

INFANT AND YOUNG CHILD FEEDING PROGRAMME REVIEW

# Consolidated Report of Six-Country Review of Breastfeeding Programmes

Bangladesh



Benin



The Philippines



Sri Lanka



Uganda



Uzbekistan

April 2010

**Cover Photos:**

Bangladesh: © UNICEF/NYHQ2009-0598/Shehzad Noorani

Benin: © UNICEF Benin

The Philippines: © Hana Bee

Sri Lanka: © Luann Martin

Uganda: © UNICEF/NYHQ1999-0128/Giacomo Pirozzi

Uzbekistan: © UNICEF Uzbekistan/2007/Giacomo

Infant and Young Child Feeding Programme Review – Consolidated Report of Six Country Programme Review

© United Nations Children's Fund (UNICEF)

April 2010

Permission to reproduce any part of this publication is required. The views expressed in this document are solely the responsibility of the contributors and not of UNICEF.

For more information contact:

UNICEF Nutrition Section

3 United Nations Plaza, H-8A

New York, NY 10017, USA

# Acknowledgements

This review of infant feeding programmes was conducted as a joint effort between UNICEF's Nutrition Section and the Academy for Educational Development (AED), in order to understand the factors that influenced breastfeeding programme outcomes, distil general lessons learned from the experience of these countries and make recommendations for programming on infant and young child feeding. The review included detailed individual case studies from six countries, and the findings of this consolidated report draw upon these case studies. The six countries are Bangladesh, Sri Lanka, Uganda, Benin, the Philippines and Uzbekistan, chosen to represent a range of regions and diverse scenarios in terms of breastfeeding programming efforts and outcomes.

On the part of AED, the review was led by Luann Martin, who prepared this report and the country case study reports for Bangladesh, Sri Lanka and Uganda. Ann Brownlee also contributed to the consolidated report, and prepared the case studies for the Philippines and Benin, while Alexander Golubov prepared the report for Uzbekistan.

Special recognition is extended to the UNICEF nutrition and health officers who facilitated the assessments in the six countries: Josephine Iziku Ippe and Mohsin Ali, Bangladesh; Paul Adovohekpe and Anne-Sophie le Dain, Benin; Martha Cayad-an and Elham Monsef, the Philippines; S.M. Moazzem Hossain and Renuka Jayatissa, Sri Lanka; Eric-Alain Ategbo and John Musinguzi, Uganda; and Ali Mahdi, Uzbekistan.

The Infant and Young Child Nutrition Unit team at UNICEF Headquarters – Nune Mangasaryan, Christiane Rudert, Mandana Arabi, and David Clark provided technical inputs and oversight during the review process, and reviewed and finalized this consolidated report and the six country case study reports, especially with regard to the recommendations and UNICEF's role in future IYCF programming. Julia Krasevec contributed to the preparations for the review and the development of the questionnaires.

Interviewees at the Ministries of Health, WHO, development partners, nongovernmental organizations, universities, and professional associations were generous in sharing their experiences and suggestions.

Funding for the case studies was provided by UNICEF, USAID through the Africa's Health in 2010 Project, and AED.

# Acronyms and abbreviations

<b>AED</b>	Academy for Educational Development
<b>AFASS</b>	acceptable, feasible, affordable, sustainable and safe
<b>BBF</b>	Bangladesh Breastfeeding Foundation
<b>BCC</b>	behaviour change communication
<b>BF</b>	breastfeeding
<b>BFHI</b>	Baby-Friendly Hospital Initiative
<b>DHS</b>	Demographic and Health Survey
<b>EBF</b>	exclusive breastfeeding
<b>ECD</b>	early childhood development
<b>ENA</b>	Essential Nutrition Actions
<b>EPI</b>	Expanded Programme on Immunization
<b>HDI</b>	human development index
<b>HRBAP</b>	human rights-based approach to programming
<b>IBFAN</b>	International Baby Food Action Network
<b>IEC</b>	information, education, communication
<b>ILO</b>	International Labour Organization
<b>IMCI</b>	integrated management of childhood illness
<b>IRR</b>	implementing rules and regulations
<b>IYCF</b>	infant and young child feeding
<b>LAM</b>	lactational amenorrhea method
<b>MCH</b>	maternal and child health
<b>MDG</b>	Millennium Development Goal
<b>MTCT</b>	mother-to-child transmission (of HIV)
<b>MNH</b>	maternal and neonatal health
<b>MOH</b>	Ministry of Health
<b>NGO</b>	non-governmental organization
<b>NNP</b>	National Nutrition Programme (Bangladesh)
<b>PHM</b>	public health midwife
<b>PMTCT</b>	prevention of mother-to-child transmission (of HIV)
<b>TIPs</b>	trials of improved practices
<b>UNICEF</b>	United Nations Children’s Fund
<b>USAID</b>	United States Agency for International Development
<b>VHT</b>	village health team
<b>WABA</b>	World Alliance for Breastfeeding Action
<b>WBW</b>	World Breastfeeding Week
<b>WHO</b>	World Health Organization

# Table of Contents

Acronyms and abbreviations	ii
Executive summary	2
<b>1. Introduction</b>	<b>10</b>
<b>2. Country profiles</b>	<b>11</b>
2.1 Demographic, Health, and Development Indicators	11
2.2 Breastfeeding Trends and Contributing Factors	13
<b>3. The problem</b>	<b>19</b>
3.1 Assessment of needs	19
3.2 Main challenges and obstacles	19
<b>4. Response to the problem</b>	<b>21</b>
4.1 Global initiatives	21
4.2 IYCF programme coordination and partners	22
4.3 IYCF-related policies, guidelines, strategies, and action plans	27
<b>5. Key programme components and lessons learned</b>	<b>29</b>
5.1 Advocacy	29
5.2 Code of Marketing of Breastmilk Substitutes	31
5.3 Maternity legislation and workplace support	33
5.4 The Baby-friendly Hospital Initiative	36
5.5 Training and education	40
5.6 Communication	42
5.7 Community-based promotion and support	44
5.8 Infant feeding in difficult circumstances	48
5.9 Integration strategies	51
<b>6. Scale and sustainability</b>	<b>55</b>
<b>7. Challenges and recommendations</b>	<b>56</b>
Appendix A. Questionnaire on IYCF for UNICEF staff	61
Appendix B. IYCF Indicators – Trend Data from the Six Case Study Countries	68
Appendix C. Key resources	69

# Executive Summary

This review of infant and young child feeding (IYCF) was planned in response to UNICEF's midterm review of its Medium-Term Strategic Plan (2006-2013). It examined national efforts to improve IYCF, primarily breastfeeding, during the past 10-15 years in Bangladesh, Benin, the Philippines, Sri Lanka, Uganda, and Uzbekistan. The purpose was to understand the factors that influenced breastfeeding practices and learn from the experience of these countries. An additional aim was to identify main lessons learned for future programming. Information was collected through document review and country visits between July and November 2008.

## EXCLUSIVE BREASTFEEDING TRENDS

Over a 10-year period, the greatest gains in exclusive breastfeeding in the six countries studied were in countries with the lowest baseline rates. Exclusive breastfeeding rates in Benin increased from 10 to 44 percent, in Sri Lanka from 17 to 76 percent, and in Uzbekistan from 2.4 to 26 percent. The Philippines started at 25 percent, rose to 37 percent, and then dropped to 34 percent. Both Bangladesh and Uganda's exclusive breastfeeding rates remained flat at around 45 percent and 57 percent, respectively.

## FACTORS INFLUENCING EXCLUSIVE BREASTFEEDING RATES

A review of the experiences in the six countries suggests various factors that affected programme results in the countries reviewed. However, evaluation data are not available in all cases to make definitive statements on the impact of specific programme interventions. The factors identified in this review include the following:

- **International leadership.** UNICEF and WHO played critical roles at the global level in providing guidance in IYCF, which greatly affected the programmatic choices at country level. The 1990 Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding focused attention on four areas (national breastfeeding committees, maternity practices, maternity legislation, and the regulation of marketing of breastmilk substitutes). The Baby-friendly Hospital Initiative (BFHI) flourished in many countries in the early years due to intensive advocacy by UNICEF and WHO and the dedicated work of breastfeeding professionals. However, insufficient effort both by international agencies and the countries themselves to effectively integrate BFHI into national health systems led to slippage in compliance. When the international donor community was seen as giving greater priority in the late 1990s to other health and development areas as compared to breastfeeding, some countries did so as well. The WHO/UNICEF 2002 Global Strategy for IYCF has infused new energy and prompted countries to re-examine their strategies.

- Enabling environment.** The targets set in the Innocenti Declaration were intended to create an enabling environment for breastfeeding in the workplace, marketplace, and health facility. Maternity protection legislation is likely to have had a relatively small effect on breastfeeding rates in the countries reviewed since most of the legislation now only applies to the very small percentage of women who work in selected public and private institutions which have implemented the legislation, with the exception of Uzbekistan. National Codes of marketing of breastmilk substitutes have diminished the influence of formula companies in the marketplace and health facility, particularly in Bangladesh and Sri Lanka. The importance of ongoing promotion of breastfeeding, laws to regulate the marketing of breastmilk substitutes, and enforcement of these laws was particularly evident in the Philippines where the rates of exclusive breastfeeding dropped when breastfeeding promotion waned and the marketing campaigns of infant formula companies intensified. Recent Code advocacy with impressive results has again energized government and breastfeeding advocates.
- Results orientation and coverage.** The focus on improving support for breastfeeding in maternity facilities had the biggest payoff in Benin, Sri Lanka, and Uzbekistan where from three-fourths to almost all women deliver in health institutions. In Bangladesh and the Philippines, the Baby-friendly Hospital Initiative generated support for breastfeeding among hospital-based health professionals and increased their knowledge and skills. However, a more results-oriented strategy in those countries would have complemented BFHI with a strategy to reach those who do not deliver in health facilities—the majority of women—as well as reaching women beyond the first few days of their infants’ lives. Data show that in countries with low rates of institutional deliveries, significant focus and high coverage of BFHI will not result in increased rates of exclusive breastfeeding in the absence of implementation of IYCF counseling and support at other MCH contacts, community IYCF actions, and at-scale communication efforts. Small-scale and non-comprehensive approaches leave major barriers to improved practices unaddressed and fail to reach critical populations.
- Coordination.** The policy/advocacy, health service provision, and community elements of a comprehensive strategy require coordination. When this occurred, such as in the Philippines around implementation of the Code and development of a national IYCF strategy, the IYCF agenda moved forward. In some countries IYCF was scattered across different ministries with lack of clarity on roles and responsibilities. The result was often lost momentum and opportunities and inefficient use of resources.
- IYCF champions.** Respected, trustworthy champions in many of the countries reviewed have dedicated decades to the protection, promotion, and support of breastfeeding. These individuals often felt part of a global child survival movement. Their evidence-based advocacy, passion, persistence, and persuasive skills moved the agenda globally and nationally.

- **Community outreach.** The community component remains the most underdeveloped component in all country programmes, with small-scale projects and pilots rarely scaled up being common in the countries reviewed. The cadre of public health midwives in Sri Lanka is the most striking example of a country with a programme that reaches women with breastfeeding support in health facilities and their homes. Sri Lanka, however, has not fully tapped into other potential community resources for breastfeeding support. The biggest increase in exclusive breastfeeding rates in Benin happened when the programme included community activities, yet scaling up has proved challenging. In the Philippines the remoteness of some island areas limits posed by a decentralized or “devolved” system and long-term conflict in some regions have presented particular challenges. The human resource requirements, cost, supervision, incentives, coordination requirements, and quality control have been barriers to scaling up community interventions.
- **Timing and frequency of caregiver contacts with health workers.** The results reflect the extent to which programmes took advantage of multiple opportunities to promote and support breastfeeding during contact points in the health system and the community. Sri Lanka provides a continuum of care with contacts at key moments in the life cycle. In Uganda most women do not have any postpartum contact with a health worker. In Bangladesh contact with a community nutrition promoter can be limited to growth monitoring sessions. A common theme in the case studies is the need to improve the interpersonal counseling and problem-solving skills of health providers and community workers to foster trial and adoption of improved feeding practices.
- **Use of multiple channels of communication.** Delivering IYCF messages through multiple channels of communication tailored to the local context – such as literacy levels, media use and evidence on specific barriers to optimal IYCF practices – has been shown to be effective. Uzbekistan was able to increase reach and impact through a creative mix of mass media and traditional channels of communication. A “quick win” approach to communication focusing on the main barrier to exclusive breastfeeding – i.e. giving water together with breastmilk before six months – was used successfully in a national communication strategy in Benin. Both Benin and Uganda used results from formative research to design their communication strategies and messages. In Bangladesh, a communication initiative used an “edutainment” approach through a comic book/animated series to deliver messages on IYCF through schools, radio and TV. The approach proved highly successful, with high recognition levels. The likely impact of print materials in a context of low literacy was considered to be limited. On the other hand the booklets used as part of Sri Lanka’s communication strategy proved successful because of high literacy levels.

## LESSONS LEARNED

The following are some of the lessons that emerge from the experience in the six countries.

- *A diverse set of partners* and integration into existing programme platforms broadens support for IYCF, extends programme reach, and fosters sustainability. Involving government and development partners in the design of strategies and tools helps ensure ownership, implementation of the strategies, and use of the tools.
- *Continuous, effective leadership moves the agenda.* Lack of coordination and weak leadership leads to delays, duplication of efforts, confusion, and ad hoc, often small-scale activities.
- *Evidence-based advocacy* is needed to address lack of awareness, complacency, controversy, and competing priorities. Compelling scientific evidence, authoritative testimony of trusted experts, and coalitions of breastfeeding champions can ignite change.
- *Widespread dissemination of policies and strategies along with orientation of personnel* will help remove them from the shelf and put them into practice.
- *Effective national Code legislation with sustained advocacy*, ongoing monitoring, publicity of violations, and enforcement helps keep negative marketing practices in check.
- *An appropriate balance* is needed for breastfeeding support at maternity, health facility and community levels. A coordinated effort at all levels, with a clear vision of scale and harmonized messages, is essential. BFHI alone cannot be expected to have significant impact on exclusive breastfeeding rates, especially in countries with low institutional delivery rates, unless accompanied by IYCF counseling, promotion and support at key MCH contacts, as well as effective community-based strategies for promotion, counseling, and support that reach the majority of the population.
- *Effective implementation of the “Ten Steps for Successful Breastfeeding”* in health facilities can be an important component in countries where a substantial portion of women deliver in health facilities. The impact will be minimal, however, unless BFHI is institutionalized within the countries’ health systems and cost-effective strategies and mechanisms for decision-maker advocacy, refresher training, and monitoring of the Ten Steps as a mandatory component of norms and standard operating and accreditation procedures are put in place.
- Planning to achieve scale at the outset through broad-based implementation of evidence-based interventions reduces the likelihood of small, ad hoc pilot projects that are never scaled up.
- Training in interpersonal counselling and problem-solving skills increases the effectiveness of health providers and community nutrition promoters. Strategies that engage mothers and their families in making choices and trying improved practices have more impact than the traditional approach of providing “one-way” advice to clients.

- Performance-based training methodologies take into consideration the knowledge and skills required to improve job performance. Training content needs to be tailored to specific job responsibilities and tasks to engage and motivate health workers.
- An integrated training strategy that includes ongoing mentoring, supportive supervision, and a management information system to track training activities results is essential for the effective use of both human and financial resources. Pre-service education on key aspects of IYCF, including adequate clinical practice, is the most cost-effective way to strengthen health workers' IYCF-related knowledge and skills.
- A coherent and comprehensive communication strategy with clearly identified objectives and participant groups and a mix of communication channels can ensure that attention to IYCF extends beyond World Breastfeeding Week and reaches primary audiences. Well-designed and implemented formative research can provide valuable guidance for design of the communication strategy.
- Trusted community members are indispensable resources for IYCF promotion and support, and they need continual mentoring and encouragement. Unreasonable expectations, lack of incentives, and an ever increasing set of duties can diminish the effectiveness of volunteers and increase the dropout rate. Payment of volunteers could help reduce turnover but in the absence of resources for salaries, the effectiveness of various non-monetary incentives should be further explored.
- Advance preparations, training of health workers on infant feeding in emergencies, and ongoing briefings with the media during emergencies can reduce the chances of misguided actions and misinformation.

## RECOMMENDATIONS

The review concludes with a set of recommendations to address eight common issues.

### **1. Develop and implement a comprehensive IYCF strategy for implementation at scale**

- Review programme elements to determine gaps. Assess potential actions in terms of short-term and long-term results, cost-effectiveness, coverage, equity, and potential for sustainability. Use a mix of interventions, based on a generic menu of key interventions, prioritizing them based on contextual factors.
- Develop targeted strategies to reach specific groups, focusing on key actions needed to adequately serve clients at various points of contact, both in the community and health system.
- Focus on the continuum of care for mother and child, from pregnancy through the first two years of life.

- Incorporate gender considerations in the IYCF strategy, including issues such as gender disaggregated IYCF data, gender issues in formative research and situation assessment, gender considerations as appropriate in the recruitment of community based cadres and addressing gender barriers towards good feeding practices in workplace support and communication strategies.
- Develop measurable objectives for IYCF programmes and devise monitoring and evaluation strategies that provide the information needed for informed planning. Institute mechanisms for periodic dissemination and review of evaluation results that encourage use by key decision-makers.

## **2. Establish and support a coordination mechanism for IYCF**

- Establish an adequately staffed and funded coordinating mechanism. Strengthen the technical and managerial capacity of those responsible for IYCF coordination.
- Develop annual implementation plans that clearly specify who will do what and when and how progress will be measured and how activities will be funded.
- Put in place a management information system for tracking programme inputs, communication activities, and people trained in IYCF at all levels, including community.
- Ensure that standard indicators are used by programme partners.

## **3. Foster an enabling environment**

- Develop an evidence-based advocacy strategy, using data from the various relevant Lancet Series (Child Survival, Nutrition, Child Development, Newborn, etc), and considering the use of nutrition advocacy tools such as “Profiles,” making sure that adequate attention is paid to follow-up and support for effective use of the tool with key IYCF decision-makers.
- Strengthen Code legislation and training, as needed, and ensure that strong monitoring and enforcement systems are in place, with adequate sanctions for violations that will deter Code infractions.
- Strengthen maternity protection legislation and encourage employers to provide breastfeeding rooms and breaks using information on the benefits to mother, baby and the employer. Offer guidance on how best to arrange for more supportive workplaces.
- Ensure that IYCF programmes - at health system and community levels and within the communication strategies - include actions to foster improved conditions and support for breastfeeding women and for infant and young child feeding in the immediate family, social and working environments, especially related to informal labour or subsistence agriculture.

#### **4. Strengthen the organizational and technical capacity for IYCF**

- Build the capacity of the MOH, NGOs, IYCF advocacy groups, consumer associations, professional societies, and other organizations in a country for sustained ownership of IYCF programming.
- Build the capacity of training centres and integrate IYCF in the pre-service curricula and in continuing and in-service education programmes of educational institutions, making use of the WHO/UNICEF Integrated IYCF Counseling Course, the BFHI “20 hour” course, and the model chapter for IYCF published recently by WHO for medical student and allied health professional pre-service education.
- Develop and oversee implementation of an integrated training and capacity building strategy and budget that will support scale up of interventions, including orientation of replacement staff, follow-up and supervision, and refresher training or updates often enough to reinforce knowledge and skills.

#### **5. Take steps to improve breastfeeding practices in maternities (including revitalizing BFHI where appropriate) and ensure full institutionalization and sustainability**

- Ensure adequate coordination at national, regional, and facility levels.
- Assess the current status of compliance with the “Ten Steps” in all maternity facilities, including accredited baby-friendly facilities.
- Determine the level of effort that should be focused on improving maternity practices/BFHI, taking into account the percentage of women delivering in facilities. Coordinate the approach with IYCF services in other MCH contacts, PMTCT services and community-based programmes.
- Devise a strategy for institutionalizing the Ten Steps as part of standard operating procedures in maternity facilities, ensuring that systems for training and monitoring are well integrated into the health care system and that quality assurance and accreditation procedures for all hospitals are in place.
- Establish a mechanism to ensure that all new and existing staff working in maternity facilities are trained on breastfeeding management and implementation of the “Ten Steps,” using the updated BFHI 20-hour course for maternity staff. There should be a system for ongoing supportive supervision, as well as for tracking whether facilities still have trained staff, in order to avoid gaps due to staff turnover.
- Ensure that regular supervision and mentoring of trained maternity staff takes place.

#### **6. Extend IYCF counselling and support beyond maternity services**

- Integrate IYCF into all existing health services for mothers and children, ensuring that IYCF is addressed at appropriate contact points during pregnancy and throughout the first two years of a child’s life both within the health system and the community. Focus on those contact points with higher coverage such as antenatal care and immunization/well child services.

- Incorporate IYCF counseling, support and data collection in the job description of various cadres of workers.
- Conduct training in integrated IYCF counseling (using the WHO/UNICEF relevant courses as standard) and build/reinforce the IYCF counselling and problem-solving skills of health care providers using performance-based training and mentoring methodologies.
- Ensure that regular supervision and mentoring takes place of trained staff who counsel on IYCF at multiple contact points. Ensure that adequate, skilled supervisors are available for all areas, mechanisms for supervision and mentoring exist and adequate resources are allocated for this.

## **7. Scale up community-based interventions**

- Build coalitions with a diverse group of partners to achieve scale. Engage new partners and, when possible, integrate IYCF content into successful community initiatives of committed NGOs.
- Use multiple platforms at the community level to advance IYCF including IMCI, female literacy programmes, schools, growth promotion, PMTCT, maternal and neonatal health, community management of severe acute malnutrition, household food security, and social protection schemes.
- Outline a plan for mobilizing, equipping, and supporting human resources to deliver programme interventions at the community level. Identify incentives and put in place supportive supervision systems to maximize their services and prevent high rates of attrition.
- Explore peer-counseling at scale as a strategy and document results and lessons learned to develop a model that can be replicated
- Build capacity of community cadres to promote and support optimal IYCF practices, including counselling, communication and problem-solving skills
- Establish a system for ongoing supportive supervision and mentoring of community workers, as well as data collection on programme activities.

## **8. Implement evidence-based, comprehensive communication strategies**

- Develop a national IYCF communication strategy that is evidence based and comprehensive to build support for optimal feeding practices.
- Develop behaviour change strategies based on formative research on barriers and enablers to improved practices, involving mothers, their families, and communities in active problem-solving. Address barriers such as lack of information and support, inadequate resources (time, money, and food), engrained cultural practices, work, and limited decision-making authority.
- Work with all “actors” in the communication system to harmonize messages targeted at various levels, from physicians and nurses to community health workers and families.

## 1. INTRODUCTION

This report highlights findings of six case studies that reviewed the contributions of UNICEF and its partners to infant and young child feeding (IYCF) over the past few years, with the primary focus on breastfeeding. The countries studied were Bangladesh, Benin, the Philippines, Sri Lanka, Uganda, and Uzbekistan.

**Aim of the review.** The aim of the IYCF review was to: 1) better understand the contextual and programmatic factors that led to changes in feeding practices in selected countries 2) assess the contributions by different actors, 3) document a series of innovations, good practices, and lessons learned to improve future programming, and 4) identify ways of overcoming challenges to improved practices. The review focuses primarily on the past 10 to 15 years.

**Terms of reference.** The terms of reference included design of a methodology for the assessment and interview process, a literature review, country visits, and development of country case studies and a consolidated report highlighting efforts to implement components of the Global Strategy for Infant and Young Child Feeding, factors contributing to programme results, and lessons learned and innovations.

**Country selection.** The Nutrition Section of UNICEF's New York office identified the countries for the review. Selection criteria included a range of achievements and experiences (both positive and negative), geographical representation, potential for significant cross-country learning, and interest by UNICEF country offices.

**Methodology.** The Academy for Educational Development (AED) worked with UNICEF New York to develop assessment tools and report outlines. The tools included a list of organizations with potential key informants, a list of documents to collect and analyze, a list of issues to address in the review, and separate questionnaires for staff from the Ministry of Health (MOH), UNICEF, and development partners (NGOs). The questionnaire developed for UNICEF staff is found in Annex 1. Country visits, ranging in length from 5 to 7 days, were held between July and November 2008. From 16 to 28 semi-structured interviews were conducted during each country visit with key informants from government ministries and facilities, UNICEF, other UN agencies, NGOs, and professional associations. Interviews with development partners, health professionals, academicians, and researchers also provided valuable information. In some cases the country assessment involved visits to health facilities and project sites outside of the capital.

Those interviewed and additional stakeholders were invited to attend a working session on the final day of the consultant's visit to review and discuss the consultant's findings and to reflect on the evolution of the country's breastfeeding programme, assess progress, and recommend key strategies for the future. The format of the working sessions varied from consultant presentation with commentary by participants to working groups on key aspects of IYCF, focusing on milestones, achievements, challenges, lessons learned, and recommendations. The sessions lasted from 2½ to 6 hours.

## 2. COUNTRY PROFILES

### 2.1 Demographic, Health, and Development Indicators

Table 1 features demographic, nutrition, health and other related indicators that can affect feeding practices, reflect the outcome of these practices, and influence the design of IYCF interventions.

It shows the progress the six countries are making in achieving the Millennium Development goals to halve between 1990 and 2015 the proportion of people who suffer from hunger as indicated by the prevalence of underweight in children under five and to reduce by two thirds the under-five mortality rate. The human development index (HDI) is another measurement of progress. The HDI is a composite measure of life expectancy, adult literacy, education, and standard of living indicators. The indicators and HDI for each of the six countries are presented in Table 1. Among the 179 countries ranked in 2008, the countries in this review rank as follows: Philippines, 102; Sri Lanka, 104; Uzbekistan, 119; Bangladesh, 147; Uganda, 156; and Benin, 161<sup>1</sup>.

The under-five mortality rate in these countries ranges from 21 deaths per 1,000 live births in Sri Lanka to 130 in Uganda. The high rates of child mortality and fertility in Uganda and Benin show the correlation between these two indicators.

<sup>1</sup> Human Development Index, United Nations Development Programme. 2008. <http://hdr.undp.org/en/statistics/>

**Table 1. Country Profiles<sup>2</sup>**

Indicator	Bangladesh	Benin	Philippines	Sri Lanka	Uganda	Uzbekistan
<b>Demographic indicators</b>						
Total population (millions)	158.7	9.0	88.0	19.3	30.0	27.4
Population under 5 (millions)	19.0	1.5	11.1	1.5	6.0	2.9
Urban population (%)	26	41	64	15	13	37
Total fertility rate	2.9	5.5	3.3	1.9	6.5	2.5
<b>Mortality indicators</b>						
Under-five mortality rate	61	123	28	21	130	41
Infant mortality rate	47	78	23	17	82	36
Neonatal mortality rate	36	36	15	8	30	26
<b>Nutrition indicators</b>						
Low birthweight (%)	22	15	20	22	14	5
Moderate and severe stunting (%)	36	38	30	14	32	15
Moderate and severe wasting (%)	16	7	6	14	5	3
Moderate and severe underweight (%)	46	23	28	29	20	5
<b>Health indicators</b>						
Adult HIV prevalence (15-49 years)	<0.1	1.2	<0.1	<0.1	5.4	0.1
Antenatal care coverage (%)	51	84	88	99	94	99
Institutional deliveries (%)	15	78	38	98	41	97
% using improved drinking water	80	65	93	82	64	88
% using adequate sanitation facilities	36	30	78	86	33	96
<b>Human development indicators</b>						
Life expectancy at birth (years)	63.1	55.4	71.0	71.6	49.7	66.8
Adult literacy rate ages 15 & older (%)	47.5	34.7	92.6	90.7	66.8	99.3
Gross school enrollment (%)*	56.0	50.7	81.1	62.7	63.0	73.8
Gross Development Product per capita (PPP US\$)**	\$2,053	\$1,141	\$5,137	\$4,595	\$1,141	\$2,063
Human Development Index	0.524	0.459	0.745	0.742	0.493	0.701
<b>Progress in Achieving Millennium Development Goals 1 and 4</b>						
<b>MDG 1: Eradicating Hunger</b> Underweight in children <5 years	●	◐	◐	●	◐	●
<b>MDG 4: Reducing Child Mortality</b> Under-five mortality	●	◐	●	●	◐	◐

\*Combined primary, secondary, and tertiary gross enrollment ratio, \*\* Purchasing power parity

● On track      ◐ Insufficient progress

<sup>2</sup> Sources: The State of the World's Children 2009, UNICEF; HDI 2008: <http://hdr.undp.org/en/statistics>; Progress for Children: A World Fit for Children Statistical Review, Number 6, December 2007 UNICEF

Breastfeeding contributes to a number of the above indicators, affecting birth spacing, reducing total fertility, and improving child survival and nutrition status. The role of breastfeeding is particularly important to child survival. *The Lancet* 2003 Child Survival series estimates that with 90 percent coverage of exclusive breastfeeding for the first six months and 99 percent coverage of continued breastfeeding from 6 to 12 months; child mortality could be reduced by 13 percent. *The Lancet* 2008 Nutrition Series estimates that optimal breastfeeding practices up to 2 years could potentially save 1.4 million lives annually in developing countries. However, the actual exclusive breastfeeding rates in developing countries are far from these ideal rates, with global exclusive breastfeeding being around 37 per cent.

According to *the Lancet* 2003 Child Survival series, high coverage with optimal complementary feeding for children 6-24 months, together with continued breastfeeding, has the potential to reduce child mortality by 6%, saving as many as 0.55 million child lives per year. Complementary feeding is the only nutrition intervention shown to have a direct and significant effect in reducing stunting<sup>3</sup>.

About 30% of children in the developing world today are stunted (SOWC 2009), and a majority of the cases occur during the first two years of life, a period considered a “critical window of opportunity” for prevention of undernutrition and stunting. Illness, foods inadequate in quantity and quality, and poor care and feeding practices during the complementary feeding period contribute to the problem. Reducing childhood undernutrition remains a major challenge in all regions and among countries classified as middle income and low income. In the reviewed countries, continuing high levels of undernutrition among children under five, as shown by the **nutrition indicators** in Table 1, indicate the urgency of addressing complementary feeding.

## 2.2 Breastfeeding Trends and Contributing Factors

From around 1996 to 2006, exclusive breastfeeding in developing countries<sup>4</sup> increased from 33 percent to 37 percent. In 14 countries the rate increased by more than 20 percentage points or an average of 2 per cent per year. How did the six countries in this review fare over a ten-year period?

The Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) provide a basis for analyzing IYCF trends through the years, although in a few cases the questions posed have changed slightly.<sup>5</sup> The detailed results for the six countries studied are found in Annex 2 with indicators on breastfeeding, bottle feeding, formula feeding, and complementary feeding. Figures 1 and 2 below show trends in timely initiation of breastfeeding (<1 hour) and exclusive breastfeeding (0-5 months).

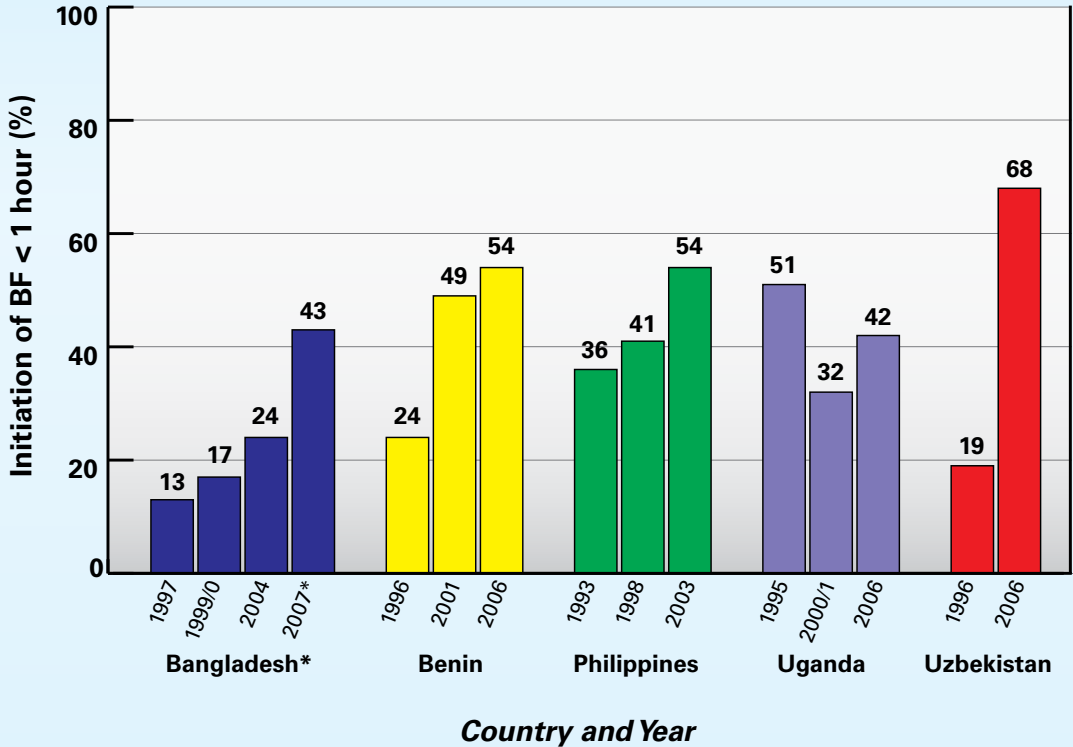
<sup>3</sup> Effects of micronutrients on growth of children under 5 y of age: meta-analyses of single and multiple nutrient interventions<sup>1–3</sup> Usha Ramakrishnan, Phuong Nguyen, and Reynaldo Martorell. *Am J Clin Nutr* 2009; 89:191–203.

<sup>4</sup> Source: UNICEF Progress for Children 2007; data excludes China due to its divergent definition of exclusive breastfeeding, which has a significant impact on the rates.

<sup>5</sup> In DHS, the 24 hour recall question (for estimation of exclusive breastfeeding rates), for example, was changed in the early 2000s. The mother was first asked to report on what she had fed her child in the last 7 days, responding to a more extensive list of liquids and foods than used earlier. She was then asked what she had fed the child in the last 24 hours for the same list of liquids and foods. This could result in slightly different EBF rates than if the question had remained the same.

The experience of each case study country is then summarized with a focus on exclusive breastfeeding and the factors that most likely influenced trends in the last 15 years. Exclusive breastfeeding, which is measured in the DHS and MICS studies through 24-hour recall, is the most important breastfeeding practice indicator because of its impact of on child survival, morbidity, and nutritional outcomes.

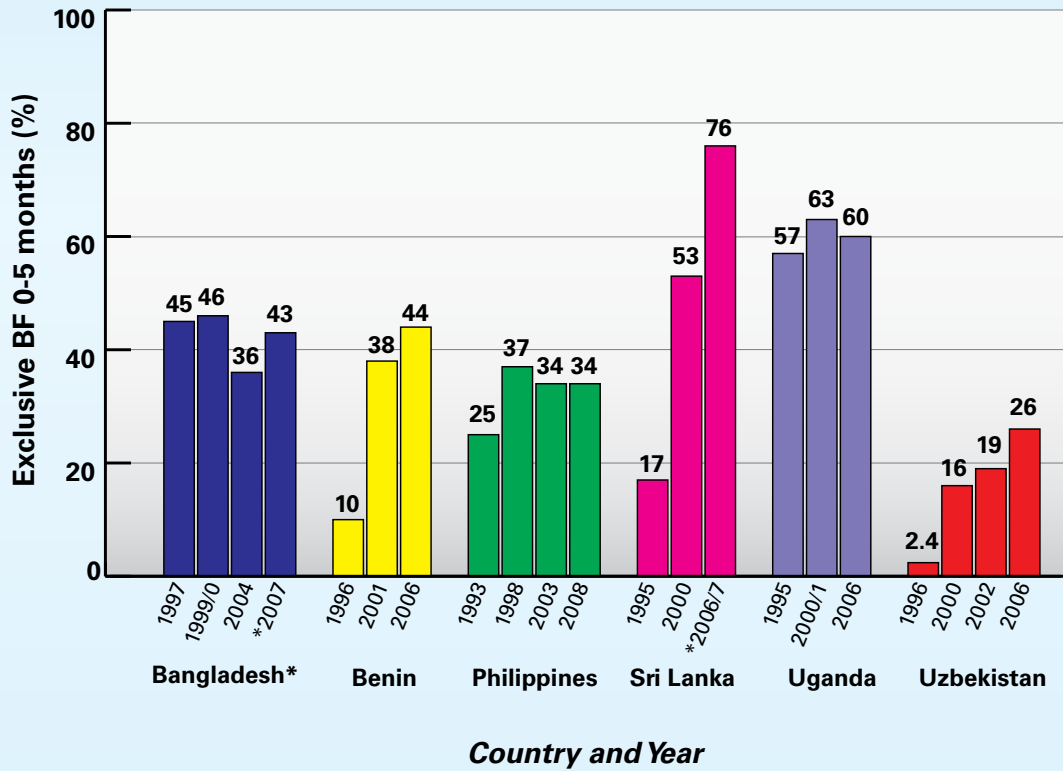
**Figure 1. Early Initiation of BF Trends from Five Countries**



Source: Demographic Health Survey (DHS) or national DHS reports except for the final Uzbekistan report which is a Multiple Indicator Cluster Survey (MICS)

\*Preliminary DHS

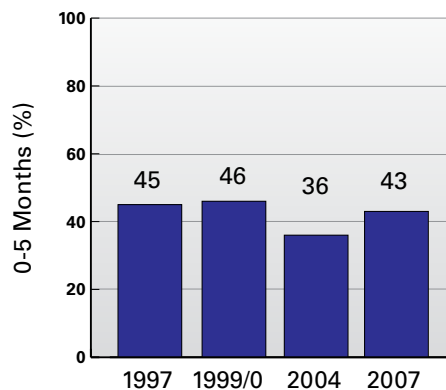
**Figure 2. Exclusive BF Trends from Six Countries**



**Source:** Demographic Health Survey (DHS) or national DHS reports except for the final Uzbekistan report which is a Multiple Indicator Cluster Survey (MICS)

\*Preliminary DHS

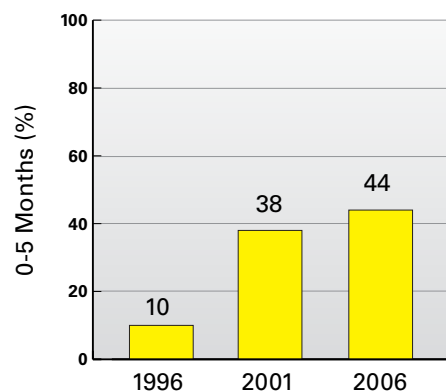
### EXCLUSIVE BF IN BANGLADESH



**BANGLADESH.** Strong breastfeeding advocates in Bangladesh helped develop a code of marketing, maternity legislation, and BFHI programming. Several factors may help explain the lack of progress in Bangladesh in improving exclusive breastfeeding rates despite these achievements. In a country with 15 percent of the births outside health facilities, greater attention should have been given to community promotion and support. BFHI training did, however, form a cadre of health professionals committed to breastfeeding promotion and support. The review revealed a lack of overall programme coordination and oversight, weak national commitment, sporadic donor support, lost momentum due to bureaucratic delays, high staff turnover, inadequately trained

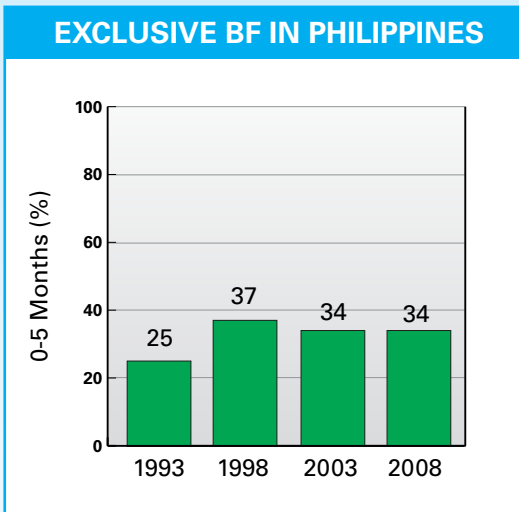
community-based workers, and missed opportunities within the health system to counsel women on IYCF. Bangladesh has developed some promising community-based strategies, including use of community nutrition promoters and organization of mother support groups (MSGs). However, the promoters only work in one-fifth of Bangladesh's sub-districts, focusing mainly on growth monitoring and supplementary feeding with little time for education and counseling. MSGs have only been organized in a few places thus far. Thus, large-scale expansion of community support is needed to achieve the impact needed.

### EXCLUSIVE BF IN BENIN



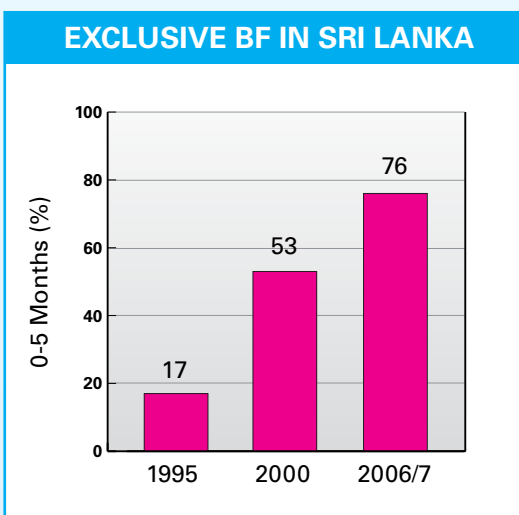
**BENIN.** Programmatic inputs that likely contributed to sizable gains in exclusive breastfeeding in Benin include work on BFHI in a country with 78 percent of deliveries in health facilities, a strong emphasis on improving IYCF practices within the Essential Nutrition Actions project area and later in other programmes, promotion of exclusive breastfeeding as a diarrhea prevention strategy, and communication of IYCF messages through other nutrition programmes. It is likely that the increases in EBF rates slowed from 2001-2006 following the international shift in support to other areas, with Benin lessening its focus on IYCF as well. Further progress was also hindered by the lack of emphasis on nutrition at policy level; weaknesses within the health delivery system, such as lack of well trained

staff, rapid staff turnover, poor supervision and follow-up; and difficulties in bringing good programmes such as ENA and other programme initiatives to scale. Cultural beliefs favoring early introduction of water, herbal teas, and foods, and an increase in women in the labour force, where support for breastfeeding is still not the norm, as well as low educational and economic levels, continue to pose challenges. Only recently has interest in IYCF resurfaced, partially due to urging from international agencies. The MOH and its partners are exploring possibilities for a more integrated nutrition programme, including both health facility and community components.



**PHILIPPINES.** In the Philippines exclusive breastfeeding increased in the mid 90s after a period of intense Mother-Baby Friendly Hospital Initiative (MBFHI) and Code monitoring activities but then decreased after a lull for several years in breastfeeding promotion, protection, and support. At the same time the reorganization at the Philippines Department of Health in the late 1990s decreased managerial capacity and support for MBFHI, staff turnover continued, and compliance with the “Ten Steps to Successful Breastfeeding” slipped. Formula companies continued to step up their marketing campaigns, infiltrating the media, professional groups, and health facilities. Little work was done at community level although approximately 68% of women deliver at home.

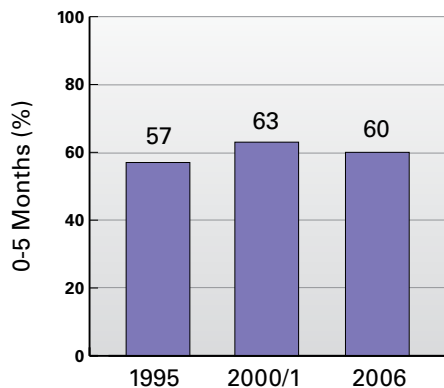
The “devolved” or decentralized system continued to prove a challenge for community work. Detrimental breastfeeding practices and external factors such as poverty, poor economic growth, corruption, reoccurring natural disasters, and civil war continue to provide challenges. Interest in breastfeeding and IYCF has recently been renewed due to endorsement of the Global Strategy and an energetic and successful campaign to strengthen the national Milk Code. Promising developments include a new IYCF action plan and a more integrated approach, with added emphasis on community outreach and support.



**SRI LANKA.** Sri Lanka, with its well-developed health system and good health infrastructure, experienced the most impressive improvements in exclusive breastfeeding of the countries studied. Over 95 percent of women receive antenatal care and deliver in health facilities. Extensive lactation management training is provided for nearly all health workers in the field and hospitals, making it possible to provide skilled assistance to mothers. High political commitment at various points in time, a culture supportive of breastfeeding and parents, effective transmission of IYCF messages through multiple communication channels, a high literacy rate among women, and good “health-seeking behaviors” of parents likely contributed to the results. The public health midwife is also a

major factor. Community outreach is performed primarily by public health midwives. Two home visits are made within the first 10 days of a normal delivery. IYCF is a component of the current UNICEF integrated health and nutrition package, and thus Sri Lanka is poised to provide continued support in this important area. The end of the civil war could open up areas that were previously cut off from IYCF activities.

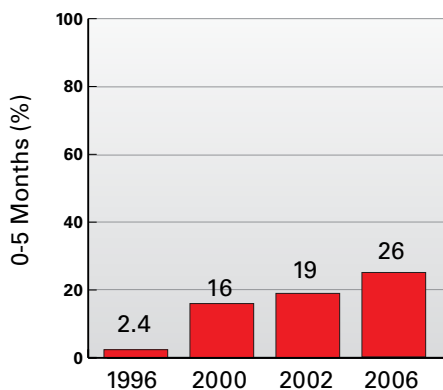
### EXCLUSIVE BF IN UGANDA



**UGANDA.** Unlike many countries where early introduction of other liquids and foods is practiced widely, exclusive breastfeeding for young infants is an accepted practice in Uganda. Exclusive breastfeeding rates remained fairly steady during a period when breastfeeding was called into question because of concerns about HIV transmission. Uganda responded by tackling the issue head on with the nutrition and HIV units of the MOH working closely together. BFHI was never a major focus of breastfeeding activities in Uganda where the majority of women do not deliver in health facilities. Little attention has been given to reaching women who deliver in their homes. For a number of years, UNICEF and many NGOs have concentrated on treatment of malnourished

children, due in part to the selection of conflict-affected areas as focus districts and an emphasis on vulnerable children. Greater improvements in IYCF practices at the national level might have been achieved if more attention and resources had been given to preventive care and community-based interventions. The new national IYCF strategy, donor collaboration, and heightened interest in preventive care and community-based interventions are encouraging signs.

### EXCLUSIVE BF IN UZBEKISTAN



**UZBEKISTAN.** UNICEF began to encourage compliance with the "Ten Steps to Successful Breastfeeding" in 1998. Currently 31 percent of maternities are certified as baby friendly. Ninety-seven percent of deliveries take place in health facilities within the country, so the health system is an important target for reform. The Government and its MOH have been supportive of activities to improve IYCF practices. A generous two-year maternity leave makes it easier for women to effectively maintain breastfeeding practices. A major challenge in Uzbekistan is the lack of effective Code implementation: adoption and implementation of the Code are urgently needed. Some work has been done at community level, with UNICEF, the MOH, and international organizations

working to educate peer leaders in various health promotion activities including IYCF, with the focus, thus far, on model oblasts (regions). Exclusive breastfeeding rates have reached 83 percent in focus communities, causing UNICEF to make plans for similar breastfeeding training and promotional events in other communities.

### 3. THE PROBLEM

How were IYCF and nutrition problems identified? What were the main challenges and obstacles that the six countries faced when working to improve practices? This section of the paper responds to these questions.

#### 3.1 Assessment of needs

Needs assessments or situational analyses were conducted in all six countries to assist in identifying IYCF and nutrition problems, programme gaps, and measures needed to address them. *Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes* (2003) developed by WHO and LINKAGES was used in all but Uzbekistan as part of the needs assessment process when developing national IYCF strategies and plans.

A number of other needs assessments were carried out by government ministries, UNICEF, or partner organizations in the countries reviewed. IYCF played a minor role in the nutrition review funded by the World Bank in Uzbekistan; but in Uganda comprehensive analyses focused squarely on IYCF. In some cases baseline studies and/or studies of breastfeeding beliefs and practices complemented the assessments. One recurring challenge is adequate dissemination of assessment results and effective use of the findings in the planning process.

#### 3.2 Main challenges and obstacles

Certain challenges were widespread within the countries reviewed, including lack of knowledge and detrimental practices at the family level; poor support within communities, workplaces, and health facilities; and inadequate IYCF programmes at national and local levels. The list below highlights the main challenges.

##### **Lack of infant feeding knowledge and skills among caregivers**

- Lack of knowledge of benefits of breastfeeding and the importance of exclusive breastfeeding
- Assumption that breastmilk is not enough to nourish infants
- Lack of infant feeding management skills, such as proper positioning and attachment and appropriate complementary feeding
- Lack of understanding that insufficient milk is due to poor suckling techniques and not feeding frequently enough.

##### **Cultural beliefs and practices**

- Prelacteal feeds, delayed initiation, and discarding of colostrum
- Giving water, herbal teas, watery porridges, and other drinks within the first six months
- Using feeding bottles and various breastmilk substitutes
- Poor complementary feeding practices such as delaying introduction beyond six months of age and/or giving foods with insufficient variety, energy density, or feeding frequency

### **Lack of family support**

- Extended family members encouraging mothers to give other liquids and foods early
- Family members not able to support mothers through help with household tasks or other children

### **Unsupportive work environments**

- Limited or no maternity leave
- Inflexible working hours and lack of breastfeeding breaks
- No breastfeeding rooms or space for expressing and storing breastmilk

### **Commercial pressures**

- Widespread advertising of breastmilk substitutes through print media, radio, TV, and billboard ads
- Provision of gifts and incentives to influence health workers to promote formula products
- Lack of monitoring and enforcement of marketing regulations for breastmilk substitutes

### **Unsupportive health facility and community-based services**

- Health facility practices not conducive to the establishment of good breastfeeding practices
- Limited knowledge on IYCF and lactation management, complementary feeding, and counselling skills among health providers and volunteers and lack of time to provide needed support
- Poor supervision and monitoring of staff and volunteers trained to provide IYCF support

### **Administrative and political challenges**

- Weak national commitment to IYCF and nutrition and inadequate resources
- Poor coordination among government offices and partners and lack of integrated, cost-effective and sustained approaches to address health and nutrition needs
- Rapid turnover of administrative, health service, and community staff and volunteers with IYCF skills

## 4. RESPONSE TO THE PROBLEM

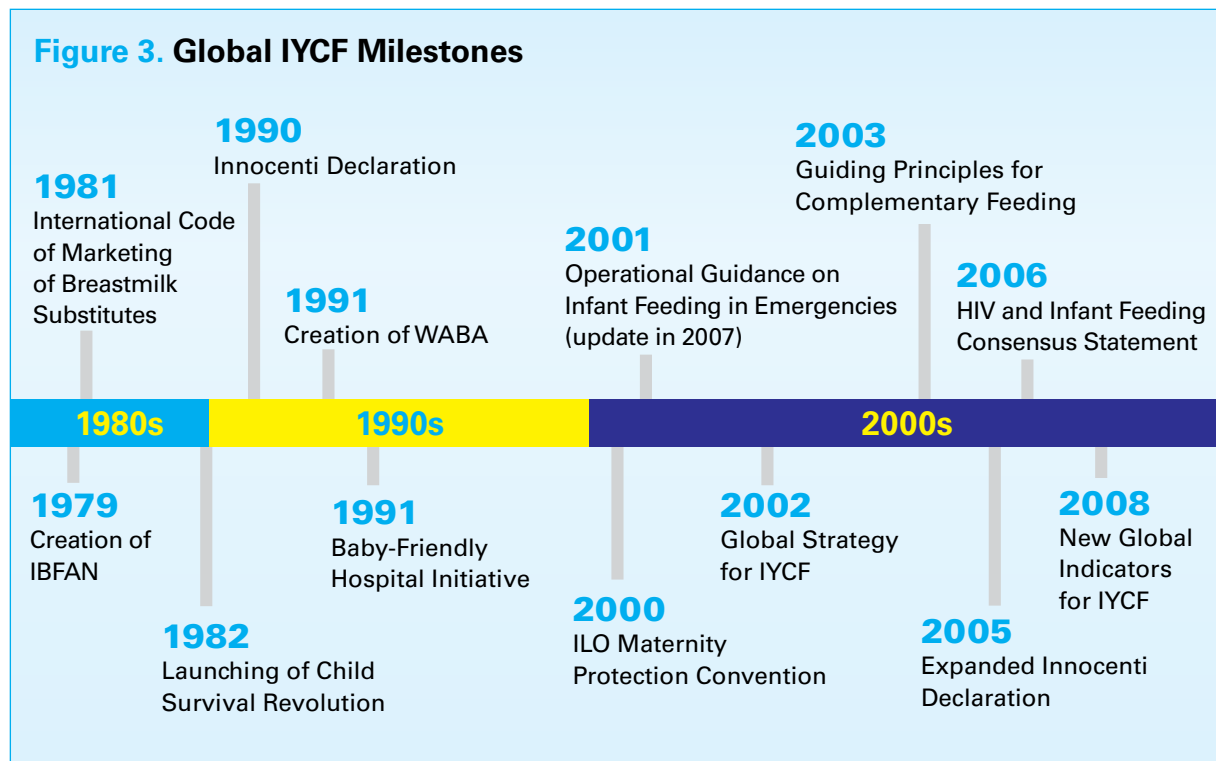
The response to the challenges outlined above included global initiatives, partner mobilization, development of country policies and strategies, and implementation of programme activities to address specific barriers to improved infant and young child feeding practices. This section of the report discusses these efforts and summarizes lessons learned.

### 4.1 Global initiatives

UNICEF's and WHO's roles at the global level in providing guidance on IYCF greatly affected the programmatic choices at country level. Figure 3 shows events in the history of IYCF that continue to guide programmes. The 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding set four operational targets: establishment of national breastfeeding committees, implementation of the Ten Steps to Successful Breastfeeding in maternity services, national legislation to protect the breastfeeding rights of working women, and action to give effect to the International Code of Marketing of Breastmilk Substitutes. The targets of the Innocenti Declaration guided countries for years. These targets, however, did not reflect the full comprehensive approach required for widespread change. They stressed only national and facility level changes, neglecting the community and other important components.

In 1991 WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI). In the early years BFHI galvanized global resources, provided a common focus, and generated political will at the highest levels. With growing concerns about HIV transmission through breastmilk, a shift of resources to other aspects of child survival, and lack of institutionalization and built-in mechanisms for sustainability of the BFHI, the initiative faltered in many countries.

Several events since 2000 have encouraged countries to reconsider IYCF as a significant element of their development plans. These events include adoption by the World Health Assembly and the UNICEF Executive Board of the Global Strategy for Infant and Young Child Feeding, endorsement of the 2005 Innocenti Declaration on Infant and Young Child Feeding, publication of the landmark Lancet Child Survival and Nutrition series, and new programmatic and scientific evidence concerning the impact of improved IYCF practices. The Global Strategy reaffirms the operational targets of the 1990 Innocenti Declaration while adding targets to reflect a more comprehensive approach that includes complementary feeding, provides guidance on feeding in exceptionally difficult circumstances, and reaches out to the community.



## 4.2 IYCF programme coordination and partners

**Programme coordination:** The first operational target of the 1990 Innocenti Declaration on the Protection, Promotion and Support for Breastfeeding, reaffirmed in the 2002 Global Strategy for IYCF and the 2005 Innocenti Declaration on Infant and Young Child Feeding, is the appointment of “a national breastfeeding coordinator of appropriate authority” and establishment of a multisectoral national breastfeeding committee. In all six countries the lead agency for IYCF is the Ministry of Health although various aspects of IYCF in some countries are assigned to other ministries. A frequently stated concern among those interviewed as part of the country assessments was the lack of overall coordination for IYCF, low priority given to nutrition, and frequent turnover among administrative and technical staff.

The Philippines is the only country with an IYCF multisectoral committee with representatives from government, NGOs, health professionals, and the private sector. This IYCF Interagency Group has been organized to provide technical assistance to the IYCF Management Committee within the Department of Health. Similar interagency committees have been mandated at the sub-national level. In Uzbekistan IYCF falls under the direction of the National Interdepartmental Committee on Nutrition. In Benin no one serves as the national breastfeeding coordinator any longer. The National Committee for Food and Nutrition is not as active as it had been earlier, although the Government and its partners are currently designing a stronger coordinating mechanism. For several years an IYCF focal person in the Nutrition Unit in Uganda helped coordinate activities, but this position has been vacant for more than a year.

Some countries divide up responsibilities for IYCF within the MOH. In Sri Lanka the Newborn Care Unit oversees implementation of BFHI and coordination of activities related to the Code of Marketing while the Child Health Unit focuses on appropriate feeding practices for children from one month to five years of age. In Uganda IYCF involves both the Nutrition Unit and the AIDS Control Programme. Stable, effective leadership in both departments for many years helped advance IYCF programming. Uganda does not have a standing committee, but multisectoral task forces have effectively addressed specific policy issues. In Bangladesh the Ministry of Health oversees delivery of a package of essential services, including IYCF, and the Institute of Public Health Nutrition coordinates formulation of IYCF policies and monitors adherence to the Code. This division of responsibility has at times resulted in delayed action.

The process for developing a national IYCF strategy illustrates the value of having an active IYCF multisectoral committee. In the Philippines the IYCF strategy was developed and approved in a year. In several countries the process dragged on for years in the absence of a clear focal point or the diffusion of responsibility among different offices and departments. Experience shows that when a national breastfeeding committee lacks vision and purpose, it soon becomes inactive. Many of the countries reviewed are now realizing the importance of a strongly integrated approach, with IYCF as an active sub-component of an overall multisectoral nutrition coordinating mechanism.

**IYCF partners:** IYCF partners include government agencies, civil society, development partners, professional societies, academia, and the private sector, as described below. The community as a partner is discussed in section 5.7. The poster on the right was developed in the Philippines to communicate that a variety of partners have joined forces to revitalize the culture of breastfeeding.

**Central government.** In addition to the Ministry of Health, other government institutions are involved in IYCF, such as the following:

- The Department of Interior and Local Government mobilizes local councils in the Philippines to prioritize IYCF in their plans.
- The Ministry of Local Government, Rural Development and Cooperatives in Bangladesh has jurisdiction over health activities in all city corporations and municipalities.



- The Ministry of Family and National Solidarity in Benin conducts nutrition-related work through its network of community outreach workers and social promotion centres.
- The MOH, National Bureau of Standards, Ministry of Trade, and Ministry of Justice in Uganda have oversight responsibilities for the National Regulations on Marketing of Infant and Young Child Foods.

*District and local government.* Lower levels of government, such as regions, provinces, districts, and/or localities often play a role in providing IYCF services. In countries with decentralized or “devolved” health care systems, they may have the major responsibility. In the Philippines, for example, the local government units make the decisions concerning the health services they will provide. IYCF support may vary greatly, depending on local priorities, creating challenges in providing equitable coverage.

*Civil Society.* Civil society organizations comprise international and national NGOs and community and faith-based organizations. The health system in Bangladesh is dependent on NGOs for delivery of health services, but NGOs play a limited role in Sri Lanka and Uzbekistan. The Bangladesh Breastfeeding Foundation, registered in 1995, and IBFAN Uganda Foundation Limited, founded in 2004, are strong breastfeeding NGOs involved in advocacy, training, policy formulation, revitalization of BFHI, and development of training and IEC materials. IBFAN played an active role in Benin in the 1990s but currently suffers from lack of resources. Arugaan, a network of NGOs providing mother-to-mother support in the Philippines, has been an engaged and effective breastfeeding advocate for years in the areas of supportive workplaces for breastfeeding women and enforcement of a national code of marketing of breastmilk substitutes. Examples of faith-based organizations supportive of breastfeeding include the Imam Training Academy of Islamic Foundation in Bangladesh and the Catholic Bishops Conference of the Philippines. In some countries the media, trade unions, and consumer association are also IYCF partners.

*Development partners.* Multilateral UN organizations, international finance institutions, and bilateral agencies form the group of development partners.

- *UN organizations.* WHO supports governments in providing sound technical leadership. The extent of WHO's involvement in IYCF at the country level depends to a great extent on the technical expertise of the local staff and WHO's priority areas of work in the country. The World Food Programme is also involved in IYCF in some countries through supplementary feeding programmes or national IYCF activities. UNICEF has played a key role in supporting and developing the IYCF programmes, encompassing advocacy and communication, technical support, capacity building, catalyzing partnerships and leveraging resources.
- *Financial institutions.* For more than a decade, the World Bank has supported national-level and community-based nutrition activities in Bangladesh. The World Bank has also funded nutrition activities in Uganda and Benin. The Asian Development Bank has supported breastfeeding activities in the Philippines and the African Development Bank in Benin.
- *Bilateral agencies.* The United States Agency for International Development (USAID) is among the largest donors of foreign assistance for IYCF through child survival, nutrition, and/or PMTCT activities in Benin, the Philippines, Uganda, and Uzbekistan. USAID's support for Demographic and Health Surveys provides vital data to analyze IYCF trends. For a number of years the Canadian International Development Agency funded breastfeeding promotion activities through the Bangladesh Breastfeeding Foundation. The Australian Agency for International Development (AusAID) is another funder of IYCF-related activities in Asia. The aid agencies of Japan, Belgium, Switzerland, and Germany and others also provide support in some of the countries reviewed.
- *Professional societies.* Pediatric associations have often been among the most forceful advocates for breastfeeding, although some report that the younger generation of pediatricians is not as engaged in breastfeeding promotion as those who were involved in the early days of advocacy. The Bangladesh Pediatric Association and the Sri Lanka College of Pediatricians have been particularly influential. In Uganda the nutrition community through Uganda Action on Nutrition (UGAN) provides a national forum for professionals to advance the nutrition agenda. In some cases professional societies have been less supportive of breastfeeding than desirable due to the influence of formula companies and the reluctance of health professionals and their societies to give up the perks they offer.

*Research and training institutes.* These institutions are a valuable resource for conducting surveys, research and training activities in countries and can contribute to building sustainable national capacity to support IYCF programmes. Of particular note for their contributions to IYCF in the countries reviewed are the Institute for Child and Mother Health and ICDDR-B in Bangladesh, Makerere University in Uganda, and the Medical Research Institute in Sri Lanka.

*Private sector.* Many health services are provided through hospitals and clinics managed by the private sector, yet delivery of breastfeeding support through private sector health facilities has often been overlooked. Discussions are underway in countries such as Uganda to assess the role of the private sector in providing access to affordable, high quality fortified complementary foods and related products. The Ministry of Health in Benin is working to encourage active contribution by the private sector to meeting national nutrition goals.

Uganda offers a good example of collaboration among many of the above groups. The MOH, UNICEF, WHO, the World Food Programme, and USAID provided financial and technical support for the formulation of policy guidelines on infant and young child feeding. Members of a technical working group made up of representatives from these organizations as well as IBFAN Uganda, pediatricians, and university researchers helped refine and finalize the guidelines. Failure to engage key actors can derail activities. In the Philippines active partnering with committed NGOs helped strengthen the implementation of the national Code. Community-based breastfeeding activities were limited in some regions because local authorities were not committed to the proposed IYCF initiatives although in certain localities IYCF initiatives thrived with inspired leaders benefiting from the autonomy and added resources available in a decentralized system. Major changes in IYCF leadership in the Philippines during a period of “re-engineering” resulted in changed priorities and loss of momentum. In Benin lack of coordination among various ministries and donors hindered “going to scale” with the community strategy that had been adopted by the government.

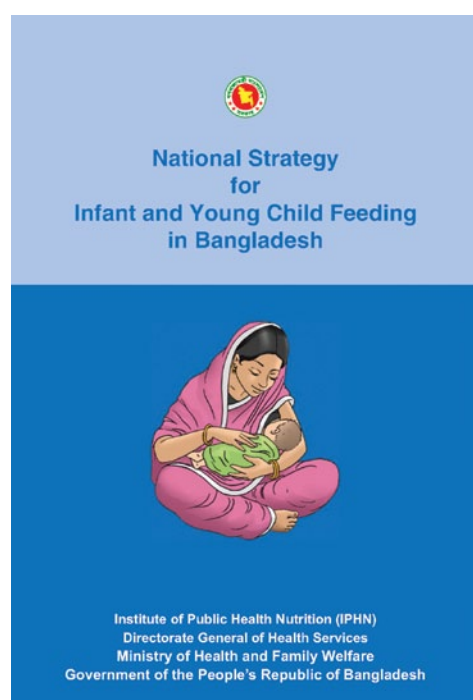
### **Lessons Learned in Partnerships and Programme Coordination**

- Engaging a diverse set of partners is a prerequisite for large-scale implementation. Doing so broadens support for IYCF and programme reach. Appropriate partners and coordinating mechanisms vary, depending on the mix of organization and human resources available nationally. Lack of coordination and weak leadership leads to delays, duplication of efforts, confusion over roles and responsibilities, mixed messages, and ad hoc activities.
- Continuous, effective leadership moves the agenda. Frequent turnover of staff within both government and donor agencies results in lost momentum, unattended agendas, and changes in priorities.
- Decentralization creates new opportunities as well as additional challenges for coordination and resource mobilization.

### 4.3 IYCF-related policies, guidelines, strategies, and action plans

In the 1980s Bangladesh, Sri Lanka and the Philippines were early adopters of supportive breastfeeding policies and initiators of national breastfeeding campaigns. In the 1990s the Innocenti Declaration and BFHI gave impetus to policy work and breastfeeding activities in Benin, Uganda, and Uzbekistan. In the 2000s the new recommendations on the duration of exclusive breastfeeding, updated guidelines on infant feeding in the context of HIV and emergencies, guiding principles on complementary feeding, and the comprehensive approach outlined in the Global Strategy for IYCF prompted re-examination of policies and guidelines and the development of national IYCF strategies. The speed and extent to which countries adopted new global guidelines varied, as illustrated below.

**Duration of exclusive breastfeeding.** Following a comprehensive study and recommendations by an expert panel on the optimal duration of exclusive breastfeeding, in 2002 WHO recommended 6 months of exclusive breastfeeding rather than 4 to 6 months. Five of the six countries have adopted this recommendation. Effective advocacy by the Bangladesh Breastfeeding Foundation led to adoption by the MOH of the 6 month recommendation in 2003. In Sri Lanka WHO's new recommendation caused confusion and met with resistance by health professionals. With firm and sustained engagement by various individuals in the government, 6 months became official policy in 2006. Some pediatricians remain unconvinced and continue to recommend earlier introduction of complementary foods. In Benin, the MOH is still revising its policy to bring it in line with the WHO recommendation.



**Replacement feeding.** The issue of replacement feeding in the context of PMTCT created considerable debate and discussion in Uganda in particular and delayed finalization of IYCF policy guidelines. Globally, WHO no longer recommends modified animal milk as a replacement food for infants less than 6 months old, but some health professionals and programme managers in Uganda resisted eliminating it as an option for younger infants. They felt that this option should be presented in resource-poor areas where animal milk is the one replacement feeding alternative that is available. After much debate, a compromise was reached by keeping animal milk as an option while including a cautionary note on its use. In the other countries the issue of replacement feeding did not generate this kind of debate and formula is the recommended replacement feeding option.

**Comprehensive IYCF strategies and plans.** Action plans in the 1990s were often focused on breastfeeding, with an emphasis on the Innocenti targets and little attention to other key IYCF components such as health services initiatives beyond BFHI, community-based IYCF, communications, and support for IYCF in difficult circumstances, which are all important for increasing impact. Often little attention was paid to strategies for going to scale, especially with community-based initiatives. The development and endorsement of the Global Strategy for Infant and Young Child Feeding in 2002 served as a strong impetus for countries to develop more comprehensive national strategies and begin to devise the approaches needed to increase coverage. The time required to do so varied greatly. In 2004 an IYCF task force in the Philippines was created to prepare a national strategy. The following year a national policy on IYCF and a comprehensive plan of action for 2005-2010 were in place. Bangladesh began the process of developing a strategy around the same time, but it took until 2007 for a strategy to be adopted by the Government. No single governmental body to provide leadership for nutrition as well as changes in personnel slowed down the process. The same has been true in Sri Lanka, which has yet to finalize a national IYCF strategy.

Once policies and strategies are adopted, there is often considerable lag in updating training and communication materials and introducing the policies outside the capital. For example, many of the print materials still in use in Sri Lanka continue to promote exclusive breastfeeding for 4 to 6 months. Further work is needed in most of the countries reviewed to fine-tune cost-effective programme strategies and increase coverage.

### **Lessons Learned in Development of Policies, Strategies, and Action Plans**

- Policies, strategies, and action plans that are limited in scope and fail to address key challenges are likely to have limited impact. For example, strategies that fail to provide the support needed at both the health service and community levels in a coordinated manner are likely to lead to only limited gains in improved practices. Strategies for bringing successful programmes to scale, with commitment over the long-term have often been lacking, but are essential.
- Advocacy and education cannot end with the signing of a policy. Pockets of resistance often remain among health professionals, and many are unaware of the policy change or the reasons behind it. More attention needs to be given to widespread dissemination of policies and strategies as well as orientation of personnel at all levels on the actions they are expected to take to implement these guidelines, with measures put in place to audit progress. Resources need to be allocated to update training and educational materials with the new guidelines.
- In some countries the time taken to complete certain steps in programme planning, such as policy development, review, and ratification, was very long, leading to delay in development and implementation of needed programmes. Consideration should be given to moving ahead with programmes, if necessary, before policies are finalized.

## 5. KEY PROGRAMME COMPONENTS AND LESSONS LEARNED

### 5.1 Advocacy

Advocacy for IYCF is needed to address lack of awareness, complacency, controversy, and competing priorities. In some cases, policy makers were not convinced that IYCF practices were a problem. Even if they did recognize the problem, they were unsure of the solution. And some appeared to think that exclusive breastfeeding rates of 50 or 60 percent are “good enough” – ignoring the burden of large numbers of non-exclusively breastfed children - and that efforts should be focused elsewhere.

High-level political commitment at various points helped advance IYCF in the Philippines, but changes in key government positions at times disrupted or even halted activities. Decentralization demanded new strategies for advocacy. In Bangladesh weak national commitment and sporadic donor support impeded progress. In Benin lack of emphasis on nutrition as a key development factor resulted in limited resources for IYCF.

To gain political support for IYCF, advocates have used evidence, authoritative testimony of trusted experts, coalitions, special events, and publicity.

**Evidence-based advocacy.** Benin and Uganda applied the “Profiles”<sup>6</sup> process to raise awareness of the magnitude of the problem. During 2-week workshops, multi-disciplinary teams used computer-based simulation models to demonstrate the contribution of improved nutrition to human and economic growth in given situations. The Profiles country teams incorporated information from the model in advocacy presentations made to key stakeholders at the conclusion of the workshops and drew up advocacy and communication plans. Lack of follow-up after the workshops lessened their effectiveness. Countries have also used the Lancet child survival and nutrition series for evidence-based arguments in support of IYCF programming, but more could be done to highlight the potential gains from improved practices. Often countries have neglected to extend advocacy efforts beyond the national level. This is particularly important in decentralized health systems, such as that in the Philippines, where priorities are determined locally.

**Trusted authorities.** The endorsement of highly regarded national and international figures adds an authoritative voice to public discourse and policy dialogue. For decades outstanding leadership has been provided by dedicated pediatricians in selected countries, including Professor M Q-K Talukder in Bangladesh; Professor Priyani Soysa in Sri Lanka; Dr. Natividad Clavano in the Philippines; and Dr. Gelasius Mukasa in Uganda. Professor Soysa used scientific evidence of the benefits of breastfeeding, findings from her research studies, and persuasive skills to argue for legislation on maternity protection and a Code of Marketing of Breastmilk Substitutes. Dr. Clavano, through her research at Baguio General

<sup>6</sup>The Profiles nutrition advocacy and policy development process uses current scientific knowledge to estimate the cost and effectiveness of proposed nutrition interventions. PROFILES estimates the impact on development indicators, such as child mortality using computer graphics and proved evidence-based estimations for advocacy with decision makers. More information about the tool can be found at <http://www.aedprofiles.org>

Hospital, provided a clear example of the strong impact implementation of such measures as closing the hospital nursery, providing rooming-in and limiting formula use could have on infant morbidity and mortality. Advocacy by the UNICEF country offices in the early 1990s and high-profile country visits moved the agenda forward. The UNICEF “brand” in all of the countries visited during this review continues to carry a lot of weight, opening doors to opinion leaders, legislators, and influential journalists.

**Coalitions.** In the 1970s church organizations, journalists, activists, public health professionals, and consumer, women, and student groups joined forces to bring pressure on the infant formula companies to change their marketing practices, leading to the development of an International Code of Marketing of Breastmilk Substitutes. Three decades later, similar groups joined forces in the Philippines to highlight aggressive marketing practices. The collaborative, high-energy efforts of UNICEF, WHO, mothers, faith-based organizations, professional societies, NGOs and international organizations helped achieve success in support of Government efforts to control unethical practices. The coalition used a variety of strategies including demonstrations, petitions, celebrity endorsement, an intense media campaign, and events that generated publicity. Personal relationships with influential policy makers helped gain support for the cause.

### **Lessons Learned in Advocacy**

- A one-time “push” to encourage advocacy, such as through a breastfeeding campaign or Profiles workshop, is usually not enough to foster lasting change and commitment to action. It is critical to institutionalize the advocacy process, ensure it is organized around motivating concrete actions and decisions to achieve specific objectives, and provide on-going technical and financial support as needed.
- A core group of breastfeeding champions led by dedicated, respected individuals who engage the government, donors, civil society, and health professionals can motivate and ignite change.
- Scientific evidence of the benefits of breastfeeding, findings from surveys and research studies, international recommendations, persistency, the art of persuasion, and the engagement of non-traditional partners can help gain approval for policy changes.
- Advocacy is critical at all levels, even more so with decentralized health systems where priorities and budgets are determined by district and other local officials.

## 5.2 Code of Marketing of Breastmilk Substitutes

The *International Code of Marketing of Breastmilk Substitutes* was adopted by the World Health Assembly in 1981 with the aim of contributing to the provision of safe and adequate nutrition for infants by protecting and promoting breastfeeding and ensuring the proper use of breastmilk substitutes, when needed. The World Health Assembly revisits the issue of infant and young child nutrition regularly and has adopted a series of subsequent Resolutions that clarify the Code and address emerging concerns and scientific developments. WHO's Member States have been urged over the years to give effect to the Code and subsequent Resolutions by adopting national laws or regulations, providing guidelines, and monitoring and enforcing compliance. Three of the six countries studied – Sri Lanka, Bangladesh, and the Philippines – passed laws in the 1980s, with Sri Lanka starting the process at the same time the International Code was being developed. All but Uzbekistan now have laws or regulations in place. (See Table 2).

**Table 2: Status of the Code in the Six Countries Reviewed**

Country	No action	Many provisions law	Law passed	Date of passage	Later developments
<b>Bangladesh</b>		✓		<b>1984</b>	Amended in 1990, rules added in 1993, and new provisions proposed in 2008
<b>Benin</b>			✓	<b>1997</b>	Revision in process
<b>Philippines</b>			✓	<b>1986</b>	Rules and regulations ratified in 2007
<b>Sri Lanka</b>			✓	<b>1981</b>	Additional provisions in 1993, amended in 2002
<b>Uganda</b>			✓	<b>1997</b>	Revision in 2005 but still pending
<b>Uzbekistan</b>	✓				Order for facilities passed in 2004

A strong Code of Marketing, with active monitoring and enforcement, is a critical part of effective national breastfeeding programmes. In countries such as the Philippines and Sri Lanka, with high GDPs, marketing pressure from formula companies is likely to be strong, as the potential for profits is high. The Philippines has the highest rates of bottle and formula feeding at 0-3 months (26 percent and 17 percent respectively in 2006) of the five countries for which data are available. (No figures are available for Sri Lanka.) Benin and Uganda have the lowest percentages of improved drinking water (65% and 64%) and adequate sanitation (30% and 33%, respectively), making bottle and formula feeding the riskiest. In these countries marketing from formula companies is not as active as in higher income countries, but vigilance is important. These same countries, along with Bangladesh and Uzbekistan, have the highest percentage of families (46 percent or more) living below the international poverty line of \$1.25 a day, making formula use prohibitive for a large portion of the population.

Code-related activities varied widely in the countries studied, ranging from studies of violations, drafting and passage of laws and regulations, sensitization of the public and media on provisions and the importance of a code, training on code monitoring, code monitoring, and code enforcement with penalties for violations. Efforts in Bangladesh at Code monitoring and enforcement are highlighted in [Box 1](#), and the Philippines in [Box 2](#):

### **Box 1. Efforts at Code compliance in Bangladesh**

- Passed law in 1984, amended it in 1990, added rules in 1993, and recommended revisions in 2008
- Participated in four-country study of Code violations (1998) – had fewest number of free samples
- Succeeded in getting companies to comply with labeling restrictions
- Product registration required, and NGOs, journalists, and volunteers involved in Code monitoring
- Press conferences, orientation sessions on Code for journalists through Institute of Public Health
- National and district-level training on Code monitoring
- Sued companies in violation of the Code and won the case although the penalty was small

### **Box 2. Efforts at Code compliance in the Philippines:**

The Philippines drafted a Code in 1981, but it took 5 years of forceful advocacy, including street marches and public discussions, before it was signed into law. During the next 20 years, the Department of Health, in collaboration with NGOs and international agencies, fought for passage of effective implementing rules and regulations (IRRs), while the formula companies continued to find ways to more aggressively advertise and promote their products.

In 2000 the IRR was revised in favor of the formula companies. In 2004 the struggle to close the loopholes began again, with 12 drafts of IRRs prepared. Finally in 2006 a revised IRR was signed which included guidance on enforcement. It was temporarily delayed by a restraining order requested by an industry association representing the formula industry. Finally, after intense and creative advocacy, including eye-catching demonstrations at public hearings, record-breaking simultaneous breastfeedings, and a massive media campaign, with UNICEF and NGOs playing key leadership roles, the Revised IRR was re-instated, with most of its provisions intact.

Most countries have experienced difficulties in mounting sustained and effective Code monitoring programmes. Training has been held for Code monitors both regionally and in country at various levels in all five countries with Codes. In the 1980s and sometimes in the 1990s NGOs such as IBFAN and various national breastfeeding advocacy groups were active in Code monitoring. Recently Code monitoring activity has declined in most countries. Enforcement has posed even greater challenges, with no or very weak penalties in place for companies that persist in violating regulations.

Uzbekistan has the farthest to go in developing an effective strategy for controlling detrimental formula marketing. While an order ("*prikaz*") was adopted in 2004 that prohibited advertisements and promotion of breastmilk substitutes in maternity and pediatric health care settings, it has not been widely distributed, and few facilities follow the directive. A systematic effort is needed in Uzbekistan to determine the extent of Code violations and coordinate an initiative by key stakeholders to develop and adopt effective legislation with adequate provisions for monitoring and enforcement.

### **Lessons Learned in Development and Monitoring of National Regulations**

- Strong effective regulations, sustained advocacy with policy-makers, and ongoing monitoring and enforcement help keep negative marketing practices in check. The threat of bad publicity, fines, and lawsuits acts as a deterrent.
- Steps needed to put a sustained monitoring system in place include a study of violations, formation of an active inter-agency monitoring task force free of conflict of interest, development of practical monitoring tools, identification and training of monitors, on-going financial support for the monitoring process, and agreements on how violations will be addressed.

### **5.3 Maternity legislation and workplace support**

The Innocenti Declaration called for enacting "imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement." The International Labour Organization (ILO) Maternity Protection Convention (C-183) set the following standards in 2000:

- Health protection, employment protection, and non-discrimination for working women during pregnancy, after delivery and while breastfeeding.
- 14 weeks of maternity leave with at least two-thirds salary
- One or more daily paid nursing breaks or a paid reduction of work hours for breastfeeding women after returning from maternity leave

Breastfeeding advocates used the provisions of the ILO Maternity Protection Convention and WHO's adoption of 6 months of exclusive breastfeeding to advocate for revisions to existing maternity protection legislation and to raise awareness of women's rights and their contribution to the health of their children and the economy of their countries. Table 3 presents the current status of maternity protection in the six countries reviewed. All of them mandate paid maternity leave in the public sector, and some do in the private sector as well. The informal sector—where most women work—is not covered, although the challenges for breastfeeding women are often most difficult in this sector. Since 2000, Bangladesh and Uganda have increased the length of paid maternity leave. Uganda also extended leave to women in the private sector and provided paternity leave. Since adoption of the amended legislation, the Ministry of Health in Uganda formed a Maternity Protection Technical Working Group with members from several other ministries (health, labor, and justice), a national trade union, a federation of employers, and IBFAN Uganda. The objectives of the Working Group are to publicize the law, advocate for ratification of the ILO Maternity Protection Convention, and develop guidelines on how to implement the law.

Even if leave is guaranteed, the workplace itself may not accommodate breastfeeding or breastmilk expression upon the mothers' return. To address this issue, the nongovernmental organization ARUGAAN in the Philippines used a seed grant from WABA to help create mother-baby friendly workplaces. ARUGAAN collaborated closely with a trade union, set up crèches in pilot sites, offered informal seminars on health topics during the lunch hour, and helped raise awareness of maternity protection through audio tapes and posters displayed in the workplace. The Department of Health, WHO, and UNICEF are now working with union leaders in six factories in the Philippines to establish facilities for expressing and storing breastmilk.

The extent to which maternity legislation affected breastfeeding rates in the countries reviewed needs further exploration. The legislation is likely to have had a small effect in countries where the leave is limited to public sector employees, particularly since most of the legislation currently applies to a fairly small percentage of women, with the exception of Uzbekistan. In the countries studied, there is a gap between the law and its application. Many women, even if covered, are reluctant to ask for their rights for fear of losing their jobs. A better understanding of the primary barriers to improved feeding practices among working mothers will help in assessing the role of maternity legislation and initiatives to improve workplace support and in determining whether the interventions selected adequately addressed these barriers.

**Table 3. Status of Maternity Protection in the Six Countries Reviewed**

Country	PAID MATERNITY LEAVE					Comments	Paternity leave (in days)	Paid breast-feeding breaks
	60 days	12 weeks	14 weeks	≥ 17 weeks	2 years			
<b>Bangladesh</b>				✓		For public sector employees 2 maternity leaves allowed while employed	0	No
<b>Benin</b>			✓			For public sector employees 6 weeks must be taken after birth	3	60 minutes/day for 6 months
<b>Philippines</b>	✓					For any woman who has worked an aggregate of at least 6 months during last 12 months: 2 weeks fully paid leave prior to delivery and 4 weeks after birth Paid leave allowed only for first 4 deliveries	7	30 minutes/day
<b>Sri Lanka</b>				✓		<b>Public sector:</b> Full pay for first 84 working days; ½ pay for next 84 days; leave without pay from months 6-12; <b>Private sector:</b> Limits full benefits for first 2 children for 12 weeks; leave reduced in ½ for subsequent births; receive 6/7th pay	0	60 min/ 9 hrs for 12 mos if crèche at workplace; if no crèche, 120 min/ 9 hrs for 12 months
<b>Uganda</b>		✓				For private and public sector employees 4 weeks must follow birth	4	No
<b>Uzbekistan</b>					✓	For private and public sector employees Full salary for 4 months and then twice the national minimum salary per month until the child is 2	0	30 min every 3 hrs for 24 months

**Source:** Status of Maternity Protection by Country, WABA, 2008; country interviews

## Lessons Learned in Maternity Legislation and Workplace Support

- The ILO Maternity Protection Conventions (1919, 1952 and 2000) have been an important factor in setting standards and institutionalization of maternity protection in the public sector. Countries, however, have modified the recommendations to their own context, with significant variability in duration and payment schemes. There is a need for additional advocacy with the private sector.
- Providing workplace support often poses the greatest challenge in the informal sector, especially in large urban settings where traditional support is lacking and working conditions and travel distances make it difficult for mothers to take their young infants with them. A survey of working conditions for breastfeeding women, documentation of the benefits to employer and family of breastfeeding, and publicity of innovative initiatives to support working women can be first steps in drawing attention to workplace barriers to improved feeding practices.
- Some women are reluctant to advocate for maternity protection because they think that the benefits will diminish their chance of employment. Many are unaware of their benefits, and others fear reprisal if they claim them. This suggests the need for public awareness and sensitization to the value of women's work.

### 5.4 The Baby-friendly Hospital Initiative

The Baby-friendly Hospital Initiative (BFHI), launched by WHO and UNICEF in 1992, attracted world attention because of the perceived simplicity of the “Ten Steps for Successful Breastfeeding” and energetic advocacy both at the highest levels and at the grassroots level by breastfeeding enthusiasts ready to support changes in their nations' maternity services. By 2005 almost 20,000 health facilities worldwide were awarded baby-friendly status.

***The early days of BFHI:*** In the early 1990s BFHI was launched in all of the countries studied except Uzbekistan. During this time UNICEF and WHO were actively promoting BFHI at both the global and country levels. In Bangladesh, Benin, the Philippines, and Sri Lanka, work on the Initiative was initially intense and brought energy and enthusiasm to the breastfeeding movement. But the failure to adequately monitor compliance, provide refresher training, and fully institutionalize the BFHI led to a decline in the compliance with the “Ten Steps.”

The emphasis on improving support for breastfeeding in health facilities was most appropriate in Benin, Sri Lanka, and Uzbekistan where from three-fourths to almost all women deliver in health institutions. Uzbekistan's engagement in BFHI began in 1998 and is now a significant component of breastfeeding programming. The major focus placed on BFHI in the Philippines and Bangladesh had a more limited effect because institutional deliveries represent only 38 percent of all deliveries in the Philippines and a mere 15 percent in Bangladesh. BFHI has never played a major role in Uganda.

Statistics regarding the percentages of infants delivering in baby-friendly facilities are not available, but the data on percentages of institutional deliveries in the countries studied indicates that Uganda, the Philippines, and Bangladesh are in particular need of additional strategies to reach the majority of women who deliver at home. Table 5 summarizes available data<sup>7</sup> on the current status of BFHI in the six countries reviewed.

**Table 4: BFHI in the Six Countries Reviewed**

Indicator	Bangladesh	Benin	Philippines	Sri Lanka	Uganda	Uzbekistan
<b>Health indicators</b>						
Antenatal care coverage (%)	51%	84%	88%	99%	94%	99%
Institutional deliveries (%)	15%	78%	38%	98%	41%	97%
<b>BFHI indicators</b>						
Number of facilities designated baby friendly	498	Maternities in 12 hospitals & 15 health centres	1,427	84	15	102 maternities; 76 polyclinics
% of all (or targeted) facilities	74% of govt. maternities	25% of facilities <sup>8</sup>	79% of total hospitals & maternities <sup>9</sup>	14% of govt. facilities	14% of govt. hospitals	31% of maternities; 2% of polyclinics
BFHI committee functioning	Yes (BBF)	Inactive	Yes	No	No	Yes
Active monitoring	Some	No	Yes (restarting)	No	No	Some
Active reassessment	Some	No	Yes (restarting)	No	No	Some
Revitalization of BFHI planned or underway	Yes	Possibly	Yes	Yes	Possibly	Yes

**Innovations and challenges.** As these countries worked to implement the Initiative, creative approaches served to increase success. In Sri Lanka, for example, the Ministry of Health recommends that specialized institutions with maternal and neonatal care services set up Mother Baby Centres in the hospital that enable mothers to stay with babies with special needs such as premature babies and multiple births and receive assistance in establishing good feeding practices.

<sup>7</sup> Reliable data on BFHI indicators were difficult to obtain for many of the countries studied. Statistics sent to UNICEF NY at times conflicted with numbers available in country reports. The “denominators” for many of the figures (whether for “all facilities” or only those “targeted”) were, at times, unclear. The information provided in the table 5 is the best estimate that could be provided, given these challenges.

<sup>8</sup> Percentage of “facilities ever designated”, according to the UNICEF BFHI report for 2005/2006.

<sup>9</sup> There were 1798 hospitals/maternities in the Philippines, according to the UNICEF BFHI Report for 2005/2006, with 79% designated. The DOH reports that 83% of targeted hospitals (1,713) were designated.

The Centres include a lactation management room where mothers at the hospital or in the community can drop by for assistance. In the Philippines, a number of innovative strategies helped to energize the Initiative (See [Box 3](#)).

Sustainability and integration of BFHI are challenges facing all the countries studied. Respondents reported the following issues that need to be addressed if BFHI is to be revitalized.

- *National ownership.* National ownership of an initiative is essential if it is to be sustained. In many countries, including those reviewed, there was insufficient institutionalization of BFHI within the health system. UNICEF and WHO, in the early years, pressed for its national partners to train staff and designate facilities with, perhaps, insufficient attention to encouraging national partners to integrate BFHI within their systems in a sustainable way.
- *Human resources and training.* Rapid turnover of personnel and lack of systems for training replacements depleted the cadres of trained trainers and assessors available to the Initiative. In Uzbekistan, for example, out of 260 staff trained as BFHI and lactation managers from 1998-2006, only 10 percent were still available to serve as trainers in 2008. Newly arrived hospital administrators also lacked orientation and thus commitment.
- *Monitoring and reassessment.* As Table 5 above indicates, systems for monitoring and reassessment are active in very few of the countries. BFHI and IYCF evaluations, such as recent studies in Bangladesh (1999 and 2005), the Philippines (2006), Sri Lanka (2005), and Uganda (2000 and 2005) indicate that slippage in compliance is very common. Insufficient work has been done to incorporate BFHI criteria into general quality control and accreditation systems.
- *Link with community.* Implementation of “StepTen” has generally been weak, with mother support groups too often held at the hospital and led by health staff, with little community involvement or sustainability. Opportunities for providing support at community level for exclusive breastfeeding in many cases have not been pursued. In most of the countries studied, there has been insufficient attention to community-based breastfeeding promotion and support and lack of sufficient coordination between this essential intervention and BFHI.

### **Box 3. Innovative BFHI strategies in the Philippines**

- Requiring orientation of hospital administrators as first step in implementing BFHI
- Instituting cost-cutting measures to make baby-friendly changes more affordable (adapting beds, using nursery staff for BF education, etc.)
- Using retired midwives or volunteers to ecounsel newly delivered mothers
- Assigning baby-friendly hospitals as mentors to other facilities working for designation
- Calculating cost-savings from “rooming-in” to convince decision-makers to implement BFHI
- Organizing a “training of trainer” system country-wide that resulted in a “multiplier effect” with 79% of all hospitals designated baby-friendly
- Requiring BFHI designation to receive certification for payments by national health insurance “PhilHealth”

**Revitalization and institutionalization of BFHI:** Revitalization of BFHI is either underway or planned for the near future in several of the countries visited. The endorsement of the Global Strategy, strong advocacy by UNICEF and WHO for its targets, availability of revised BFHI materials, and hosting of multi-country workshops generated renewed interest in breastfeeding and IYCF at country level, with a desire to craft a more comprehensive, integrated approach. The ownership for implementation needs to be firmly with the Government. Better institutionalization needs to be ensured by making the Ten Steps and their monitoring a mandatory component of standard operating procedures, norms, and accreditation procedures for all maternity facilities and by making training in lactation management or IYCF counseling a requirement for all new staff joining maternity facilities (i.e. by including it in pre-service curricula), as well as a requirement for all existing staff. In addition, more attention needs to be given to ensuring capacity building in IYCF counseling and support for staff in other key MCH contacts – not just maternity facilities – as well as ensuring that these activities actually take place at these contacts, which could include ante-natal care, community newborn care, EPI, well-child/growth monitoring, IMCI, acute malnutrition screening and PMTCT.

### **Lessons Learned on BFHI**

- As efforts continue to revitalize the Initiative, it is important to consider how to simplify the process as well as to institutionalize the Initiative into country health systems at central and lower levels. BFHI needs to be part of an integrated approach that cost-effectively provides the continuum of care needed for mother and child.
- As countries develop their overall IYCF plans, an appropriate balance is needed for support at the health facility (maternity services as well as all relevant MCH contacts) and community levels. Some countries neglected to provide sufficient support for activities at MCH contacts and for outreach to the community, which is necessary to reach women who give birth at home and to provide the support that all women need in the first days and months after delivery. Data show that significant focus and high coverage of BFHI will not result in increased rates of exclusive breastfeeding up to six months in the absence of implementation of IYCF counselling and support at other MCH contacts, community IYCF actions, and at-scale communication efforts. This is particularly the case in countries with low rates of institutional deliveries. A coordinated effort at health facility and community levels is essential, and appropriate prioritization of actions is required, depending on the context.
- Revitalization and institutionalization of BFHI or improvement of breastfeeding practices in maternities should include other elements shown to be important to successful national Initiatives, including national ownership and financing, systematic orientation of policy makers and hospital administrators, close collaboration with NGOs and professional organizations, good pre-service training, on-going in-service training and updating of health personnel, strong Code monitoring, appropriate support and guidance for HIV-positive mothers, and integration of the Ten Steps into monitoring and accreditation systems.

## 5.5 Training and education

Capacity building of health care providers was a major component of the programmes reviewed. Capacity building took three forms: in-service training, pre-service education, and professional development courses. In-service training is designed to update knowledge and skills and motivate staff. Pre-service education helps ensure that future health care providers are equipped with correct information and practical skills to provide IYCF counselling and support. Professional development courses provide in-depth training to individuals with major responsibilities for IYCF in government agencies, health facilities, or academic institutions.

***In-service training:*** The primary curricula used for in-service training between 1995 and 2005 were WHO's 40-hour breastfeeding counselling course and the WHO/UNICEF 18-hour BFHI course. In the past couple of years, countries have started to introduce the 40-hour integrated IYCF counselling course, which draws upon three courses on breastfeeding, complementary feeding, and HIV and infant feeding counselling.

Training has been at the centre of Sri Lanka's efforts to promote and support breastfeeding. Since 1995 the vast majority of health care providers have participated in the breastfeeding counselling course. In Bangladesh around 20,000 health care providers attended a BFHI training in the past 15 years. Although few women in Bangladesh deliver in a hospital, the BFHI training did help create a network of advocates and skilled professionals who could provide appropriate infant feeding support at other points of contact. In Benin health care providers are exposed to IYCF during sessions on the Essential Nutrition Actions in IMCI training. The training on breastfeeding is not as in depth as the WHO five-day counseling course and does not have much focus on building counseling and problem solving skills. However, this level of training may be adequate as an orientation for many providers to conduct promotive activities on IYCF. Sri Lanka depends primarily on the public health midwife for provision of IYCF services and support so one standard course may be appropriate. Most countries use many different types of providers to deliver services, so a single course on breastfeeding would not be suitable or necessarily cost effective. However, in many of the countries studied, little was done to analyze the IYCF-related knowledge and skills needed by various health providers and to tailor the courses and clinical practice sessions to their needs.

Common challenges mentioned during the country assessments were the high demand for and the cost of in-service training because of high turnover of trained staff. Decentralization presents new challenges in funding and rolling out training at the district level. A frequent theme is the need to improve counselling and problem solving skills and to follow-up and mentor after training. Those conducting the assessment visits found that good training records were absent, making it difficult to determine who had been trained, the number trained, and the content of the training. No reports of training evaluations were provided. The limited information available on the effectiveness of the training points to a major gap.

**Pre-service education:** Curricula reviews provide an opportunity to add or enhance the IYCF content. In Sri Lanka aspects of the lactation management course were inserted in the curriculum for nurses and midwives when it was under review. The Bangladesh Breastfeeding Foundation conducted workshops to review and update the breastfeeding content in the undergraduate medical course and the nursing curriculum. In the Philippines there have been periodic recommendations, including in the current IYCF action plan, to strengthen the lactation management and IYCF content in the curricula of medical, nursing, and other health science schools. A challenge in all of the countries is to address IYCF in more than a rudimentary way. Pre-service education often focuses on theoretical knowledge, without much practical guidance for dealing with lactation management issues, and the messages are not always harmonized in the different curricula. In many of the educational systems that provide pre-service education for health professionals, the professors and other instructors make the decisions concerning what topics to include in their courses, making it difficult to institute sustainable curriculum reforms.

**Professional development courses:** UNICEF, USAID, WHO, and the World Bank funded participation of individuals in the one-month course on Breastfeeding: Practice and Policy at the Institute of Child Health in London and/or the one-month lactation management course at Wellstart International in San Diego, California. Many of these individuals inspired the next generation of professionals, held influential positions, and remained breastfeeding advocates for decades. The Uganda graduates of the Wellstart course started a breastfeeding NGO and set up the first lactation clinic in sub-Saharan Africa. Many of the primary actors in the Philippines national breastfeeding programme had attended the Wellstart course as well.

### Lessons Learned in Training and Education

- Training strategies need to take into consideration the knowledge and the skills in IYCF required by different cadres of health providers and determine the essential content and skills required to improve their job performance.
- Inadequate attention to training in interpersonal counselling and problem solving skills reduces the effectiveness of health providers and community nutrition promoters.
- The lack of an integrated training strategy that includes ongoing mentoring, supportive supervision, and a management information system to track training activities results in ineffective use of both human and financial resources.
- Pre-service education on key aspects of IYCF, including adequate clinical practice, is the most cost-effective way to strengthen health workers' IYCF-related knowledge and skills.

## 5.6 Communication

To change breastfeeding practices, evidence shows that successful efforts use multiple channels to reach priority audiences with age- and context-specific messages. These messages are consistently delivered and mutually reinforced by health providers, communities, and various types of media, and they reach the primary audience frequently enough to stimulate lasting behavioural change. A creative mix of mass media and traditional channels is likely to have greater reach and impact than a single channel.

***Development of messages and identification of communication channels.*** Use of formative research methods such as Trials of Improved Feeding Practices, and pre-testing in Benin and Uganda helped tailor messages to the specific conditions of targeted audiences. Youth and women's group representatives, health workers, professors and graduate students, journalists, traditional singers, and artists participated in a workshop in Benin to develop messages to use in traditional media such as theatre, song, print, and radio. Media audience research can also guide the development of communication strategies. Based on its research, a firm in Uganda recommended that drama, dance, radio, and social and community gatherings be used in the communication strategy for IYCF.

***Print materials for mothers.*** Literacy is high and the number of languages is few in Sri Lanka, the Philippines, and Uzbekistan, which make print materials a feasible communication channel. Sri Lanka relies heavily on print materials written for mothers to communicate breastfeeding messages, particularly through the five antenatal booklets and the child health development record. These materials are available in three languages. In Uganda 39 percent of women are literate. Take-home flyers for mothers on feeding options that were recently produced had to be printed in seven languages, increasing costs. Uganda was able to reduce the cost for the development and design of PMTCT materials by adapting ones produced in Tanzania. Low literacy rates and multiple languages present similar challenges in Benin. In Bangladesh most people speak Bangla, but only one-third of women can read. Such conditions make it more difficult for the print materials to have a significant impact on the target population, and other communication channels that do not require literacy need to be utilized.

***Mass Media.*** Mass media has been used to a limited extent in Bangladesh but was instrumental in educating and motivating the target audience in the Philippines and Uzbekistan. In Bangladesh 46 percent of women reported watching television at least once a week, and 33 percent listened to the radio at least once a week compared with 80 percent and 78 percent, respectively, in the Philippines (BDHS, 2004; PDHS, 2003). As part of the campaign against Code violations in the Philippines, the Department of Health, UNICEF, and WHO waged an intense multi-media campaign on the web and through posters, radio and TV spots, and the video "Formula for Disaster," which was produced by UNICEF and widely aired. Mass media also featured prominently in Uzbekistan's "Breastmilk is a Gift of Nature" campaign along with other channels of communication (Box 4).

**World Breastfeeding Week (WBW).**

World Breastfeeding Week was launched by the World Alliance for Breastfeeding Action (WABA) in 1992 to raise awareness and stimulate action globally in support of breastfeeding. The different themes each year provide an opening for outreach to new partners. All six countries use WBW for more intense breastfeeding promotion. Common activities include conferences, seminars, festivals, mass media spots, and dissemination of posters and educational and advocacy materials. Media sensitization workshops also occur as part of WBW. Creativity has been expressed through art and poetry competitions in Bangladesh, celebrations organized by mother support groups in Benin, and contests for simultaneous breastfeeding in a single site in the Philippines.

**Job aids.** Interpersonal communication is critical to changing individual behaviour in a culture where “talk” is the primary form of communication. Job aids such as counselling cards and flip charts can assist health providers and community workers in individual counselling and group discussions and remind them of key messages at different points in the life cycle, such as antenatal and postpartum contacts. Of the six countries, Uganda appears to have the most extensive, up-to-date set of job aids for counselling on IYCF. One of the cards is shown above. Benin also has a full set of flip chart counselling aids on IYCF. In most of the countries, few resources exist on complementary feeding.

**Box 4. Uzbekistan’s “Breastmilk is a Gift of Nature” Campaign**

- 6-week campaign in 2 provinces
- 2 episodes of a TV soap opera
- Radio messages and TV spots
- Press materials, brochures, flyers, posters
- Drama
- Seminars and meetings with young mothers and their mothers-in-law
- Open house days at village clinics to discuss

**Result:** After the campaign, one province reported a 20 percentage point increase in knowledge that a woman could satisfy the needs of her baby through exclusive breastfeeding for 6 months.



## Lessons Learned in Communication

- Use of formative research methods such as trials of improved feeding practices and use of the results in the design of strategies and messages is important, as is pre-testing of messages and materials help ensure that the messages and materials are tailored to the target audiences. Involving the community and potential audiences in this process is essential.
- Channels to reach the audience should be selected by taking into account literacy, access to media, and the level of contact with health providers and community workers.
- Involving a wide range of stakeholders and communication specialists in the development of materials helps harmonize messages, ensure dissemination and use of the materials, and reduce printing costs per unit if stakeholders buy into the print run.
- World Breastfeeding Week can energize breastfeeding advocates and bring short-term visibility. However, on its own, World Breastfeeding Week is not sufficient as a strategy to ensure sustained behaviour change, and a continuous, comprehensive communication strategy using multiple channels is needed in order to ensure sustained behaviour change.

## 5.7 Community-based promotion and support

Community-based promotion and support is the underdeveloped component of most programmes although it is widely recognized as critical for improving IYCF practices on a large scale. The case studies provide examples of various types of community resources engaged in breastfeeding promotion and support.

**Public health midwives.** In Sri Lanka the public health midwife is the main link between the health facility and the community. She provides antenatal care both in the home and the clinic. Her responsibilities include two home visits in the first 10 days after a normal delivery, another visit around 28-30 days postpartum, and a visit at the end of 6 weeks. This stands in sharp contrast to Uganda where less than one-fourth of women receive care within the first two days postpartum and three-quarters receive no care within the first six weeks after delivery

**Community nutrition workers.** In Benin the World Bank-supported Community Food Security Project (1996-2000) covered 10 percent of the population and used community nutrition workers for monitoring pregnant and lactating women, growth monitoring and promotion, and establishment of village nutrition committees. In the Philippines the government established 2,220 health and nutrition posts between 1999 and 2002; however, only 30 percent of the posts

are filled, and the last training these workers received was about 5 years ago. In Bangladesh the National Nutrition Programme (NNP) covers one-fifth of the population with activities revolving around more than 23,000 community nutrition centres in NNP districts. At the centre, a community nutrition promoter distributes a cereal-pulse mixture for on-site feeding of pregnant women and malnourished and the poorest children who are 7-24 months old. Depending on her motivation and the management of the implementing NGO, the promoter may conduct home visits. She is expected to work 4-6 hours per day and receives an honorarium of \$15 per month for her services. Food distribution and growth monitoring often leave her with little time for nutrition education and individual counselling. BRAC, a large NGO in Bangladesh, takes another approach. Community health volunteers are present during home deliveries to provide essential neonatal care and breastfeeding support. BRAC's community health workers make several home visits to mothers after delivery to encourage exclusive breastfeeding and help resolve problems.

**Community growth promoters.** From 2004 to 2007 the USAID-supported UPHOLD Project in Uganda trained more than 1,200 community growth promoters and introduced monthly village weighing sessions in over 500 villages in five districts. The project reached approximately 15,000 children under 2 years of age each month. An evaluation in four of the districts found that the proportion of children who were malnourished declined from 13 percent to 8 percent over an 8-month period. Growth monitoring and promotion is a component of Community-IMCI, which is at various stages of being rolled out in the countries studied. In Benin Community-IMCI reaches 29 percent of the population while it is only now getting started in Bangladesh. Feeding and nutrition is one of the five priority areas in Bangladesh's Community-IMCI strategy, providing a new opportunity and a good entry point for IYCF promotion and support.

**Community leaders.** Community leaders are an important resource in influencing IYCF practices and generating and sustaining support for community based IYCF activities. A good example of active participation of community leaders is in Uzbekistan, where they work with the Institute of Health to develop and distribute IEC materials and organize breastfeeding week activities. Women leaders bring together young mothers and grandmothers for community breastfeeding sessions where mothers demonstrate proper positioning and attachment and share their experiences.

**Peer counsellors.** Peer counselling is a promising practice that has not yet been attempted on a large scale. A randomized controlled trial in Dhaka showed that women who were visited in their homes by community-based peer counsellors in the last trimester of pregnancy and in the first months postpartum had higher rates of exclusive breastfeeding at five months than in the control group (70 percent versus 6 percent).<sup>10</sup> In the Philippines and Benin several community outreach programmes have used a “negotiation” strategy as part of their IYCF peer counselling approach, with promising results. This involves at least three visits to households with pregnant women, new mothers, or families with malnourished children to: 1) review the situation and current feeding practices, 2) discuss and negotiate with the mother (and her family) to try one or more improved infant feeding practices, and 3) assess what has been tried and what more needs to be done to achieve success.

**Mother support groups.** Step 10 of BFHI encourages health facilities with maternity services to foster mother support groups for breastfeeding. This is often the criterion that hospitals seeking certification fail to meet. Many of the hospitals that meet the criterion have a support group in their own facility rather than a link to a community support group. As part of Step 10 of BFHI, Benin formed mother support groups, but many of them were inactive after a few years. Since 2007 the MOH has worked to reactivate 79 groups.

In Bangladesh the term “mother support group” is applied to a group of women that provides support to other women in the community. The Bangladesh Breastfeeding Foundation, through the National Nutrition Programme, introduced mother support groups as a new strategy in 17 sub-districts. At one point 4,000 groups had been formed in 12 of the sub-districts, but only 65 percent were functioning at the time of



© Ann Brownlee, UCSD

an evaluation in 2005. Recognizing the potential of mother support groups, UNICEF changed the composition of the group and is trying the new model in five sub-districts. In Sri Lanka mothers and fathers groups are key components of community-based breastfeeding activities of Sarvodaya, an NGO involved in women’s empowerment, community development, and micro-credit.

<sup>10</sup> Haider R, Ashworth A, Kabir I, Huttly SRA. Effect of community-based peer counsellors on exclusive breastfeeding practices in Dhaka, Bangladesh: a randomized controlled trial. *Lancet* 2000; 356:1643-1647.

**Community mobilization.** Several approaches have been used to mobilize communities. For example, in Bangladesh Save the Children promotes good IYCF practices through courtyard sessions and community meetings as well as prenatal home visits and growth monitoring. The Bangladesh National Nutrition Programme established village union and sub-district nutrition management committees for community mobilization. In the first years of the National Nutrition Programme, street theatre was found to be the most effective tool for communicating directly with the public on social issues. The Participatory Nutrition Improvement Programme in Sri Lanka formed community groups and offered school seminars. The paid “external facilitators” were not part of the existing structure, and the programme was eventually discontinued. Community mobilization is one of the roles of the Village Health Teams (VHTs) in Uganda. Establishment of VHTs has been slow, but the goal is to have trained VHTs in all villages by 2010. In Benin’s Essential Nutrition Actions (ENA) programme, community leaders and mothers were actively involved in formative research and planning strategies to address the problems discovered. This led to active efforts by these local stakeholders to mobilize other community members to participate in implementing the needed actions. For example, when one community found that pregnant women were not coming for needed antenatal care, grandmothers and other concerned women conducted a campaign resulting in almost 100 percent attendance.

**Model breastfeeding communities:** The Department of Health and other partners in the Philippines are advocating for the establishment of model breastfeeding communities. Innovative community-based pilot programmes are currently underway. Several cities have passed ordinances in line with recommended feeding practices and worked to create breastfeeding rooms, monitor and report Code violations, establish community support groups, train health workers, and prepare peer counsellors to aid pregnant and new mothers with IYCF problems. Breastfeeding stations have been set up within many shopping malls and within provincial and city government offices, plantations, and UNICEF itself.

The examples above suggest that there is no one roadmap for community-based breastfeeding promotion. Many of the successful strategies such as peer counsellors and mother support groups have yet to be implemented on a large scale. Challenges include training large numbers of volunteers, linking with health facilities, ensuring enough time for individualized counselling, and providing adequate mentoring, encouragement, and effective incentives. Incentives to encourage sustained participation in support groups and peer counselling have included training, celebrations, support for food and transportation costs, bicycles for transport, priority-setting by group members, and public recognition.

The degree to which programmes have taken advantage of the various opportunities for promoting and supporting IYCF in health facilities and the community is reflected in the results. In Sri Lanka public health midwives have multiple contacts with pregnant and postpartum women in their homes and in the clinic as part of a continuum of care. In Uganda most women do not have any postpartum contact with a health worker, which greatly limits the impact the health system can have in affecting feeding practices. Although multiple contact points exist, some programmes tend to focus almost entirely on growth monitoring while overlooking other opportunities to counsel mothers on IYCF.

### **Lessons Learned in Community-based Promotion and Support**

- Plans should be put in place at the outset to achieve broad-scale implementation of evidence-based interventions. Without this vision and plan, the end result is often small, ad hoc pilot projects that are never scaled up.
- Tapping into existing community structures, support groups, and programmes such as C-IMCI and community management of acute malnutrition (CMAM) should be explored before creating new ones. However, where such structures do not exist or community workers are already overloaded with multiple tasks, exploring the scale-up of peer-counseling as a strategy may be considered, since it appears to show promise at smaller scale.
- Trusted community members are indispensable resources for IYCF promotion and support. They need continual mentoring and encouragement, as well as appropriate training that builds communication, counseling, and problem-solving skills in IYCF. Unreasonable expectations, lack of incentives, and an ever increasing set of duties can diminish their effectiveness and increase the dropout rate.
- Community support is often most effective when community leaders and respected members are engaged in assessing their own resources, opportunities, and needs and devising strategies to develop an enabling environment for IYCF in the community and household.

### **5.8 Infant feeding in difficult circumstances**

The Global Strategy for IYCF states that “Families in difficult situations require special attention and practical support to be able to feed their children adequately.” Infants and young children in these situations include those who are malnourished, born with low birthweight, born to HIV-infected women, and victims of natural or human-induced emergencies. This section will discuss the latter two scenarios.

***Feeding infants and young children of HIV-infected women:***

The HIV prevalence rate is 0.1 percent or less among adults 15-49 years old in Bangladesh, the Philippines, Sri Lanka, and Uzbekistan, and 1.2 percent in Benin. Uganda has the highest rate at 5.4 percent. Keeping up to date on feeding recommendations in the HIV context is challenging. In 2006 WHO/UNICEF issued guidelines recommending exclusive breastfeeding by HIV-infected women for 6 months except when replacement feeding is acceptable, feasible, affordable, sustainable, and safe (AFASS). If these conditions are not achieved at 6 months, HIV-infected women are encouraged to continue breastfeeding while giving appropriate complementary foods. These recommendations are included in the national guidelines awaiting government approval in Bangladesh and the approved guidelines in Benin and Uganda. The national IYCF policy in the Philippines states that concern for HIV transmission through breastfeeding needs to be balanced with the increased risk of morbidity and mortality when infants are not breastfed, and that all HIV-infected mothers will receive counselling to guide them in selecting the most suitable options for their situations. In Uzbekistan formula feeding is recommended to HIV-positive mothers. Mothers receive free infant formula while in the hospital. Once discharged, they must purchase the formula, which may create issues of affordability and compromise the appropriate feeding of the infant. In Sri Lanka the Government provides free infant formula for the total recommended duration for HIV-positive women choosing this feeding option.

***Feeding infants and young children who are victims of natural or human-induced emergencies.*** The geographic location and topography of Bangladesh makes it prone to cyclones, floods, and tornados. In most cases Bangladesh has been an early adopter of international recommendations on IYCF but was slow to focus on this aspect. Joint statements on infant feeding in emergencies were only issued after the floods and cyclone in 2007.



© Tanvir Ahmed/IRIN

For a period, infant formula was distributed after a cyclone until UNICEF and respected Bangladeshi pediatricians convinced the government to keep the donated milk in the warehouse. A rapid assessment after the cyclone by Save the Children UK found that neither of the joint statements on feeding during emergencies had been distributed widely to local government offices and NGOs. In 2008 UNICEF translated the Government guidelines on infant feeding in emergencies into Bangla, printed copies, and distributed them to peripheral areas. The interagency resource on infant feeding in emergencies for health and nutrition workers<sup>11</sup> was also translated into Bangla.

The December 2004 tsunami also found Sri Lanka without guidelines on infant feeding in emergencies. The tsunami resulted in the death of 35,000 people—one-third of them children—and the displacement of hundreds of thousands of people. After the tsunami, the mass media broadcast appeals for infant formula and bottles. Initially, formula and feeding bottles were distributed without controls to protect breastfeeding, particularly in the eastern border areas, until the MOH and development partners acted. National guidelines on infant feeding during emergencies were formulated and issued 18 days after the disaster. UNICEF and the MOH launched a mass media campaign to prevent formula donations and distribution, produced IEC materials, and helped develop and distribute the national guidelines.

### **Lessons Learned in Feeding in Difficult Circumstances**

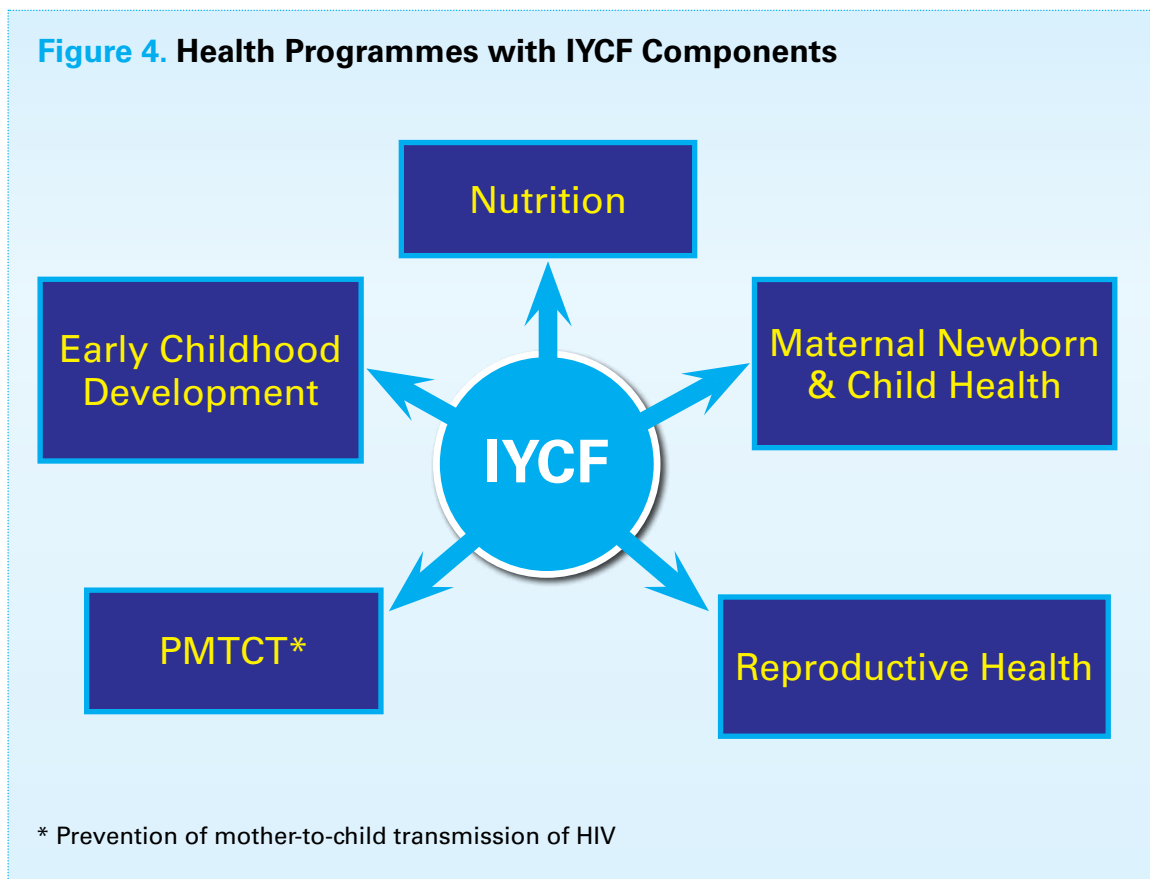
- Lack of guidelines, coordination, and awareness among the media and relief workers of the dangers of formula feeding opens the door to the indiscriminate and inappropriate distribution of infant formula. Advance preparations, training of health workers on infant feeding in emergencies, and ongoing briefings with the media during emergencies can reduce the chances of misguided actions and misinformation.
- Changing recommendations on infant feeding in the context of HIV continue to cause confusion. Achieving consensus and clarity among public health specialists, academicians, and practitioners remains a challenge requiring advocacy and communication strategies, as well as appropriate training of counsellors.

<sup>11</sup> IFE Core Group/Emergency Nutrition Network. Infant Feeding in Emergencies: Module 2, for health and nutrition workers in emergencies. 2007. Available at <http://www.enonline.net/ife>

## 5.9 Integration strategies

The Child Survival Revolution in the 1980s launched vertical programmes in growth monitoring, the control of diarrheal diseases, expanded promotion of immunization, and breastfeeding. BFHI functioned as a vertical programme. In the mid-1990s the viability of a vertical approach for breastfeeding was called into question because of fewer resources for breastfeeding promotion and the realization that broad-scale change would require going beyond the Innocenti targets and reaching out to the community. Existing programmes and new initiatives provided an opportunity to strengthen and expand their IYCF components, leverage resources, and scale up interventions at a more rapid pace. In Sri Lanka the well-established health structure contributed to its achievements. In Bangladesh, Benin, Uganda, and the Philippines, high staff turnover, poor supervision, missed opportunities, and other weaknesses in the health delivery system limited gains that could have been achieved.

Figure 4 illustrates the various types of health programmes with breastfeeding or IYCF components in the countries that were assessed. A discussion of the features of these programmes follows.



**Nutrition Programmes.** IYCF is a component of the following types of nutrition programmes.

- **Integrated nutrition.** Before the introduction of the Promotion of the Minimum Package of Essential Nutrition Actions (ENA) in Benin, nutrition activities were scattered across various ministries with little integration of nutrition activities within routine health services. The objective of the ENA programme is to deliver a set of proven actions at the health facility and community levels and to reinforce key nutrition behaviours through a communication programme. In Benin, the six action areas are exclusive breastfeeding for 6 months, complementary feeding with continued breastfeeding from 6 to 24 months, vitamin A supplementation, iron/folic acid supplementation for pregnant women, iodized salt consumption, and nutritional assessment and counselling of the sick child. Other countries have adopted a similar approach. Although the action areas may be slightly different, exclusive breastfeeding and complementary feeding are uniformly part of the package. The ENA approach is being promoted by some development partners in Uganda, and elements of ENA are evident in the Essential Nutrition Services package in Uzbekistan. The current integrated UNICEF programme in Sri Lanka addresses nutritional needs during pre-pregnancy and pregnancy, optimal IYCF practices, and enhanced micronutrient intake to combat anemia and low birthweight.
- **Growth monitoring and promotion.** The ENA approach emphasizes several key contact points during the life cycle. Some programmes, such as the former USAID-assisted UPHOLD Project in Uganda, focus primarily on one contact point—growth monitoring and promotion.
- **Supplementary feeding.** The Maternal and Child Health Programme supported by the World Food Programme in Uganda and the National Nutrition Programme supported by the World Bank in Bangladesh provide food for malnourished children 6-24 months old and children showing growth faltering as part of growth monitoring and health education sessions.
- **Nutrition rehabilitation.** Therapeutic feeding centres in northern and eastern Uganda receive therapeutic milks, high-energy biscuits, and food for the mothers from UNICEF and the World Food Programme. In the Nutrition Unit at the Mulago Hospital in Kampala, mothers participate in daily education sessions where they learn about appropriate foods and feeding practices during the 4-6 weeks when their children receive in-patient care. Ready to use therapeutic food was introduced into the hospital's in-patient and out-patient programme in 2007. In 2009 UNICEF will support operations research on the use of supplemental ready to use foods for the treatment of moderate malnutrition. In Benin nutrition demonstration centres, under the "Hearth" programme, focus on identifying model mothers who have nurtured their children successfully in disadvantaged circumstances. These mothers help others with malnourished children prepare healthy local foods using their kitchens as "hearths". The families are followed up through home visits, and finally their children are re-integrated into the growth monitoring programme.

**Maternal, Newborn, and Child Health Programmes.** These programmes incorporate nutrition within a broader health framework. Child survival programmes often promote the ENAs along with other family care practices such as antenatal care, immunization, hygiene, treatment of diarrhea, and malaria prevention. Feeding of the sick child is a major component of Integrated Management of Childhood Illness (IMCI). Early and exclusive breastfeeding are part of the essential newborn care package that Save the Children promotes in its Saving Newborn Lives programme in Bangladesh. These practices are also part of the packages promoted by the Department of Health and various donors in the Philippines and in other countries as well.

**Reproductive Health.** Exclusive and on demand breastfeeding contributes to maternal health and child spacing. Breastfeeding also has a number of benefits for the mother immediately post-delivery (e.g. reduced bleeding) and in the longer term, such as preventing certain cancers and obesity. Uganda's reproductive health policy recommends early and exclusive breastfeeding, feeding on demand, and extended duration of breastfeeding to help suppress fertility. Sri Lanka does not recognize the lactational amenorrhea method as one of the contraceptive options because women are encouraged to use modern methods of contraception as early as possible after birth.

**Programmes for the Prevention of Mother-to-Child Transmission (PMTCT) of HIV.** As mentioned above, the prevalence rate of HIV is low in all but Uganda; however, conditions exist in some countries that could result in increased prevalence unless actions are taken now.

In Benin, PMTCT activities started in 2000 at 33 maternity facilities and covered 185 (39 percent) of all public and private maternity homes by the end of 2006. Benin recommended exclusive breastfeeding for 6 months for all mothers, including those with HIV, except if replacement feeding was AFASS<sup>12</sup>, even before this was recommended internationally. The Uganda IYCF Policy (2008) also recommends exclusive breastfeeding of HIV exposed children unless replacement feeding is AFASS.

Initially the HIV pandemic caused confusion about the risks and benefits of breastfeeding which later studies helped clarify. In Uganda concerns about HIV ended up being the force that stimulated action and generated resources for IYCF. In 2000 UNICEF introduced pilot PMTCT interventions in five hospitals. These interventions included distribution of free, generic infant formula to HIV-positive mothers who chose not to breastfeed. In 2002 UNICEF discontinued the procurement and distribution of free infant formula to the PMTCT pilot sites in Uganda and seven other African countries following evaluations that showed that the formula increased the risk of morbidity and mortality.

<sup>12</sup> Acceptable, feasible, affordable, sustainable and safe.

The number of health facilities in Uganda offering PMTCT services grew from 5 sites in 2000 to 701 in August 2008, representing 57 percent of hospitals and grade III and IV health centres. Quality national policies, training resources, and IEC materials are in place. Despite these achievements in a short period of time, women continue to have limited access to PMTCT services and counselling on IYCF. A recent assessment team recommended scaling up services in basic health centres (level II), reaching out to the community, and strengthening counselling and support services.

**Early Childhood Development.** In 1997 UNICEF New York produced a document on the Care Initiative that identified six essential elements of care: care for women, breastfeeding and feeding practices, psychosocial care, food preparation, hygiene practices, and home health practices. In the following years, the Care Initiative influenced the design of UNICEF country programmes. In UNICEF's medium-term strategic plan for 2002-2005, the elements of the Care Initiative were reflected in one of the strategy's priority areas: early childhood development (ECD). Bangladesh, Sri Lanka, and Uganda all developed ECD programmes. In Sri Lanka ECD initially concentrated on pre-school education for children 3-5 years old and psychosocial dimensions but then shifted to a home-based programme with greater attention to health and nutrition issues of children 0-3. The World Bank provided a \$34 million loan to the Government of Uganda for the Nutrition and Early Child Development Project (1997-2003). Improving IYCF, particularly complementary feeding, was one of the project's three behaviour change interventions. UNICEF's current ECD programming approach in Uganda focuses on early childhood centres, psychosocial stimulation, and child care training for parents with little recognition of nutrition.

### **Lessons Learned in Integration of IYCF in Other Programmes**

- Integration works best if it begins during the planning stage with a clear definition of the roles and responsibilities of implementing partners and involves partners in the development of communication materials and training manuals.
- Mainstreaming IYCF into programmes such as early childhood development can add new energy to a familiar topic and engage new stakeholders, but care must be taken to ensure that breastfeeding does not get lost in the enthusiasm for new topics and initiatives.
- PMTCT programming offers the opportunity to improve health delivery services and counselling services on IYCF, not only for HIV-positive women but for all women. However, this opportunity is often lost because providers lack the counseling skills to provide this support.

## 6. SCALE AND SUSTAINABILITY

At present, there are few examples of national-scale breastfeeding programmes. Sri Lanka, with its extensive network of public health midwives, comes the closest to achieving scale, but the contribution that NGOs can make has yet to be realized. Many of the BFHI activities in Uzbekistan are still in pilot regions, but BFHI will be expanding to all regions in 2009-2010. The vast majority of the population in Bangladesh, the Philippines, and Uganda remain untouched by community-based breastfeeding activities; however, efforts are underway to scale up. Effective scale-up has been hampered in many of the countries by lack of coordination between the various partners involved in IYCF. Good programmes are often dropped once the funding from the particular project ends rather than “built upon” to achieve greater coverage. The experience in Benin and elsewhere indicates that scaling up requires making adjustments to the strategies used in pilot activities to reduce cost, complexity, and labour intensity. Maintaining quality control during scale up is a challenge.

In many of the countries studied, sustainability of initially successful programmes was hindered by the failure of planners to integrate promising interventions into the health system and make provisions for ongoing government and donor support beyond the life of individual projects. Insufficient coordination among development partners led to unnecessary inefficiencies. Lack of stable political, social, and economic environments, with resources periodically redirected to address unpredicted natural disasters or situations created because of civil conflict, lessened the possibility of continued support for proven strategies.

### Lessons Learned in Scale and Sustainability

- Building on existing systems, broadening the base of support for IYCF, and integrating processes, strategies, and tools into multiple programmes, agencies, and organizations contribute to scale up and sustainability.
- Sustainability requires political support, dedicated financial resources for IYCF, good stewardship of funds, adequate numbers of skilled human resources, and evidence-based interventions.
- To achieve scale and sustainability, it is essential that programme planners design strategies that are cost-effective and affordable and include plans for scale-up from the beginning. Additionally, Government and its partners should agree to continued, coordinated support beyond the life of individual projects.

## 7. CHALLENGES AND RECOMMENDATIONS

This review concludes by setting forth common challenges and recommendations and the role UNICEF can play to enact the recommendations. These recommendations will need to be prioritized based on the conditions, actors, and resources within specific countries. Country-specific recommendations are found in the individual case studies.

### ***1. Develop and implement a comprehensive IYCF strategy for implementation at scale***

The Global Strategy for IYCF lays out a comprehensive framework, yet the tendency is to focus on one or two of the components. Piecemeal approaches and ad hoc activities leave major barriers to improved practices unaddressed and fail to reach critical populations.

#### ***Recommendations:***

- Review programme elements to determine gaps. Assess potential actions in terms of short-term and long-term results, cost-effectiveness, coverage, equity, and potential for sustainability. Use a mix of interventions based on a generic menu of interventions, prioritizing them based on contextual factors.
- Develop targeted strategies to reach specific groups such as mothers of infants less than 6 months old, mothers of infants 6-24 months old, those who deliver in health facilities and those who deliver at home, urban and rural residents, family members, policy makers, employers, health administrators, and district officials.
- Focus on the continuum of care for mother and child, from pregnancy through the first two years of life and key points of contact, both in health facilities and the community. This would mean that strategies need to address maternal nutrition during pregnancy, exclusive breastfeeding for 6 months, and continued breastfeeding with appropriate and timely complementary feeding from 6-24 months of age.
- Incorporate gender considerations in the IYCF strategy, including issues such as collecting and using gender disaggregated IYCF data, gender issues in formative research and situation assessment, gender considerations as appropriate in the recruitment of community based cadres and addressing gender barriers towards good feeding practices in workplace support and communication strategies.
- Develop measurable objectives for IYCF programs and devise monitoring and evaluation strategies that provide the information needed for informed planning.
- Institute mechanisms for periodic dissemination and review of evaluation results that encourage use by key decision-makers.

### ***2. Establish and support a coordination mechanism***

The policy/advocacy, health service provision, and community elements of a comprehensive strategy require coordination. IYCF is often scattered across

different ministries with lack of clarity on roles and responsibilities and inefficient use of resources. Lack of concerted and unified action among government and development partners results in lost opportunities to extend reach and coverage, economize, harmonize messages, and learn from each other.

***Recommendations:***

- Establish an adequately staffed and funded coordinating mechanism, including all key partners. Strengthen the technical and managerial capacity of those responsible for IYCF coordination.
- Develop annual implementation plans that clearly specify who will do what and when and how progress will be measured and how activities will be funded.
- Put in place a management information system for tracking IYCF programme inputs, communication activities, and people trained in IYCF at all levels, including the community.
- Ensure that standard indicators are used by programme partners.

***3. Foster an enabling environment***

IYCF continues to be undervalued, leading to underinvestment. New initiatives and an infusion of resources for other public health interventions can push IYCF off the agenda, leaving IYCF policies unattended. Breastmilk substitute manufacturers continue to look for new markets and opportunities to promote their products. Women struggle to practice exclusive breastfeeding in non-supportive workplaces.

***Recommendations:***

- Develop an evidence-based advocacy strategy demonstrating how improved infant and young child feeding can help a country achieve the Millennium Development Goals. Use evidence from the Lancet child survival, nutrition and child development series, data generated from “Profiles” type workshops or other methods that allow nutrition interventions to be linked with health, economic and broader development, and results from successful IYCF programmes to advocate for IYCF.
- Strengthen Code legislation, implementation and training as needed and ensure that strong monitoring and enforcement systems are in place, with consequences for violations that deter Code infractions.
- Strengthen maternity protection legislation, as needed, in accordance with international standards.
- Encourage employers to provide breastfeeding rooms and breaks, using information on the benefits to employer and family. Offer guidance on how best to arrange for more supportive workplaces.
- Ensure that IYCF programmes - at health system and community levels and within the communication strategies - include actions to foster an enabling environment for breastfeeding women and for infant and young child feeding in the immediate family and social environments.

#### **4. Strengthen the organizational and technical capacity for IYCF**

Projects, initiatives, and champions come and go. Unless best practices, strategies, and tools are identified and mainstreamed into institutions, they are unlikely to stand the test of time.

##### **Recommendations:**

- Build the capacity of the MOH, NGOs, IYCF advocacy groups, consumer associations, professional societies, and other organizations for sustained ownership of IYCF programming.
- Build the capacity of training centres and integrate IYCF in the pre-service curricula of educational institutions with the WHO/UNICEF Integrated IYCF Counselling Course, the BFHI “20-hour” course and the model chapter for IYCF recently published by WHO for medical students and allied health professionals.
- Develop and oversee implementation of integrated training and supervision strategies and budgets that will support scale up of interventions, including orientation of replacement staff, follow-up and supervision, and refresher training or updates often enough to reinforce knowledge and skills.

#### **5. Take steps to improve breastfeeding practices in maternities (including revitalizing BFHI where appropriate) and ensure full institutionalization and sustainability**

The Baby-friendly Hospital Initiative flourished in many countries in the early years, due to intensive advocacy by UNICEF and WHO and the dedicated work of breastfeeding professionals. However, insufficient effort both by international agencies and the countries themselves to effectively integrate BFHI into the norms and requirements of national health systems and institute mechanisms for ongoing refresher training, monitoring and reassessment, led to slippage in compliance and decrease in focus on the Initiative. Some countries are now working to revitalize BFHI, and countries are being encouraged to ensure that the Ten Steps are institutionalized as part of the norms and standard operating procedures of maternity facilities, as part of a comprehensive IYCF programme.

##### **Recommendations:**

- Ensure adequate coordination at national, regional, and facility levels.
- Assess the current status of compliance with the “Ten Steps” in all maternity facilities, including accredited baby-friendly facilities.
- Determine the level of effort that should be focused on improving maternity practices/BFHI, taking into account the percentage of women delivering in facilities. Coordinate the approach with IYCF services in other MCH contacts, PMTCT services and community-based programmes.

- Devise a strategy for institutionalizing the Ten Steps as part of standard operating procedures in maternity facilities, ensuring that systems for training and monitoring are well integrated into the health care system and that quality assurance and accreditation procedures for all hospitals are in place.
- Establish a mechanism to ensure that all new and existing staff working in maternity facilities are trained on breastfeeding management and implementation of the “Ten Steps,” using the updated BFHI 20-hour course for maternity staff. There should be a system for ongoing supportive supervision, as well as for tracking whether facilities still have trained staff, in order to avoid gaps due to staff turnover.
- Ensure that regular supervision and mentoring of trained maternity staff takes place.

### **6. Extend IYCF counselling and support beyond maternity services**

Maternity services are one important contact point with women, but many other opportunities exist to provide IYCF counselling and support. These opportunities are often overlooked.

#### **Recommendations:**

- Integrate IYCF into all existing health services for mothers and children, ensuring that IYCF is addressed at contact points during pregnancy and throughout the first two years of a child’s life. Focus on those contact points with higher coverage such as antenatal care and immunization/well child services.
- Incorporate IYCF counseling, support and data collection in the job descriptions of various cadres of workers involved in maternal and child health and nutrition.
- Build the IYCF counselling and problem-solving skills of health care providers using performance-based training methodologies.
- Ensure that regular supervision and mentoring takes place of staff trained to counsel on IYCF at multiple contact points.

### **7. Scale up community-based interventions**

Scaling up community-based interventions is perhaps the greatest challenge most countries face because of the enormity of the task, the human resource requirements and the cost.

#### **Recommendations:**

- Build coalitions with a diverse group of partners to achieve scale. Engage new partners and, when possible, integrate IYCF content into successful community initiatives of committed NGOs.
- Use multiple platforms at the community level to advance IYCF including IMCI, female literacy, schools, growth promotion, PMTCT, maternal and neonatal health,

community management of severe malnutrition, household food security, and income generation and social protection schemes.

- Outline a plan for mobilizing, equipping, and supporting human resources to deliver programme interventions at the community level. Identify incentives and put in place supportive supervision systems to maximize their services and prevent high rates of attrition.
- Explore the scale-up of peer-counseling at scale as a strategy and document results and lessons learned to develop a model that can be replicated
- Build capacity of community cadres to promote and support optimal IYCF practices, including counseling, communication and problem-solving skills.
- Establish a system for ongoing supportive supervision and mentoring, as well as data collection on programme activities.

### ***8. Implement evidence-based, comprehensive communication strategies***

Interpersonal communication, mass media, and traditional media all play a role in efforts to help individuals and communities adopt and advocate for healthy behaviors. Together, they reinforce messages and remind audiences of the recommended behaviours.

- Develop a national IYCF communication strategy that is evidence based and comprehensive to build support for optimal feeding practices.
- Develop behaviour change strategies based on formative research (e.g. Trials of Improved Practices) on barriers and enablers to improved practices. Involve mothers, their families, and communities in active problem-solving. Address barriers such as lack of information and support, inadequate resources (time, money, food), engrained cultural practices, work, and limited decision-making authority.
- Work with all “actors” in the communication system to harmonize messages targeted at various levels, from physicians and nurses to community health workers and families.

# Appendices

## A. Questionnaire on IYCF for UNICEF staff

## B. IYCF Indicators – Trend Data from the Six Case Study Countries

## C. Key Resources

### Appendix A. Questionnaire on IYCF for UNICEF staff

**Name of respondent, Position/title, Organization, Interviewer, Date:**

(Give brief introduction regarding purpose of review, confidentiality.)

#### QUESTIONS

##### 1. General history

- 1.1. How long have you been working with UNICEF here in *(country)*?  
What positions have you held (what sections have you worked in and when)? What activities or programmes have you been involved in?
- 1.2. *(If respondent has knowledge:)* Could you tell me what you know of the history of programming in the fields of breastfeeding and other areas of infant and young child feeding? For example:
  - What were the early days of BF programming like in the mid 90s?  
What were the policies and programmes and activities like at that time?
  - What was the capacity among health workers, CHWs and other community outreach workers, etc., to provide support in this field?
  - How much financial support was there during that period?

##### 2. Problems and situational or needs assessments

- 2.1. What do you feel are the major problems have been *(in the country)* in the past 10 years, related to infant and young child feeding?
- 2.2. Has UNICEF, the MOH, or any other partner organizations done situational or needs assessments focused on IYCF in the past 10 years?
  - *(If so:)* What studies have been done? By whom? *(Inquire about how to get copies, if don't already have all the studies mentioned.)*
  - What were the major needs identified by these studies?
  - Were these studies used in any way to help focus strategies & plans to address problems in the area of IYCF? If so, how?

## QUESTIONS

### 3. Mobilization of potential partners and resources

- 3.1.** What was done, if anything, to mobilize possible partners and the resources needed for activities and programmes to address IYCF or BF problems? How successful were these efforts? Why or why not?
- 3.2.** Who have been the major groups and organizations working in the area of IYCF in the past ten years? (*Probe, as necessary, for govt., international orgs, Faith Based Organizations (FBOs), PVOs & NGOs, bilateral orgs. and projects, etc.*).
- For each of these, what have they done?
  - Have any of these organizations worked in collaboration on IYCF activities? If so, what have they done and how well have they worked together?
  - What role has UNICEF played, if any, in working with various partners on IYCF activities?
  - Are there strategies for collaboration that you think might have worked better? If so, what more might be done along these lines?

### 4. Policy development

- 4.1.** Are there any policies or legislative documents that have been developed to support IYCF? (*If so, explore what documents exist and how they can be obtained, including, for example, IYCF or BF policies, policies mandating BFHI, policies and/or bills supporting BF in the workplace, etc. – See 2.1.1 in “Questions for Exploration”*) (*Note: Milk Code will be covered later in the interview.*)
- When were these various policies developed? Who developed them? Were they changed over time? If so, how and why?
  - What key factors, in your opinion, have influenced policy development in the area of IYCF?
  - How useful do you feel the policies and legislation have been in guiding efforts in the area of IYCF and/or providing protection for mothers and children in the past 10 years? Please explain.
  - What challenges have there been to IYCF policy development? What more needs to be done?

*(If it's possible to compare the current BF and/or IYCF policy with what is recommended in the GSIYCF, ask about any recommended components that are missing from the policy, why they aren't there, whether there has been any advocacy from groups trying to get things changed, etc.)*

### 5. Strategies, plans and programme design

- 5.1.** What strategies and plans have been prepared in the last 10 years by the government and various partner agencies, including UNICEF, to address needs in the area of IYCF?

## QUESTIONS

### 5.2. How and when were the strategies and plans developed?

- Who was involved?
- Have any adaptations been made since that time?
- Have you been involved in the process? If so, how?
- What were the main objectives focused on in these plans?
- To what extent, in your opinion, do the plans focus on needs identified in earlier situation or needs assessments?

### 5.3. Was the WHO Global Strategy for IYCF used in any way to help focus the strategies and plans?

- If so, which plans and how? How helpful was the Global Strategy in helping focus strategy and plan development?
- Was the Assessment Tool or Planning Guide that accompanies the Global Strategy used in any way? If so, how?
- What documents were used to provide guidance for plan development before the Global Strategy was available? (*Explore use of UNICEF, WHO or other documents.*) How helpful were they?

### 5.4 Was the “**human rights-based approach to programming**” considered when health and nutrition and IYCF strategies and plans were developed? If so, when, for which plans, and how? What affect did this guidance have on the content or focus of the strategies or plans?

### 5.5. To what extent was “**gender equality**” considered, as various IYCF strategies and plans were developed? Again, what effect did this have on the content or focus plans? What guidelines do the plans have, if any, to assure that women, men, grandparents, etc., are given equal opportunity to participate in various aspects of the programme? Was there any input from “duty bearers” and “claim holders” during plan development? If so, how did they participate?

## 6. Programme implementation (Response to the problem)

### 6.1. How have the programme strategies and plans been implemented over time at the national, sub-national and community levels? Who was involved in each of them? What has been the coverage of these various components in terms of population and geographic areas?

*(Explore the sequencing of activities, level of effort going into them and the scope and coverage of each. Elements or components that could be explored are listed in 2.4.2 of “Questions for Exploration.” Make a list of suggested components, based on the list in this section to review with the respondent, if he or she knows the programme in sufficient detail. Collect samples of training, counselling and communication materials and tools, if available.)*

## QUESTIONS

### **Milk Code implementation**

What work has been done on Milk Code enactment, monitoring, enforcement?  
Are there any copies of Code advocacy and IEC materials available?

### **BF in the workplace**

What has been done related to legislation, BF promotion in the workplace, setting up BF rooms, crèches, etc., in the workplace or public places? Other workplace initiatives?

### **BF promotion (mass media, IEC, key events)**

What has been done and by whom? Are there any copies of IEC materials available?

### **Health system improvements (BFHI, counselling, integration of BF/IYCF into other components, strengthening M&E)**

What has been history of BFHI, administrator orientation, TOT and staff training, efforts to sustain or revitalize BFHI? Role of national and regional training centres, if any? Monitoring? Any other accreditation integration needed? Use of updated materials, including non-BF support and MFC and HIV modules? Work on MBF home deliveries? Efforts to integrate the Ten Steps into insurance programmes, hospital accreditation schemes, quality assurance initiatives? Other health system initiatives?

### **Capacity building (pre-service and in-service training)**

What about training on IYCF counselling, other? What about any pre-service training related to BF, IYCF, BFHI? Other? Has IYCF been sufficiently integrated into IMCI training? Training on community-managed maternal and newborn care? What about a more integrated "life cycle approach" or other?

### **Community promotion and support**

Community outreach, home visits, mother support groups, involvement of NGOs, religious groups, other?

### **BF/IYCF in difficult circumstances (Emergencies, HIV/AIDS)**

Has UNICEF, WHO or the MOH reviewed international IF in emergencies materials and adapted and made them available for use? What about HIV and IF: Guidelines for decision-maker and health-care managers and supervisors and PMTCT materials? The IYCF counselling: An integrated course (including HIV content)?

**6.2.** What, specifically, was UNICEF's role in the implementation of the various programmes or projects? How helpful has UNICEF been as a partner? What might have been done better?

**6.3.** What financial and human resources were available for the programmes at various points over the last ten years? From what sources?

## QUESTIONS

- *(If appropriate for this respondent:)* How much was spent by UNICEF on the various components? Was more needed?
- If you know this information, could you tell me how much the government and other agencies have spent on IYCF? What factors affected the level of resources available?

*(Note: This information may be difficult to obtain; please collect what is available even if the relevant information is limited.)*

### 7. Results and challenges

- 7.1.** What monitoring and/or evaluations have been conducted that have been focused on the IYCF-related programmes and projects?
- What other studies have been done that have provided feedback on programme process, outcomes and impact?
  - What is the quality and usefulness of these studies, in your opinion?  
*(If any studies are mentioned that you haven't seen, ask if you can see a copy.)*
- 7.2.** What have been the key achievements and results of the IYCF programmes or projects?

*Explore:*

- *Relevance of the programme to beneficiary needs*
- *Programme process results (effectiveness in meeting process objectives) (changes in policies; numbers of baby-friendly hospitals, health workers trained, MSGs started; resources allocated,, work on HRBAP, gender mainstreaming, etc.) – see list in 1.7 and pp. 34-35 of Planning Guide.*
- *Programme efficiency (whether the programme was cost-efficient, given the inputs and alternative uses of resources)*
- *Developmental outcomes (effectiveness in meeting outcome objectives, changes in IYCF indicators) – see list in 2.5.2 of “Questions for exploration”*
- *Any “impact” data (on morbidity, mortality, etc.) available.*

*(Note: Compare responses to these questions with results in reports.)*

- 7.3.** What problems or challenges were there with programme implementation over time?
- How were they addressed, if at all?
  - What strategies didn't work? Why?
  - What challenges remain to be addressed?

### 8. Scale-up, replication and sustainability

- 8.1.** Are there plans or efforts underway to “scale up” or replicate elements of the projects or programmes that have been successful or “high impact”?

## QUESTIONS

- If so, how are these efforts progressing?
- What coverage has been achieved through scale-up thus far? What further actions are needed to increase coverage?
- To achieve national coverage, what would be the cost of scale up? How feasible would this be, in your estimation?
- When you or others worked to design and implement projects or programmes in the area of IYCF, was anything done to try to help insure that the projects or programmes would be sustainable? *(If so:)* What? How well do you think these strategies for sustainability have worked (or will work in the future)?

*(If review of the materials indicates that strategies for sustainability have been incorporated, also ask about these strategies and how well they have worked.)*

- Does it appear that the government and other partners are committed to further action and provision of the necessary resources? *(If so:)* What are the indications of this? What plans are in place for the future? *(If not:)* What more needs to be done to increase the likelihood that progress will be sustained and continued?

### 9. Factors contributing to programme results

- 9.1. What, in your opinion, have been the major factors that have contributed to the results (both positive and negative) in the IYCF programme?
- What do you think are the main reasons for both successes and failures?
  - *(Review the key BF indicators and trends over time with respondent)* To what extent do you think various parts of the **programme or specific projects** have contributed to **changes in IYCF practices**? Why?
  - How do you think the contributions of UNICEF, the MOH and other partners in the area of IYCF may have affected the changes in IYCF practices?
  - Are there **external factors** that you think are likely to have influenced results?
  - *If so: How? (Probe, if appropriate:)* For example, what about economic, political, or environmental factors, urbanization, civil conflicts, natural disasters, changes in primary school enrolment, literacy, prevalence of HIV/AIDS, emigration of trained staff, etc.)
- 9.2. *(If UNICEF, the MOH and/or other partners have included a “human rights based approach”:*) Do you think the “human rights-based approach” implemented *(refer to what was done)* has affected the programme process and results in the area of IYCF? If so, how?
- 9.3. How appropriate was the financial investment of the government, UNICEF and various partners in IYCF programming, given the needs? Did the amount allocated to IYCF appear to be “fair”, given resources available? Could more resources have been allotted?

## QUESTIONS

### 10. Recommendations

- 10.1.** Are there any recommendations that you would like to make either to UNICEF, the MOH or other partners, related to future IYCF programming, when you reflect back on experiences thus far and what has been learned?
- 10.2.** Could you look back at what UNICEF has done in the area of IYCF and how it has worked with the government and other partners? In summary, in what areas do you think UNICEF has made the most contributions and how? Where has it made the least contributions and why?
- 10.3.** How do you think the UNICEF country office should focus its efforts in relation with other partners to improve IYCF practices in the country in the future? Could UNICEF be doing more in particular areas? If so, in which areas and how? Would UNICEF need additional funds, staff, or other resources to do this additional work?

### 11. Discoveries (Lessons learned, innovations and good practices)

*(Note: For each of these types of “discoveries”, if the respondent has sufficient involvement and knowledge, review the definition and work together to flesh out the details that might be useful to include in the case study. (See tables at end of “Methodology” for items to explore.)*

- 11.1.** As you reflect back on the work that has been done by UNICEF, the MOH and other partners in the area of IYCF, what have been some of the **“lessons learned”**, based on the experiences thus far – both positive and negative?

*(If you have noticed other possible “lessons learned” in your review of the documents, ask the respondent about these as well.)*

- 11.2.** During the process of programme planning and implementation, have there been any “innovations” that were successful (or not), that you think it would be useful to share with others?

*(If you have noticed other possible “innovations”, ask the respondent about these as well. Also ask whether the respondent can mention any “outside the box” innovations that have worked, and probably haven’t been tried elsewhere.)*

- 11.3.** Are there any **“good practices”** that you feel it would be useful to feature in our case study?

*(If you have noticed other possible “good practices”, ask the respondent about these as well.)*

## Appendix B. IYCF Indicators – Trend Data from the Six Case Study Countries

Indicator	Bangladesh	Benin	Philippines	Sri Lanka	Uganda	Uzbekistan
<b>Initiation of BF &lt; 1 hr</b>						
	13% (1996/7)	24% (1996)	36% (1993)	— (1995)	51% (1995)	19% (1996)
	17% (1999/0)	49% (2001)	41% (1998)	— (2000)	32% (2000/1)	— (2002)
	43% (2007)	54% (2006)	54% (2003)	— (2006/7)	42% (2006)	68% (2006 (MICS))
<b>Exclusive BF 0-5 months</b>						
	45%	10%	25%	17%	57%	2.4%
	46%	38%	37%	53%	63%	9%
	43%	44%	34%	76%	60%	26%
<b>Median duration BF</b>						
	32.8 mo.	22.8 mo.	14.1 mo.	—	19.5 mo.	17.3 mo.
	30.5 mo.	22.3 mo.	12.8 mo.	—	21.6 mo.	—
	32.4 mo	21.9 mo.	14.1 mo.	—	20.4 mo.	—
<b>Bottle feeding 0-3 months</b>						
	—	4%	33%	—	5.5%	35%
	17%	—	30%	—	4.6%	41%
	21%	3%	26%	—	7.5%	—
<b>Formula feeding 0-3 months</b>						
	11%	3%	25%	—	1.8%	12%
	6%	20%	25%	—	1.1%	—
	—	10%	17%	6% (estimate)	1.0%	—
<b>Breastfeeding with complementary foods 6-9 months (From State of the World's Children 2009)</b>						
	52%	72%	58%	86% DHS 2006/7	80%	45%
<b>IYCF practices indicator: Infants 6-23 months fed according to 3 IYCF practices<sup>13</sup></b>						
1) rec'd BM, milk & milk products	94%	93%	62%	—	89%	—
2) fed at least a min. of food groups	71%	61%	58%	—	56%	—
3) fed solid/semi at least min. times /day	70%	49%	58%	—	36%	—
<b>Composite indicator (all children 6-23 mo.)</b>	56% [2004] Fanta	32% [2006] DHS	36% [2003] Fanta	—	24% [2006] DHS	—

**Note:** The results are from Demographic Health Survey (DHS) or national DHS reports except for the final Uzbekistan report (2006), which is a Multiple Indicator Cluster Survey (MICS) report.

<sup>13</sup>The 3 practices include whether the child 1) received BM, milk or milk products 2) was being fed solid and semi-solid foods at least minimum number of times per day, and 3) was being fed at least minimum number of food groups. The IYCF practices indicator has been replaced with modified indicators to reflect a Minimum Adequate Diet.

## Appendix C. Key resources

Infant and young child feeding programme reviews. UNICEF, 2009.

**Case study:** Bangladesh. Martin L.

**Case study:** Benin. Brownlee A.

**Case study:** The Philippines. Brownlee A.

**Case study:** Sri Lanka. Martin L.

**Case study:** Uganda. Martin L.

**Case study:** Uzbekistan. Golubov A.

### Global Documents:

IFE Core Group (WHO, UNICEF, UNHCR, WFP, IBFAN-GIFA, CARE USA, Foundation Terre des Hommes and the Emergency Nutrition Network (ENN)). Infant and Young Child Feeding in Emergencies. Operational guidance for emergency relief staff and programme managers, February 2007, version 2.1. <http://www.enonline.net/pool/files/ife/ops-guidance-2-1-english-010307.pdf>

International Code Documentation Centre (2005). International Code of Marketing of Breastmilk Substitutes. ([http://www.unicef.org/nutrition/files/nutrition\\_code\\_english.pdf](http://www.unicef.org/nutrition/files/nutrition_code_english.pdf)) and subsequent relevant World Health Assembly Resolutions, IBFAN/ICDC, Malaysia ([http://www.ibfan.org/site2005/Pages/list2.php?iui=1&cat\\_id=46](http://www.ibfan.org/site2005/Pages/list2.php?iui=1&cat_id=46))

Menon L. Mulford C (2008). Innovative Initiatives Supporting Working Women's Right to Breastfeed. WABA, Malaysia.

PAHO/WHO (2003). Guiding Principles for Complementary Feeding of the Breastfed Child. PAHO/WHO, Washington, DC. [http://www.who.int/nutrition/publications/infantfeeding/guiding\\_principles\\_compfeeding\\_breastfed.pdf](http://www.who.int/nutrition/publications/infantfeeding/guiding_principles_compfeeding_breastfed.pdf)

UNICEF (2006). Celebrating the Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding: Past achievements, present challenges, and priority actions for infant and young child feeding. Innocenti Research Centre, Florence.

UNICEF. The State of the World's Children 2009. Maternal and Newborn Health. UNICEF, New York.

WHO/UNICEF/USAID/AED (2008). Learning from Large-scale Community-based Programmes to Improve Breastfeeding Practices. <http://www.who.int/nutrition/publications/infantfeeding/9789241597371/en/index.html>

WHO (2001). The Optimal Duration of Exclusive Breastfeeding: Report of a Technical Consultation. WHO, Geneva. [http://www.who.int/nutrition/publications/infantfeeding/WHO\\_NHD\\_01.09/en/index.html](http://www.who.int/nutrition/publications/infantfeeding/WHO_NHD_01.09/en/index.html)

WHO (2003). Community-based Strategies for Breastfeeding Promotion and Support in Developing Countries. WHO, Geneva. [http://www.who.int/child\\_adolescent\\_health/documents/9241591218/en/index.html](http://www.who.int/child_adolescent_health/documents/9241591218/en/index.html)

WHO (2003). HIV and Infant Feeding: Framework for Priority Action. [http://www.who.int/child\\_adolescent\\_health/documents/9241590777/en/index.html](http://www.who.int/child_adolescent_health/documents/9241590777/en/index.html)

WHO (2008.) Indicators for Assessing Infant and Young Child Feeding Practices. UNICEF, USAID, AED, UCDAVIS, IFPRI, 2008. Available at: <http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/index.html>

WHO. (2008) The International Code of Marketing of Breastmilk Substitutes: Frequently asked questions (updated version 2008). Available at: <http://www.who.int/nutrition/publications/infantfeeding/9789241594295/en/index.html>

WHO (2006) Infant and Young Child Feeding Counselling: An Integrated Course. WHO, Geneva. <http://www.who.int/nutrition/publications/infantfeeding/9789241594745/en/index.html>

WHO (2009) Infant and Young Child Feeding: Model Chapter for Textbooks for Medical Students and Allied Health Professionals. WHO, Geneva. <http://www.who.int/nutrition/publications/infantfeeding/9789241597494/en/index.html>

WHO. (2006) Update on HIV and Infant Feeding based on the Technical Consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants Geneva, October 25-27, 2006. Available at: [http://www.who.int/child\\_adolescent\\_health/documents/9789241595964/en/index.html](http://www.who.int/child_adolescent_health/documents/9789241595964/en/index.html)

WHO/LINKAGES (2003). Infant and Young Child Feeding: A Tool for Assessing National Practices, Policies and Programmes. WHO, Geneva. Available at: <http://www.who.int/nutrition/publications/infantfeeding/9241562544/en/index.html>

WHO/UNICEF (2006). Baby-Friendly Hospital Initiative, revised, updated and expanded for integrated care, preliminary version for country implementation. Available at: [http://origin-www.unicef.org/nutrition/index\\_24850.html](http://origin-www.unicef.org/nutrition/index_24850.html) and <http://www.who.int/nutrition/publications/infantfeeding/9789241595018/en/index.html>

WHO/UNICEF (2003). Global Strategy for Infant and Young Child Feeding. WHO, Geneva. Available at: [www.who.int/child-adolescent-health/New\\_Publications/NUTRITION/gs\\_icyf.pdf](http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/gs_icyf.pdf)

WHO/UNICEF (2007). Planning Guide for National Implementation of the Global Strategy for Infant and Young Child Feeding. WHO, Geneva. Available at: <http://www.who.int/nutrition/publications/infantfeeding/9789241595193/en/index.html>

WHO/UNICEF/USAID/AED (2008). Learning from Large-scale Community-based Programmes to Improve Breastfeeding Practices. Available at: <http://www.who.int/nutrition/publications/infantfeeding/9789241597371/en/index.html>

### **Websites:**

Demographic and Health Surveys  
<http://www.measuredhs.com/>

International Code Documentation Centre  
[http://www.ibfan.org/site2005/Pages/article.php?art\\_id=476&iui=1](http://www.ibfan.org/site2005/Pages/article.php?art_id=476&iui=1)

LINKAGES  
<http://www.linkagesproject.org>

UNICEF, Multiple Indicator Cluster Survey (MICS)  
[http://www.unicef.org/statistics/index\\_24302.html](http://www.unicef.org/statistics/index_24302.html) and <http://www.childinfo.org/>

WABA Women and Work  
<http://www.waba.org.my/whatwedo/womenandwork/index.htm>

WHO. Nutrition, Infant and young child feeding list of publications  
<http://www.who.int/nutrition/publications/infantfeeding/en/>

WHO. Child and adolescent health and development, Topic: infant feeding/breastfeeding  
[http://www.who.int/child\\_adolescent\\_health/documents/infant\\_feeding/en/index.html](http://www.who.int/child_adolescent_health/documents/infant_feeding/en/index.html)



