearly specified.

The assessment will probably involve both a series of working meetings and periods of data collection. For example:

- An initial orientation and assessment planning meeting could be held with the members of the core team. During this meeting the *Tool* and the assessment process would be reviewed, roles and responsibilities for data gathering would be agreed upon, and a schedule would be established for data collection and meetings for data review and development of recommendations.

- Following this initial meeting, individual team members could gather information agreed upon at the meeting, to be fed into the various parts of the *Tool*.

- A second meeting or series of meetings could then be held to review data, agree on the scoring and rating of indicators and components, and propose recommendations. How this part of the assessment process would be organized would depend on the resources available and preferred style of working in the particular country

  In some countries the process of reviewing data, agreeing on scoring and rating and proposing recommendations, may be completed during one meeting or workshop, lasting several hours to a day.

  In other countries several meetings may be needed for this process. For example, a separate meeting could be held to consider each of the three parts of the *Tool,* consecutively (with data collected on each part in the interim), followed by a final meeting which would focus on the development of recommendations and consideration of the next steps in the planning process. (*Note.* Since the data for Part three usually takes the most time to gather, it may be preferable to schedule any meeting for review of this data after the reviews of Parts one and two have been completed).

- If both a core team and larger team have been identified, the members of the core team could be assigned to collect data, and the larger team invited to participate in one or more meetings to review the data, make final decisions on scoring and rating, and develop recommendations.

Experience thus far indicates that it is preferable, if possible, to complete all parts of the *Tool* during one assessment process. This approach not only allows the team to gain a full picture of the infant and young child feeding situation in the country, but also is more cost-effective. It is recommended that all the indicators in the various parts of the *Tool* be used – even if there is currently little activity in some programme areas – in order to obtain the most comprehensive view of achievements and areas where improvements are needed.

[1] Team members may vary from country to country, as mentioned. Individuals who might attend the larger group meetings could include, for example, officials from government ministries and departments that could be involved in supporting infant and young child feeding programmes; representatives of advocacy groups and professional organizations; heads of health-related schools and research institutes; representatives of international organizations and donor agencies.

The assessment process should be organized in such a way that it:

- increases awareness of the range of issues to consider when strengthening infant and young child feeding policies and programmes;
- promotes ownership of the results; and
- increases commitment to making the changes needed.

It is critical that, from the outset, the use of the *Tool* never be viewed as an end in itself, but rather as a means to obtain the data needed for actively planning and implementing policies and programmes that will lead to improved infant and young child feeding practices.

Reviewing and using the results

As mentioned above, the use of the *Tool* is only the first step in a longer process of improving national infant and young child feeding practices, policies and programmes. The process allows the assessment team to:

- obtain an overview of progress made;
- analyse determinants of successes and failures;
- identify areas that should be strengthened; and
- draft key recommendations concerning next steps.

Since the possible depth of the investigation during a first assessment is likely to be limited, the next step may often be a more thorough needs assessment and analysis of selected areas. Documents that may be very helpful in this process include the set of tools produced in the following publications:

- WABA's Global Participatory Action Research (GLOPAR) Project, including Chetley & Amin, *Investigating breastfeeding* (*9*);
- MotherCare, USAID. *Guide for country assessment of breastfeeding practices and promotion* (*10*); and
- UNICEF. *The Care Initiative: assessment, analysis and action to improve care for nutrition* (*11*).

The approach involving assessment, analysis and action can be undertaken at the community, regional and national levels. The assessment phase, which includes the initial data gathering can be completed using the *Tool* as a guide. The analysis phase usually involves further investigation of the determinants of the problems (or areas needing improvement) identified during the assessment. A clear understanding of why certain deficiencies exist is essential to determining how to address them. The analysis may focus on how current beliefs and practices are affected by the economic, political, social and cultural context, what resources are needed and available, and what strategies are most likely to help achieve progress towards meeting the targets identified in the *Global Strategy.*

When the assessment and analysis phases are complete, the results, including recommendations for action, should be presented to key decision-makers and, if desired, to potential donor agencies. Once the results are reviewed and analysed, decision-makers should decide which areas for improvement are of highest priority and most feasible to address, given the available human and financial resources, thus setting in motion a process of short-term, mid-term and long-term planning and implementation.

Periodic reassessments

As mentioned earlier, consideration should be given to using the *Tool* for periodic reassessments, every few years, in order to:

- track trends on the various indicators;
- assess progress on implementing the *Global Strategy for Infant and Young Child Feeding* and related local, regional and national strategies and plans;
- collect the data needed for country reports required for the World Health Assembly and/or the *WHO Global Data Bank on Breastfeeding and Complementary Feeding;*
- identify areas still needing improvement, to help guide the planning process at all levels and the development of periodic action plans.

The timing of periodic reassessments will depend on the needs for data at various levels. For example:

- If national health plans are prepared every five years, assessments could be scheduled several months prior to the initiation of each planning process.
- If the data are used primarily for reporting to the World Health Assembly every four years, data collection and review could be scheduled to feed into that process. The data could also be sent to the *WHO Global Data Bank on Breastfeeding and Complementary Feeding* at that time.
- If the *Demographic and Health Survey* or a national health and nutrition survey takes place every few years, the assessment might be scheduled soon after the results of those surveys are available, in order to take advantage of the new data.

Each country should determine what reassessment schedule provides the best and most timely data for its various needs.

INFANT AND YOUNG CHILD FEEDING

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Part one

INFANT AND YOUNG CHILD FEEDING PRACTICES

AND BACKGROUND DATA

INFANT AND YOUNG CHILD FEEDING PRACTICES
AND BACKGROUND DATA

Contents

Infant and young child feeding practices

1. Initiation of breastfeeding

Question: ***What is the percentage of babies who are breastfed within an hour of birth?***

Background

Step Four of the *Ten steps to successful breastfeeding* recommends early initiation of breastfeeding (*12*). The Baby-friendly Hospital Initiative (BFHI) assessment tool suggests that the baby should be placed "skin-to-skin" with the mother within the first half-hour following delivery. Within the first hour, assistance with positioning and attachment should be given, or if the mother has had a caesarean section, within an hour of when she is able to respond. Often, mothers who have undergone caesarean section need extra help with breastfeeding. Otherwise, these mothers on average initiate breastfeeding much later and terminate breastfeeding sooner. Optimally, the baby should be breastfed before any routine procedure (such as bathing, weighing, umbilical cord care, administration of eye medications) is performed. Early breastfeeding enhances bonding, increases chances of breastfeeding success, and generally lengthens the duration of breastfeeding.

Possible sources of data

Use a study carried out in your country within the past five years. Ideally, it should be a study that is national in scope. If not, note the area on which it focuses. Consider using data from the *Demographic and Health Survey* (*DHS*) (*5*) when available. Refer to the "Breastfeeding initiation" table in the chapter on "Infant feeding and maternal and child nutrition". (See the *DHS* web site at *http://www.measuredhs.com/data/indicators/*. Select survey; select indicators "Maternal & Child Nutrition", "Initial BF", "Started within one hour".) The UNICEF *Multiple Indicator Cluster Survey* (*MICS*) (*6*) and the *WHO Global Data Bank on Breastfeeding and Complementary Feeding* (*7)* are other sources.

Data source and date ☐ **Data not available**

(*Indicate if year of data collection is different from year of publication*):

……

Coverage of study: ☐ national ☐ other *(describe*): ……..

Guidelines for rating	
Percentage of babies breastfed within one hour of birth: ……. %	
Percentage	***Rating***
0 – 29%	Poor
30 – 49%	Fair
50 – 89%	Good
90 – 100%	Very good
Rating on breastfeeding initiation:	……

Additional information (not rated)	
Percentage of babies ever breastfed.	..... %
Average time of initiation of breastfeeding for all breastfed babies.	…. hr(s)/ …. days
Percentage of babies delivered by caesarean section.	…… %
Average time of initiation of breastfeeding for caesarean section babies.	…. hr(s)/ …. days
Average time of initiation of breastfeeding for babies delivered vaginally.	…. hr(s)/ …. days

2. Exclusive breastfeeding

Question: ***What is the percentage of babies 0–6 months of age who are exclusively breastfed?***[2]

Background

Exclusive breastfeeding in the early months of life is correlated strongly with increased infant survival and lowered risk of illness, particularly from diarrhoeal disease (*3*). To achieve optimal growth, development and health, WHO recommends that infants should be exclusively breastfed for the first six months of life. This is formulated in the Conclusions and Recommendations of a WHO Expert Consultation held in March 2001, which completed a systematic review of the optimal duration of exclusive breastfeeding (*13).*

Possible sources of data

Use a study carried out in your country within the past five years. Ideally, it should be a study that is national in scope. If not, note the area on which it focuses. Consider using data from the *DHS* (*5*) when available. Refer to the "24-hour recall" question presented in the table on "Breastfeeding status" in the chapter on "Infant feeding and maternal and child nutrition". (See the *DHS* web site at *http://www.measuredhs.com/data/indicators/*. Select survey; select indicators "Maternal & Child Nutrition", "BF Status", "Exclusive BF" – currently listed by two-month increments.) The *MICS* (*6*) and the *WHO Global Data Bank on Breastfeeding and Complementary Feeding* (*7*) are other sources.

If *DHS* data are used, the two-month data increments can be converted into a 0–<6 months of age rate for exclusive breastfeeding. You can either use the 'automatic' calculator on the next page – if you are using the electronic version of the *Tool* and have access to Microsoft Excel – or use the manual calculator provided in Annex 2. It is recognized that 24-hour recall may not capture the true breastfeeding pattern since birth. It is useful to explore whether babies have ever received anything but breast milk from birth. Unfortunately, however, reliable and valid data on these long-term patterns are not yet widely available.

Data source and date ☐ **Data not available**

(*Indicate if year of data collection is different from year of publication*):

……

Coverage of study: ☐ national ☐ other (*describe*): ……

Guidelines for rating	
Percentage of babies 0–<6 months of age exclusively breastfed in the last 24 hours: …… **%**	
Percentage	***Rating***
0 – 11%	Poor
12 – 49%	Fair
50 – 89%	Good
90 – 100%	Very good
Rating on exclusive breastfeeding:	…….

Additional information (not rated)	
Percentage of babies 0–<4 months of age exclusively breastfed in the last 24 hours	…… %
Percentage of babies 4–<6 months of age exclusively breastfed in the last 24 hours	..…… %

[2] See the definition of "exclusive breastfeeding" in Annex 1, Glossary of terms.

If you are using the Microsoft Word file version of this document and also have Microsoft Excel installed, double click on the Excel table below to activate and use it to calculate the exclusive breastfeeding rate for children 0–<6 months of age. If the computer software needed is not available, the calculations can be performed manually using the calculator in Annex 2.

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

Instructions: Fill in yellow shaded boxes (only) with appropriate data from the published tables to generate the EBR for children 0-<6 months.

		From the published tables:
EBR, 0-1 mo		the EBR rate in percentages given for children 0-< 2 months
EBR, 2-3 mo		the EBR rate in percentages given for children 2-< 4 months
EBR, 4-5 mo		the EBR rate in percentages given for children 4-< 6 months
EBR, 0-5 mo	#DIV/0!	the calculated EBR for children 0-<6 months

		From the published tables:
Number, 0-1 mo		the total number of children in the age group 0-<2 months
Number, 2-3 mo		the total number of children in the age group 2-<4 months
Number, 4-5 mo		the total number of children in the age group 4-<6 months
Number, 0-5 mo	0	the total number of children aged 0-<6 months

		Generated absolute numbers:
Numbers EBF, 0-1 mo	0	children 0-<2 months who are exclusively breastfed
Numbers EBF, 2-3 mo	0	children 2-<4 months who are exclusively breastfed
Numbers EBF, 4-5 mo	0	children 4-<6 months who are exclusively breastfed
Numbers EBF, 0-5 mo	0	children 0-<6 months who are exclusively breastfed

(Adapted from EBR Calculator developed by Nadra Franklin, LINKAGES Project, 1999)

Note: 0–1 mo = 0–<2 months, etc. Results obtained using the automatic and manual calculators may be slightly different, depending on whether and how numbers are rounded off.

3. Duration of breastfeeding

Question: ***What is the median duration of breastfeeding?***[3]

Background

The *Innocenti Declaration* (*4*) recommends that babies continue to be breastfed for up to two years of age or beyond. When provided along with appropriate and adequate complementary food, breast milk continues to be an important source of nutrition and fluids and immunological protection for the child after six months of age. The continued bonding between mother and child provided by breastfeeding encourages optimal psychosocial development.

Possible sources of data

Use a study carried out in your country within the past five years. Ideally, it should be a study that is national in scope. If not, note the area on which it focuses. Consider using data from the *DHS* (*5*) when available. Refer to the table on "Median duration and frequency of breastfeeding" in the chapter on "Infant feeding and maternal and child nutrition". The *DHS* measures the median duration of breastfeeding among children under three years of age, based on current status. (See the *DHS* web site at *http://www.measuredhs.com/data/indicators/*. Select survey; select indicators "Maternal & Child Nutrition", "Median duration of BF", "Median BF duration", "Any breastfeeding".) The *MICS* (*6*) and the *WHO Global Data Bank on Breastfeeding and Complementary Feeding* (*7*) are other sources.

.

Data source and date ☐ **Data not available**

(*Indicate if year of data collection is different from year of publication*):

……

Coverage of study: ☐ national ☐ other (*describe*): ……

Guidelines for rating	
Median duration of breastfeeding of children under 36 months of age: ……. **months**	
Median duration of breastfeeding	***Rating***
0 – 17 months	Poor
18 – 20 months	Fair
21 – 22 months	Good
23 – 24 months or beyond	Very good
Rating on duration of breastfeeding:	…….

[3] See the definition of "median duration of breastfeeding" in Annex 1, Glossary of terms.

4. Bottle-feeding

Question: **W*hat is the percentage of breastfed babies 0–12 months of age who are fed any food or drink (even breast milk) by bottle?***[4]

Background

Babies should be breastfed exclusively until six months (180 days) of age. If unable to feed directly from the mother's breast, the baby should be fed breast milk from a cup. (If the baby is unable to swallow, breast milk can be provided by means of an infant-feeding tube.) After six months of age, any liquids given should be fed by cup rather than by bottle. Feeding-bottles with artificial nipples and pacifiers (teats or dummies) may cause nipple confusion and infants may refuse to breastfeed after their use (*14)*. Feeding-bottles are more difficult to keep clean than cups, and the ingestion of pathogens can lead to illness and even death (*15*). Pacifiers can also easily become contaminated and cause illness.

Possible sources of data

Use a study carried out in your country within the past five years. Ideally, it should be a study that is national in scope. If not, note the area on which it focuses. Consider using data from the *DHS* (*5*) when available. Refer to the table on "Types of food received by children in the preceding 24 hours" in the chapter on "Infant feeding and maternal and child nutrition" or the *DHS* web site at *www.measuredhs.com/data/indicators/*.

However, in both sources, data are only listed in two-month or three-month increments. If these sources are used, the two-month data increments can be converted into a 0–<12 month bottle-feeding rate either by using the 'automatic' calculator on the next page – if you are using the electronic version of the *Tool* and have Microsoft Excel – or by using the manual calculator provided on page 2 of Annex 1. See *DHS Comparative Study No.30* (*16*) for data reported for 0–<12 months. The *MICS* (*6*) and the *WHO Global Data Bank on Breastfeeding and Complementary Feeding* (*7*) are other sources.

.

Data source and date ☐ **Data not available**

(*Indicate if year of data collection is different from year of publication*):

……

Coverage of study: ☐ national ☐ other (*describe*): ……

Guidelines for rating	
Percentage of breastfed babies 0–<12 months of age who received any food or drink (even breast milk) from bottles in the last 24 hours: …….. **%**	
Percentage	***Rating***
30 – 100%	Poor
5 – 29%	Fair
3 – 4%	Good
0 – 2%	Very good
Rating on bottle-feeding:	……

Additional information (not rated)	
Percentage of non-breastfed babies 0–<12 months of age who received any food or drink from bottles in the last 24 hours	…….. **%**

[4] See the definition of "bottle-feeding" in Annex 1, Glossary of terms.

If you are using the Microsoft Word file version of this document and also have Microsoft Excel installed, double click on the Excel table below to activate and use it to calculate the bottle-feeding rate for breastfeeding children 0–<12 months of age. If the computer software needed is not available, the calculations can be performed manually using the calculator in Annex 2.

		From the published tables:
BOT, 0-1 mo		the BOT rate in percentages given for BF children 0-< 2 months
BOT, 2-3 mo		the BOT rate in percentages given for BF children 2-< 4 months
BOT, 4-5 mo		the BOT rate in percentages given for BF children 4-< 6 months
BOT, 6-7 mo		the BOT rate in percentages given for BF children 6-< 8 months
BOT, 8-9 mo		the BOT rate in percentages given for BF children 8-<10 months
BOT, 10-11 mo		the BOT rate in percentages given for BF children 10-<12 months
BOT, 0-11 mo	#DIV/0!	the calculated BOT rate for BF children 0-<12 months

		From the published tables:
Number, 0-1 mo		the total number of BF children in the age group 0-<2 months
Number, 2-3 mo		the total number of BF children in the age group 2-<4 months
Number, 4-5 mo		the total number of BF children in the age group 4-<6 months
Number, 6-7 mo		the total number of BF children in the age group 6-<8 months
Number, 8-9 mo		the total number of BF children in the age group 8-<10 months
Number, 10-11 mo		the total number of BF children in the age group 10-<12 months
Number, 0-11 mo	0	the total number of BF children aged 0-<12 months

		Generated absolute numbers:
Numbers BOT, 0-1 mo	0	BF children 0-<2 months who are bottlefed
Numbers BOT, 2-3 mo	0	BF children 2-<4 months who are bottlefed
Numbers BOT, 4-5 mo	0	BF children 4-<6 months who are bottlefed
Numbers BOT, 6-7 mo	0	BF children 6-<8 months who are bottlefed
Numbers BOT, 8-9 mo	0	BF children 8-<10 months who are bottlefed
Numbers BOT, 10-11 mo	0	BF children 10-<12 months who are bottlefed
Numbers BOT, 0-11 mo	0	BF children 0-<12 months who are bottlefed

(Adapted from EBR Calculator developed by Nadra Franklin, LINKAGES Project, 1999)

Note: 0–1 mo = 0–<2 months, etc. Results obtained using the automatic and manual calculators may be slightly different, depending on whether and how numbers are rounded off.

5. Complementary feeding

Question: ***What is the percentage of babies aged six through nine months who are receiving complementary foods[5] while continuing to breastfeed?***

Background

Because babies need nutritious foods in addition to breast milk from the age of six months, WHO recommends that babies should begin receiving complementary foods at that age. Locally available and affordable foods that enrich the baby's diet with additional calories and micronutrients should be offered – soft or mashed – in small quantities, several times a day. These complementary foods should gradually increase in amount and frequency as the baby grows (see Annex 3, principles 5 and 7). Breastfeeding, on demand, should continue until the age of two years or beyond (*17*–*21*). The indicator proposed here measures the percentage of babies fed complementary foods from ages six through nine months, while continuing to breastfeed.

To gain a full understanding of whether complementary foods are introduced at the appropriate time, it is also important to know if foods are introduced too early or too late. To obtain a full picture of the timeliness of complementary feeding, additional information is requested on the percentage of babies who are not breastfed, of those who are exclusively breastfed, or who – in addition to being breastfed – are receiving plain water only, or supplements (other foods or liquids) at various ages. Feeds should also be adequate, safe and properly fed. Work is currently under way, sponsored by WHO, to identify suitable indicators for measuring these key aspects of complementary feeding. A set of guiding principles endorsed by a WHO global consultation (*22*) will serve to direct the development of these indicators (see Annex 3). The *WHO Global Data Bank on Breastfeeding and Complementary Feeding* will be revised to include these new indicators.

Possible sources of data

Use a study carried out in your country within the past five years. Ideally, it should be a study that is national in scope. If not, note the area on which it focuses. Some studies list data for 6–<10 months and some for 7–<10 months of age. Consider using data from the *DHS* (*5*) when available. Refer to the table on "Breastfeeding status" in the chapter on "Infant feeding and maternal and child nutrition" which has data for 7–<10 months of age. (See DHS web site at *http://www.measuredhs.com/data/indicators/*. Select survey; select indicators "Maternal & child nutrition", "BF status", "BF & supplements", "7–9 months".) The data requested as "additional information" are also available from the table on "BF status" from the *DHS* web site. The *MICS* (*6*) and the *WHO Global Data Bank on Breastfeeding and Complementary Feeding* (*7*) are other sources of information.

.

Data source and date ☐ **Data not available**

(*Indicate if year of data collection is different from year of publication*):

……

Coverage of study: ☐ national ☐ other (*describe*): ……

Guidelines for rating	
Percentage of breastfed babies 6–<10 or 7–<10 months of age (depending on data available) who received complementary foods in the last 24 hours: …… **%**	
Percentage	***Rating***
0 – 59%	Poor
60 – 79%	Fair
80 – 94%	Good
95 – 100%	Very good
Rating on timely complementary feeding:	……..

[5] See the definitions of "complementary foods" and "complementary feeding" in Annex 1, Glossary of terms.

Additional information (not rated)				
Age	***Not breastfed***	***Exclusively breastfed***	***Breastfed and given:***	
			plain water only	***supplements (other foods and/or liquids)***
0 – 3 months	…… %	…… %	…… %	…… %
4 – 6 months	…… %	…… %	…… %	…… %
7 – 9 months	…… %	…… %	…… %	…… %

Summary of infant and young child feeding practices and recommendations

Summary of practices		
Practices	***Result***	***Rating***
1. **Initiation of breastfeeding** (% of babies breastfed within one hour of birth).	…… %	……
2. **Exclusive breastfeeding** (% of babies 0–<6 months of age exclusively breastfed in the last 24 hours).	…… %	……
3. **Duration of breastfeeding** (median duration in months of breastfeeding of children under three years of age).	…… months	……
4. **Bottle-feeding** (% of breastfed babies 0–<12 months of age fed from bottles in the last 24 hours).	…… %	……
5. **Complementary feeding** (% of breastfed babies 6–<10 or 7–<10 months of age who received complementary foods in the last 24 hours).	…… %	……

Summary of results and recommendations
Summarize which infant and young child feeding practices are good, and which practices need improvement and why. Identify areas needing further analysis and make recommendations for action.

Background data

This section asks for information on key indicators. This information should help to provide a better understanding of the health, nutritional and socioeconomic context which both influences and is influenced by infant and young child feeding practices and programmes. Use data from your own country if the studies are methodologically sound and have been conducted recently. Many of the results are available in key international documents such as the UNDP *Human Development Report* (*23*), UNICEF's *State of the World's Children* (*24*), and the *Demographic and Health Surveys* (*5*) and *Multiple Indicator Cluster Surveys* (*6*) which have been undertaken in many countries.

The use of this section is flexible. Indicators can be added, dropped, or adapted to fit the needs of each country to provide the most useful background data for understanding the national and local context. Results may be influenced by place of residence (urban or rural, geographical differences, etc.), ethnicity, economic status, age, gender, educational level, and other factors. If feasible, it would be useful to explore these differences to determine which population groups have the greatest need.

References for generally available documents and web sites where data for specific countries can be found are listed below for each indicator under "data source and date". The data source used can be circled, highlighted or listed in the space provided.

1.	**Population of country (in thousands)** % urban % rural % under one year of age % under five years of age	…… …… % …… % …… % …… %
	Definition: The total number of inhabitants in the country in a given year	
	Data source and date ☐ **Data not available** UNICEF, *State of the World's Children,* 2001, Table 1 (*http://www.unicef.org/sowc01/tables/*, Table 1). Macro International, *DHS* for country; *Introduction,* section on *Population, (date*) …… *Other sources*: …….	
2.	**Infant mortality rate (IMR) (per 1000)**	…….
	Definition: Number of deaths of infants under one year of age in a given year divided by the total number of live births in that year multiplied by 1000.	
	Data source and date ☐ **Data not available** UNICEF, *State of the World's Children,* 2001, Table 1 (*http://www.unicef.org/sowc01/tables/*, Table 1). Macro International, *DHS* for country, chapter on *Infant and child mortality*, (*date*) …….. (*http://www.measuredhs.com/data/indicators*. Select survey; select indicators "Early childhood mortality", "Infant and child mortality", "5 yr rates", "0–4 yrs"). *Other sources*: …….	

3.	**Low birth weight**	……%
	Definition: Percentage of infants with birth weight of less than 2500 grams.	
	Data source and date **☐ Data not available** WHO *Global Database on Child Growth and Malnutrition* (*http://ww.who.int/nutgrowthdb* – register at no cost and look for data on your country). UNICEF, *State of the World's Children,* 2001, Table 2 (*http://www.unicef.org/sowc01/tables/*, Table 2). *Other sources*: ……	
4.	**Underweight (under-fives)**	……%
	Definition: Percentage of children under the age of five suffering from moderate or severe underweight (below minus two standard deviations from median weight-for-age of reference population).	
	Data source and date **☐ Data not available** WHO *Global Database on Child Growth and Malnutrition* (*http://ww.who.int/nutgrowthdb* – register at no cost and look for data on your country). UNICEF, *State of the World's Children,* 2001, Table 2 (*http://www.unicef.org/sowc01/tables*/, Table 2). Macro International, *DHS* for country, chapter on *Infant feeding and maternal and child nutrition*, (*date*) ……. (*http://www.measuredhs.com/indicators*. Select survey; select indicators "Maternal and child nutrition", "Nutritional status", "Nutritional status by background characteristics", "Weight-for-age below –2SD"). *Other sources*: ……	
5.	**Wasting (under-fives)**	…… %
	Definition: Percentage of children under the age of five suffering from moderate or severe wasting (below minus two standard deviations from median weight-for-height of reference population).	
	Data source and date **☐ Data not available** WHO *Global Database on Child Growth and Malnutrition* (*http://ww.who.int/nutgrowthdb* – register at no cost and look for data on your country). UNICEF, *State of the World's Children,* 2001, Table 2 (*http://www.unicef.org/sowc01/tables/*, Table 2). Macro International, *DHS* for country, chapter on *Infant feeding and maternal and child nutrition*, (*date*) …… (*http://www.measuredhs.com/indicators*. Select survey; select indicators "Maternal and child nutrition", "Nutritional status", "Nutritional status by background characteristics", "Weight-for-height below –2SD"). *Other sources*: ……..	

6.	**Stunting (under-fives)**	…… %
	Definition: Percentage of children under the age of five suffering from moderate or severe stunting (below minus two standard deviations from median height-for-age of reference population).	
	Data source and date ☐ **Data not available** WHO *Global Database on Child Growth and Malnutrition* (*http://ww.who.int/nutgrowthdb* – register at no cost and look for data on your country). UNICEF, *State of the World's Children,* 2001, Table 2 (*http://www.unicef.org/sowc01/tables/*, Table 2). Macro International, *DHS* for country, chapter on *Infant feeding and maternal and child nutrition*, (*date*) …… (*http://www.measuredhs.com/data/indicators*. Select survey; select indicators "Maternal and child nutrition", "Nutritional status", "Nutritional status by background characteristics", "Height-for-age below –2SD"). *Other sources*: ……	
7.	**Prevalence of anaemia**	…… %
	Definition: Percentage of children aged six months to two years with anaemia (Hb < 11 g/L).	
	Data source and date ☐ **Data not available** Macro International, *DHS* for country, chapter on *Infant feeding and maternal and child nutrition* (*date*) …… (*http://www.measuredhs.com/data/indicators.* Select survey; select indicators, "Maternal and child nutrition", "Micronutrient intake", "Prevalence of anemia", "Prevalence of anemia in children" (6–9 and 10–11 months-old). *Other sources*: ……	
8.	**Prevalence of use of iodized salt**	…… %
	Definition: Percentage of households consuming iodized salt.	
	Data source and date ☐ **Data not available** UNICEF, WHO. *Ending iodine deficiency forever: A goal within our grasp.* (*http://www.unicef.org/pubsgen/salt/*). Macro International, *DHS* for country, chapter on *Infant feeding and maternal and child nutrition,* (*date*) …….. (*http://www.measuredhs.com/data/indicators.* Select survey; select indicators "Maternal and child nutrition", "Iodization of household salt", "Percentage of households with no salt". *Other sources*: ……	

9.	**Prevalence of low serum retinol**	…… %
	Definition: Percentage of children aged 6–71 months with serum retinol ≤ 0.70 µmol/L.	
	Data source and date ☐ **Data not available** National surveys. Prevalence of subclinical vitamin A deficiency is considered mild if the percentage of children with low serum retinol is ≥2 – <10%, moderate if the percentage is >10 –<20 %, and severe if >20 %. *Other sources*: ……	
10.	**Households with clean water supply**	…… %
	Definition: Percentage of households within 15 minutes of a safe water supply.	
	Data source and date ☐ **Data not available** Macro International, *DHS* for country*, World Summit for Children Indicators*, inside front cover, (*date*)……. (*http://www.measuredhs.com/data/indicators.* Select survey; select indicators "Characteristics of households", "Housing characteristics", "Time to water source", "Water within 15 minutes"). *Other sources*: ……	
11.	**Diarrhoeal disease rate** 0 – 5.9 months 6 – 11.9 months 12 – 23.9 months	 …… % …… % …… %
	Definition: Percentage of children of various ages who had diarrhoea (three or more loose or watery stools in a 24-hour period or any blood in the stools) in the preceding two weeks.	
	Data source and date ☐ **Data not available** Macro International, *DHS* for country, chapter on *Child health*, (*date*) ……. (*http://www.measuredhs.com/data/indicators.* Select survey; select indicators "Maternal and Child Health", "Diarrhea prevalence.", "Diarrhea prevalence. last 2 weeks", "Child's age"). *Other sources*: ……	

12.	**Acute respiratory infection (ARI) rate** 0 – 5.9 months 6 – 11.9 months 12 – 23.9 months	 …… % …… % …… %
	Definition: Percentage of children of various ages ill with coughing accompanied by short, rapid breathing in preceding two weeks.	
	Data source and date ☐ **Data not available** Macro International, *DHS* for country; chapter on *Child health*, (*date*) …… (*http://www.measuredhs.com/data/indicators*. Select survey; select indicators "Maternal and child health", "Prevalence & treatment of ARI and fever", "Respiratory or fever infection", "Cough and fast breathing", "Child's age"). *Other sources*: ……	
13.	**HIV prevalence among pregnant women**	…… %
	Definition: Percentage of HIV-positive pregnant women attending antenatal clinics = (number of pregnant women attending antenatal clinics with HIV/total number of pregnant women attending antenatal clinics) x 100.	
	Data source and date ☐ **Data not available** UNAIDS, *Report on the Global HIV/AIDS epidemic*, 2002 (Table of country-specific HIV/AIDS estimates and data as of end 2001) (*http://www.unaids.org/epidemic_update/report_july02/english/table.pdf*) *Other sources*: ……	
14.	**Mothers with low body mass index**	…… %
	Definition: Percentage of mothers with a body mass index (weight in kilograms divided by height in metres squared) of less than 18.5 (kg/m^2), which indicates chronic energy deficiency.	
	Data source and date ☐ **Data not available** Macro International, *DHS* for country*, World Summit for Children Indicators*, inside front cover, (*date*)…… (*http://www.measuredhs.com/data/indicators*. Select survey; select indicators "Maternal and child nutrition", "Anthropometric indicators", "Women's body mass index", for *severe, moderate, and mild* not for *less than 18.5 (kg/m^2)*). *Other sources*: ……..	

15.	**Maternal mortality rate (per 100 000)**	……
	Definition: Annual number of deaths of women from pregnancy-related causes per 100 000 live births.	
	Data source and date ☐ **Data not available** UNICEF, *State of the World's Children,* 2001, Table 7 (*http://www.unicef.org/sowc01/tables/*, Table 7). *Other sources*: ……	
16.	**Births attended by trained health personnel**	…… %
	Definition: Percentage of births attended by physicians, nurses, midwives, or primary health care workers trained in midwifery skills.	
	Data source and date ☐ **Data not available** UNICEF, *State of the World's Children,* 2001, Table 7 (*http://www.unicef.org/sowc01/tables/*, Table 7). Macro International, *DHS* for country, chapter on *Maternal health care, (date)*…….. (*http://www.measuredhs.com/data/indicators*. Select survey; select indicators "Maternal and child health", "Assistance during delivery", "Doctor and trained nurse/midwife or other health professional", "Births in the 5 years before survey".) *Other sources*: ……	
17.	**Births in health facility**	…… %
	Definition: Percentage of births in health (or medical) facility.	
	Data source and date ☐ **Data not available** Macro International, *DHS* for country, *World Summit for Children Indicators*, inside front cover, or chapter on *Maternal and child health*, (*date*)…… (*http://www.measuredhs.com/data/indicators*. Select survey; select indicators "Maternal and child health", "Place of delivery", "Health facility"). *Other sources*: ……	

18.	**Total fertility rate**	……
	Definition: The number of children that would be born per woman if she were to live to the end of her childbearing years and bear children at each age in accordance with prevailing age-specific fertility rates.	
	Data source and date ☐ **Data not available** UNICEF, *State of the World's Children,* 2001, Table 8 (*http://www.unicef.org/sowc01/tables/*, Table 8). *Other sources*: ……	
19.	**Duration of postpartum amenorrhoea (in months)**	……
	Definition: Median duration of postpartum amenorrhoea (in months). (Postpartum amenorrhoea is the period of time following birth during which a woman's menstrual cycle has not yet resumed.)	
	Data source and date ☐ **Data not available** Macro International, *DHS* for country*,* chapter on *Proximate determinants of fertility*, (*date*)…… (*http://www.measuredhs.com/data/indicators/*. Select survey; select indicators "Other proximate determinants of fertility", "Postpartum amenorrhea", "Median durations", "Amenorrheic"). *Other sources*: ……	
20.	**Contraceptive prevalence**	…… %
	Definition: Percentage of women of reproductive age who are using (or whose partners are using) a modern contraceptive method at a particular point in time (often reported for women who are married or in sexual union).	
	Data source and date ☐ **Data not available** Macro International, *DHS* for country, chapter on *Current use of family planning* or *Fertility regulation*, (*date*)…… (*http://www.measuredhs.com/data/indicators/*. Select survey; select indicators "Family planning", "Current use of contraception", "Any modern method", "Marital status", "All"). *Other sources*: ……	
21.	**Government expenditure allocated to health**	…… %
	Definition: Percentage of central government expenditure allocated to health (from International Monetary Fund data).	
	Data source and date ☐ **Data not available** UNICEF, *State of the World's Children,* 2001, Table 6 (*http://www.unicef.org/sowc01/tables/*, Table 6). *Other sources*: ……	

Summary of background data

Background indicator	*Result*	*Source and date*
1. **Population (in thousands)** % urban % rural % children under 1 year % children under 5 years	.... % ..... % ..... % ..... %	
2. **IMR rate (per 1000)**	...../1000	
3. **Low birth weight**	..... %	
4. **Underweight (under-fives)**	..... %	
5. **Wasting (under-fives)**	..... %	
6. **Stunting (under-fives)**	..... %	
7. **Prevalence of anaemia**	..... %	
8. **Prevalence of use of iodized salt**	..... %	
9. **Prevalence of low serum retinol**	..... %	
10. **Households with clean water supply**	..... %	
11. **Diarrhoeal disease rate** 0–5.9 months 6–11.9 months 12–23.9 months	 ..... % ..... % ..... %	
12. **ARI rate** 0–5.9 months 6–11.9 months 12–23.9 months	 ..... % ..... % ..... %	
13. **HIV prevalence among pregnant women**	..... %	
14. **Mothers with low body mass index**	..... %	
15. **Maternal mortality rate (per 100 000)**	...../100 000	
16. **Births attended by trained health personnel**	..... %	
17. **Births in health facility**	..... %	
18. **Total fertility rate**	.....	
19. **Duration of postpartum amenorrhoea**	..... months	
20. **Contraceptive prevalence**	..... %	
21. **Government expenditure allocated to health**	..... %	

INFANT AND YOUNG CHILD FEEDING

A tool for assessing national practices, policies and programmes

Part two

INFANT AND YOUNG CHILD FEEDING POLICIES AND TARGETS

INFANT AND YOUNG CHILD FEEDING POLICIES AND TARGETS

Contents

Policies and targets

1. National infant and young child feeding policies

Question: ***Do national policies protect, promote and support optimal infant and young child feeding?***

Background

The *Innocenti Declaration* (*4*), endorsed by 139 governments at the 1990 World Summit for Children, recommends that "all governments should develop national breastfeeding policies…". The *Global Strategy on Infant and Young Child Feeding* (*1*) which was developed by WHO in collaboration with UNICEF, was unanimously endorsed by the 55th World Health Assembly in May 2002, and by the Executive Board of UNICEF in September 2002. The Global Strategy specifies key topics that should be covered by national policies, many of which are included in the criteria below. In addition, national authorities are urged to integrate their infant and young child feeding policies into other relevant policies, whenever appropriate.

Possible sources of information

Discussions can be held with national coordinators for infant and/or young child feeding; officials from the ministries of health, planning, and/or labour; representatives of government regulatory authorities; representatives of UNICEF and WHO; and country breastfeeding promotion groups. Review any national policies that cover infant and young child feeding.

Information sources used *(please list): …* ……... ... ...

……

Guidelines for scoring	
Criteria for effective national policies on infant and young child feeding	***Score*** *Circle or highlight those that apply*
▪ A national policy on infant and young child feeding has been officially adopted by the government. Date(s) adopted: ……	2
▪ The policy promotes infant and young child feeding practices consistent with international guidelines.	2
▪ The policy addresses provision of skilled counselling and support in the health system and communities.	1
▪ The policy covers guidelines for HIV and infant feeding and provides for counselling and support related to this issue.	1
▪ The policy addresses the issue of how to manage infant and young child feeding in emergency situations.	1
The policy covers the other issues outlined in the policy section of the *Global Strategy on Infant and Young Child Feeding* (see Annex 4 for a summary list of issues).	1
▪ The policy is routinely distributed and communicated to those managing and implementing relevant programmes.	1
Infant and young child feeding policy is appropriately integrated into other relevant national policies (health, nutrition, AIDS, family planning, Integrated Management of Childhood Illness (IMCI), integrated child health policies, etc.) *List which*: ……..	1
Total score:	……

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*		
Title of policy covering infant and/or young child feeding	***Date adopted***	***Issues/topics covered***

Guidelines for rating	
Score on criteria for national infant and young child feeding policies: …… **points**	
Score	***Rating***
0 – 4	Poor
5 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on national infant and young child feeding policies:	……..

Conclusions and recommendations
Summarize which aspects of the infant and young child feeding policies are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

2. National coordinators and committees

Question: ***Are there national breastfeeding and/or infant and young child feeding coordinators and committees?***

Background

The *Innocenti Declaration* calls upon all governments to appoint "a national breastfeeding coordinator of appropriate authority" and to establish "a multisectoral national breastfeeding committee composed of representatives from relevant government departments, nongovernmental organizations, and health professional associations" (*4*).

The *Global Strategy for Infant and Young Child Feeding* (*1*) confirms the continued importance of the Innocenti targets. It suggests that future strategies should reflect a comprehensive approach to meeting feeding requirements during the first three years of life. Accordingly, it is important that the position description of the breastfeeding coordinator, as well as the terms of reference of the national breastfeeding committee, be broadened to include "young child feeding". If another entity is responsible for young child feeding, its work should be closely coordinated with the breastfeeding coordinator and the breastfeeding committee.

Possible sources of information

Data can be gathered from the chairperson of the national breastfeeding and/or infant and young child feeding committee(s); the national coordinator(s) for these programme components; ministry of health officials; representatives of UNICEF and WHO; and representatives of relevant NGOs and/or donor agencies.

Information sources used *(please list:* ……...

……

Guidelines for scoring	
Criteria	***Score*** *Circle or highlight those that apply* .
▪ A national coordinator[6] is responsible for breastfeeding or infant feeding.	2
▪ A national coordinator is responsible for young child feeding (either the same or separate from the coordinator for breastfeeding).	2
▪ The national coordinator(s) work at least half time in salaried position(s) managing the national infant and young child feeding programme(s).	2
▪ Official national committee(s) or commission(s) meet on a regular basis[7] and provide guidance to national programme(s).	2
▪ Coordination takes place between sectors and initiatives dealing with breastfeeding and complementary feeding.	2
Total score:	.....

[6] The titles of the coordinators responsible for breastfeeding, infant feeding and/or young child feeding may vary from country to country.

[7] What constitutes meeting "on a regular basis" may vary from country to country, depending on the role of the national committee and the programme's need for guidance. For a full score on this criterion, committee meetings should be scheduled and take place at least twice a year (preferably more often) rather than simply on an ad hoc basis.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Is there more than one infant and young child feeding coordinator? If yes, how many and what are their responsibilities?	☐ Yes ☐ No
Names of related committee(s) or commission(s).	
Frequency of meetings.	
Number and percentage of members attending.	
Accomplishments during the past five years.	

Guidelines for rating	
Score on criteria for national coordinator(s) and committee(s): …… **points**	
Score	***Rating***
0 – 4	Poor
5 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on national coordinator(s) and committee(s):	.....

Conclusions and recommendations
Summarize which aspects related to the appointment and functioning of the national coordinator(s) and committee(s) are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

3. Baby-friendly Hospital Initiative achievements

Question: ***What percentage of hospitals and facilities that provide maternity services has been designated "baby-friendly" based on the global criteria?***

Background

The *Innocenti Declaration* (*4*) calls for all facilities offering maternity care to practise fully the *Ten steps to successful breastfeeding*. These are set out in a joint WHO/UNICEF statement on *Protecting, promoting and supporting breastfeeding: the special role of maternity services* (*12*).The Baby-friendly Hospital Initiative (BFHI) has encouraged all hospitals and facilities providing maternity care to follow the *Ten steps*. It is recommended that hospitals and maternity facilities needing to purchase breast-milk substitutes should do so at full price through normal procurement channels, accepting no free or low-cost supplies.

UNICEF's periodic progress reports on BFHI (*25*) list the total number of hospitals/maternity facilities in each country and the total number designated "baby-friendly". Some countries have also encouraged "baby-friendly" care in health centres, other similar facilities, and, in a few cases, during home deliveries. The assessment in this part of the *Tool* focuses only on the percentage of hospitals and maternity facilities designated "baby-friendly". Strategies for monitoring, reassessing, and sustaining the Initiative are explored in Part three.

Possible sources of information

Interviews can be held with the national BFHI coordinator or equivalent in the ministry of health; staff of NGOs involved with breastfeeding; and representatives of UNICEF and WHO. Review any summary reports on the status of the BFHI, including numbers (and percentages) of hospitals declared "baby-friendly". Refer to the latest status report on BFHI prepared by UNICEF Headquarters, for official figures reported by each country. Divide the number of hospitals designated "baby-friendly" by the total number of hospitals with maternity services to obtain the percentage of "baby-friendly" hospitals in the country concerned.

Information sources used *(please list):*……..

……

Guidelines for rating	
…… of **……** hospitals and facilities offering maternity services have been designated "baby-friendly"**: …… %**	
Percentage	***Rating***
0 – 7%	Poor
8 – 49%	Fair
50 – 89%	Good
90 – 100%	Very good
Rating on BFHI achievements:	……..

Additional information (not rated)	
Percentage of births that take place in facilities with “baby-friendly” care	…… %
Percentage of teaching hospitals designated “baby-friendly”	…… %
Percentage of public hospitals designated “baby-friendly”	…… %
Percentage of private hospitals designated “baby-friendly”	…… %

Conclusions and recommendations
Summarize progress made towards achieving “baby-friendly” targets, and any aspects of the BFHI needing improvement and why. Identify areas needing further analysis and make recommendations for action.

4. International Code of Marketing of Breast-milk Substitutes

Question: ***Is the International Code of Marketing of Breast-milk Substitutes in effect?***

Background

The *Innocenti Declaration* (*4)* calls for all governments to take action to implement all articles of the *International Code of Marketing of Breast-milk Substitutes* adopted by the 34th World Health Assembly in 1981 and subsequent resolutions. As stated in the *Code*, its aim is "to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution" (*26*). The *State of the Code by country* report (*27*) describes progress made in implementing the *Code*.

The International Code of Marketing of Breast-milk Substitutes: a common review and evaluation framework (*28*) provides useful guidelines for reviewing and monitoring implementation of the *Code*. Since the adoption of the *Code* in 1981 (see resolution WHA34.22), 162 of WHO's 191 Member States (85%) have reported on their actions to give effect to its aim and principles. These actions include adoption of new, or revision of existing legislation, regulations, codes, guidelines, agreements, and monitoring and reporting mechanisms.

Possible sources of information

Current data on *Code* implementation by country can be obtained from the International Code Documentation Centre of the International Baby Food Action Network (IBFAN) which periodically publishes the *State of the Code by country* report mentioned above (*27*). Information may also be obtained from the local IBFAN office; other groups that have conducted national surveys on *Code* compliance; and/or the WHO Department of Nutrition for Health and Development. Other key sources may include officials of the ministry of health, and staff of the UNICEF and WHO regional offices.

Information sources used *(please list):*……... ... ...

.

Guidelines for scoring	
Criteria	***Score*** *Circle or highlight the statement(s) that apply. If more than one, record the highest score.*
▪ All articles of the *Code* are implemented, monitored and enforced.	10
▪ All articles of the *Code* are implemented and monitored.	8
▪ All articles of the *Code* are implemented.	6
▪ Some articles of the *Code* are implemented.	4
▪ National action has been drafted, awaiting final approval.	2
▪ No action taken/planned or no information.	0
Total score:	……

Additional information, if applicable (not rated)	
Date the *Code* was enacted:	
How and by whom is the *Code* monitored?	
How and by whom is the *Code* enforced?	
Main findings of last monitoring (e.g. progress made, or inadequate practices).	

Guidelines for rating	
Score on criteria for implementation of the *Code*: …… points	
Score	***Rating***
0 – 4	Poor
5 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on implementation of the *Code*:	……..

Conclusions and recommendations
Summarize which aspects of *Code* implementation have been achieved, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

5. Legislation protecting and supporting breastfeeding among working mothers

Question: ***Does legislation meet International Labour Organization (ILO) standards for protecting and supporting breastfeeding among working mothers?***

Background

The *Global Strategy for Infant and Young Child Feeding* calls for adopting and monitoring the application of a policy of maternity entitlements, consistent with the ILO Maternity Protection Convention No.183 (*29*) and recommendations. ILO Convention 183 specifies that women should receive:

- at least 14 weeks of paid maternity leave
- one or more paid breastfeeding breaks daily or a daily reduction of hours of work to breastfeed
- job protection and non-discrimination for breastfeeding workers.

ILO Recommendation 191 specifies that:

- women should receive 16 weeks of paid maternity leave;
- parental leave should be given;
- breastfeeding facilities should be available in the workplace.

Possible sources of information

Interviews can be held with officials of the ministries of health, labour, welfare, or women's affairs, as well as staff of UNICEF, the local ILO office, the local UNFPA office, and NGOs such as IBFAN and the World Alliance for Breastfeeding Action (WABA). Data on ILO conventions and progress in ratifying them in various countries can be requested from the ILO or from the WABA Women and Work Task Force. The text of the Convention can be obtained from the ILO (*29*) or at web site *http://ilolex.ilo.ch:1567/cgi-lex/convde.pl?C183*). The ILO report, *Maternity protection at work*, provides information from various countries, including length of maternity leave, level of cash benefits and who pays for them (*30*).

Information sources used *(please list):*……

……

Guidelines for scoring	
Criteria	***Score*** *Circle or highlight those that apply*
▪ Women covered by the Convention are allowed at least one paid breastfeeding break daily.	1
▪ Women covered by the Convention are allowed at least 14 weeks of paid maternity leave.	2
▪ In the formal sector, national legislation encourages the establishment of breastfeeding rooms or facilities, with adequate, hygienic conditions, at or near the work place.	2
▪ The ILO Maternity Protection Convention (No.183) has been ratified.	1
▪ ILO Convention 183 has been enacted.	1
▪ Legislation prohibits employment discrimination and assures job protection for breastfeeding workers.	1
▪ Measures are in place to protect breastfeeding mothers in atypical forms of work or in the informal workforce.	2
Total score:	…….

Additional information (not rated)
Information on women covered by ILO Maternity Protection Convention 183. ▪ Length of allowed paid maternity leave: …… weeks ▪ Other measures, e.g. crèches, are in place: ☐Yes ☐No If yes, describe: …… ▪ Percentage of pay received during maternity leave: …… %
Describe measures in place to protect breastfeeding mothers in the informal work force.

Guidelines for rating	
Score on criteria for legislation protecting and supporting breastfeeding: …… **points**	
Score	***Rating***
0 – 5	Poor
6 – 7	Fair
8 – 9	Good
10	Very good
Rating on legislation:	……..

Conclusions and recommendations
Summarize which aspects of the legislation are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

Note*:* International Labour Conventions have the legal status of international treaties. The Constitution governs conditions for their drawing up and adoption by a two-thirds majority of Conference delegates. Once adopted, a Convention must be submitted to the competent authorities of each member State for ratification or other appropriate action. At the request of the Governing Body, member States must report on the state of their law and practice within the area covered by a Convention, whether it has been ratified or not. The ratification of a Convention involves a commitment by the member State to render its provisions effective within its national legal system, and to provide information to relevant ILO supervisory mechanisms for this purpose.

International Labour Recommendations do not have the binding force of Conventions, and are not subject to ratification. Often Recommendations are adopted at the same time as Conventions to supplement the latter with additional or more detailed provisions. These provisions enable the underlying principles of the Convention to be set out and stated more precisely, and serve as a guide to national policies.

6. Operational targets of the Global Strategy

Question: ***What progress has been made in planning and implementing strategies to meet the new operational targets of the Global Strategy for Infant and Young Child Feeding?***

Background

The *Global Strategy for Infant and Young Child Feeding* (*1*) – endorsed by the World Health Assembly in May 2002 – both reaffirms the relevance and urgency of the four operational targets of the *Innocenti Declaration* (*4*) and announces five additional operational targets:

- to develop, implement, monitor and evaluate a comprehensive policy on infant and young child feeding, in the context of national policies and programmes for nutrition, child and reproductive health, and poverty reduction;

- to ensure that the health and other relevant sectors protect, promote and support exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require – in the family, community and workplace – to achieve this goal;

- to promote timely, adequate, safe and appropriate complementary feeding with continued breastfeeding;

- to provide guidance on feeding infants and young children in exceptionally difficult circumstances, and on the related support required by mothers, families and other caregivers;

- to consider what new legislation or other suitable measures may be required, as part of a comprehensive policy on infant and young child feeding, to give effect to the principles and aim of the *International Code of Marketing of Breast-milk Substitutes* and to subsequent relevant World Health Assembly (WHA) resolutions.

The achievement of these targets is measured in Part one of this tool through indicators 2, 3 and 5; in Part two through components 4 and 5; and in Part three through components 5, 10 and 11. The criteria below measure progress made in planning to meet these targets.

Possible sources of information

The complete text of the *Global Strategy* is available on web sites *http://www.who.int/gb/EB_WHA/PDF/WHA55/ewha5525.pdf* and *http://www.who.int/gb/EB_WHA/PDF/WHA55/ea5515.pdf*. Discussions concerning national activities related to implementing the *Global Strategy* can be held with the national infant and young child feeding coordinators, chairpersons of national committees, and other officials in the ministries of health, planning and other sectors, as well as with staff of UNICEF, WHO and relevant NGOs.

Information sources used *(please list)*:

……

Guidelines for scoring	
Criteria	***Score*** *Circle or highlight those that apply*
▪ Operational targets that are simple, measurable, achievable and time-oriented have been agreed upon.	2
▪ Progress in meeting each of the operational targets included in the *Global Strategy* has been assessed.	2
▪ A national strategy or action plan for achieving these targets has been developed.	2
▪ The action plan is being implemented.	2
▪ Mechanisms for monitoring and evaluating progress have been developed.	2
Total score:	……..

Guidelines for rating	
Score on criteria for new operational targets: …… **points**	
Score	***Rating***
0 – 2	Poor
3 – 5	Fair
6 – 8	Good
9 – 10	Very good
Rating on planning to meet new operational targets:	……..

Conclusions and recommendations
Summarize which aspects of the plan to meet the new operational targets are in place, and which aspects need further work and why. Identify areas needing further analysis and make recommendations for action.

Summary of achievements related to national infant and young child feeding policies and targets and recommendations

National policies and targets	***Score*** *(out of 10)*	***Rating***
▪ Development of national infant and young child feeding policies.		
▪ Appointment of national breastfeeding or infant and young child feeding coordinators and establishment of national committee(s).		
▪ Baby-friendly Hospital Initiative achievements.	…… %	
▪ Implementation of the *International Code of Marketing of Breast-milk Substitutes.*		
▪ Enactment of legislation protecting and supporting breastfeeding among working mothers.		
▪ Planning and implementing strategies to meet the new operational targets of the *Global Strategy.*		

Summary of conclusions, and recommendations
Summarize achievements related to national policies and targets, indicate which areas still need further work, and make recommendations for action.

INFANT AND YOUNG CHILD FEEDING

A tool for assessing national practices, policies and programmes

Part three

NATIONAL INFANT AND YOUNG CHILD FEEDING PROGRAMME

NATIONAL INFANT AND YOUNG CHILD FEEDING PROGRAMME

Contents

1. National infant and young child feeding programme

Question: ***Is there a national infant and young child feeding programme?***

Background

A national programme focused on infant and young child feeding is necessary if mothers and children are to receive adequate support for optimal breastfeeding and complementary feeding practices. The national programme should also ensure that infants and young children receive required micronutrients through foods or supplements, if necessary (see Annex 5 for more information on micronutrient recommendations). The programme should be managed by a national coordinator.[8] It should also have adequate funding, of which at least part is provided by the government. In some countries all the activities related to this area are organized within one programme. In others, there may be several entities and programmes with responsibilities for its various aspects.

If it is to have maximum impact, it is important that the programme be comprehensive, be an integral part of the health care system, and include strategies for providing support at the regional and local levels. The key aspects of a comprehensive programme are covered in the remaining components or items in this part of the *Tool*.

Possible sources of information

Data can be gathered from the chairperson of the national breastfeeding and/or infant and young child feeding committee; national coordinator(s) of related programmes; officials of the ministry of health; representatives of UNICEF and WHO; and staff of local and international NGOs and/or coordinators of donor agencies.

Information sources used *(please list):* ……..

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ There is an official[9] national infant and young child feeding programme. (It may be one or several programmes focused on breastfeeding, complementary feeding, and micronutrients.)	2	1	0
▪ The national programme has identified targets or measurable objectives that it is mandated to achieve.	2	1	0
▪ The national programme is making progress towards achieving those targets and objectives.	2	1	0
▪ The national programme has adequate[10] funds for its implementation, with at least part of its financial support provided through the government.	2	1	0
▪ The national programme is multisectoral and involves regional and local components, with coordination among existing programmes and initiatives.	2	1	0
Total score:	…….		

[8] This target is specified in the *Innocenti Declaration* and is included in Part two of this tool.

[9] A national programme can be considered "official" if it is formally mentioned in government documents as a national programme and receives some funding and logistical support from the government. It is "national" if it is officially designated as national in scope, even if 100% of the relevant population is not yet benefiting from it.

[10] Funds can be considered "adequate" if they are sufficient to implement most of the activities in the national programme for infant and young child feeding.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
List national programme(s), the strategies and activities related to IYCF that are included, and their coverage.	
Document(s) describing the national programme(s) if available.	
Name and title of the national coordinator(s).	
Level and time period of funding available nationally, regionally, and locally for related IYCF activities.	

Guidelines for rating	
Score on criteria for national infant and child feeding programme: …… **points**	
Score	***Rating***
0 – 4	Poor
5 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on national programme:	……..

Conclusions and recommendations
Summarize which aspects of the national programme are good and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

2. An active and sustainable Baby-friendly Hospital Initiative

Question: ***Is there an active and sustainable Baby-friendly Hospital Initiative?***

Background

The *Innocenti Declaration* (*4*) calls for all facilities offering maternity care to implement the *Ten steps to successful breastfeeding* (*12*). Many countries have taken part in the Baby-friendly Hospital Initiative (BFHI) – indicator 3 in Part two of this tool assesses the percentage of hospitals so designated. To have a lasting impact, it is important that the BFHI become integrated within the health care system, and actively continue to train new maternity staff, assess additional health facilities, monitor and/or reassess designated facilities, and provide technical support when improvements are needed. National decision-makers may also consider expanding the Initiative to cover other health facilities, such as private hospitals and health or MCH centres, if they include maternity services.

Possible sources of information

Interviews can be held with the national breastfeeding coordinator, the BFHI coordinator, or equivalent in the ministry of health; BFHI national or regional trainers; UNICEF and WHO officials; breastfeeding management experts; and staff of NGOs that support the BFHI. Review any summary reports on status of the BFHI, including numbers (and percentages) of hospitals declared "baby-friendly". Refer to the latest status report on BFHI prepared by UNICEF Headquarters for official figures reported by countries.

Information sources used *(please list):* .....

……...

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ A national BFHI coordinator or equivalent is working within the official health care system structure, on at least a half-time basis, to implement the Initiative.	1	0.5	0
▪ A national BFHI training programme has provided training or refresher training in the past year.	2	1	0
▪ Members of the national training team are replaced, as needed, and receive refresher training.	1	0.5	0
▪ Health facilities are assessed within 12 months of being ready.	2	1	0
▪ When needed, facilities are assisted in making improvements to implement fully the *Ten steps*.	1	0.5	0
▪ "Baby-friendly" hospitals are currently being monitored or reassessed within five years of designation, or are being reassessed regularly as part of a national quality assurance, quality of care, or hospital accreditation programme.	2	1	0
▪ The BFHI has been integrated within the national health care system and receives adequate resources to sustain it.	1	0.5	0
Total score:	…….		

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Describe BFHI training, refresher training, and assessment activities during the past year.	
Describe the process for monitoring or reassessing "baby-friendly" facilities.	
Indicate which other health facilities or services are encouraged to follow the BFHI *Steps* that apply.	☐ private hospitals ☐ health or MCH centres ☐ prenatal services ☐ home births ☐ other (*describe*): ……
If there are problems in sustaining BFHI, indicate the key obstacles.	

Guidelines for rating	
Score on criteria for an active and sustainable BFHI: …… **points**	
Score	***Rating***
0 – 4	Poor
5 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on an active and sustainable BHFI:	……..

Conclusions and recommendations
Summarize which aspects of the Baby-friendly Hospital Initiative are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

3. Mother-friendly childbirth strategies

Question: ***Has a mother-friendly childbirth or safe motherhood strategy (or equivalent) been implemented, which encourages birth procedures that are supportive of breastfeeding?***

Background

A technical meeting convened in Fortaleza, Brazil in 1985 made a number of recommendations for appropriate birth procedures (*31*). These recommendations address issues of caring and respect for the mother, as well as the use of appropriate birth technology which minimizes invasive procedures in order to preserve the normalcy of birth and support the early initiation of breastfeeding. The 1989 joint WHO/UNICEF statement on *Protecting, promoting and supporting breastfeeding: the special role of maternity services* (*12*) includes a section on care of the mother during labour, delivery, and immediate postpartum. Also discussed are the routines and procedures (support in labour, minimizing invasive routines and medications) which best support breastfeeding. In 2001, the WABA, through its *Global Initiative on Mother Support*, called for "support to mothers during pregnancy, labour and delivery . . ." and ". . . transformation of birthing practices that affect breastfeeding into those that are more human and gender sensitive . . ." (*32*).

Possible sources of information

Interviews can be held with ministry of health officials, especially those responsible for safe motherhood or maternal and child health activities; the national IYCF coordinator; administrators and staff of maternity services and birth centres; staff of professional associations and NGOs; and representatives of UNICEF and WHO. Discussions concerning guidelines for home-birth attendants can be held with leaders of traditional birth attendant associations, trained midwives who work with home-birth attendants, and others. If possible, conduct observations and informal interviews with health personnel and home-birth attendants who deliver babies.

Information sources used *(please list):* .....

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ A national mother-friendly childbirth strategy[11] has been developed.	2	1	0
▪ An initiative or programme promotes appropriate mother-friendly birth procedures supportive of breastfeeding. (See Annex 6 for an example of criteria for mother-friendly care.)	2	1	0
▪ A national coordinator or other programme official is responsible for promoting birth procedures supportive of breastfeeding.	2	1	0
▪ Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care.	2	1	0
▪ Health personnel involved in health-facility births, and home-birth attendants are trained in "mother-friendly" practices.	2	1	0
Total score:	.....		

[11] The strategy for promoting mother-friendly childbirth supportive of breastfeeding may be organized in various ways. For example, it may be included in a country's safe motherhood programme, a mother-friendly or mother-baby-friendly initiative, or a reproductive health programme. See WHO, *Care in normal birth: a practical guide* (*33*) for suggestions regarding appropriate care.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Name of national coordinator for mother-friendly initiative (or equivalent).	
Describe the key components of the mother-friendly initiative (or equivalent).	
Describe the type of training given on mother-friendly practices; who provides it, and who receives it.	
Indicate any key challenges to developing and implementing an effective mother-friendly childbirth strategy.	

Guidelines for rating	
Score on criteria for mother-friendly childbirth strategies: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on mother-friendly childbirth strategies:	……..

Conclusions and recommendations
Summarize which aspects of mother-friendly childbirth strategies are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

4. Health care provider (pre-service) education

Question: ***Do the curricula or session plans of medical, nursing, midwifery, allied/public health, and nutrition education programmes provide students with the attitudes, knowledge and skills necessary to protect, promote, and support optimal breastfeeding and complementary feeding?***

Background

New graduates of health care provider programmes should be able to promote optimal breastfeeding and complementary feeding practices from the outset of their careers. All health care providers who interact with mothers and their young children should attain the basic attitudes, knowledge and skills necessary to integrate into their care breastfeeding, lactation management, and infant and young child feeding principles. Since the topics lend themselves to courses covering the human life cycle in both basic and applied sciences, the overall education programme in these fields should be reviewed.

Possible sources of information

Interviews can be held with officials of the ministries of health and education; human resource personnel; specialists in infant feeding management (such as Wellstart Associates, graduates of the Institute of Child Health, IBFAN trainers); representatives of WHO; staff of other donor-funded projects involved in curriculum review and reform; and school or programme faculty, administrators and graduates. Review curricula or session plans for appropriate departments in each school. Ask for written curricula. (Annex 7*,* Education checklist, can be used to judge whether infant and young child feeding learning objectives and content are adequate.)

Information sources used *(please list):* .....

Guidelines for scoring *(Please fill out "Additional information" worksheet on next page before scoring)*			
Criteria	*Circle or highlight one number in each row*		
A review of health care provider schools and pre-service education programmes in your country[12] indicates that infant and young child feeding curricula or session plans are adequate (see Annex 7) in "all", "some" or "none" of the:	***All***	***Some***	***None***
▪ medical schools	2	1	0
▪ nursing schools	2	1	0
▪ midwifery education programmes	2	1	0
▪ allied/public health education programmes	2	1	0
▪ nutrition/dietetic education programmes.	2	1	0
Total score:	……..		

[12] Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. The departments responsible for teaching the various topics within the various schools 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.

Additional information (not rated) *(Adapt the form if reporting on more than one of each type of school, programme or department)*						
Type of school or education programme	***Name of school***	***Department or programme (paediatrics, obstetrics, etc.)***	***Curriculum or session plans are adequate* in***			
			Breastfeeding		***Complementary feeding***	
			Yes	***No***	***Yes***	***No***
Medical						
Nursing						
Midwifery						
Allied/public health						
Nutrition						

* See Annex 7 for a list of key topics that should be covered by the curriculum as a whole.

Guidelines for rating	
Score on criteria for health care provider (pre-service) education: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on health care provider (pre-service) education:	……..

Conclusions and recommendations
Summarize which aspects of health care provider education are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

5. In-service training for health care providers

Question: ***Do in-service training or continuing education programmes for health care providers update their knowledge and skills related to infant and young child feeding?***

Background

Scientific and behavioural research is constantly adding new knowledge to the field of infant and young child feeding. In-service training courses will help to ensure that practitioners remain current. In addition, until preparatory programmes strengthen their teaching content (see Section 4, Health care provider (pre-service) education) some 'remedial' courses will be necessary. Governmental programmes and departments, NGOs and donor-funded projects may provide continuing education programmes.

Possible sources of information

Interviews can be held with officials of the ministries of health and education; directors of national training centres; managers and/or trainers of relevant continuing education programmes; and directors and deputy directors of NGOs that include training in their scope of work. If possible, review course and workshop teaching content and the percentage of time allocated to the clinical or practical sessions. (See Annex 7, Education checklist, for points to consider when reviewing whether various curricula cover essential content.)

Information sources used *(please list):* .....

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ In-service training programmes provide knowledge and skills related to infant and young child feeding for relevant health care providers.[13]	2	1	0
▪ In-service training programmes are provided throughout the country.[14]	2	1	0
▪ Training programmes cover most of the essential topics related to infant and young child feeding (see Annex 7).	2	1	0
▪ Clinical and counselling skills needed on the job are integrated into the content of the training programmes.	1	0.5	0
▪ Clinical and counselling skills are allotted at least 30% of training time.	1	0.5	0
▪ Content and skills related to infant and young child feeding are integrated, as appropriate, into training programmes focusing on relevant topics (including diarrhoeal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the International Code of Marketing of Breast-milk Substitutes, HIV/AIDS).	1	0.5	0
▪ Training programmes cover infant and young child feeding for most relevant community-based health practitioners, including traditional practitioners.	1	0.5	0
Total score:	……..		

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

[14] 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.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*					
Training programmes and centres* providing training on IYCF	***Courses with IYCF content***	***Content related to IYCF in each course***	***% content focused on clinical/ practical skills***	***Number and types of staff who would benefit from each course***	***Number and types of staff who have completed each course during past 12 months***

* These can include training programmes and centres organized either by the government or by NGOs.

Guidelines for rating	
Score on criteria for in-service training for health care providers: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on in-service training for health care providers:	……..

Conclusions and recommendations
Summarize which aspects of in-service training are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

6. Community outreach and support

Question: ***Are community outreach and support mechanisms in place to protect, promote and support optimal infant and young child feeding?***

Background

Community outreach and support is an essential component of a comprehensive national infant and young child feeding programme. Community outreach and support activities related to breastfeeding and complementary feeding may be health-facility based (as called for in Step 10 of the BFHI) and/or community-based. They can also be integrated into existing non-health activities, where appropriate. These may include individual counselling, group counselling, community health education, cooking demonstrations, provision of mother-to-mother support, activities in women's groups/clubs, trials of new feeding practices, and positive deviance discussion groups.[15] Community support activities should ideally include not only mothers, but also fathers, grandmothers and other family decision-makers. (See Annex 8 for more suggestions regarding possible contact points, channels and community outreach and support activities.)

Possible sources of information

Discussions can be held with officials of the ministries of health, social welfare, and women's affairs, or any government organization involved in social welfare; the national breastfeeding and/or infant and young child feeding coordinator; representatives of mother-support group organizations, such as La Leche League; and representatives of relevant NGOs (health and non-health).

Information sources used *(please list): .....*

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ Health facility based community outreach and support activities related to infant and young child feeding (IYCF) are being implemented (at least two of the activities listed in Annex 8*).*	2	1	0
▪ Health facility based community outreach and support activities related to IYCF have national (or regional) coverage.[16]	2	1	0
▪ Community-based IYCF outreach and support activities are being implemented (at least two of the activities listed in Annex 8*).*	2	1	0
▪ Community-based IYCF outreach and support activities have national (or regional) coverage.[16]	2	1	0
▪ Non-health organizations (e.g. agricultural extension, education, credit groups) are conducting IYCF outreach and support activities at the community level.	1	0.5	0
▪ IYCF community outreach and support activities are integrated into an overall infant and child health strategy (intersectoral and intrasectoral).	1	0.5	0
Total score:	……...		

[15] Positive deviants are children who grow and develop adequately in low-income families living in impoverished environments, where a majority of children suffer from growth retardation and malnutrition (*34*).

[16] Define the minimal geographic or political unit that will be considered for coverage, e.g. district, municipality, etc. National (or regional) coverage would be when at least some community outreach and support activities are conducted in each one of these defined units.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*			
Outreach or support activity or programme (health or non-health)	***Implementing organization***	***Activities or content related to infant and young child feeding***	***Level of coverage achieved (%)***

Guidelines for rating	
Score on criteria for community outreach and support: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on community outreach and support:	……..

Conclusions and recommendations
Summarize which aspects of community outreach and support are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

7. Information, education and communication

Question: ***Are comprehensive information, education and communication strategies being implemented for improving infant and young child feeding?***

Background

Information, education and communication (IEC) strategies are critical aspects of a comprehensive programme to improve infant and young child feeding practices. These approaches may include the use of electronic media (TV, radio, video), print (posters, counselling cards, flip charts, manuals, newspapers, magazines), interpersonal skills (counselling, group education, support groups) and community activities, to communicate important information and motivational material to mothers, families and the community. Behavioural change is an important interpersonal strategy, often used in counselling sessions, home visits, action-oriented group discussions and dramas focused on problem solving. Comprehensive IEC strategies use a wide variety of media and channels to convey concise, consistent, appropriate, action-oriented and correct messages to targeted audiences at national, facility, community and family levels.

Possible sources of information

Interviews can be held with representatives of national communication or information agencies; national TV and radio stations; officials of the ministry of health, such as the national breastfeeding and/or infant and young child feeding coordinator, the communications officer or coordinator, and health education officers; officials of the ministry of social welfare; and representatives of UNICEF, WHO and NGOs. Consider reviewing samples of electronic media spots and printed material, and observing counselling, education and community media events.

Information sources used *(please list):* .....

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ There is a comprehensive national IEC strategy for improving IYCF.	2	1	0
▪ A national IEC campaign or programme[17] using electronic, print and event media and activities has channelled messages on infant and young child feeding to targeted audiences during the past 12 months.	1	0.5	0
▪ IEC programmes (either governmental or nongovernmental) that include infant and young child feeding issues are being actively implemented at both regional and local levels.	1	0.5	0
▪ Individual counselling and group education services related to IYCF are available within the health care system or through community outreach.	2	1	0
▪ The content of IEC messages is technically and clinically sound, based on national or international guidelines.	2	1	0
▪ The focus and wording of messages is based on formative research and pretested with target audiences before use.	1	0.5	0
▪ A mechanism is in place, involving all major players, to assure that IEC messages provided through electronic, print and event media as well as education and counselling activities, are coordinated and consistent.	1	0.5	0
Total score:	.....		

[17] An IEC campaign or programme is considered "national" if its messages can be received by the target audience in all major geographical or political units in the country (e.g. regions or districts).

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*			
Media activities	***Producer/sponsor***	***Timing***	***Content related to IYCF***
Counselling and education services	***Where available***	***Who delivers***	***Content related to IYCF***
Describe mechanisms in place, if any, for assuring the coordination and consistency of IEC messages provided through the media, education, and counselling.			

Guidelines for rating	
Score on criteria for information, education and communication: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on information, education and communication:	……..

Conclusions and recommendations
Summarize which aspects of the IEC programme are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

8. Contraceptive support for breastfeeding women

Question: ***Do relevant policies and programmes provide contraceptive support for breastfeeding women?***

Background

Breastfeeding women have a choice of short-term, long-term or permanent contraceptive methods to fit their needs. The Lactational Amenorrhoea Method (LAM) is a modern contraceptive method that uses a pattern of breastfeeding that can effectively suppress ovulation and prevent pregnancy provided that the following stipulated three criteria are met: (1) the woman's menstrual periods have not resumed; (2) the baby is fully or nearly fully breastfed frequently day and night; and (3) the baby is less than six months old. The choice of LAM as the contraceptive method reinforces optimal breastfeeding practices. It is very important to ask the woman who is seeking contraceptive counselling whether she is breastfeeding at present.

Contraceptive methods are safe to use during breastfeeding. However, estrogen-containing pills or estrogen-containing injections may decrease the quantity or quality of breast milk and are not recommended before six months postpartum. Progestogen-only methods are recommended at six weeks postpartum when lactation is well established. Other barrier methods, such as diaphragms and cervical caps, need to be refitted at six weeks postpartum.

Possible sources of information

Interviews can be held with key officials in relevant government ministries (e.g. population, health); staff of international and local family planning NGOs, agencies and donors; and with staff of maternal and child health (MCH) and breastfeeding programmes. If possible, review protocols or guidelines for contraceptive choice and family planning counselling, and the family planning data collection system, as well as guidelines or curricula for breastfeeding training.

Information sources used *(please list):* ……..

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ Family planning and MCH policies include standards and guidelines for providing breastfeeding women with adequate advice concerning contraceptive methods, including LAM, and their effects on lactation.	2	1	0
▪ Family planning and MCH counsellors and care providers receive adequate training on these guidelines.	2	1	0
▪ Family planning and MCH programmes provide guidance and support for breastfeeding women concerning contraceptive methods, including LAM. (See Annex 9 for details.)	2	1	0
▪ Contraceptive methods for breastfeeding women are addressed in breastfeeding education and counselling sessions both at the community and health facility levels.	2	1	0
▪ Data on LAM rate (number of clients using LAM as family planning method/number of clients with infants < 6 months) are among the statistics routinely collected and reported by the national family planning programme.	2	1	0
Total score:	……..		

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*		
Family planning and MCH programmes that address contraceptive needs of breastfeeding women	***Implementing organizations***	***Types of support provided*** (*including provider training, and contraceptive counselling and services for breastfeeding women*)

Guidelines for rating	
Score on criteria for contraceptive support for breastfeeding women: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on contraceptive support for breastfeeding women:	……..

Conclusions and recommendations
Summarize which aspects of contraceptive support for breastfeeding women are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

9. HIV and infant feeding

Question: ***Do relevant policies and programmes ensure that mothers with HIV are informed about the risks and benefits of different infant feeding options and supported in their infant feeding decisions?***

Background

The risk of HIV transmission through breastfeeding presents a difficult dilemma to policy-makers, infant feeding counsellors and mothers. They must balance the risks of artificial feeding against the risk of HIV transmission through breastfeeding. These risks are dependent on the age of the infant and household conditions. At the same time, other factors must be considered such as the risk of stigmatization (not breastfeeding may signal the mother's HIV status), the financial costs of replacement feeding, and the risk of becoming pregnant again. Policies and programmes to meet this challenge should provide access to HIV testing and counselling (VCT). Counselling on infant feeding options should be available to HIV-positive mothers. The content of counselling programmes should be refined based on local formative research. Safeguards should be in place to protect, promote and support breastfeeding in the rest of the population.

Possible sources of information

Information on the availability and uptake of VCT among pregnant women and on the content and availability of infant feeding counselling should be available from the national AIDS control programme (or equivalent), and the departments of nutrition, maternal and child health, and/or reproductive health within the ministry of health. International recommendations related to HIV and infant feeding are available from UNAIDS, UNICEF and WHO (*35*–*39*) and other sources (*40*–*42*).

Information sources used *(please list):* ……..….

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers, and how to provide counselling and support.	1	0.5	0
▪ Antenatal VCT is available and offered routinely to pregnant women and, where possible, to their partners.	2	1	0
▪ Locally appropriate infant feeding counselling in line with current international recommendations is provided to HIV-positive mothers. (See Annex 10, HIV and infant feeding recommendations.)	2	1	0
▪ Mothers are supported in their infant feeding decisions with further counselling and follow-up to make these decisions as safe as possible.	2	1	0
▪ Special efforts are made to counter misinformation on HIV and infant feeding and to protect, promote, and support breastfeeding in the general population.	1	0.5	0
▪ Ongoing monitoring is in place to determine the effects of interventions to prevent HIV transmission upon infant feeding practices and health outcomes for mothers and infants – including those who are HIV-negative or of unknown status ("spillover effect").	1	0.5	0
▪ In settings with high HIV prevalence, the national Baby-friendly Hospital Initiative provides guidance to hospital administrators and staff on how to assess the needs of, and provide support to HIV-positive mothers.	1	0.5	0
Total score:	…….		

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Describe existing HIV and infant feeding policies and guidelines, when they were developed, and what they cover.	
If commercial infant formula is distributed to HIV-positive mothers, describe how it is procured.	
Describe who is covered by antenatal activities to prevent mother-to-child transmission (MTCT), what activities are included, and where these take place.	
Describe the training and job aids provided for health workers in support of their counselling of mothers on HIV and infant feeding, and indicate who provides the training.	

Guidelines for rating	
Score on criteria for HIV and infant feeding: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on HIV and infant feeding:	

Conclusions and recommendations
Summarize which aspects of HIV and infant feeding programming are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

10. Infant and young child feeding in emergencies

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

Background

Infants and young children are among the most vulnerable groups in emergencies. Interruption of breastfeeding and inappropriate complementary feeding increase the risks of malnutrition, illness and mortality. In emergency and relief situations the responsibility for protecting, promoting and supporting beneficial infant and young child feeding practices and minimizing harmful practices should be shared by the emergency-affected host country and responding agencies. Concise guidance on how to facilitate appropriate feeding in emergency situations and comply with international emergency standards has been developed by interagency expert working groups. Practical details on how to implement the guidance are included in companion training materials, also developed through interagency collaboration. (See Annex 11 for a list of such training materials.)

Possible sources of information

Information on policy and guideline development and the implementation of preparedness activities can be obtained from the designated staff of the national health and nutrition programmes responsible for emergency preparedness and response. (See Annex 11 for a detailed list of the criteria necessary to protect, promote and provide support for appropriate infant and young child feeding practices during emergencies. This list provides useful references and information to assist in scoring the criteria presented below).

Information sources used *(please list):* ……...

……

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ A policy that addresses key issues related to infant and young child feeding in emergencies has been endorsed or developed.	3	1.5	0
▪ Person(s) have been appointed who are tasked with responsibility for national coordination with the United Nations, donor agencies, the military and NGOs regarding infant and young child feeding in emergency situations.	2	1	0
▪ A contingency plan has been developed to undertake activities to facilitate exclusive breastfeeding and appropriate complementary feeding and to minimize the risk of artificial feeding, and resources have been identified for implementation of the plan during emergencies.	3	1.5	0
▪ Appropriate material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.	2	1	0
Total score:	……		

Guidelines for rating	
Score on criteria for emergency preparedness: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 5	Fair
6 – 8	Good
9 – 10	Very good
Rating on emergency preparedness:	……..

Conclusions and recommendations
Summarize which aspects of emergency preparedness are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

11. Research for decision-making

Question: ***Are research studies conducted on priority topics and results used to improve infant and young child feeding practices?***

Background

The effectiveness of policy and programme decisions can be greatly enhanced if policy-makers, managers, and staff have access to up-to-date information on the issues and strategies being considered. Well-designed and timely research can provide some of the information needed. The research itself may be conducted by staff of the national programme, a university faculty, research organizations, or by independent researchers. It is important that an inventory be made of research pertinent to the programme, if not already available.

Priority needs for information should be identified at the national level and mechanisms developed for dissemination, review, and utilization of research results and other information to guide policy and programme decisions. If the country has few resources for supporting research, it may decide to rely, whenever feasible, on the use of existing information (either domestic or international) and, when necessary, apply for support from donor agencies for priority studies.

Possible sources of information

Interviews can be held with research managers, key researchers, national breastfeeding and/or infant and young child feeding committee members, those who fund research, and decision-makers and managers responsible for the various infant and young child feeding programmes. Interviews can also be held with staff of NGOs, organizations such as UNICEF, USAID and WHO, and others who may support or conduct research. Review any research inventories and major research reports that are available.

Information sources used *(please list):* ……..

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ A national research advisory group or body provides guidance on research in the area of infant and young child feeding.	1	0.5	0
▪ A national inventory of applied and basic research on key topics related to IYCF has been developed or updated within the past three years.	1	0.5	0
▪ Priority needs for infant and young child feeding related information are identified by the national breastfeeding and/or infant and young child feeding committee or an appropriate research advisory group.	1	0.5	0
▪ Needed information is gathered, when feasible, from existing studies and other data sources (either domestic or international).	2	1	0
▪ Research on priority topics is financed by the national infant and young child feeding programme and/or by other appropriate donors.	2	1	0
▪ Research results are routinely disseminated to key decision-makers.[18]	1	0.5	0
▪ Research results are used to guide policy and programme decisions as part of the planning and management process.	2	1	0
Total score:	……..		

[18] Decision-makers include policy-makers and programme managers who make decisions about infant and young child feeding policies and/or programmes.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Title of inventory of research related to infant and young child feeding (if one exists).	
Organizations or agencies funding infant and young child feeding related research.	
Mechanisms used for disseminating research results to decision-makers.	

Guidelines for rating	
Score on criteria for research for decision-making: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on research for decision-making:	……..

Conclusions and recommendations
Summarize which aspects of research for decision-making are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

12. Monitoring and evaluation

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

Background

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

When appropriate, both baseline and follow-up data should be collected to measure outcomes. In an effort to increase availability of comparable data, use of internationally-agreed indicators and data collection strategies should be considered.[19] It is important that strategies be devised to help ensure that key decision-makers receive significant evaluation results and are encouraged to use them.

Possible sources of information

Interviews can be held with officials, programme managers, and/or evaluation specialists overseeing or conducting monitoring and evaluation activities within the national infant and young child feeding programme. Staff who conduct surveys such as the *Demographic and Health Survey* (or a similar national survey) can also provide information. Review any major evaluation reports that are available. Talk with key decision-makers who should receive and use monitoring and evaluation results.

Information sources used *(please list)*: ……..

Guidelines for scoring			
Criteria	*Circle or highlight one score in each row*		
	Yes	***To some degree***	***No***
▪ Monitoring and evaluation components are built into major infant and young child feeding programme activities.	2	1	0
▪ Monitoring or MIS data are considered by programme managers as part of the planning and management process.	2	1	0
▪ Adequate baseline and follow-up data are collected to measure outcomes of major infant and young child feeding programme activities.	2	1	0
▪ Evaluation results related to major infant and young child feeding programme activities are reported to key decision-makers, both at national and regional/local levels.	2	1	0
▪ Monitoring of key infant and young child feeding practices is built into a broader nutritional surveillance and/or health monitoring system, or into periodic national health surveys.	2	1	0
Total score:	……..		

[19] See the WHO report on *Indicators for assessing breastfeeding practices* (*2*) for suggestions concerning breastfeeding indicators and data collection strategies. WHO is in the process of considering appropriate indicators for measuring complementary feeding practices.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Major IYCF programmes that have monitoring and evaluation components, and what they include.	
Programmes for which baseline and follow-up data are collected and types of data collected.	
Decision-makers who regularly receive evaluation results related to IYCF, and who provides those results.	

Guidelines for rating	
Score on criteria for monitoring and evaluation: …… **points**	
Score	***Rating***
0 – 3	Poor
4 – 6	Fair
7 – 8	Good
9 – 10	Very good
Rating on monitoring and evaluation:	……

Conclusions and recommendations
Summarize which aspects of monitoring and evaluation are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

Summary of achievements related to programme components

Programme components	*Score (out of 10)*	*Rating*
1. National infant and young child feeding programme		
2. An active and sustainable Baby-friendly Hospital Initiative		
3. Mother-friendly childbirth strategies		
4. Health care provider (pre-service) education		
5. In-service training for health care providers		
6. Community outreach and support		
7 Information, education and communication		
8. Contraceptive support for breastfeeding women		
9. HIV and infant feeding		
10. Infant and young child feeding in emergencies		
11. Research for decision-making		
12. Monitoring and evaluation		

Summary of conclusions and recommendations
Summarize the achievements on the various programme components, indicate which areas still need further work, and make recommendations for action.

INFANT AND YOUNG CHILD FEEDING

A tool for assessing national practices, policies and programmes

Part three

NATIONAL INFANT AND YOUNG CHILD FEEDING PROGRAMME

Alternative checklist version

NATIONAL INFANT AND YOUNG CHILD FEEDING PROGRAMME

Contents

1. National infant and young child feeding programme

Question: ***Is there a national infant and young child feeding programme?***

Background

A national programme focused on infant and young child feeding is necessary if mothers and children are to receive adequate support for optimal breastfeeding and complementary feeding practices. The national programme should also ensure that infants and young children receive required micronutrients through foods or supplements, if necessary (see Annex 5 for more information on micronutrient recommendations). The programme should be managed by a national coordinator.[20] It should also have adequate funding, of which at least part is provided by the government. In some countries all the activities related to this area are organized within one programme. In others, there may be several entities and programmes with responsibilities for its various aspects.

If it is to have maximum impact, it is important that the programme be comprehensive, be an integral part of the health care system, and include strategies for providing support at the regional and local levels The key aspects of a comprehensive programme are covered in the remaining components or items in this part of the *Tool*.

Possible sources of information

Data can be gathered from the chairperson of the national breastfeeding and/or the infant and young child feeding committee; national coordinator(s) of related programmes; officials of the ministry of health; representatives of UNICEF and WHO; and staff of local and international NGOs and/or coordinators of donor agencies.

Information sources used *(please list):*……

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ There is an official[21] national infant and young child feeding programme. (It may be one or several programmes focused on breastfeeding, complementary feeding, and micronutrients.)			
▪ The national programme has identified targets or measurable objectives that it is mandated to achieve.			
▪ The national programme is making progress towards achieving those targets and objectives.			
▪ The national programme has adequate[22] funds for its implementation, with at least part of its financial support provided through the government.			
▪ The national programme is multisectoral and involves regional and local components, with coordination among existing programmes and initiatives.			

[20] This target is specified in the *Innocenti Declaration* and is included in Part two of this tool.

[21] A national programme can be considered "official" if it is formally mentioned in government documents as a national programme and receives some funding and logistical support from the government. It is "national" if it is officially designated as national in scope, even if 100% of the relevant population is not yet benefiting from it.

[22] Funds can be considered "adequate" if they are sufficient to implement most of the activities in the national programme for infant and young child feeding.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
List national programme(s), the strategies and activities related to IYCF that are included, and their coverage.	
Document(s) describing the national programme(s) if available.	
Name and title of the national coordinator(s).	
Level and time period of funding available nationally, regionally, and locally for related IYCF activities.	

Conclusions and recommendations
Summarize which aspects of the national programme are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

2. An active and sustainable Baby-friendly Hospital Initiative

Question: ***Is there an active and sustainable Baby-friendly Hospital Initiative?***

Background

The *Innocenti Declaration* (*4*) calls for all facilities offering maternity care to implement the *Ten steps to successful breastfeeding* (*12*). Many countries have taken part in the Baby-friendly Hospital Initiative (BFHI) – indicator 3 in Part two of this tool assesses the percentage of hospitals so designated. To have a lasting impact, it is important that the BFHI become integrated within the health care system, and actively continue to train new maternity staff, assess additional health facilities, monitor and/or reassess designated facilities and provide technical support when improvements are needed. National decision-makers may also consider expanding the Initiative to cover other health facilities, such as private hospitals and health or MCH centres, if they include maternity services.

Possible sources of information

Interviews can be held with the national breastfeeding coordinator, the BFHI coordinator, or equivalent in the ministry of health; BFHI national or regional trainers; UNICEF and WHO officials; breastfeeding management experts; and staff of NGOs that support the BFHI. Review any summary reports on status of the BFHI, including numbers (and percentages) of hospitals declared "baby-friendly". Refer to the latest status report on BFHI prepared by UNICEF Headquarters for official figures reported by countries.

Information sources used *(please list):* .....

.....

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ A national BFHI coordinator or equivalent is working within the official health care system structure, on at least a half-time basis, to implement the Initiative.			
▪ A national BFHI training programme has provided training or refresher training in the past year.			
▪ Members of the national training team are replaced, as needed, and receive refresher training.			
▪ Health facilities are assessed within 12 months of being ready.			
▪ When needed, facilities are assisted in making improvements to implement fully the *Ten steps*.			
▪ "Baby-friendly" hospitals are currently being monitored or reassessed within five years of designation, or are being reassessed regularly as part of a national quality assurance, quality of care, or hospital accreditation programme.			
▪ The BFHI has been integrated within the national health care system and receives adequate resources to sustain it.			

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Describe BFHI training, refresher training, and assessment activities during the past year.	
Describe the process for monitoring or reassessing "baby-friendly" facilities.	
Indicate which other health facilities or services are encouraged to follow the BFHI S*teps* that apply.	☐ private hospitals ☐ health or MCH centres ☐ prenatal services ☐ home births ☐ other (*describe*) ……
If there are problems in sustaining BFHI, indicate the key obstacles.	

Conclusions and recommendations
Summarize which aspects of the Baby-friendly Hospital Initiative are good, and which aspects need improvement and why. Identify areas needing further analysis and recommendations for action.

3. Mother-friendly childbirth strategies

Question: ***Has a mother-friendly childbirth or safe motherhood strategy (or equivalent) been implemented, which encourages birth procedures that are supportive of breastfeeding?***

Background

A technical meeting convened in Fortaleza, Brazil in 1985 made a number of recommendations for appropriate birth procedures (*31*). These recommendations address issues of caring and respect for the mother, as well as the use of appropriate birth technology which minimizes invasive procedures in order to preserve the normalcy of birth and support the early initiation of breastfeeding. The 1989 joint WHO/UNICEF statement on *Protecting, promoting and supporting breastfeeding: the special role of maternity services* (*12*) includes a section on care of the mother during labour, delivery, and immediate postpartum. Also discussed are the routines and procedures (support in labour, minimizing invasive routines and medications) which best support breastfeeding. In 2001, the WABA, through its *Global Initiative on Mother Support*, called for "support to mothers during pregnancy, labour and delivery . . ." and ". . . transformation of birthing practices that affect breastfeeding into those that are more human and gender sensitive . . ." (*32*).

Possible sources of information

Interviews can be held with ministry of health officials, especially those responsible for safe motherhood or maternal and child health activities; the national IYCF coordinator; administrators and staff of maternity services and birth centres; staff of professional associations and NGOs; and representatives of UNICEF and WHO. Discussions concerning guidelines for home-birth attendants can be held with leaders of traditional birth attendant associations, trained midwives who work with home-birth attendants, and others. If possible, conduct observations and informal interviews with health personnel and home-birth attendants who deliver babies.

Information sources used *(please list):* .....

……..

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ A national mother-friendly childbirth strategy[23] has been developed.			
▪ An initiative or programme promotes appropriate mother-friendly birth procedures supportive of breastfeeding. (See Annex 6 for an example of criteria for mother-friendly care.)			
▪ A national coordinator or other programme official is responsible for promoting birth procedures supportive of breastfeeding.			
▪ Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care.			
▪ Health personnel involved in health-facility births and home-birth attendants are trained in "mother-friendly" practices.			

[23] The strategy for promoting mother-friendly childbirth supportive of breastfeeding may be organized in various ways. For example, it may be included in a country's safe motherhood programme, a mother-friendly or mother-baby-friendly initiative, or a reproductive health programme. See WHO, *Care in normal birth: a practical guide* (*33*) for suggestions regarding appropriate care.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Name of national coordinator for mother-friendly initiative (or equivalent).	
Describe the key components of the mother-friendly initiative (or equivalent).	
Describe the type of training given on mother-friendly practices; who provides it, and who receives it.	
Indicate any key challenges to developing and implementing an effective mother-friendly childbirth strategy.	

Conclusions and recommendations
Summarize which aspects of mother-friendly childbirth strategies are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

4. Health care provider (pre-service) education

Question: ***Do the curricula or session plans of medical, nursing, midwifery, allied/public health, and nutrition education programmes provide students with the attitudes, knowledge and skills necessary to protect, promote, and support optimal breastfeeding and complementary feeding?***

Background

New graduates of health care provider programmes should be able to promote optimal breastfeeding and complementary feeding practices from the outset of their careers. All health care providers who interact with mothers and their young children should attain the basic attitudes, knowledge and skills necessary to integrate into their care breastfeeding, lactation management, and infant and young child feeding principles. Since the topics lend themselves to courses covering the human life cycle in both basic and applied sciences, the overall education programme in these fields should be reviewed.

Possible sources of information

Interviews can be held with officals of the ministries of health and education; human resource personnel; specialists in infant feeding management (such as Wellstart Associates, graduates of the Institute of Child Health, IBFAN trainers); representatives of WHO; staff of other donor-funded projects involved in curriculum review and reform; and school or programme faculty, administrators and graduates. Review curricula or session plans for appropriate departments in each school. Ask for written curricula. (Annex 7*,* Education checklist, can be used to judge whether infant and young child feeding learning objectives and content are adequate.)

Information sources used *(please list):* .....

Checklist			
Criteria	*Check the category that applies*		
A review of health care provider schools and pre-service education programmes in your country[24] indicates that infant and young child feeding curricula or session plans are adequate (see Annex 7) in "all", "some" or "none" of the:	***All***	***Some***	***None***
▪ medical schools			
▪ nursing schools			
▪ midwifery education programmes			
▪ allied/public health education programmes			
▪ nutrition/dietetic education programmes.			

[24] Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. The departments responsible for teaching the various topics within the various schools 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.

Additional information (not rated) *(Adapt the form if reporting on more than one of each type of school, programme or department)*						
Type of school or education programme	***Name of school***	***Department or programme (paediatrics, obstetrics, etc.)***	***Curriculum or session plans are adequate* in***			
			Breastfeeding		***Complementary feeding***	
			Yes	***No***	***Yes***	***No***
Medical						
Nursing						
Midwifery						
Allied/public health						
Nutrition						

* See Annex 7 for a list of key topics that should be covered by the curriculum as a whole.

Conclusions and recommendations
Summarize which aspects of health care provider education are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

5. In-service training for health care providers

Question: ***Do in-service training or continuing education programmes for health care providers update their knowledge and skills related to infant and young child feeding?***

Background

Scientific and behavioural research is constantly adding new knowledge to the field of infant and young child feeding. In-service training courses will help to ensure that practitioners remain current. In addition, until preparatory programmes strengthen their teaching content (see Section 4, Health care provider (pre-service) education) some 'remedial' courses will be necessary. Governmental programmes and departments, NGOs and donor-funded projects may provide continuing education programmes.

Possible sources of information

Interviews can be held with officials of the ministries of health and education; directors of national training centres; managers and/or trainers of relevant continuing education programmes; and directors and deputy directors of NGOs that include training in their scope of work. If possible, review course and workshop teaching content and the percentage of time allocated to the clinical or practical sessions. (See Annex 7, Education checklist, for points to consider when reviewing whether various curricula cover essential content.)

Information sources used *(please list):* .....

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ In-service training programmes provide knowledge and skills related to infant and young child feeding for relevant health care providers.[25]			
▪ In-service training programmes are provided throughout the country.[26]			
▪ Training programmes cover most of the essential topics related to infant and young child feeding (see Annex 7).			
▪ Clinical and counselling skills needed on the job are integrated into the content of the training programmes.			
▪ Clinical and counselling skills are allotted at least 30% of training time.			
▪ Content and skills related to infant and young child feeding are integrated, as appropriate, into training programmes focusing on relevant topics (including diarrhoeal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the International Code of Marketing of Breast-milk Substitutes, HIV/AIDS).			
▪ Training programmes cover infant and young child feeding for most relevant community-based health practitioners, including traditional practitioners.			

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

[26] 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.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*					
Training programmes and centres* providing training on IYCF	***Courses with IYCF content***	***Content related to IYCF in each course***	***% content focused on clinical/ practical skills***	***Number and types of staff who would benefit from each course***	***Number and types of staff who have completed each course during past 12 months***

* These can include training programmes and centres organized either by the government or by NGOs.

Conclusions and recommendations
Summarize which aspects of in-service training are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

6. Community outreach and support

Question: ***Are community outreach and support mechanisms in place to protect, promote and support optimal infant and young child feeding?***

Background

Community outreach and support is an essential component of a comprehensive national infant and young child feeding programme. Community outreach and support activities related to breastfeeding and complementary feeding may be health-facility based (as called for in Step 10 of the BFHI) and/or community-based. They can also be integrated into existing non-health activities, where appropriate. These may include individual counselling, group counselling, community health education, cooking demonstrations, provision of mother-to-mother support, activities in women's groups/clubs, trials of new feeding practices, and positive deviance discussion groups.[27] Community support activities should ideally include not only mothers, but also fathers, grandmothers and other family decision-makers. (See Annex 8 for more suggestions regarding possible contact points, channels and community outreach and support activities.)

Possible sources of information

Discussions can be held with officials of the ministries of health, social welfare, and women's affairs, or any government organization involved in social welfare; the national breastfeeding and/or infant and young child feeding coordinator; representatives of mother-support group organizations, such as La Leche League; and representatives of relevant NGOs (health and non-health).

Information sources used *(please list): .....*

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ Health facility based community outreach and support activities related to infant and young child feeding (IYCF) are being implemented (at least two of the activities listed in Annex 8*).*			
▪ Health facility based community outreach and support activities related to IYCF have national (or regional) coverage.[28]			
▪ Community-based IYCF outreach and support activities are being implemented (at least two of the activities listed in Annex 8*).*			
▪ Community-based IYCF outreach and support activities have national (or regional) coverage.[28]			
▪ Non-health organizations (e.g. agricultural extension, education, credit groups) are conducting IYCF outreach and support activities at the community level.			
▪ IYCF community outreach and support activities are integrated into an overall infant and child health strategy (intersectoral and intrasectoral).			

[27] Positive deviants are children who grow and develop adequately in low-income families living in impoverished environments, where a majority of children suffer from growth retardation and malnutrition (*34*).

[28] Define the minimal geographic or political unit that will be considered for coverage, e.g. district, municipality, etc. National (or regional) coverage would be when at least some community outreach and support activities are conducted in each one of these defined units.

Additional information (not rated) (*Use multiple sheets or adapt the form, as necessary*)			
Outreach or support activity or programme (health or non-health)	***Implementing organization***	***Activities or content related to infant and young child feeding***	***Level of coverage achieved (%)***

Conclusions and recommendations
Summarize which aspects of community outreach and support are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

7. Information, education and communication

Question: ***Are comprehensive information, education and communication strategies being implemented for improving infant and young child feeding?***

Background

Information, education and communication (IEC) strategies are critical aspects of a comprehensive programme to improve infant and young child feeding practices. These approaches may include the use of electronic media (TV, radio, video), print (posters, counselling cards, flip charts, manuals, newspapers, magazines), interpersonal skills (counselling, group education, support groups) and community activities, to communicate important information and motivational material to mothers, families and the community. Behavioural change is an important interpersonal strategy, often used in counselling sessions, home visits, action-oriented group discussions and dramas focused on problem solving. Comprehensive IEC strategies use a wide variety of media and channels to convey concise, consistent, appropriate, action-oriented and correct messages to targeted audiences at national, facility, community and family levels.

Possible sources of information

Interviews can be held with representatives of national communication or information agencies; national TV and radio stations; officials of the ministry of health, such as the national breastfeeding and/or infant and young child feeding coordinator, the communications officer or coordinator, health education officers; officials of the ministry of social welfare; and representatives of UNICEF, WHO and NGOs. Consider reviewing samples of electronic media spots and printed material, and observing counselling, education and community media events.

Information sources used *(please list):* .....

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ There is a comprehensive national IEC strategy for improving IYCF.			
▪ A national IEC campaign or programme[29] using electronic, print and event media and activities has channelled messages on infant and young child feeding to targeted audiences during the past 12 months.			
▪ IEC programmes (either governmental or nongovernmental) that include infant and young child feeding issues are being actively implemented at both regional and local levels.			
▪ Individual counselling and group education services related to IYCF are available within the health care system or through community outreach.			
▪ The content of IEC messages is technically and clinically sound, based on national or international guidelines.			
▪ The focus and wording of messages is based on formative research and pretested with target audiences before use.			
▪ A mechanism is in place, involving all major players, to assure that IEC messages provided through electronic, print and event media as well as education and counselling activities, are coordinated and consistent.			

[29] An IEC campaign or programme is considered "national" if its messages can be received by the target audience in all major geographical or political units in the country (e.g. regions or districts).

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*			
Media activities	***Producer/sponsor***	***Timing***	***Content related to IYCF***
Counselling and education services	***Where available***	***Who delivers***	***Content related to IYCF***
Describe mechanisms in place, if any, for assuring the coordination and consistency of IEC messages provided through the media, education, and counselling.			

Conclusions and recommendations
Summarize which aspects of the IEC programme are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

8. Contraceptive support for breastfeeding women

Question: ***Do relevant policies and programmes provide contraceptive support for breastfeeding women?***

Background

Breastfeeding women have a choice of short-term, long-term or permanent contraceptive methods to fit their needs. The Lactational Amenorrhoea Method (LAM) is a modern contraceptive method that uses a pattern of breastfeeding that can effectively suppress ovulation and prevent pregnancy provided that the following stipulated three criteria are met: (1) the woman's menstrual periods have not resumed; (2) the baby is fully or nearly fully breastfed frequently day and night; and (3) the baby is less than six months old. The choice of LAM as the contraceptive method reinforces optimal breastfeeding practices. It is very important to ask the woman who is seeking contraceptive counselling whether she is breastfeeding at present.

Contraceptive methods are safe to use during breastfeeding. However, estrogen-containing pills or estrogen-containing injections may decrease the quantity or quality of breast milk and are not recommended before six months postpartum. Progestogen-only methods are recommended at six weeks postpartum when lactation is well established. Other barrier methods, such as diaphragms and cervical caps, need to be refitted at six weeks postpartum.

Possible sources of information

Interviews can be held with key officials in relevant government ministries (e.g. population, health); staff of international and local family planning NGOs, agencies and donors; and with staff of maternal and child health (MCH) and breastfeeding programmes. If possible, review protocols or guidelines for contraceptive choice and family planning counselling, the family planning data collection system, as well as guidelines or curricula for breastfeeding training.

Information sources used *(please list):* ……..

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ Family planning and MCH policies include standards and guidelines for providing breastfeeding women with adequate advice concerning contraceptive methods, including LAM, and their effects on lactation.			
▪ Family planning and MCH counsellors and care providers receive adequate training on these guidelines.			
▪ Family planning and MCH programmes provide guidance and support for breastfeeding women concerning contraceptive methods, including LAM. (See Annex 9 for details.)			
▪ Contraceptive methods for breastfeeding women are addressed in breastfeeding education and counselling sessions both at the community and health facility levels.			
▪ Data on LAM rate (number of clients using LAM as family planning method/number of clients with infants < 6 months) are among the statistics routinely collected and reported by the national family planning programme.			

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*		
Family planning and MCH programmes that address contraceptive needs of breastfeeding women	***Implementing organizations***	***Types of support provided*** (*including provider training and contraceptive counselling and services for breastfeeding women*)

Conclusions and recommendations
Summarize which aspects of contraceptive support for breastfeeding women are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

9. HIV and infant feeding

Question: ***Do relevant policies and programmes ensure that mothers with HIV are informed about the risks and benefits of different infant feeding options and supported in their infant feeding decisions?***

Background

The risk of HIV transmission through breastfeeding presents a difficult dilemma to policy-makers, infant feeding counsellors and mothers. They must balance the risks of artificial feeding against the risk of HIV transmission through breastfeeding. These risks are dependent on the age of the infant and household conditions. At the same time, other factors must be considered such as the risk of stigmatization (not breastfeeding may signal the mother's HIV status), the financial costs of replacement feeding, and the risk of becoming pregnant again. Policies and programmes to meet this challenge should provide access to HIV testing and counselling (VCT). Counselling on infant feeding options should be available to HIV-positive mothers. The content of counselling programmes should be refined based on local formative research. Safeguards should be in place to protect, promote and support breastfeeding in the rest of the population.

Possible sources of information

Information on the availability and uptake of VCT among pregnant women and on the content and availability of infant feeding counselling should be available from the national AIDS control programme (or equivalent), and the departments of nutrition, maternal and child health, and/or reproductive health within the ministry of health. International recommendations related to HIV and infant feeding are available from UNAIDS, UNICEF and WHO (*35*–*39*) and other sources (*40*–*42*).

Information sources used *(please list):* .....

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers, and how to provide counselling and support.			
▪ Antenatal VCT is available and offered routinely to pregnant women and, where possible, to their partners.			
▪ Locally appropriate infant feeding counselling in line with current international recommendations is provided to HIV-positive mothers. (See Annex 10, HIV and infant feeding recommendations.)			
▪ Mothers are supported in their infant feeding decisions with further counselling and follow-up to make these decisions as safe as possible.			
▪ Special efforts are made to counter misinformation on HIV and infant feeding and to protect, promote, and support breastfeeding in the general population.			
▪ Ongoing monitoring is in place to determine the effects of interventions to prevent HIV transmission upon infant feeding practices and health outcomes for mothers and infants – including those who are HIV-negative or of unknown status ("spillover effect").			
▪ In settings with high HIV prevalence, the national Baby-friendly Hospital Initiative provides guidance to hospital administrators and staff on how to assess the needs of, and provide support to HIV-positive mothers.			

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Describe existing HIV and infant feeding policies and guidelines, when they were developed, and what they cover.	
If commercial infant formula is distributed to HIV-positive mothers, describe how it is procured.	
Describe who is covered by antenatal activities to prevent mother-to-child transmission, what activities are included, and where these take place.	
Describe the training and job aids provided for health workers in support of their counselling of mothers on HIV and infant feeding, and indicate who provides the training.	

Conclusions and recommendations
Summarize which aspects of HIV and infant feeding programming are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

10. Infant and young child feeding in emergencies

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

Background

Infants and young children are among the most vulnerable groups in emergencies. Interruption of breastfeeding and inappropriate complementary feeding increase the risks of malnutrition, illness and mortality. In emergency and relief situations the responsibility for protecting, promoting and supporting beneficial infant and young child feeding practices and minimizing harmful practices should be shared by the emergency-affected host country and responding agencies. Concise guidance on how to facilitate appropriate feeding in emergency situations and comply with international emergency standards has been developed by interagency expert working groups. Practical details on how to implement the guidance are included in companion training materials, also developed through interagency collaboration. (See Annex 11 for a list of such training materials.)

Possible sources of information

Information on policy and guideline development and the implementation of preparedness activities can be obtained from the designated staff of the national health and nutrition programmes responsible for emergency preparedness and response. (See Annex 11 for a detailed list of the criteria necessary to protect, promote and provide support for appropriate infant and young child feeding practices during emergencies. This list provides useful references and information to assist in rating the criteria presented below).

Information sources used *(please list):* ……..

……

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ A policy that addresses key issues related to infant and young child feeding in emergencies has been endorsed or developed.			
▪ Person(s) have been appointed who are tasked with responsibility for national coordination with the United Nations, donor agencies, the military and NGOs regarding infant and young child feeding in emergency situations.			
▪ A contingency plan has been developed to undertake activities to facilitate exclusive breastfeeding and appropriate complementary feeding and to minimize the risk of artificial feeding, and resources have been identified for implementation of the plan during emergencies.			
▪ Appropriate 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.			

Conclusions and recommendations
Summarize which aspects of emergency preparedness are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

11. Research for decision-making

Question: ***Are research studies conducted on priority topics and results used to improve infant and young child feeding practices?***

Background

The effectiveness of policy and programme decisions can be greatly enhanced if policy-makers, managers, and staff have access to up-to-date information on the issues and strategies being considered. Well-designed and timely research can provide some of the information needed. The research itself may be conducted by staff of the national programme, a university faculty, research organizations, or by independent researchers. It is important that an inventory be made of research pertinent to the programme, if not already available.

Priority needs for information should be identified at the national level and mechanisms developed for dissemination, review, and utilization of research results and other information to guide policy and programme decisions. If the country has few resources for supporting research, it may decide to rely, whenever feasible, on the use of existing information (either domestic or international) and, when necessary, apply for support from donor agencies for priority studies.

Possible sources of information

Interviews can be held with research managers, key researchers, national breastfeeding and/or infant and young child feeding committee members, those who fund research, and decision-makers and managers responsible for the various infant and young child feeding programmes. Interviews can also be held with staff of NGOs and organizations such as UNICEF, USAID and WHO, and others who may support or conduct research. Review any research inventories and major research reports that are available.

Information sources used *(please list):* ……..

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ A national research advisory group or body provides guidance on research in the area of infant and young child feeding.			
▪ A national inventory of applied and basic research on key topics related to IYCF has been developed or updated within the past three years.			
▪ Priority needs for infant and young child feeding related information are identified by the national breastfeeding and/or infant and young child feeding committee or an appropriate research advisory group.			
▪ Needed information is gathered, when feasible, from existing studies and other data sources (either domestic or international).			
▪ Research on priority topics is financed by the national infant and young child feeding programme and/or by other appropriate donors.			
▪ Research results are routinely disseminated to key decision-makers.[30]			
▪ Research results are used to guide policy and programme decisions as part of the planning and management process.			

[30] Decision-makers include policy-makers and programme managers who make decisions about infant and young child feeding policies and/or programmes.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Title of inventory of research related to infant and young child feeding (if one exists).	
Organizations or agencies funding infant and young child feeding related research.	
Mechanisms used for disseminating research results to decision-makers.	

Conclusions and recommendations
Summarize which aspects of research for decision-making are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

12. Monitoring and evaluation

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

Background

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

When appropriate, both baseline and follow-up data should be collected to measure outcomes. In an effort to increase availability of comparable data, use of internationally-agreed indicators and data collection strategies should be considered.[31] It is important that strategies be devised to help ensure that key decision-makers receive significant evaluation results and are encouraged to use them.

Possible sources of information

Interviews can be held with officials, programme managers, and/or evaluation specialists overseeing or conducting monitoring and evaluation activities within the national infant and young child feeding programme. Staff who conduct surveys such as the *Demographic and Health Survey* (or a similar national survey) can also provide information. Review any major evaluation reports that are available. Talk with key decision-makers who should receive and use monitoring and evaluation results.

Information sources used *(please list)*:……

Checklist			
Criteria	*Check the category that best applies*		
	Yes	***To some degree***	***No***
▪ Monitoring and evaluation components are built into major infant and young child feeding programme activities.			
▪ Monitoring or MIS data are considered by programme managers as part of the planning and management process.			
▪ Adequate baseline and follow-up data are collected to measure outcomes of major infant and young child feeding programme activities.			
▪ Evaluation results related to major infant and young child feeding programme activities are reported to key decision-makers, both at national and regional/local levels.			
▪ Monitoring of key infant and young child feeding practices is built into a broader nutritional surveillance and/or health monitoring system or into periodic national health surveys.			

[31] See the WHO report on *Indicators for assessing breastfeeding practices* (*2*) for suggestions concerning breastfeeding indicators and data collection strategies. WHO is in the process of considering appropriate indicators for measuring complementary feeding practices.

Additional information (not rated) *(Use multiple sheets or adapt the form, as necessary)*	
Major IYCF programmes that have monitoring and evaluation components, and what they include.	
Programmes for which baseline and follow-up data is collected and types of data collected.	
Decision-makers who regularly receive evaluation results related to IYCF, and who provides those results.	

Conclusions and recommendations
Summarize which aspects of monitoring and evaluation are good, and which aspects need improvement and why. Identify areas needing further analysis and make recommendations for action.

Summary of achievements related to programme components

Programme components	*Level of achievement**
1. National infant and young child feeding programme	
2. An active and sustainable Baby-friendly Hospital Initiative	
3. Mother-friendly childbirth strategies	
4. Health care provider (pre-service) education	
5. In-service training for health care providers	
6. Community outreach and support	
7 Information, education and communication	
8. Contraceptive support for breastfeeding women	
9. HIV and infant feeding	
10. Infant and young child feeding in emergencies	
11. Research for decision-making	
12. Monitoring and evaluation	

**Note:* Rate achievement on the programme components as “high”, “medium” or “low”, depending on how well each of the components meets the criteria listed.

Summary of conclusions, and recommendations
Summarize the achievements on the various programme components, indicate which areas still need further work, and make recommendations for action.

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REFERENCES

References

1. *Global Strategy for Infant and Young Child Feeding*. Geneva, World Health Organization, 2002. (Resolution WHA 55.25 and document A55.15. Available at web sites: *http://www.who.int/gb/EB_WHA/PDF/WHA55/ewha5525.pdf* and *http://www.who.int/gb/EB_WHA/PDF/WHA55/ea5515.pdf.*

2. *Indicators for assessing breast-feeding practices: report of an informal meeting.* Geneva, World Health Organization, 1991 (WHO/CDD/SER/91.14).

3. *The optimal duration of exclusive breastfeeding. Note for the Press N° 7*. Geneva, World Health Organization, 2001.

4. *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*. Florence, Italy, WHO/UNICEF (Spedale degli Innocenti), 1990. Available at web site: *http://www.unicef.org/programme/breastfeeding/innocenti/htm.*

5. *Demographic and Health Survey.* Calverton, Maryland, Macro International (countries and dates vary).

6. *Multiple Indicator Cluster Survey.* New York, United Nations Children's Fund (countries and dates vary).

7. *WHO Global Data Bank on Breastfeeding and Complementary Feeding.* Geneva, World Health Organization, 1996 (WHO/NUT/96.1).

8. MEASURE Communications. *Breastfeeding patterns in the developing world.* Washington, DC, Population Reference Bureau and MEASURE Communications, 1999.

9. Chetley A, Amin S. *Investigating breastfeeding: questions, ideas and issues to explore.* Penang, Malaysia, World Alliance for Breastfeeding Action (WABA), 1993.

10. Anderson M, Griffiths M. *Guide for country assessment of breastfeeding practices and promotion*. Washington, DC, MotherCare, USAID, 1993.

11. Engle P. *The Care Initiative: assessment, analysis and action to improve care for nutrition.* New York, United Nations Children's Fund, Nutrition Section, 1997.

12. *Protecting, promoting and supporting breast-feeding: the special role of maternity services.* A joint WHO/UNICEF statement. Geneva, World Health Organization, 1989.

13. *Report of the Expert Consultation on the optimal duration of exclusive breastfeeding, Geneva, 2001.* Geneva, World Health Organization, 2001 (WHO/NHD/01.09, WHO/FCH/CAH/01.24).

14. *Evidence for the Ten Steps to Successful Breastfeeding.* Geneva, World Health Organization, 1998 (WHO/CHD/98.9).

15. Habicht J-P, DaVanzo J, Butz WP. Mother's milk and sewage: their interactive effects on infant mortality. *Pediatrics*, 1988, 81:456–461.

16. Haggerty PA, Rutstein S. *Breastfeeding and complementary infant feeding, and the postpartum effects of breastfeeding* (Demographic and Health Surveys Comparative Studies No. 30*).* Calverton, Maryland, Macro International, 1999.

17. WHO/UNICEF/University of California (Davis). *Complementary feeding of young children in developing countries: a review of current scientific knowledge*. Geneva, World Health Organization, 1998 (WHO/NUT/98.1).

18. *Complementary feeding: family foods for breastfed children*, Geneva, World Health Organization, 2000 (WHO/NHD/00.1).

19. *Complementary feeding counselling: a training course.* Geneva, World Health Organization (anticipated publication in 2004).

20. Daelmans B, Martines J, Saadeh R, eds. Special issue based on a World Health Organization expert consultation on complementary feeding. *Food and Nutrition Bulletin*, 2003, 24(1).

21. *Guiding principles for complementary feeding of the breastfed child*. Washington, DC, Pan American Health Organization, 2003.

22. *Global consultation on complementary feeding. Report of a WHO Expert Consultation.* Geneva, World Health Organization, 2002.

23. *UNDP Human Development Report.* New York, United Nations Publications, 2000 (email: publications@un.org).

24. *State of the World's Children*. New York, United Nations Children's Fund, 2001.

25. *Baby-Friendly Hospital Initiative progress reports*. New York, Programme Division of the United Nations Children's Fund (published periodically).

26. *International Code of Marketing of Breast-milk Substitutes*. Geneva, World Health Organization, 1981.

27. *State of the Code by country: a survey of measures taken by governments to implement the provisions of the International Code of Marketing of Breast-milk Substitutes*. Penang, Malaysia, International Code Documentation Centre of the International Baby Food Action Network (IBFAN), (various dates).

28. *The International Code of Marketing of Breast-milk Substitutes: a common review and evaluation framework.* Geneva, World Health Organization, 1996 (WHO/NUT/96.2).

29. *Maternity Protection Convention No. 183*. Geneva, International Labour Organization, 2000 (available from the International Labour Organization Database on International Labour Standards (ILOLEX) at web site: *http://ilolex.ilo.ch:1567/cgi-lex/convde.pl?C183*).

30. International Labour Organization. Maternity protection at work. *World of Work,* 1998, 24:15–19.

31. World Health Organization. Appropriate technology for birth. *Lancet,* 1985, ii:436–437.

32. World Alliance for Breastfeeding Action (WABA). *GIMS for Breastfeeding, Global Initiative for Mother Support.* WABA, 2001. Available at web site*: http://www.waba.org.br/gims/*

33. *Care in normal birth: a practical guide.* Geneva, World Health Organization, 1996 (WHO/FRM/MSM/96.24).

34. Zeitlin M et al. *Positive deviance in child nutrition – with emphasis in psychosocial and behavioural aspects and implications for development*. Tokyo, United Nations University, 1990.

35. UNAIDS. *HIV and infant feeding.* A policy statement developed collaboratively by UNAIDS, UNICEF and WHO, 1997. Available at web site: *http://www.unaids.org/publications/documents/mtct/infantpole.html*.

36. WHO/UNICEF/UNAIDS/UNFPA/World Bank/UNHCR/WFP/IAEA/FAO. *HIV and infant feeding: a framework for priority action*. Geneva, World Health Organization, 2003 (in press).

37. WHO/UNAIDS/UNICEF. *HIV and infant feeding: guidelines for decision-makers*. Geneva, World Health Organization, 1998 (under revision). Available at web site: *http://www.unaids.org/publications/documents/mtct/infantpolicy.html*

38. WHO/UNAIDS/UNICEF. *HIV and infant feeding: a guide for health care managers and supervisors*. Geneva, World Health Organization, 1998 (under revision). Available at web site: *http://www.unaids.org/publications/documents/mt ct/infantguide.html*

39. *New data on the prevention of mother-to-child transmission of HIV and their policy implications*. Conclusions and recommendations of a WHO Technical Consultation on behalf of the UNFPA/UNICEF/WHO/UNAIDS Interagency Task Team on Mother-to-Child Transmission of HIV, Geneva, 11–13 October 2000. Geneva, World Health Organization, 2001 (WHO/RHR/01.28).

40. De Cock KM et al. Prevention of mother-to-child HIV transmission in resource-poor countries: translating research into policy and practice. *Journal of the American Medical Association,* 2000, 283:1175–1182.

41. LINKAGES Project. *Breastfeeding and HIV/AIDS, Frequently Asked Questions (FAQ).* FAQ Sheet 1. Washington, DC, LINKAGES Project, Academy for Educational Development, updated May 2001. Available at web site: *http://www.linkagesproject.org/FAQ_Html/FAQhivrev.htm*

42. Nduati R, Ross J. Mother-to-child transmission of HIV through breastfeeding: strategies for prevention. In: Lamptey PR, Gayle H. *HIV/AIDS prevention and care in resource-constrained settings: a handbook for the design and management of programs*. Arlington, Virginia, Family Health International, 2001. Available at web site: *http://www.fhi.org/en/aids/impact/impactpdfs/HIVAIDSPreventionCare.pdf*

43. UNICEF, UNU, WHO*. Iron deficiency anaemia: assessment, prevention, and control. A guide for programme managers.* Geneva, World Health Organization, 2001 (WHO/NHD/01.3).

44. *Assessment of Iodine Deficiency Disorders and monitoring their elimination. A guide for programme managers,* 2nd edition. Geneva, World Health Organization, 2001.

45. UNICEF, WHO. *Ending iodine deficiency forever: a goal within our grasp*. New York, UNICEF, 2002.

46. *Indicators for assessing Vitamin A Deficiency and their application in monitoring and evaluating intervention programmes*. Geneva, World Health Organization, 1996 (WHO/NUT/96.10).

47. Interagency Working Group on Infant and Young Child Feeding in Emergencies. *Infant and young child feeding in emergencies: operational guidance for emergency relief staff and programme managers.* November 2001. Available at web site: *www.ennonline.net* or from *fiona@ennonline.net*.

48. Ad Hoc Group on Infant Feeding in Emergencies*. Infant feeding in emergencies: policy, strategy and practice*. May 1999. Available at web site: *www.ennonline.net* or from *fiona@ennonline.net*.

49. Core Group on Infant Feeding in Emergencies. *Infant feeding in emergencies. Module 1 for emergency relief staff: manual for orientation, reading and reference.* Draft, November 2001. Available at web site: *www.ennonline.net* or from *fiona@ennonline.net.*

50. Core Group on Infant Feeding in Emergencies. *Infant feeding in emergencies. Module 2 for health and nutrition workers in emergency situations: manual for practice, instruction and reference.* Draft 2003. Available at web site: *www.ennonline.net* or from *fiona@ennonline.net.*

51. WHO, UNHCR, IFRC, WFP. *The management of nutrition in major emergencies. Annex 6: Guiding principles for feeding infants and young children in emergencies.* Geneva, World Health Organization, 2000.

INFANT AND YOUNG CHILD FEEDING

A tool for assessing national practices, policies and programmes

ANNEXES

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Annex 1. Glossary of terms[32]

AIDS: Acquired immune deficiency syndrome, which means that the HIV-positive person has progressed to active disease.

Artificial feeding: Feeding an infant on a breast-milk substitute.

Baby-friendly Hospital Initiative (BFHI): An approach to transforming maternity practices as recommended in the joint WHO/UNICEF statement on *Protecting, promoting and supporting breastfeeding: the special role of maternity services* (1989). The BFHI was launched in 1991 by UNICEF and WHO. Baby-friendly hospitals practise the *Ten steps to successful breastfeeding* (part of the joint statement) and observe the principles and aim of the *International Code of Marketing of Breast-milk Substitutes*, including not accepting free or low-cost supplies of breast-milk substitutes, feeding bottles, teats and pacifiers. To acquire the "baby-friendly" designation, a hospital must be externally assessed according to an agreed procedure using the Global criteria.

Bottle-feeding: Feeding an infant from a bottle, whatever is in the bottle, including expressed breast milk, water, formula, etc.

Breast-milk substitute: Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose.

Commercial infant formula: A breast-milk substitute formulated industrially in accordance with applicable *Codex Alimentarius* standards to satisfy the nutritional requirements of infants during the first months of life up to the introduction of complementary foods.

Complementary food: Any food, whether manufactured or locally prepared, suitable as a complement to breast milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant.

Complementary feeding: The process of giving an infant food in addition to breast milk or infant formula, when either becomes insufficient to satisfy the infant's nutritional requirements. The practice of giving complementary foods.

Cup-feeding: Feeding from an open cup without a lid, whatever is in the cup.

Early cessation of breastfeeding in the context of HIV/AIDS: Stopping breastfeeding sooner than is usually recommended in order to reduce the risk of transmitting HIV via breastfeeding. Exclusive breastfeeding, followed by early cessation as soon as acceptable, feasible, affordable, sustainable and safe – taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (including infections other than HIV) – is one of the options to be discussed with HIV-positive mothers. **Acceptable** means that the mother perceives no barrier to choosing the option for cultural or social reasons, or for fear of stigma and discrimination. **Feasible** means that the mother (or family) has adequate time, knowledge, skill and other resources to prepare and feed her infant, and the support to cope with family, community and social pressures. **Affordable** means that the mother and family, with available community and/or health system support, can pay for the costs of the purchase/production, preparation and use of the feeding option – including all ingredients, fuel and clean water – without compromising the health and nutrition spending of the family. **Sustainable** means availability of a continuous and uninterrupted supply and dependable system of distribution

[32] Adapted from lists of terms in the *WHO Global Strategy for Infant and Young Child Feeding* (*1*); and WHO/UNAIDS/UNICEF, *HIV and infant feeding: guidelines for decision-makers* (*37*).

for all ingredients and commodities needed to safely implement the feeding option, for as long as the infant needs it. **Safe** means that replacement foods are correctly and hygienically stored and prepared in nutritionally adequate quantities, and fed with clean hands using clean utensils, preferably with cups.

Exclusive breastfeeding: Breastfeeding while giving no other food or liquid, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Expressed breast milk: Milk that has been removed from the breasts manually or by using a pump.

HIV: Human immunodeficiency virus, which causes AIDS (acquired immune deficiency syndrome).

HIV testing and counselling: Testing which is voluntary, with fully informed consent, and confidential. This expression means the same as the terms **voluntary testing and counselling (VCT)** and **voluntary and confidential testing and counselling (VCCT)**. Counselling should include life planning for the HIV-positive client, and if the client is pregnant or has recently given birth, counselling should include infant feeding considerations.

HIV-positive: Refers to persons who have taken an HIV test, whose results have been confirmed and who know and/or their parents know that they tested positive. **HIV-negative** refers to people who have taken a test with a negative result and who know their result. **HIV-status unknown** refers to people who have not taken an HIV test or who do not know the result of their test. **HIV-infected** refers to a person infected with HIV, but who may not know that he/she is infected.

Infant: A child not more than 12 months of age.

International Labour Organization (ILO) Maternity Protection Convention 183 and Recommendation 191: The most up-to-date international labour standards on maternity protection. They were adopted by the International Labour Conference in June 2000. The Convention, which applies to all employed women, provides the right to maternity leave of not less than 14 weeks, cash and medical benefits, job security, workplace health protection and breastfeeding breaks. Mothers who continue breastfeeding after their return to work have the right to nursing breaks or a reduction in hours of work in order to breastfeed or to express breast milk. Additional provisions regarding the adaptation of nursing breaks to particular needs and the establishment of facilities for breastfeeding at or near the workplace are found in the Recommendation. ILO Conventions are international treaties, subject to ratification by ILO Member States. Recommendations are non-binding instruments, which set out guidelines for national policy and action. Both forms are intended to have a concrete impact on working conditions and practices in every country of the world.

International Code of Marketing of Breast-milk Substitutes, and subsequent relevant World Health Assembly resolutions: The instrument that was adopted in the form of a recommendation by the World Health Assembly (WHA) in May 1981 to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. Since 1981, the WHA has also adopted a number of resolutions that clarify the *Code*, and have the same status. The *Code* and subsequent relevant resolutions are referred to collectively in the present context as the *International Code*.

Maternity entitlements: Provisions for maternity leave, cash and medical benefits, job security, workplace health protection, breastfeeding breaks, and other measures to protect the health and employment rights of employed women before and after childbirth. (See also **ILO Maternity Protection Convention**).

Median duration of breastfeeding: The age in months when 50% of children are no longer breastfed.

Micronutrient supplements: Preparations of vitamins and minerals needed for infants. One important indication for giving micronutrient supplements is for infants who receive home prepared infant formulas (in some cases because their HIV-positive mothers have chosen to replacement feed).

Milk expression: Removing milk from the breasts manually or by using a pump.

Mother-support group: A community-based group of women providing support for optimal breastfeeding and complementary feeding. A group may be informal or part of a larger network providing information, help and support from trained counsellors and experienced mothers. Groups may meet regularly or simply provide individual mother-to-mother contacts. They may be organized by health workers or lactation consultants, but frequently they are managed autonomously by mothers within their own communities.

Mother-to-child-transmission (MTCT): Transmission of HIV to a child from an HIV-infected woman during pregnancy, delivery or breastfeeding. The term is used in this document because the immediate source of the child's HIV infection is the mother. A woman can acquire HIV through unprotected sex with an infected partner, through receiving contaminated blood or through non-sterile instruments (such as with intravenous drug users) or medical procedures.

Optimal infant and young child feeding: Exclusive breastfeeding for the first six months of life. Thereafter, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.

Relactation: Re-establishing breastfeeding after a mother has stopped, whether in the recent or distant past.

Replacement feeding: The process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients the child needs until the child is fully fed on family foods. During the first six months this should be with a suitable breast-milk substitute. After six months it should be with a suitable breast-milk substitute, as well as complementary foods made from appropriately prepared and nutrient-enriched family foods.

Young child: A person from the age of more than 12 months up to the age of 3 years (36 months).

Annex 2. Exclusive breastfeeding rate and bottle-feeding rate calculators

Exclusive breastfeeding rate (EBR) calculator [33] *using DHS data available for two-month intervals*			
			From the published tables:
1a	EBR, 0–1 mo	%	EBR rate in percentages for children 0–< 2 months
1b	EBR, 2–3 mo	%	EBR rate in percentages for children 2–< 4 months
1c	EBR, 4–5 mo	%	EBR rate in percentages for children 4–< 6 months
1d	EBR, 0–5 mo	%	**Calculated EBR for children 0–< 6 months**
			From the published tables:
2a	Number, 0–1 mo		Total number of children in the age group 0–<2 months
2b	Number, 2–3 mo		Total number of children in the age group 2–<4 months
2c	Number, 4–5 mo		Total number of children in the age group 4–<6 months
2d	Number, 0–5 mo		Calculated total number of children aged 0–<6 months
			Calculated absolute numbers
3a	Numbers EBF, 0–1 mo		Children 0–<2 months who are exclusively breastfed
3b	Numbers EBF, 2–3 mo		Children 2–<4 months who are exclusively breastfed
3c	Numbers EBF, 4–5 mo		Children 4–<6 months who are exclusively breastfed
3d	Numbers EBF, 0–5 mo		Children 0–<6 months who are exclusively breastfed

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

1. Find the table on "breastfeeding status" in the chapter on infant, child and maternal nutrition in the most recent *Demographic and Health Survey* (*DHS*) for the selected country.

2. Locate the data on percentage of breastfeeding children "exclusively breastfed" and the data on the "number of living children" for the same age groups – usually the second and last columns in the table.

3. List the exclusive breastfeeding rates (EBR) in percentages for children ages 0–1, 2–3, and 4–5 in rows 1a–1c in the table above. (Use figures with one decimal point e.g. 15.6%).

4. List the total number of living children ages 0–1, 2–3, and 4–5 in rows 2a–2c in the table above.

5. Calculate the number of children in the survey aged 0–5 months by adding the numbers in rows 2a–2c and insert this number in row 2d above.

6. Calculate the number of children exclusively breastfed for each age group by multiplying the total number in each age group by the percentage exclusively breastfed in that age group and insert in the appropriate rows above (1a x 2a = 3a; 1b x 2b = 3b; 1c x 2c = 3c). Round each number to the nearest whole number.

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

8. Calculate the exclusive breastfeeding rate for children 0–5 months by dividing the number of children 0–5 months exclusively breastfed by the total number of children for these same ages, and insert the percentage in row 1d above (3d /2d = 1d).

[33] Adapted from the *EBR Calculator* developed by Nadra Franklin, LINKAGES Project, 1999.

Annex 2 (continued)

Bottle feeding rate (BOT) calculator [34] *using DHS data available for two-month intervals*			
			From the published tables:
1a	BOT, 0–1 mo	%	BOT rate in percentages for BF children 0–< 2 months
1b	BOT, 2–3 mo	%	BOT rate in percentages for BF children 2–< 4 months
1c	BOT, 4–5 mo	%	BOT rate in percentages for BF children 4–< 6 months
1d	BOT, 6–7 mo	%	BOT rate in percentages for BF children 6–< 8 months
1e	BOT, 8–9 mo	%	BOT rate in percentages for BF children 8–< 10 months
1f	BOT, 10–11 mo	%	BOT rate in percentages for BF children 10–< 12 months
1g	BOT, 0–11 mo	%	**Calculated BOT rate for BF children 0–< 12 months**
			From the published tables:
2a	Number, 0–1 mo		Total number of BF children in the age group 0–<2 months
2b	Number, 2–3 mo		Total number of BF children in the age group 2–<4 months
2c	Number, 4–5 mo		Total number of BF children in the age group 4–<6 months
2d	Number, 6–7 mo		Total number of BF children in the age group 6–<8 months
2e	Number, 8–9 mo		Total number of BF children in the age group 8–<10 months
2f	Number, 10–11 mo		Total number of BF children in the age group 10–<12 months
2g	Number, 0–11 mo		Calculated total number of BF children aged 0–<12 months
			Calculated absolute numbers
3a	Numbers BOT, 0–1 mo		BF children 0–<2 months who are bottle-fed
3b	Numbers BOT, 2–3 mo		BF children 2–<4 months who are bottle-fed
3c	Numbers BOT, 4–5 mo		BF children 4–<6 months who are bottle-fed
3d	Numbers BOT, 6–7 mo		BF children 6–<8 months who are bottle-fed
3e	Numbers BOT, 8–9 mo		BF children 8–<10 months who are bottle-fed
3f	Numbers BOT, 10–11mo		BF children 10–<12 months who are bottle-fed
3g	Numbers BOT, 0–11 mo		BF children 0–<12 months who are bottle-fed

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

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

[34] Adapted from the *EBR Calculator* developed by Nadra Franklin, LINKAGES Project, 1999.

Annex 3. Guiding principles for complementary feeding of the breastfed child[35]

1. *Practise exclusive breastfeeding from birth to six months of age, and introduce complementary foods at six months of age (180 days) while continuing to breastfeed.*

2. *Continue frequent, on-demand breastfeeding until two years of age or beyond*.

3. *Practise responsive feeding applying the principles of psychosocial care, specifically*:

   Feed infants directly and assist older children when they feed themselves, being sensitive to their hunger and satiety cues. Feed slowly and patiently, and encourage children to eat, but do not force them. If children refuse many foods, experiment with different food combinations, tastes, textures, and methods of encouragement. Minimize distractions during meal times if the child loses interest easily. Remember that feeding times are periods of learning and love. Talk to children during feeding, with eye-to-eye contact.

4. *Practise good hygiene and proper food handling*.

5. *Start at six months with small amounts of food and increase the quantity as the child gets older, while maintaining frequent breastfeeding.*

   The energy needs from complementary foods for infants with average breast-milk intake in developing countries are approximately 200 kcal/day at 6–8 months of age; 300 kcal/day at 9–11 months; and 550 kcal/day at 12–23 months.

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6. *Gradually increase food consistency and variety as the infant gets older, adapting to the infant's requirements and abilities.*

   Infants can eat pureed, mashed and semi-solid foods beginning at 6 months. By 8 months most infants can also eat 'finger foods'. By 12 months, most children can eat the same types of food as consumed by the rest of the family.

7. *Increase the number of times that the child is fed complementary foods as he/she gets older.*

   For the average healthy breastfed infant, meals of complementary foods should be provided 2–3 times per day at 6–8 months of age and 3–4 times per day at 9–11 and 12–24 months of age, with additional nutritious snacks offered 1–2 times per day, as desired.

8. *Feed a variety of foods to ensure that nutrient needs are met.*

   Meat, poultry, fish, or eggs should be eaten daily, or as often as possible.
   Vitamin A-rich fruits and vegetables should be eaten daily. Provide diets with adequate fat content.

9. *Use fortified complementary foods or vitamin–mineral supplements for the infant, as needed. In some populations, breastfeeding mothers may also need vitamin–mineral supplements or fortified products.*

10. *Increase fluid intake during illness, including more frequent breastfeeding, and encourage the child to eat soft, varied, appetizing, favourite foods. After illness, give food more often than usual and encourage the child to eat more.*

[35] From PAHO/WHO, *Guiding principles for complementary feeding of the breastfed child* (*21*).

Annex 4. Policy issues[36]

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

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

Policies on infant and young child feeding should be:

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

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

Annex 5. Micronutrient recommendations

A national programme should ensure that infants and young children receive required micronutrients through foods or supplements, if necessary (*43–46*).

Iron

Iron deficiency is mainly a consequence of poverty. Even in industrialized countries, iron deficiency affects a significant proportion of people in groups that are particularly vulnerable. Prevention strategies must involve the input and resources of a wide range of sectors and organizations. Children are at greatest risk because of the iron needed for rapid growth.

Prevention of iron deficiency involves a range of interventions, including food-based approaches to improve iron intakes and iron supplementation. These approaches should include:

- dietary improvement through strategies that improve the year-round availability of micronutrient-rich foods, ensure the access of households to these foods, and change feeding practices with respect to these foods;
- food fortification (including fortified foods for young children and emergency foods); and
- food aid.

Other actions that indirectly affect iron status might include parasitic disease control programmes (particularly those directed to hookworm, schistosomiasis and malaria control), incentive policies and improved farming systems that favour the development, availability, distribution, and use of foods that enhance iron absorption.

Iron supplementation is indicated in settings where the diet of children 6–23 months of age does not include foods fortified with iron or where anaemia prevalence is above 40%. If iron supplementation is decided and needed, consider its integration with other micronutrient control programmes. Iron supplementation is also used to correct iron deficiency anaemia (following IMCI guidelines).

Iron supplementation programmes should be integrated into broader public health programmes. For maximum effectiveness, links should be established with programmes such as malaria prophylaxis, hookworm control, immunization, environmental health, control of micronutrient malnutrition, and community-based primary health care.

Iodine

WHO, UNICEF and ICCIDD recommend a daily intake of iodine of 90 µg for children 0–59 months of age. Iodine deficiency occurs when iodine intake falls below recommended levels.

The most critical period for Iodine Deficiency Disorders (IDD) is from the second trimester of pregnancy to the third year after birth. Infants who are not exclusively breastfed are at risk of IDD. Populations living in areas with iodine deficient soils are particularly vulnerable to IDD and its effects. An estimate of the iodine situation among children under five years of age could be done by urinary iodine status of school-age children.

It is well recognized that the most effective way to achieve the virtual elimination of IDD is through universal salt iodination. A successful salt iodination programme at the national level depends upon the implementation of activities by various public and private sectors. The commitment to salt iodination should be expressed in clear legislation containing provisions for quality monitoring as well as partnerships with local, national or global salt producers. It also requires creation of public awareness about iodine deficiency.

Information on iodine deficiency (urinary iodine and goitre) in specific countries is available at the following links:

- WHO Database on Iodine Deficiency, soon to be available at: *http://www.who.int/nut/db_mdis.htm#idd*
- International Council for the Control of Iodine Deficiency Disorders at: *http://www.people.virginia.edu/~jtd/iccidd/*
- Information concerning salt iodization is available at: http://www.unicef.org/pubsgen/salt/

Vitamin A

Usually surveys help to determine Vitamin A Deficiency (VAD) magnitude, severity and distribution, helping to identify high-risk populations for targeting interventions.

Biological indicators of vitamin A status include

- indicators of clinical deficiency:
  - conjunctival xerosis with Bitot's spot
  - corneal xerosis, ulceration, keratomalacia
  - corneal scars;
- indicators of subclinical vitamin A deficiency:
  - functional: night blindness I
  - biochemical: serum retinol; breast-milk retinol; RDR (relative dose response test); MRDR (modified relative dose response test); S30DR (serum 30-day dose response)
  - histological: CIC/ICT (conjunctival impression cytology/impression cytology with transfer).

Serum retinol levels among children 6–71 months of age can be used as a proxy for vitamin A status in early infancy.

A public health problem exists when:

- the prevalence in a population of at least two biological indicators of vitamin A status is below the cut-off level;

or when

- one biological indicator of deficiency is supported by at least four (two of which are nutrition and diet-related – see below) of a composite of demographic and ecological risk factors. These risk factors include:

  – Infant mortality rate (IMR) >75/1000 live births;
  under-5 year mortality rate >100/1000 live births

  – Full immunizations coverage, or particularly measles immunization coverage, in < 50% of children 12–23 months of age

  – < 50% prevalence of breastfeeding in infants 6 months of age

  – Median dietary intake < 50% of recommended safe level of intake among 75% of children 1–6 years of age

  – Two-week period prevalence of diarrhoea $\geq$ 20%

  – Measles CRF (case fatality) rate $\geq$ 1 %

  – No formal schooling for $\geq$ 50% of women 15–44 years of age

  – < 50% of households with a safe water source.

- Two risk factors can involve nutrition and diet-related ecological indicators of areas/populations at risk of VAD. These nutrition and diet-related risk factors include:

  – Breastfeeding pattern:
  (a) < 50% of infants 0–6 months of age receive breast milk;
  (b) < 75% of children 6–18 months of age receive vitamin A-containing complementary foods at least three times per week.

  – Nutritional status: a prevalence of stunting $\geq$ 30% in children under 5 years of age, and wasting $\geq$ 10% in children under 5 years of age.

  – Low birth weight: $\geq$ 15%

  – Food availability: < 75% of households consume vitamin A-rich foods three times a week.

  – Dietary patterns for children 6–71 months of age and pregnant/lactating women: < 75% consume vitamin A-rich foods three times a week.

  – Food frequency: foods of high vitamin A content are eaten less than three times a week by $\geq$ 75% of vulnerable groups.

VAD control activities include:

- improving dietary diversity and quantity;
- improving dietary quality through food fortification; and
- appropriate amount and frequency of supplements.

It is usually appropriate to promote a mix of these activities.

Annex 6. Example of criteria for mother-friendly care[37]

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 follow-up 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.

[37] Adapted with permission from the Mother-Friendly™ Childbirth Initiative of the CIMS (Coalition for Improving Maternity Services) and from the ten priorities for perinatal care developed during a meeting of the Task Force on Monitoring and Evaluation of Perinatal Care (Bologna, Italy, 2000) organized by the Child Health and Development Unit of the WHO Regional Office for Europe. More information on this Initiative and references for the scientific evidence for these recommendations can be found on *www.motherfriendly.org* and in *Birth*, 2001, 28(2):79–83) and *Birth*, 2001, 28(3):202–207).

Annex 7. Education checklist

Infant and young child feeding topics

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

13. Assist mothers to sustain lactation during separation from their infants, including during hospitalization or illness of mother or child and when returning to work or school.	Milk expression, handling and storage; alternative feeding methods; cup-feeding; cause, prevention and management of common associated difficulties such as low milk supply; coordinating out-of-home activities with breastfeeding; workplace support.
14. Explain the *International Code of Marketing of Breast-milk Substitutes* and World Health Assembly resolutions, current violations, and health worker responsibilities under the *Code*.	Main provisions of the *Code* and WHA resolutions, including responsibilities of health workers and the breast-milk substitute, bottles and teats industries; violations by infant food companies; monitoring and enforcement of the *Code*.
15. Describe what foods are appropriate to introduce to children at various ages and which foods are available and affordable to the general population.	Developmental approach to introducing complementary foods; foods appropriate at various ages; available foods and their costs; incomes of local families and how income levels affect their abilities to afford various foods.
16. Ask appropriate questions of mothers and other caregivers to identify sub-optimal feeding practices with young children between 6 and 24 months of age.	Growth patterns of breastfed infants; complementary foods: when, what, how, how much; micronutrient deficiencies/supplements; young child feeding history; typical problems.
17. Provide mothers and other caregivers with information on how to initiate complementary feeding, using the local staple.	Local staples and nutritious recipes for first foods; practise counselling mothers; common difficulties and solutions.
18. Counsel mothers and other caregivers on how to gradually increase consistency, quantity, and frequency of foods, using locally available foods.	Guidelines for feeding young children at various ages and stages of development; potential difficulties and solutions regarding feeding and weaning; Essential Nutrition Actions.
19. Help mothers and other caregivers to continue feeding during illness and assure adequate recuperative feeding after illness.	Energy and nutrient needs; appropriate foods and liquids during and after illness; strategies for encouraging child to eat and drink; local beliefs about feeding during illness; appropriate feeding support during hospitalization; relactation.
20. Help mothers of malnourished children to increase appropriate food intake to regain correct weight and growth pattern.	Feeding recommendations for malnourished children; micronutrient supplements for malnourished children.
21. Inform mothers of the micronutrient needs of infants and young children and how to meet them through food and, when necessary, supplementation.	Micronutrient needs of infants and young children (iron, vitamin A, iodine, others); meeting these needs with food (breastfeeding and complementary foods); supplementation needs.
22. Demonstrate good interpersonal communication and counselling skills.	Listening and counselling skills, use of simple language, providing praise and support, considering mother's viewpoint, trials of new practices.
23. Facilitate group education sessions related to infant and young child nutrition and maternal nutrition.	Adult education methods; strategies for preparing and facilitating competency-based, participatory sessions.
24. Counsel mothers about prevention and reduction of mother-to-child-transmission of HIV/AIDS; options and risks of various feeding methods to consider when HIV-positive.	Modes of mother-to-child-transmission of HIV and how to prevent or reduce them; counselling confirmed HIV-positive mothers about feeding options and risks.
25. Provide guidance on feeding of infants and young children in emergencies and appropriate protection, promotion and support in these circumstances.	Policies and guidelines on feeding in emergencies; appropriate promotion and support; compliance with the *International Code of Marketing of Breast-milk Substitutes* and WHA resolutions.

Annex 8. Community outreach and support for infant and young child feeding

Contact points that can be used for community outreach and support

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

Channels that can be used for community outreach and support

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

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

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

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

Annex 9. Family planning for the breastfeeding woman[38]

Breast milk is the best food for babies. In some situations the baby's life depends on continuing to breastfeed. Therefore it is very important to prevent another pregnancy that would cut off breastfeeding.

Breastfeeding itself helps to prevent pregnancy. Breastfeeding alone, without another family planning method, can provide effective protection against pregnancy for the first six months after delivery. It does so if:

- the woman has not had her first menstrual period since childbirth (bleeding in the first 56 days – 8 weeks – after childbirth is not considered menstrual bleeding); and

- the woman is fully or nearly fully breastfeeding – at least 85% of the baby's feedings are breast milk.

This is called the Lactational Amenorrhoea Method (LAM).

By definition, a woman is not using LAM if the baby gets substantial food other than breast milk ***or*** the mother's menstrual periods return ***or*** the baby reaches six months of age. To protect herself from pregnancy, she should then:

- Choose another effective family planning method that does not interfere with breastfeeding (not combined oral contraceptives before her baby is six months old); and

- Continue to breastfeed her baby if possible, even while beginning to give the baby other food. Breast milk is the healthiest food for most babies during the first two years of life.

All breastfeeding women, whether or not they are using LAM, should be counselled on:

- when they can and should start particular family planning methods; and

- the advantages and disadvantages of each method, including any effects on breastfeeding.

If a breastfeeding woman needs or wants protection from pregnancy in addition to LAM, she should first consider non-hormonal methods (IUDs, condoms, female sterilization, vasectomy, or vaginal methods). She also can consider fertility awareness-based methods, although these may be hard to use. None of these methods affects breastfeeding or poses any danger to the baby.

Women who are breastfeeding can start progestogen-only methods – progestogen-only oral contraceptives, long-acting injectables, or *Norplant* implants – as early as six weeks after childbirth.

The estrogen hormone in combined oral contraceptives may reduce the quantity and quality of breast milk. Therefore the World Health Organization recommends that breastfeeding women wait at least six months after childbirth to start using them. Another method, if needed, can be used until then.

[38] Adapted from Johns Hopkins, WHO, USAID. *The Essentials of Contraceptive Technology*. *A Handbook for Clinic Staff*. Johns Hopkins Population Information Program.

Annex 10. HIV and infant feeding recommendations

Situation	*Guidelines for health workers*
Mother's HIV status is unknown	▪ Promote availability and use of HIV testing and counselling ▪ Promote breastfeeding as safest infant feeding method (exclusive breastfeeding for first 6 months, introduction of appropriate complementary foods at about 6 months, and continued breastfeeding to 24 months and beyond) ▪ Counsel the mother and her partner on how to avoid exposure to HIV.
HIV-negative mother	▪ Promote breastfeeding as safest infant feeding method (exclusive breastfeeding for first 6 months, introduction of appropriate complementary foods at about 6 months, and continued breastfeeding to 24 months and beyond) ▪ Counsel the mother and her partner on how to avoid exposure to HIV.
All HIV-positive mothers	▪ Provide anti-retroviral drugs to prevent MTCT ▪ Counsel mother on the risks and benefits of various infant-feeding options, including the acceptability, feasibility, affordability, sustainability and safety of the various options ▪ Guide the mother to choose the most appropriate infant-feeding option, according to her own situation ▪ Counsel mother on infant feeding after six months ▪ Refer the mother to family planning and child care services, as appropriate.
HIV-positive mother who chooses to breastfeed	▪ Promote safer breastfeeding (exclusive breastfeeding with early cessation when replacement feeding is acceptable, feasible, affordable, sustainable and safe) ▪ Support the mother in planning and carrying out a safe transition from exclusive breastfeeding to replacement feeding ▪ Prevent and treat breast conditions of mothers. Treat thrush in infants.
HIV-positive mother who chooses other breast milk option	▪ Provide support to the mother to carry-out her option as safely as possible.
HIV-positive mother who chooses replacement feeding	▪ Provide the mother with the skills to carry out her choice ▪ Support her in her choice (including cup-feeding, hygienic preparation and storage, health care, family planning services).

Annex 11. Infant and young child feeding in emergencies

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

The country has ensured that:

1. A policy has been endorsed or developed to address:

   - Protection, promotion and support of breastfeeding and adequate complementary feeding in emergencies.

   - Procurement, management, distribution, targeting and use of breast-milk substitutes, commercial infant foods and drinks and infant feeding equipment in emergencies in compliance with the *International Code of Marketing of Breast-milk Substitutes* (*26*) and subsequent WHA resolutions.

   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, November 2001 (*47*).

   - *Infant feeding in emergencies: policy, strategy and practice.* Report of the Ad Hoc Group on Infant Feeding in Emergencies, May 1999 (*48*).

   - *Infant feeding in emergencies: module 1 for emergency relief staff.* Core Group on Infant Feeding in Emergencies, November 2001 (*49*).

   All documents are available at web site *http://www.ennonline.net.*

2. A person or team responsible for national response and coordination with 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.

   - Representation of the national government during an emergency response in the following coordination activities: policy development; intersectoral coordination; development of an action plan that identifies agency responsibilities and mechanisms for accountability; dissemination of the policy and action plan to operational and non-operational agencies, including donors.

   - Involvement of affected communities in the planning process.

3. A national contingency plan to undertake activities to facilitate exclusive breastfeeding and appropriate complementary feeding and to minimize the risk of artificial feeding has been developed and resources identified for implementation during an emergency. The plan includes the following requirements in an emergency:

   - Assessment and ongoing monitoring activities will include demographic data disaggregated by age, and data on infant and young child feeding practices and support to determine priorities for action and response.

- Conditions will be created to support exclusive breastfeeding and appropriate complementary feeding (including general conditions and supportive care for all mothers and caregivers, basic aid and skilled help for mothers/caregivers experiencing problems with feeding).

- Guidelines that comply with the *International Code of Marketing on Breast-milk Substitutes* and subsequent World Health Assembly resolutions will be provided on the appropriate procurement, management, distribution, targeting and use of breast-milk substitutes and other milks, bottles and teats; adherence to these guidelines will be monitored and enforced.

- Current contact information on national infant feeding expert groups that can be consulted in an emergency situation will be available.

4. Appropriate material on infant and young child feeding in emergencies has been integrated into existing pre-service and in-service training for emergency management and relevant health care personnel. Materials include:

    - Policies and guidelines relevant to infant and young child feeding in emergencies.

    - Appropriate knowledge and skills to support caregivers in feeding infants and young children in the special circumstances of emergencies.

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

Useful training materials include:

- Core Group on Infant Feeding in Emergencies. *Infant feeding in emergencies. Module 1 for emergency relief staff: manual for orientation, reading and reference*. Draft, November 2001. Available at web site: *www.ennonline.net* or from *fiona@ennonline.net* (*49*).

- Core Group on Infant Feeding in Emergencies. *Infant feeding in emergencies. Module 2 for health and nutrition workers in emergency situations: manual for practice, instruction and reference.* Draft 2003. Available at web site: *www.ennonline.net* or from *fiona@ennonline.net* (*50*).

- WHO, UNHCR, IFRC, WFP. *The management of nutrition in major emergencies. Annex 6: Guiding principles for feeding infants and young children in emergencies.* Geneva, World Health Organization, 2000 (*51)*. (*Note*: WHO/NHD will publish in the near future *Guiding principles for feeding infants and young children during emergencies*. The summary of this document is currently available in Annex 6 cited above.)