The status of policy and programmes on infant and young child feeding in 40 countries

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Optimal breastfeeding not only saves the lives of children under 5 years, but also improves children’s quality of life. In spite of proven benefits and repeated emphasis, the rate of exclusive breastfeeding among children less than 6 months of age is only 36% globally. The Global Strategy for Infant and Young Child Feeding provided a framework for action in 10 areas, and identified the need to assess the implementation of policies and programmes in order to identify gaps and to take action to bridge them. We have utilized the World Breastfeeding Trends Initiative (WBTi) tool to make such an assessment. The WBTi has been introduced in 81 countries and 40 of these had completed their assessment by April 2011. Their findings point out specific gaps in both the policy and programmes in all 10 areas of action identified by the tool. This shows that countries need to work in a co-ordinated manner, with clear plans and committed financial resources, to address gaps in all 10 areas of action. This can result in strong advocacy efforts as well as consensus-based action for the effective implementation of the Global Strategy for Infant and Young Child Feeding to enhance rates of optimal feeding practices.

Keywords Breastfeeding, infant and young child feeding, Millennium Development Goals (MDGs), policy

KEY MESSAGES

- There has been a paucity of information on policy and programmes to implement the Global Strategy for Infant and Young Child Feeding.
- Our analysis shows the World Breastfeeding Trends Initiative (WBTi) tool to be competent for assessing what countries are doing to give effect to policy and programmes in the 10 areas of action identified in the Global Strategy, and what specific gaps exist.
- The WBTi analysis highlights the systematic lack of attention given to policy and programmes for enhancing optimal breastfeeding practices.
Introduction

Prioritizing nutrition and building effective plans for improving the nutritional status of women and children, and especially of infants, is imperative to meet Millennium Development Goals 4 and 5: reduce under-5 mortality and morbidity, and maternal mortality (Bhutta et al. 2008; Bryce et al. 2008). Optimal infant and young child feeding (IYCF) practices—initiation of breastfeeding within 1 hour of birth, exclusive breastfeeding for the first 6 months and timely and appropriate complementary feeding after 6 months along with continued breastfeeding till 2 years or beyond—are key to reducing malnutrition and mortality of children under 5 years of age (UNICEF 2009). Interventions to improve IYCF practices have been recognized as ‘core’ interventions having the highest capacity to effect change in malnutrition (Bhutta et al. 2008). However, the global coverage of exclusive breastfeeding among children less than 6 months of age is dismally low at only 36%, which means that only 49 million out of about 136 million babies born annually could practise exclusive breastfeeding for the first 6 months (WHO 2011).

The importance of exclusive breastfeeding for the first 6 months for child survival while enhancing nutritional status has been clearly documented (Jones et al. 2003; Darmstadt et al. 2005; Bhutta et al. 2008), in particular its role in preventing diarrhoea (WHO 2009a), pneumonia (Rudan et al. 2008) and thus reducing infant morbidity and mortality. ‘Breastfeeding counseling’ has stood the test of ‘admissible evidence’, being one of the three nutritional interventions for child survival (Horton 2008).

In 2002, the World Health Assembly ( WHA) adopted the Global Strategy for Infant and Young Child Feeding. This provided a framework for action on essentially 10 areas to improve optimal IYCF practices, namely national policy, programme and co-ordination; Baby-Friendly Hospital Initiative (BFHI); implementation of the International Code of Marketing of Breastmilk Substitutes; maternity protection; health and nutrition care system; mother support and community outreach; information support; infant feeding and HIV; infant feeding during emergencies; and monitoring and evaluation (WHO/UNICEF 2002). The UNICEF executive board endorsed it in the same year.

There is a paucity of information in the public domain about the status of policy and programmes in the abovementioned areas on IYCF, though data on IYCF practices are widely available. This highlights a need to monitor and track programmes and policies to identify gaps, and initiate national actions. In 2003, the World Health Organization (WHO) published ‘Infant and Young Child Feeding: A tool for assessing national practices, policy and programmes’ (WHO 2003) to monitor implementation of the Global Strategy and encourage countries to uncover any gaps in policy and programmes so they can be filled. The World Breastfeeding Trends Initiative (WBTi) tool is an adaptation of the WHO tool; it develops the WHO tool further to mobilize national actions to enhance optimal IYCF practices.

Using feedback from regions where the WHO tool was tested, the WBTi made assessment simpler by colour coding the results. In addition, the WBTi questionnaire can be adapted to include new concerns on the implementation of each area of action addressed in the Global Strategy. For instance, the WBTi tool was updated in 2008–09 to include global developments on ‘maternity protection’ and ‘mother support’. WBTi also made it possible to add web-based software to interpret the findings, to make country findings accessible and observe trends after a few years and repeatedly. It has been introduced in 81 countries, of which 40 have completed their assessment, documented gaps and reported their findings. This paper provides key findings of the status of policy and programmes on IYCF from these 40 countries and discusses the way forward.

Methods

Process for national assessment

The International Baby Food Action Network (IBFAN) Asia prepared a set of guidelines and training materials for implementation of the WBTi at the national level. This was launched in eight countries of south Asia in 2005, and a repeat assessment was conducted in 2008 to study trends. Having seen the success in generating action locally, it was introduced to other regions of the world. An international core group was trained in June 2008. The core group members, mostly the regional co-ordinators of IBFAN, conducted regional training of national contacts in South Asia, East Asia, Southeast Asia, Africa and the Latin America and Caribbean region (LAC) in September/October 2008, leading to the introduction of the WBTi tool in 50 countries. From 2009 to 2011, 31 countries were added in the Arab world, Africa and the Oceania region.

Trained country contacts lead the assessment process at national level and co-ordinate a core group to conduct the national assessment. The core group typically consists of representatives of civil society organizations, governments, professional organizations, medical colleges, UNICEF and WHO, and other concerned organizations and individuals. The co-ordinator briefs the core group and introduces the tool and the process. Each member of the core group is assigned with a specific task to study the given indicator/s. Data on IYCF practices are used from the country data which are national in scope. Information on policy and programmes is gathered using relevant documentation and/or interviews. All information provided usually has an authentic source that needs to be documented. This information is utilized to fill up the questionnaire (http://www.worldbreastfeedingtrends.org/docs/Final-questionnaire-2011.pdf). These findings are presented to the core group members and agreed upon. This information is then presented to a larger group of stakeholders who identify and document achievements and gaps, and develop recommendations. Consensus is built among the stakeholders on gaps and recommendations. Once achieved, these are sent to the central team at IBFAN Asia Regional office. The IBFAN Asia team conducts the primary analysis as per the checklist (like authenticity of the information source used for the programme and policy indicators, and whether data used for IYCF practice indicators are national in scope) and asks for clarifications from the country co-ordinator if there are any queries.

After receiving the revised data, a reassessment is done by the regional co-ordinating office and final data are shared with the country co-ordinator for approval. Once the findings are finalized these are uploaded onto the web-based tool. The web
### Table 1: Subset of questions for each of the 10 WBTi indicators of infant and young child feeding policy and programmes

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National policy, programme and co-ordination</strong></td>
<td>(1) A national infant and young child feeding/breastfeeding policy has been officially adopted/approved by the government.</td>
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<tr>
<td></td>
<td>(2) The policy promotes exclusive breastfeeding for the first 6 months, complementary feeding to be started after 6 months and continued breastfeeding up to 2 years and beyond.</td>
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<td></td>
<td>(3) A national plan of action has been developed with the policy.</td>
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<td></td>
<td>(4) The plan is adequately funded.</td>
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<td></td>
<td>(5) There is a national breastfeeding (infant and young child feeding) committee.</td>
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<td></td>
<td>(6) The national breastfeeding (infant and young child feeding) committee meets and reviews on a regular basis.</td>
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<td></td>
<td>(7) The national breastfeeding (infant and young child feeding) committee links effectively with all other sectors like health, nutrition, information etc.</td>
</tr>
<tr>
<td></td>
<td>(8) Breastfeeding committee is headed by a co-ordinator with clear terms of reference.</td>
</tr>
<tr>
<td><strong>Baby-Friendly Hospital Initiative</strong></td>
<td>(10 steps to successful breastfeeding)</td>
</tr>
<tr>
<td></td>
<td>(1) Quantitative: percentage of BFHI hospitals.</td>
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<tr>
<td></td>
<td>(2) Qualitative to find skilled training inputs and sustainability of BFHI: this subset looks at the percentage of BFHI-designated hospitals that have been certified after a minimum recommended training of 18 hours for all its staff working in maternity services.</td>
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<td></td>
<td>(3) BFHI programme relies on training of health workers.</td>
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<tr>
<td></td>
<td>(4) A standard monitoring system is in place.</td>
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<td></td>
<td>(5) An assessment system relies on interview of mothers.</td>
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<td></td>
<td>(6) Reassessment systems have been incorporated in national plans.</td>
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<tr>
<td></td>
<td>(7) There is a time-bound programme to increase the number of BFHI institutions in the country.</td>
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<tr>
<td><strong>Implementation of the International Code</strong></td>
<td>(1) No action taken.</td>
</tr>
<tr>
<td></td>
<td>(2) The best approach is being studied.</td>
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<tr>
<td></td>
<td>(3) National breastfeeding policy incorporating the Code in full or in part but not legally binding and therefore unenforceable.</td>
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<td></td>
<td>(4) National measures (to take into account measures other than law) awaiting final approval.</td>
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<tr>
<td></td>
<td>(5) Administrative directive/circular implementing the Code in full or in part in health facilities with administrative sanctions.</td>
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<tr>
<td></td>
<td>(6) Some articles of the Code as a voluntary measure.</td>
</tr>
<tr>
<td></td>
<td>(7) Code as a voluntary measure.</td>
</tr>
<tr>
<td></td>
<td>(8) Some articles of the Code as law.</td>
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<tr>
<td></td>
<td>(9) All articles of the Code as law.</td>
</tr>
<tr>
<td></td>
<td>(10) All articles of the Code as law, monitored and enforced.</td>
</tr>
<tr>
<td><strong>Maternity protection</strong></td>
<td>(1) Women covered by the national legislation are allowed the following weeks of paid maternity leave:</td>
</tr>
<tr>
<td></td>
<td>• Any leave &lt; 14 weeks = 0.5 (score)</td>
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<td></td>
<td>• 14–17 weeks = 1 (score)</td>
</tr>
<tr>
<td></td>
<td>• 18–25 weeks = 1.5 (score)</td>
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<tr>
<td></td>
<td>• ≥26 weeks = 2 (score)</td>
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<td></td>
<td>(2) Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily.</td>
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<tr>
<td></td>
<td>• Unpaid break = 0.5 (score)</td>
</tr>
<tr>
<td></td>
<td>• Paid break = 1 (score)</td>
</tr>
<tr>
<td></td>
<td>(3) Legislation obliges private sector employers of women in the country to give at least 14 weeks paid maternity leave and paid nursing breaks.</td>
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<td></td>
<td>(4) There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector.</td>
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<td></td>
<td>(5) Women in informal/unorganized and agriculture sector are:</td>
</tr>
<tr>
<td></td>
<td>• accorded some protective measures</td>
</tr>
<tr>
<td></td>
<td>• accorded the same protection as women working in the formal sector.</td>
</tr>
<tr>
<td></td>
<td>(6) a. Information about maternity protection laws, regulations or policies is made available to workers.</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.</td>
<td>(7) Paternity leave is granted in the public sector for at least 3 days.</td>
</tr>
<tr>
<td></td>
<td>(8) Paternity leave is granted in the private sector for at least 3 days.</td>
</tr>
<tr>
<td></td>
<td>(9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.</td>
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<tr>
<td></td>
<td>(10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during the breastfeeding period.</td>
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<tr>
<td></td>
<td>(11) ILO MPC No 183 has been ratified, or the country has a national law equal to or stronger than C183.</td>
</tr>
<tr>
<td></td>
<td>(12) The ILO MPC No 183 has been enacted, or the country has enacted provisions equal to or stronger than C183.</td>
</tr>
</tbody>
</table>

**Health and nutrition care systems**

| (1) A review of health provider schools and pre-service education programmes in the country indicates that infant and young child feeding curricular session plans are adequate/ inadequate. |
| (2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care. |
| (3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers. |
| (4) Health workers are trained with responsibility towards Code implementation as a key input. |
| (5) Infant feeding-related content and skills are integrated, as appropriate, into training programmes focusing on relevant topics (diarrhoeal disease, acute respiratory infection, integrated management of childhood illness, well-child care, family planning, nutrition, the Code, HIV/AIDS, etc.) |
| (6) These in-service training programmes are being provided throughout the country. |
| (7) Child health policies provide for mothers and babies to stay together when one of them is sick. |

**Mother support and community outreach**

| (1) All pregnant women have access to community-based support systems and services on infant and young child feeding. |
| (2) All women have access to support for infant and young child feeding after birth. |
| (3) Infant and young child feeding support services have national coverage. |
| (4) Community-based support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development strategy (inter-sectoral and intra-sectoral). |
| (5) Community-based volunteers and health workers possess correct information and are trained in counselling and listening skills for infant and young child feeding. |

**Information support**

| (1) There is a comprehensive national information, education and communication (IEC) strategy for improving infant and young child feeding. |
| (2) IEC programmes (e.g. World Breastfeeding Week) that include infant and young child feeding are being actively implemented at local levels. |
| (3) Individual counselling and group education services related to infant and young child feeding are available within the health/nutrition care system or through community outreach. |
| (4) The content of IEC messages is technically correct, sound, based on national or international guidelines. |
| (5) A national IEC campaign or programme using electronic and print media and activities has channelled messages on infant and young child feeding to targeted audiences in the last 12 months. |

**Infant feeding and HIV**

| (1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding and HIV. |
| (2) The infant feeding and HIV policy gives effect to the International Code/National Legislation. |

(continued)
The tool provides a score and colour coding on the status of implementation of each of 10 indicators (1–10) on policy and programmes, and five (11–15) on IYCF practices. These findings are used for generating reports and report cards.

### The tool to rate indicators

The WBT tool is based on a wide range of indicators, which provide an impartial view of key factors responsible for ensuring optimal feeding practices. Ten indicators relate to policies and programmes, and five to IYCF practices. Each indicator that deals with policies and programmes has a subset of questions that go into finer detail to identify achievements.
Figure 1  Average scores of 10 indicators on policy and programmes

Figure 2  The state of policies and programmes on infant and young child feeding in 40 countries on a scale of 0–100
and gaps. This information indicates how a country is performing in a particular area (Table 1).

Each subset question has a possible score of 0–3 and each indicator has a maximum score of 10. The system of scoring may differ in some indicators depending on the questions asked but each indicator is measured on a scale of 10 and thus the maximum score for the 10 indicators dealing with policy and programmes is 100.

The five indicators dealing with IYCF practices reveal how effectively a country has implemented its policies and programmes. For these indicators, countries have to use secondary numerical data on each indicator from a random household survey that is national in scope. The WBT tool does not undertake primary household surveys.

The maximum score for the five indicators dealing with feeding practices is 50. The maximum score for all 15 indicators is therefore 150.

**Guidelines for scoring and colour coding**

The level of achievement on each indicator from 1 to 10 is then rated on a scale to provide colour coding, as per the guidelines (Table 2) which have been developed using the key to scoring provided in the WHO assessment tool. In the WBT tool, a score of 90% and above is coded green and considered to be maximum achievement. The other three colours in descending order of performance are blue, yellow and red. Please note that throughout the paper all graphs appear only in grey scale. Green, blue and red bars appear ‘black’ and yellow bars appear ‘greyish’. Each bar represents a score out of 10. However, these bars appear in colour in the online version of this article.

**Results**

**Average score of 10 indicators on policy and programmes**

Figure 1 shows the average score for each indicator on policy and programmes on a scale of 1–10. It is clear that many of these indicators have a long way to go to achieve optimal rates of breastfeeding. Maternity protection, HIV and infant feeding, and infant feeding during emergencies received the lowest scores.

![Figure 3](image-url)
The state of policies and programmes on IYCF in each country

Figure 2 gives the combined state of WBTi indicators related to IYCF policies and programmes, measured on a scale of 1–100 for the 40 countries assessed. The average score for the 40 countries is 54.3 for all the 10 indicators. More than half of the countries (23) fall into the yellow band, i.e. below 60; 14 countries fall into the blue band, scoring between 61 and 90; and three countries are in the red band, with scores below 30. No country has yet scored enough to enter the green level, i.e. above 90.

Status of each indicator on policy and programmes

National policy, programme and co-ordination

This indicator, which examines the existence of a national policy and mechanisms of co-ordination and budgeting around breastfeeding and IYCF programmes, gets an average score of 6.52. Figure 3 shows that only six countries scored a full 10; 13 countries scored between 7 and 9, 16 countries scored between 3 and 6.5, and five received a score below 3. An examination of the subset of questions—related to whether a country has a national policy, a national plan of action, or whether a budget is assigned for this purpose—points out exactly where the gaps are and therefore gives an idea of what needs to be done with regard to establishing policy and co-ordination for enhancing optimal breastfeeding rates (see online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-1.pdf). The findings reveal that 33 out of 40 countries report having a policy, but only 25 have a plan and only 11 report that the plan is adequately funded. Similarly, while 28 countries have national committees, only 17 function effectively.

Baby-Friendly Hospital Initiative

(10 steps to successful breastfeeding)

This indicator assesses the BFHI both quantitatively and qualitatively as well the process of re-assessment. The average score is 5.25, clearly showing that the BFHI has not yet become fully integrated into the health system in almost all the countries. Figure 4 shows that only one out of 40 countries, namely the Philippines, scored a full 10. Twelve countries fall in the red band,
scoring below 3.5, of which four countries score 0; 15 countries fall in the yellow band, and 12 in the blue band. The subset for this indicator is divided into three parts. The assessments show that only 22 countries report having more than 50% of the hospitals achieving BFHI status. Further, only 14 countries report that the majority of the BFHI hospitals used 18-hour training as a standard practice for health workers. Similarly, 18 out of 40 indicate that there are systems of re-assessment in place. The subset findings indicate the specific actions that individual countries need to take to mainstream BFHI (see online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-2.pdf for details of subset scores for each country).

Implementation of the International Code of Marketing of Breastmilk Substitutes
The average score for this indicator is 7.37, the highest of all indicators. Nine countries score a complete 10, and fall within the green band and 23 countries score between 7 and 9, falling within the blue band; the rest are below this level (Figure 5). However, as the analysis of the subsets indicates (see online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-3.pdf), there is much scope for countries to improve the protection of breastfeeding through adopting and implementing the International Code and enacting national legislation. Even countries with good scores need to work on effective implementation and monitoring, as merely having a law is not enough.

Maternity protection
This indicator, which measures the status of maternity entitlements, including maternity leave, breastfeeding breaks, paternity leave and non-discrimination, gets the second lowest score with an average of 4.37. Not a single country has a perfect score of 10; only one country scores 9, 14 countries have scores between 7 and 9, and 20 countries score below 3.5 (Figure 6). Detailed findings from the subset of questions (online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-4.pdf).
reveal that only three countries provide maternity leave of more than 26 weeks, and 29 give less than 14 weeks. At least one paid breastfeeding break is given in 29 countries, and 14 countries have legislation requiring the private sector to give at least 14 weeks of maternity leave. Six countries report similar levels of protection for women working in the unorganized sector. Legislative provisions for accommodation for breastfeeding or childcare at worksites are provided in 16 countries only. Paternity leave of at least 3 days is provided in half the countries. These findings indicate a profound lack of support to women in each of the assessed countries.

Health and nutrition care systems
This indicator examines whether health care providers undergo skilled training for counselling on breastfeeding and IYCF, whether their pre-service curriculum enables health workers to support women at birth, and their responsibility towards International Code implementation. Only three of 40 countries have a full score of 10; the average score is 6.01 (Figure 7). Eleven countries score between 7 and 9, 24 countries score between 4 and 6.5 and only two countries are in the red band, of which one has score of zero. Details of subsets reveal that in only six countries are pre-service plans adequate, in nine countries standards guidelines on support at birth are in place and in 19 countries training programmes are in place (online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-5.pdf). However, in only eight countries are health workers trained about their responsibility towards Code implementation. The scores indicate that national health and nutrition systems in the assessed countries have not integrated or built capacity to protect and support optimal breastfeeding practices.

Mother support and community outreach: community-based support for the pregnant and breastfeeding mother
This indicator examines if there are mother support and community outreach systems in place to protect, promote and support optimal practices. It gets an average score of 5.55, showing that in most countries pregnant women and women who have just given birth have limited access to community-based support systems on IYCF. No countries fall within the green band and only three countries score 9. Thirteen countries are in the blue band, scoring between

Figure 6 The state of maternity protection in 40 countries on a scale of 0–10
7 and 9. Six countries score below 3 and one scores zero (Figure 8). Deeper examination of the subset of questions reveals that although 17 countries report having community-based support integrated in the child health and development strategy, just six countries report that all pregnant and lactating women have access to such services (online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-6.pdf). Similarly, only six countries report that their community-based workers possess the skills and knowledge to counsel on breastfeeding/IYCF.

**Information support**

This indicator examines what kind of information on IYCF is handed out by the State through media or other methods, whether it is technically correct or not, and what are the Information, Education and Communication (IEC) strategies. The average score of this indicator is 6.6 with only three countries getting a full 10. The majority of countries fall in the blue band, scoring between 7 and 9; 12 countries score between 4 and 6 and five score below 3 (Figure 9). An analysis of the subsets shows that 29 countries provide technically correct information to their population, and only 11 have a comprehensive IEC strategy for improving IYCF practices (online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-7.pdf). Just half of the countries report that IEC programmes are being actively implemented at local levels. The results indicate a high level of interest but the lack of a comprehensive approach.

**Infant feeding and HIV**

This indicator examines what kind of support on IYCF is made available at policy and programme level to women who are found to be HIV-positive. The average score of the 40 countries for this indicator is 4.78 (Figure 1), with none reaching the green level. Sixteen countries fall within the red band, scoring below 3.5. Four countries score zero, indicating that these countries have very inadequate policies and programmes related
to infant feeding and HIV (Figure 10). The subsets show that out of 40 countries assessed, only 17 countries have a comprehensive national policy on IYCF that includes infant feeding and HIV (online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-8.pdf). Of all the regions studied, countries from the African region reported having adequately included infant feeding and HIV in their national policies. In only eight countries is it reported that health workers are trained in HIV and infant feeding. Six countries report that mothers are supported in their decisions on infant feeding, while only five report that ongoing monitoring is in place.

Infant feeding during emergencies
This indicator examines how women are supported during emergency or disaster situations to maintain feeding of their infants, and what kind of policy there is to protect and support mothers for appropriate feeding of their babies. The indicator scored the lowest average of all indicators, at 2.37, showing an overall lack of preparedness for such situations. Only two out of 40 countries score a 10, having prioritized infant feeding during emergencies and included it in their policy on IYCF. The majority, 28 countries, are in the red band, with 16 countries scoring zero (Figure 11). Nine countries report having a policy that includes infant feeding in emergencies; however, only two report being ready to support breastfeeding mothers if a disaster strikes (online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-9.pdf). In eight countries persons have been given responsibility for this task, four have identified resources for implementation of their plan and two have put it into their pre-service curriculum.

Monitoring and evaluation
This indicator examines if countries collect data routinely and whether these data are used to improve IYCF practices. The average score for this indicator was 5.75. Only four out of 40 countries scored a perfect 10, with 12 countries scoring between 7 and 9 and 16 countries between 4 and 6. Eight countries fall in the red band, scoring below 3; of these, three countries have
scores of zero (Figure 12). Twelve countries report that monitoring and evaluation is built into their major programmes; 14 report that the policy makers use data from a management information system (online at: http://www.worldbreastfeedingtrends.org/docs/INDICATOR-10.pdf). Monitoring of key IYCF practices is built into a broader nutrition surveillance or health monitoring system or surveys in only 15 countries. The results indicate that due emphasis is not being given to this indicator by the majority of countries in the study.

**Indicators on IYCF practices**

Optimal IYCF practices include initiation of breastfeeding within 1 hour of birth, exclusive breastfeeding for the first 6 months of life and addition of appropriate and adequate family foods for complementary feeding after 6 months, together with continued breastfeeding for 2 years or beyond. These five indicators of resultant IYCF practices are also examined from the available secondary data that is national in scope. While data on practices are based on actual figures, colour rating is done by IBFAN Asia.

Figure 13 provides an average for each IYCF practice indicator from among the countries where these data were available and reported.

The results indicate that IYCF practices in the assessed countries are nowhere near optimal. The average rate of initiation of breastfeeding within 1 hour of birth as reported by 36 countries is just above 50%. Exclusive breastfeeding for the first 6 months as reported by 38 countries is 42.5%. The median duration of breastfeeding is 18.6 months. Bottle-feeding as reported by 32 countries is 31.7%. The percentage of breastfed babies receiving complementary foods at 6–9 months is only 65.2%. Some countries do not even have national data of these indicators.

Country-wise details can be viewed online at: http://www.worldbreastfeedingtrends.org/docs/Ind-11-15.pdf.

**Discussion**

One aim of the UN Secretary General’s Global Strategy for Women’s and Children’s Health is that by 2015, 21.9 million
more infants in 49 least developed countries will be exclusively breastfed for the first 6 months of life (UN Secretary General 2010). The Global Strategy for Infant and Young Child Feeding (WHO 2002) and several World Health Assembly (WHA) resolutions on infant and young child nutrition also call for increased programme and policy focus to enhance rates of exclusive breastfeeding for the first 6 months. It is well known that rates of breastfeeding and complementary feeding can be enhanced through strengthening investments for community-based approaches (Victora et al. 2008).

A striking fact that emerges from the WBTi analysis of the Global Strategy for IYCF in 40 countries is the systematic lack of attention to policy and programmes for enhancing optimal breastfeeding practices. Policy, co-ordination, funds, training and monitoring are just some of the factors that must be mainstreamed into all child health, nutrition and development programmes, as well as in sectors such as labour, welfare and so on.

The low scores for the indicator on National Policy, Programme and Coordination highlight the need to put policies in place so as to ensure support to women at birth, at home, in the community and the workplace. Effective outreach programmes need to be created which are easily accessible to women needing help and support. Studies have shown that health policy and programme interventions can enhance exclusive breastfeeding for the first 6 months, as women who receive education on breastfeeding during pregnancy are more likely to exclusively breastfeed (Valdes et al. 1993; Pugin et al. 1996; de Oliveira et al. 2001).

The adoption of BFHI, through its 10 steps to successful breastfeeding, has been an effective strategy to promote and protect breastfeeding by the provision of necessary support to mothers to initiate and maintain lactation even after discharge from hospitals (Kramer et al. 2001). A Brazilian study (Lutter et al. 1997) highlights the vital role played by Step 10 of the BFHI: community facilitation of breastfeeding. There is clear evidence that if all women have to be reached for support, the concept ‘baby friendly’ needs to be extended to the community at large. Various studies across the world (Bhandari et al. 2003; Chapman et al. 2004; Aidam et al. 2005; Anderson et al. 2005) have highlighted the vital role of community-based skilled counselling on breastfeeding trained personnel. A recent study
has shown the value of peer counselling by well trained counsellors in Africa, and should be replicated in other parts of
the world (Tylleskar et al. 2011). Studies have also emphasized
that one-to-one counselling is required to achieve higher rates
at 6 months, while group counselling could work to enhance
exclusive breastfeeding at 4 to 6 weeks (Imdad et al. 2011).
Skilled training is essential for both providing technical support
to women on how to hold the baby, the right latching, and so
on, as well as to remove any doubts they may have about their
ability to breastfeed successfully. This health facility approach
must then be linked to community-based support.

The International Code of Marketing of Breastmilk
Substitutes and subsequent WHA resolutions to protect breast-
feeding have been ratified by nearly all countries, including the
40 countries that have carried out the WBTi assessment.
However, as the assessment shows, there are still several
actions to be taken if the Code is to effectively protect and
promote optimal breastfeeding practices. There is ample evi-
dence to show that companies continue to violate the Code or
national legislations and undermine breastfeeding (Allain et al.
2008). The 2010 report of the International Code Documenta-
tion Centre indicates a global upsurge in sales of baby food and
a double digit growth is forecast for several regions by 2015.
Companies are continuing to promote baby foods and their
practices are becoming more insidious, often riding on the
coattails of breastfeeding. Policy intervention is recommended
as strong laws may help to change the situation (International
Code Documentation Centre 2010).

The international instruments obligate States to take appro-
priate measures to ensure the realization of the human right to
adequate food for infants. The infant’s right to food is primarily
based on the mother being able to actualize her rights to
successfully breastfeed her infant. In an analysis of breastfeed-
ing it was concluded that building mothers’ capacity to perform
breastfeeding is essential, as is action to enhance the capacity of
the State to create an enabling environment for breastfeeding
women (Engesveen 2005). In the context of human rights, the
State as the duty bearer is bound to create the enabling

Figure 11 The state of infant feeding during emergencies in 40 countries on a scale of 0–10
environment for a woman to optimally feed, including breastfeed, her child. States thus need to ensure that they take action to create this enabling environment, ratifying the ILO Convention, creating national legislation for maternity protection and mobilizing sufficient resources to implement it.

The WBT assessment shows that maternity protection is not a priority in many countries. This is in spite of the fact that in order to exclusively breastfeed an infant on demand, the mother and infant have to remain in close proximity for the first 6 months of life. Women can also be supported to exclusively breastfeed by having access to lactation rooms where they can safely express and store breastmilk (Fein et al. 2008; Payne et al. 2010; Weber et al. 2011). Such breastfeeding friendly workplaces are likely to be very important in helping women to maintain exclusive and continued breastfeeding, and are more likely to be achieved than on-site daycare. While women working in the formal sector do receive some limited form of protection, women working in the informal and agricultural sectors and those who are self-employed face the most severe challenges in feeding their infants optimally. There is little support for such women in most Latin American and African countries. India offers a vivid example of how these women get left out of policy and programmes, as well as legislation. It would be ideal if all women could be financially compensated for devoting six months to exclusive breastfeeding (Gupta 2008).

The Global Strategy for IYCF highlights the importance of correct policy and programme work in the area of infant feeding and HIV for achieving the targets. The UN Framework for priority action on infant feeding and HIV activities accords the highest priority to the development of a comprehensive national infant and young child policy that includes HIV and infant feeding. The assessment also indicates that having a policy on infant feeding and HIV can pay good dividends. Various factors like risk of stigmatization, financial cost of replacement feeding with the risk of getting pregnant again and increased risk of HIV transmission when doing mixed feeding have been associated with HIV-positive women (Coovadia et al. 2003).
WHO’s guidelines on infant feeding and HIV recognize the important impact of antiretrovirals (ARVs) during the breastfeeding period, and recommend that national authorities in each country decide which infant feeding practice, i.e. breastfeeding with ARV or avoidance of all breastfeeding and feeding with a suitable replacement food, should be promoted and supported by their maternal and child health services (WHO 2010).

During emergencies, women are extremely vulnerable to stress, and this affects their ability to breastfeed successfully, especially if there is no designated space for child care and breastfeeding. Supporting breastfeeding during emergencies is particularly important as women bear the brunt of the responsibility for caring for the family during and after emergencies, and this may interfere with infant feeding. Though some progress has been made internationally to develop guidelines for infant feeding in emergencies (WHO 2007), there is a need to translate them into practice at national level. Some underlying reasons behind failure to implement the policies could be the weak institutionalization of policies, the massive quantities of unsolicited donations of infant-feeding products, the absence of monitoring systems and inadequate co-ordination mechanisms (Borrel et al. 2001). These facts have been duly emphasized in a few recent reports and studies (UNICEF 2010; Lutter et al. 2011).

### Impact of WBTi assessments in taking remedial action

The WBTi assessment underlines the need for political will to mainstream breastfeeding and IYCF policy and programmes in national action. This political will has to translate into action on several fronts to bring a change. Scoring and colour coding have been effective tools in building this political will, as in the
The case of Bhutan and Afghanistan, which were in the red band in the 2005–06 assessment, and which moved upwards in the reassessment in 2009–10. Political will is also apparent in the remedial actions taken by several countries after analyzing results of the assessment.

The process of WBTi assessment brings together several agencies that are concerned with child survival, including civil society, UN organizations and professional bodies. In almost two-thirds of the 40 countries studied, the government ministries and related departments have been actively involved, often leading the assessment. This has helped to reach a consensus on what actions need to be taken on a priority basis.

Based on the assessment, many countries have already initiated actions. Recommendations from various countries include setting up of national breastfeeding committees, establishing co-ordination mechanisms between various sectors that impact IYCF practices such as labour, health and nutrition, and making budgetary provisions available to enhance breastfeeding rates. A total of 373 stakeholders were involved from 40 countries for the assessment exercise and consensus building.

After the first assessment in South Asian countries in 2005–06, report cards on the status of IYCF were used by IBFAN groups for effective advocacy with the programme managers and policy makers. Afghanistan and Bhutan generated national data on IYCF practices between 2005 and 2008–09. After the 2008–09 assessments, the Government of Afghanistan adopted the International Code and organized training for its implementation. The WBTi process helped the Philippines in enacting a new law on expanded breastfeeding promotion that enables working women to breastfeed at workplaces.

The WBTi helps not just in identifying gaps but also in knowing what action needs to be taken to bridge them. The South Asian countries have documented a list of gaps using the WBTi as a lens, informing them where they stand on the Global Strategy. Figure 14 shows the comparative WBTi scores of 2005 and 2008 in South Asia.

**Conclusion**

The WBTi is a competent tool for assessing what countries are doing to give effect to policy and programmes in the 10 areas of action identified in the Global Strategy for Infant and Young Child Feeding. The WBTi findings point out specific gaps in the policy environment and its implementation, which need to be addressed in action plans and stimulate such action. The tool further assesses how well co-ordinated national action is towards protecting, promoting and supporting breastfeeding. Reassessment every 3 years monitors a nation’s progress towards universalizing optimal IYCF practices, and shows which actions have worked successfully and which need further strengthening. The WBTi assessment process, being participatory, brings together various stakeholders to assess the situation on policy and programmes on IYCF and identify gaps so as to create consensus for recommendations for improving programmes and policies. Countries can use the tool as a lens through which to examine the gaps and develop a plan with specific objectives and a well-defined budget in order to bridge the gaps identified.
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Conflict of interest

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