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MotherCare™

Guide for Country Assessment of Breastfeeding Practices and Promotion

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Acknowledgments

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Acronyms

A.I.D.	Agency for International Development
ARI	acute respiratory infection
BMI	body mass index
CDC	Centers for Disease Control (USA)
CDD	control of diarrheal disease
CPS	Contraceptive Prevalence Surveys
DHS	Demographic and Health Surveys
EPI	Expanded Programme on Immunization
ESF	Economic Support Funds
GNP	Gross National Product
HIV	Human Immunodeficiency Virus
IBFAN	International Breastfeeding Action Network
IEC	Information, Education and Communication
IOCU	International Organization of Consumer Unions
KAP	knowledge, attitudes and practices
LBW	low birthweight
MCH	maternal and child health
NCHS	National Center for Health Statistics (USA)
NGO	non-governmental organization
ORS	oral rehydration salts
ORT	oral rehydration therapy
PL 480	Public Law 480
PVO	private voluntary organization
SES	socio-economic status
STD	sexually transmitted disease
TBA	traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WFS	World Fertility Surveys
WHO	World Health Organization

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Purpose of the Guide and the Country Assessment

A country breastfeeding assessment is the first step in developing a nationwide strategy to improve the health and nutritional status of preschool children, especially those in their first year of life. Based on the assessment, a program can be developed with the specific objective of increasing the numbers of mothers who exclusively breastfeed their children from birth through four to six months of age, and who continue to breastfeed after they introduce complementary "weaning" foods once the child reaches four to six months. The results of this initial country assessment will be a summary of:

- the current situation (what is known or can be documented easily),
- factors supportive of or obstacles to breastfeeding, and
- the gaps requiring further investigation or immediate, direct actions.

This guide is designed to be used in-country by a carefully selected team of two to three people with clinical and program expertise related to breastfeeding. Its function is to: 1) assist the team in preparing for the assignment and in structuring their work, 2) shape an assessment report that makes obvious the elements of an action plan that could call for additional assessment work and/or the initiation of program activities that address the negative or positive factors which shape breastfeeding behavior, and 3) leave a report with enough specific information so that it can also function as a qualitative program "baseline" and be used for a mid-course program review.

It is understood that national level information may not be available in every case but that what is available will be reported and a best estimate made of its representativeness. Also, **it is not expected that information will be obtained for each point** included in the guide or even that every section will be used in every country. Instead, **the guide offers a comprehensive reference list** of important points and activities that could be reviewed. In the guide, topics are presented without detailed elaboration. The team can pursue each as appropriate.

Experience With the Assessments

As of the date of this printing, a number of different groups have used this guide to conduct assessments in seven countries in Africa and Latin America. Thus, the experience to date represents a good cross-section of situations.

Listed below are a few comments and lessons from the experience.

1. The best team composition seems to be about three members: a local person as the team leader who is active in breastfeeding promotion and/or is highly regarded by professional colleagues, usually in the health sector; another local person who works well with the team leader; and an external person who is somewhat familiar with the process and who can assist in finalizing the report to remove the burden from the local team members who are busy professionals. Sometimes a fourth person has been required to assist with the review of documents.

2. The areas of expertise on the teams need to complement each other. When possible, one member has had clinical experience and lactation management training from Wellstart or IBFAN. This person has evaluated the health services and reviewed training curricula. Another person has had the expertise to review community programming, communications, and women's support. The third person has usually focussed on policy, legal aspects like the Code of Marketing, and on program financing.

3. It has proved to be helpful to conduct the literature review (section I) prior to the field visits. It is too taxing to the team to do the two activities together.

4. The country's Demographic and Health Survey has always proved to be an excellent point of departure. It is supplemented by literature located locally and materials published internationally.

5. The experience is that this process takes several months from the initiation of the breastfeeding literature review through a finished report from the team. Note, however, that field visits and interviews usually are confined to about a three week period.

6. It is important to contemplate the preparation of a summary document from the outset. This will be a critical document for the follow-on planning workshop.

7. When the assessment is planned, a workshop for disseminating the findings, discussing implications, and planning actions to improve the situation should be planned as an integral part of the assessment package.

Structure of the Guide

The guide is separated into three sections and those sections have subdivisions. In section II, each subdivision is devoted to a single area of investigation related to an important aspect of a comprehensive country breastfeeding strategy. Each subdivision is introduced by an objectives statement, followed by a section called "Assessment Topics" and concluded with a list of "Suggested Sources of Information and Methods". This last segment lists several approaches to gathering the information, so the team can select, combine and adapt methods for the particular situation encountered in-country. A combination of several approaches to gathering information is recommended to optimize the reliability of the resulting country profile.

A section for the assessment of the economic value of breastfeeding has not been included because there is a recently developed module for this that consultant teams can obtain if a detailed review of this topic would be beneficial to the country's breastfeeding program.

The final module in section II contains a score sheet. The team is asked to score the degree to which country practices and policies are supportive of, or detrimental to, breastfeeding. The score sheet will be used to generate an overall score for the country and may permit a rough comparison of breastfeeding situations among countries.

Section I

Overview of Country Context and Review of Existing Data on the Breastfeeding Situation

1. *Country Background*

Objective: To compile available statistical information that describes the country context for the assessment.

Use: This will identify the limitations and possibilities for program design within the country.

Assessment Topics:

A. Socio-economic and demographic profile

1. Population distribution in terms of: age, sex, literacy (male/female), rural/urban residence, ethnic/religious groups, etc.
2. Economic summarys statistics:
   - average per capita income,
   - per capita GNP,
   - percent GNP spent on health,
   - percent population below poverty line,
   - cost of family food basket for families at or below the poverty line
   - percent inflation,
   - import/export situation, etc.
3. Migration patterns: domestic and international
4. Transport and communication: level of their development in urban and rural areas, e.g., percent of homes with TV and radio
5. Water, sanitation and electricity: level of coverage in urban and rural areas, e.g. percent of homes with running water or percent of communities/neighborhoods with potable water, etc.
6. Status of women: earning capacity of women, ability to determine household expenditures, literacy, etc.

B. Health profile: mortality, morbidity and nutritional status

Preschool Children

1. Infant mortality rate
2. Infant deaths due to diarrheal disease (0 up to 6 months, 6 up to 12 months)
   - estimated number per year, nationwide
   - percentage of all infant deaths due to diarrhea
3. Infant deaths due to acute respiratory infections (0 up to 3 months, 3 up to 12 months)
   - estimated number per year, nationwide
   - percentage of all infant deaths due to ARI
4. Prevalence and incidence of diarrheal disease (If possible, disaggregate in the following age categories: 0 up to 3 months, 3 up to 6 months, 6 up to 9 months, 9 up to 12 months)
   - mean number of episodes per child per year
   - percent of children with diarrhea in past 2 weeks
5. Prevalence and incidence of pneumonia in infants (0 up to 3 months, 3 up to 12 months)
   - mean number of episodes per child per year
   - percent of children with ARI in past 2 weeks
6. Nutritional status for children 0-5 years old. (Report age data at the most disaggregated level possible. Use WHO/NCHS standards when available. Disaggregate by rural/urban, geographic areas, ethnic groups, if possible.)
   - weight-for-age percent less than -2 SD (if not available in SDs or Z scores, report data using Gomez classifications or percent of standard)
   - height-for-age, percent less than -2 SD (see note above)
   - weight-for-height, percent less than -2 SD (see note above)
7. Percent of infants with low birth weight (less than 2.5 kg or 5 lbs.)
8. Extent of vitamin A deficiency (reported night blindness or other indicator) in preschool children
9. Report any studies linking feeding patterns to nutritional status, morbidity, and/or mortality.

Pregnant and Nursing Women

1. Maternal mortality
   - maternal mortality rate or ratio
2. Maternal morbidity
   - projection of morbidities per maternal death
3. Nutritional status for pregnant and nursing women (report data at most disaggregated level: rural/urban, geographic area, ethnic group, etc.)
   - percent of women below 150 cm or as reported in study
   - arm circumference
   - other indicators: weight gain during pregnancy, body mass index (BMI), etc.

4. Extent of vitamin A deficiency (reported night blindness or other indicator)
5. Extent of anemia

C. Contraception and fertility

1. Median duration of lactational amenorrhoea
2. Contraceptive prevalence rate
   - modern methods (by type, if available)
   - lactational amenorrhea
   - all other methods
3. Average number of births per woman (total fertility rate)
4. Average birth interval and percent of births < 24 months apart

D. AIDS

E. Conclusions

Based on an analysis of the information provided, state the main conclusions. Do not merely summarize the information already presented. Analyze and pass judgment on the data and what they mean for breastfeeding's impact or potential impact on the situation, and the situation's impact on breastfeeding. The conclusions section should answer the question, "So what?".

The recommended format for this section includes an opening narrative and then a series of statements describing the main factors which are obstacles or supports to breastfeeding. Where these statements relate to the same topic, they should be grouped together, similar to a "good news, bad news" scenario.

For example:

Obstacle: The fact that the majority of the population lives in very dispersed rural communities presents a significant barrier for outreach.

Support: The high percentage of the rural population which has radios provides an opportunity for interventions using this communication medium.

F. Recommendations

Based on the conclusions presented in the preceding section, state the main recommendations. These recommendations should be in answer to the question, "Given this conclusion....., what can be done to address this situation?" Not all conclusions will necessarily have a corresponding recommendation. Also, several conclusions may result in the same recommendation, or one conclusion may result in several recommendations. Recommendations should take into account the known country situation and the resources and limitations of the organizations involved in supporting positive breastfeeding practices.

Where possible, the relevant group(s) to which a given recommendation applies should be identified. In addition, the level of urgency (e.g., immediately; in the next six months, etc.) and the time frame (short-term, medium-term and long-term) of the recommendations should be given.

Suggested Sources of Information and Methods

Bibliographic Search:

- World Fertility Survey
- DHS surveys
- CDC contraceptive prevalence surveys
- Pan Arab Project on Child Health: PAP child surveys
- National Consensus and Household Expenditure Surveys
- Local surveys and studies in-country
- State of the World's Children Report, UNICEF
- World Development Report
- World Bank health sector reports

Key informant interviews with:

- Ministry of Health or social security system officials
- UNICEF/WHO or A.I.D. officials and reports
- Family planning organizations, i.e. IPPF affiliates, especially those involved in breastfeeding activities

2. *Nature and Magnitude of the Problem of Inadequate Breastfeeding Practices Described in the Literature*

Objective: To compile available quantitative and qualitative information that reflects the status and impact of suboptimal breastfeeding practices and the knowledge and attitudes related to those practices. As a point of reference, optimal breastfeeding and weaning practices taken from the A.I.D. strategy paper are:

1. Breastfeed within one hour of delivery.
2. Breastfeed exclusively from birth through four to six months of age.
3. Feed appropriate complementary foods in addition to breast milk by the end of six months of age.
4. Breastfeed for one year or longer.

Use: This analysis will: determine how much is known about breastfeeding, describe the nature and magnitude of the problem of suboptimal practices, and identify high risk areas and groups for targetting interventions. It will also suggest the scope of any needed in-depth, qualitative KAP research that would be used for formulating information, education and communication (IEC) activities.

Assessment Topics:

A. Breastfeeding practices

(Look for comparable data collected over time to show trends e.g., World Fertility Surveys and Demographic and Health Surveys; disaggregate data by rural/urban, ethnic or religious groups, geographic areas, if possible. Use regional studies to indicate variation in practices or to hypothesize about practices. Give percents, when possible. When it is not possible, try to indicate if the majority, most, half, or a few follow the practice.)

Some common errors are made in interpreting studies of breastfeeding practices. These should be considered as the team collects, analyzes and interprets the information it comes across. These warnings are found in Annex A.

In addition to these common errors in interpretation, it has proven to be important to clarify data collection and analysis procedures when interpreting qualitative studies or comparing their results. Often definitions of terms vary slightly or the denominator used to obtain a percentage is different from one study to the next. (WHO definitions are used in the text of this guide.)

1. Percent ever breastfed, per DHS.[1] If DHS data are not available for this country, then provide whatever relevant data are available.

[1] Data available through Demographic and Health Surveys 1986-1989. See Annex B.

2. Colostrum and initiation of breastfeeding

   a. Percent started at breast at following intervals of elapsed time from birth to initiation of breastfeeding: ≤1 hour; 1 up to 6 hours; 6 up to 12 hours; 12 up to 24 hours; 24 up to 48 hours; > 48 hours

      WHO indicator[2] for "Timely first suckling rate":

      Infants < 12 months of age who first suckled within one hour of birth

      Infants > 12 months of age

   b. Percent started at breast within one hour of delivery
      - hospital/clinic births
      - infants delivered at home

   c. Percent given water or other liquids before initiating breastfeeding (prelactal feeds)
      - hospital/clinic births
      - infants delivered at home

   d. Percent not fed colostrum
      - hospital/clinic births
      - infants delivered at home

3. Total number of breastfeeders[3]

   a. Percent exclusively breastfed (no water, liquids, bottles or food)

      WHO indicator:

      Infants < 4 months (<120 days) of age who were exclusively breastfed in the last 24 hours

      Infants < 4 months of age

   b. Percent predominantly breastfed (given breast milk and also water or water-based drinks). Check for evidence of seasonality in pattern of giving water to infants.

      WHO indicator:

      Infants < 4 months (<120 days) of age who are predominantly breastfed in the last 24 hours

      Infants <4 months of age

   c. Complementary feeding (given breast milk and also water, milks and/or other liquids and/or semi-solids)

[2] When possible, present information per the WHO indicator. If more disaggregation is available, present it as well. The disaggregation may be more useful for program planning.

[3] See Annex C for summary of definitions of breastfeeding terms.

WHO indicator:

Infants 6-9 months (180-299 days) of age receiving complementary foods in addition to breast milk in the last 24 hours

Live infants 6-9 months of age

d. Percent any breastfeeding (the child has received breast milk)

WHO indicator:

Live infants < 12 months of age who were ever breastfed

Live infants < 12 months of age

4. Other relevant variables (if case data are available from this perspective)

a. Percent bottlefed[4]

WHO indicator:

Infants < 12 months (< 366 days) of age who were bottlefed in the last 24 hours

Infants < 12 months of age

- discharge from hospital
- 0 up to 3 months
- 3 up to 5 months
- 5 up to 7 months
- 7 up to 10 months
- 10 up to 12 months

b. Continued breastfeeding rate (1 year)

WHO indicator:

Children 12-15 months of age breastfed in the last 24 hours

Live children 12-15 months of age

c. Continued breastfeeding rate (2 years)

WHO indicator:

Children 20-23 months of age breastfed in the last 24 hours

Live children 20-23 months of age

d. Mean or median duration of breastfeeding

[4] The child has received liquid or semi-solid food from a bottle with a nipple or teat; child may or may not also be breastfeeding.

e. Mean or median duration of exclusive breastfeeding

f. Mean or median age of introduction of
   - water
   - milks
   - other liquids
   - semi-solids
   - solid foods

B. Explanation for practices - knowledge and attitudes

(NB: Information for this part is obviously complementary to that presented about practices above and comes from the literature. Investigators need to decide to either integrate this information into the above sections or to present it separately below. The way data are available in the literature will influence this decision.)

1. Preparation to breastfeed
   a. Women's use and attitude toward prenatal care visits (Also, see Section 4 - Health Services)
   b. Pregnant women's plans for infant feeding (including duration) and reasons why
   c. Women's preparations during pregnancy for breast or bottle feeding at delivery and postpartum (look at by delivery setting and attendant)
   d. Women's perceptions of the advantages and disadvantages of breastfeeding (why they do or do not breastfeed; the opportunity cost they see in terms of time and work)
   e. Quality and quantity of women's diets
      - problem one of quantity or quality
      - seasonality
      - women eating more/less during pregnancy
      - postpartum food/beverage taboos
2. Initiation of breastfeeding (relates to data in A.2 above).
   a. Women's experience with and attitude toward initiation of breastfeeding:
      - relative effect of pregnancy on quantity and quality of women's diets and which aspect is more affected
      - prelactal feeds
      - use of colostrum
      - time of initiation
      - frequency and length of each feed
      - night feeds
      - use of both breasts and
      - exclusive versus predominant breastfeeding—early use of teas, breast milk substitutes
3. Introduction of other liquids and bottles (relates to A.3 above)
   a. Women's experience with and attitude toward other liquids (teas, water, juices) to supplement breast milk

b. Women's experience with and attitude toward breast milk substitutes or "supplements"

c. Women's experience with and attitude toward the use of bottles

4. Introduction of semi-solid and solid foods (relates to A.4 above)

   a. Women's experience with and attitude toward the type of foods (dilution, ingredients, texture, "hot" and "cold" properties), amount of food and number of daily feedings

      - semi-solids
      - solids

   b. Women's experience with, beliefs and attitude toward food that should not be given to infants (during illnesses, seasonally, certain ages)

   c. Women's experience with and attitude toward adding oil/fat, fruits and vegetables rich in vitamin A/carotene and protein sources to infant foods, specifically

      - at ages 4 up to 6 months
      - at ages 6 up to 9 months
      - at ages 9 up to 12 months

   d. Women's experience with and attitude toward adding iron-rich foods or supplements to infant's diet

   e. Women's experience with and attitude toward appropriate time that the child should share the full family diet

5. Special circumstances

   a. Women's perceptions regarding why, when, what and how to terminate breastfeeding or to initiate supplements to breastfeeding (developmental cues or other reasons given for feeding decisions), for example

      - Circumstances when women believe they should **not** breastfeed (e.g., discouraged in specific social situations, when mother is pregnant, when child or mother is ill, when breasts hurt), including any ceremonies, rituals or festivals to mark this occasion. Level of adherence, frequency, severity of interference or support

      - Circumstances when women believe they should **introduce** supplementary foods or liquids (e.g., teas), including any cerernonies, rituals or festivals to mark this occasion. Level of adherence, frequency, severity of interference or support.

   b. Differences in mother's breastfeeding behavior when baby is premature, LBW, sick with diarrhea or cough/cold or is male or female

   c. In countries with a high percentage of HIV-positive mothers: their attitude towards breastfeeding

   d. Women's experience with and attitude toward breastfeeding and working outside the home (See Section II.3, Part C)

C. Household and community members' KAP

1. Role of male partner/father in family decision making, mother/child feeding (social structure)
2. Male partner's attitudes towards breastfeeding; support for mother's nutritional and other needs during pregnancy and immediately postpartum
3. Male partner's/father's role in purchase of breast milk substitutes or in ceremonies surrounding giving food to baby
4. Attitudes and influences of:
   - other female members of household (e.g., older multiparous sisters, mothers, mothers-in-law, aunts, grandmothers, etc.)
   - female friends
   - other community members (e.g., religious leaders)
5. Frequency with which members of the household or the community:
   - care for infants
   - prepare and/or feed breast milk substitutes or supplements to infants
   - give ceremonial or weaning foods

D. Conclusions

Suggestion: Refer to guidance in Section I, Subdivision I, Part D, for writing this section.

E. Recommendations

Refer to guidance given in Section I.1, Part E for writing this section.

Suggested Sources of Information and Methods:

Bibliographic Search:

- World Fertility Survey
- DHS Survey
- CDC contraceptive prevalence surveys
- Pan Arab Project on Child Health: PAP child surveys
- National Consensus and Household Expenditure Surveys
- Local surveys and studies in-country
- State of the World's Children Report, UNICEF
- World Development Report
- World Bank Health Sector reports

- Social Science, nutrition, family planning and diarrheal diseases literature. Among A.I.D. reports are:
    - The International Nutrition Communication Service, *Maternal and Infant Nutrition Reviews*. Education Development Center, 1982-1985.
    - The Weaning Project, Child Feeding Assessments—Indonesia, Cameroon, Peru, Ecuador, Swaziland, Zaire (Kinshasa) and Ghana. The Manoff Group, 1986-1989.
    - *Feeding Infants in Four Societies* (Indonesia, Thailand, Colombia, and Kenya). The Population Council, 1980-1984.

Key informant interviews with:

- Ministry of Health or social security system officials and medical personnel
- UNICEF, WHO, A.I.D., or NGO officials and reports
- Family planning organizations, i.e. IPPF affiliates, especially those involved in breastfeeding activities
- Behavioral researchers (e.g., sociologists, anthropologists)
- Health educators and community health workers
- Community leaders (religious, women's groups, etc.)

Section II

Review of Policies, Programs and Commercial Activities Which Affect Breastfeeding Practices

3. Policy, Legal and Work Environment

Objectives: Part A. Breastfeeding policy: To assess the policy and legal environment as it relates to protecting, promoting and supporting breastfeeding practices.

Part B. Marketing and promotion of breast milk substitutes: To assess the magnitude of efforts to market breast milk substitutes, breast milk supplements, weaning foods, bottles, and teats; the influence of these efforts on breastfeeding practices.

Part C. Women's work: To review women's labor patterns as they relate to breastfeeding and laws that have been enacted to protect breastfeeding practices among working women.

Uses: Part A: To identify where national policies and legislation, or their enforcement, would have an impact on breastfeeding practices.

Part B: To design measures to counteract the negative influence of media and promotion techniques; identify the need for additional work to better understand these forces.

Part C: To identify areas for policy change needed to improve institutional, community and peer support and guidance for breastfeeding mothers working in various settings (including factories, farms and households).

Assessment Topics:

A. Breastfeeding policy

1. Stated policy for protecting, promoting and supporting breastfeeding:
   - National policy available is consistent with "optimal breastfeeding behaviors". (See Objective statement for Section I. 2.)
   - Health sector policy is consistent with international recommendations; i.e.:
     - Maternal and child health care facilities have policies consistent with

UNICEF/WHO recommended "ten steps" to support breastfeeding. (See Annex D.)

- Diarrheal disease control program policies/workplans contain recommendations consistent with "optimal breastfeeding behaviors". (See Objective statement for Section I. 2.)
- What is the breastfeeding policy for HIV+ mothers?

- Family planning program policies/workplans contain recommendations consistent with "optimal breastfeeding behaviors". (See Objective statement for Section I. 2.)
- Other sectoral policies

2. Are information systems in place to be able to demonstrate to policy-makers the benefits of breastfeeding promotion activities?
   - information systems on breastfeeding in place or planned
   - breastfeeding practices indicators being reported to key decision-makers at least annually
   - operations research and special studies on program impact and innovations:
     - budget line item for operations research or special studies
     - cost-effectiveness studies completed, funded or underway on breastfeeding program
     - economic value of breastfeeding and cost-savings estimates[5] completed and results disseminated to key decision-makers
3. Coordination of national breastfeeding policy:
   - national breastfeeding coordinator or committee (relationship of skills and politics)
   - national targets
   - monitoring
4. Policy implementation:
   - communication of policy to those responsible for managing programs (oral presentation, declarations, manuals, supervision, etc.) and to program implementors
   - pertinent legislation and how enforced (other than breast milk substitutes—see below)
   - other action to date (include description and reasons for unsuccessful attempts to get action)
   - extent to which donor agencies have been involved in encouraging breastfeeding promotion activities
   - extent to which donor agencies' assistance programs in child survival, especially diarrheal disease control, nutrition, maternal health, reproductive health and family planning programs, include optimal breastfeeding behaviors
     - PAHO
     - UNICEF
     - USAID
     - other

[5] If a detailed analysis is desirable, see Levine, R.E., *Guide to Assessing the Economic Value of Breastfeeding*, Center to Prevent Childhood Malnutrition, Washington, DC, 1990.

- extent to which private sector entities have been involved in encouraging breastfeeding promotion activities
  - professional organizations (e.g., obstetricians, pediatricians, midwives, nurses, nutritionists, etc.)
  - consumer groups
  - others

B. Government policies and commercial activities related to marketing and promotion of breast milk substitutes and infant foods

1. Policies related to marketing and promotion of breast milk substitutes and infant foods

   Adoption of and adherence to the International Code of Marketing for Breast Milk Substitutes (see Annex E) and 1986 Resolution by companies and health workers to comply with Code standards. Enforcement.

   Pertinent legislation (labeling laws, advertising laws, distribution of free samples, etc.)

   Methods and effectiveness of enforcement by whom (government, industry self-monitoring, NGO/IBFAN, etc.)

   Are food aid or food distribution programs consistent with national policies and norms proposed for: duration of exclusive breastfeeding, appropriate age for introduction of supplements and nature of supplements? And, specifically, if non-fat dry milk is provided in a program, are the policies regarding its use compliant with the recommendations of the UNHCR/WHO Guidelines (see Annex F).

   Apart from infant formulas, are labelling/promotion regulations or laws in existence and followed by infant food manufacturers regarding duration of exclusive breastfeeding, age at introduction of supplements and appropriate nature and nutritional value of baby foods?

   Foreign exchange used to import infant formula, infant foods, and bottles, etc.

2. Regulation of distribution of products

   Number of products available in the market and at hospitals—domestic/imported

   Price (per container as purchased; per ounce of correctly prepared formula and weaning food; to feed infant adequate quantity per day)

   Availability from large urban stores to small rural stalls

   Sales volume and market share of products (competitiveness)

   Mechanisms for distribution (through hospitals, health centers and providers)

3. Regulation of promotion activities

   The label—the company—explicit/implicit message

   Mass media by company
   - TV and radio advertising
   - magazine/newspaper advertising
   - professional journals
   - posters, leaflets, etc.

   Formula representatives in hospital offering free or subsidized promotional information to medical personnel and mothers or products

- Formula representatives or supplies at health centers, community health posts, etc.
- Hospital workers paid (in any way—gifts, trips, etc.) by manufacturers of breast milk substitutes or infant food to promote products in any way
- Hospital gives formula representatives lists of maternity patients' names/other indirect ways formula representatives get access to mothers.
- Other avenues for free samples for mothers:
  - hospital gift/discharge packages (contents of package)
  - accompanying "educational" materials
- Lobbying of:
  - government, especially food distribution programs
  - professionals/professional associations through: congresses, funds for research, journals or bulletins, individual grants (trips or awards)
- Gifts to students in professional schools (textbooks, etc.)
- Gifts to facilities (tapes, posters, baby booklets, etc.)

Use checklist in Annex G.

C. Women's work

1. Description of women's work
   - Types of women's work and approximate percent of female population in the formal and informal sectors, including, if possible, wage earning activity, barter activity, agriculture (day laborer or household production), etc.
   - Locations of women in the above categories, e.g., in household, in a factory, in agricultural field, etc.

2. Women's work and maternity leave policy and implementation
   - Pertinent legislation and how enforced
   - Length of time for maternity leave
     - government employees
     - private sector employees
     - actual duration (law versus practice)

3. Wage earning work environment (industry)
   - Extent to which maternity leave legislation discourages employers from hiring women
   - Relevant management and employee advocate (union) policies (same or different from national policies) and activities, especially regarding maternity leave, breastfeeding, child care, health care for women, and possibility of maternity leave.
     - managers' viewpoint
     - women's viewpoint
   - Work site accommodation for breastfeeding and/or child care (child care space, nursing breaks, lactation room, etc.). Functioning model programs. Attitudes toward creches.
     - managers' viewpoint
     - women's viewpoint
   - Problems posed by transporting a young baby to work site.
     - managers' viewpoint
     - women's viewpoint

4. Agricultural and other non-formal sector work environment
   - Potential barriers regarding logistics and time allocation for breastfeeding related to different work environments.
     - employers' viewpoint
     - women's viewpoint
   - Community-based child care schemes. Functioning model programs.

D. Conclusions

Refer to guidance given in Section I.1, Part D for writing this section.

E. Recommendations

Refer to guidance given in Section I.1, Part E for writing this section.

Suggested Sources of Information and Methods:

A. Breastfeeding policy

Bibliographic search including:

- review of breastfeeding-related legislative efforts compiled by The Clearinghouse on Infant Feeding and Maternal Nutrition, American Public Health Association
- the WHO biannual report to the World Health Assembly, "Infant and Young Child Nutrition (Progress and Evaluation Report and Status of Implementation of the International Code of Marketing of Breast Milk Substitutes)"

Key informant interviews with:

- Country breastfeeding promotion groups
- Ministry of Planning officials
- Ministry of Health officials
- Ministry of Labor officials
- Government regulatory representatives
- IBFAN
- UNICEF, WHO, ILO, A.I.D., and other bilateral representatives
- Trade union leaders
- Women's group leaders
- Infant food/drug industry representatives

B. Marketing and promotion of breast milk substitutes

Bibliographic search

- focus especially on the biennial WHO report to the World Health Assembly, "Infant and Young Child Nutrition Progress and Evaluation Report; and Status of Implementation of the International Code of Marketing of Breast Milk Substitutes".

Key informant interviews with:

- Ministry of Health officials
- Hospital and clinic administrators and staff
- formula company representatives
- representative at local IBFAN group
- UNICEF/WHO officers (Code)

Observation and informal interviews in:

- hospital maternity wards
- MCH clinics
- pharmacies
- local food shops

Observation of:

- local media—TV, radio, women's magazines
- professional journals

C. Women's work

Bibliographic search including

- the legislative review done by The Clearinghouse on Maternal Nutrition and Infant Feeding and ILO and IOCU documents

Key informant interviews with:

- Ministry of Welfare or Labor
- Ministry of Women's Affairs
- employer and union representatives
- researchers (sociologists, economists)
- La Leche League representative

- local consumer group representative
- local breastfeeding promotion and support group representatives

Site visits

- observation and informal interviews at factories, farms, households, work cooperatives, breastfeeding mothers' support groups meetings, breastfeeding mothers' support group offices

4. *Health Services*

Objectives: *Part A. Formal health services:* To summarize health service delivery statistical indicators and describe a) prenatal, b) maternity and c) immediate postpartum and/or infant health services delivery systems as these pertain to breastfeeding behaviors.

> NB: Formal health services here are defined as all services provided through an institutional structure, whether they are in the public (government) or private (including churches, NGOs or PVOs) sector. Community level workers who are part of the government health service, even if non-salaried, are to be considered as part of the formal health care system.

Part B. Traditional health care: To assess the relative importance of the role of traditional health providers.

> NB: Traditional health care here is defined as that given by but not limited to any indigenous practitioners, such as traditional birth attendants, traditional healers, injectionists, herbalists, masseuses, etc. They are not connected with any formal —or institutional—health service for training, salary or other support, although they may have been part of a training program sponsored by, for example, the Ministry of Health.

Uses: *Part A.* To identify areas for policy change to improve the availability, content and accessibility of services supportive of breastfeeding and identify the kind of work that needs to be done to know more about health services and breastfeeding practices.

Part B. To identify potential areas for program activities targeted to traditional providers or their clients.

Assessment Topics:

A. Formal health services

1. Patterns of prenatal care

   a. Summary of statistical indicators. Ideal would be to report an overall number for the country or region and then break it down by key demographic variables; some suggested key variables are indicated within parentheses below:

      - overall prenatal coverage and timing of initiation
      - average number of prenatal care visits per woman (by SES, rural/urban, etc.)
      - coverage for different types of prenatal care facilities (hospital, district health center, community-based center; public versus private)
      - coverage for type of person functioning outside a facility: (trained TBA, private doctor, etc.)

   b. Protocols/norms for prenatal visits:

      - examination of breasts
      - counselling regarding breastfeeding—review any materials used
      - nutrition counselling for mother

- discussion of breast milk substitutes
- distribution of powdered milk—recommendation related to lactation

2. Patterns for hospital or clinic-based deliveries

(Time restrictions during visit may require the team to concentrate on major maternity hospitals as proxy for all hospital-based deliveries). A separate review could be done for the major teaching hospital where there may be WellStart graduates or where UNICEF has undertaken the Baby-Friendly Hospital Programme.

a. Summary of statistical indicators. Ideal would be to report overall number for the country and for regions, and to indicate the range by key demographic variables.

- distribution of births by type of facility (e.g., hospital or clinic-based deliveries versus home-based deliveries; public versus private facility; rural versus urban, etc.)
- distribution of births by type of delivery attendant (e.g., physician, nurse-midwife, traditional birth attendant, etc.)
- percent of hospital-based births that are:
  - c-section
  - premature
  - LBW : < 1500 g
  - 1500 - 2499 g
- use of ergometrine during the third stage of labor, delivery and postpartum: routine to prevent postpartum hemorrhage (dose and duration) or restricted to treatment of actual postpartum hemorrhage
- approximate percent (or common/not common) of newborns given prelactal feeds ("gastric tolerance tests") or supplements like glucose water
- approximate percent (done/not done) of women who have rooming-in, 24 hours/day
- number of beds per room
- number of women per attendant
- number of babies in nursery
- approximate percent (common/not common) babies given formula even though mother is nursing (done/not done)
- comparison of breastfeeding initiation statistics among different types of facilities (hospital, clinic, public facility, private facility, etc.)
- comparison of statistics for deliveries at different times of day
- availability of free formula samples to mothers at discharge

b. Protocols/norms for breastfeeding (may need to restrict to observations and key informant interviews in one or two major maternity hospitals and two teaching hospitals)

- availability of mother's antenatal record
- hospital's consideration of mother's intention to breastfeed in decisions on sedatives, analgesics, anaesthesia and on use of ergometrine during labor, delivery and postpartum
- time elapsed between birth and baby being brought to the mother
- time elapsed between birth and initiation of breastfeeding
- practice regarding colostrum
- spatial set-up for delivery, recovery, nursery, rooms for mothers. Do they foster rooming-in?

- feeding schedule
  - frequency and duration of each feed—how long is baby left with the mother?
  - frequency and duration of night feeds
- examination of the mother's breasts
- observation of a feeding session to identify potential problems
- breastfeeding counselling:
  - lactation classes
  - lactation advisor (formal or informal who advises mothers)
- counselling (appropriate or inappropriate) given on when and how to use supplements under specific circumstances, e.g.,
  - infant is not gaining weight
  - infant is ill
  - mother is ill or malnourished
  - infant refuses breast milk
- type of feeding encouraged/done for low birth weight babies: < 1500 g and 1500 - 2499 g (expressed breast milk for babies < 1500 g - availability of breast pumps and refrigerators)
- availability of fluids to nursing woman, for herself
- kangaroo mother method (for low birthweight babies) practiced or other method to keep mother and infant together

c. If there is a teaching or "model" maternity hospital:
- assess breastfeeding protocols; up-to-date? comprehensive?
- assess extent of outreach training programs
- assess extent of patient education and breastfeeding promotion
- Wellstart graduates
- participation in the Baby-Friendly Hospital Programme

3. Patterns for immediate postpartum and infant care

a. Summary of statistical indicators. Ideal would be to report overall statistics for country or region, and then break them down by key demographic variables.
- existence of postpartum visits (number per woman and timing; by SES, rural/urban, type of facility, type of health personnel)
- coverage of growth monitoring programs for infants 0-12 months

b. Items in protocol for postpartum/infant visits
- women followed-up with house visits or expected to come back to facility
- asking woman about her health
- breast examination
- maternal weight monitoring
- recommended advice in nutrition counselling for mother
- in breastfeeding or growth monitoring counselling, recommendations (appropriate or inappropriate) when:
  - infant is not gaining weight
  - infant is ill

- mother is ill or malnourished
- breasts hurt/engorged/nipples cracked
- mother believes milk is bad or insufficient
- mother is pregnant

circumstances when breast milk substitutes are recommended

infant weight taken and monitored; recognition of different growth patterns for breastfed babies

distribution of powdered milk—recommendation related to lactation

4. Health staff's KAP

   a. Practitioners' knowledge and attitudes:

      advantages and disadvantages of breastfeeding

      ideas about initiation; check on whether practices vary if baby is premature, LBW, or ill

      exclusivity

      frequency

      duration

      working women

      use of water

      use of bottles

      need for vitamin or mineral supplements (e.g., iron)

      need for iron-rich foods; food supplements

      educational work done by practitioner with client

      what is needed to persuade practitioner to change point-of-view

      has practitioner or spouse breastfed own recently-born children?

      Use interview checklist in Annex H.

   b. Administrative staff's knowledge and attitudes toward advantages and disadvantages of breastfeeding

      Use interview checklist in Annex H.

   c. Practitioners' opinions of training experience: satisfactory and appropriate for their level of participation in breastfeeding program?

5. Integration of breastfeeding promotion in health programs

   a. Identify agencies or institutions that provide the majority of MCH services to the "vulnerable" population (check health services utilization patterns for high-risk populations; e.g., female, low SES, low education, rural residence, etc.). Services may include but are not limited to those of the Ministry of Health, social security system, missionary hospital system, Red Cross, PVOs, etc.

   b. Are breastfeeding activities integrated within the sub-national MOH infrastructure?

      Do state/province/region-level policy, program and operational guidelines and norms contain all key breastfeeding promotion elements as part of:

      - maternity care and newborn care
      - EPI activities
      - diarrheal disease control or ORT activities
      - family planning activities

- growth monitoring and counselling activities
- PL 480/WFP feeding program activities
- ARI activities?

Do state/provincial/regional-level education materials and training guidelines and curricula contain all key breastfeeding promotion elements as part of:

- maternity care and newborn care services
- EPI activities
- diarrheal disease control or ORT activities
- family planning activities
- growth monitoring and counselling activities
- PL 480/WFP feeding program activities
- ARI activities?

c. Have breastfeeding activities been integrated at health and/or nutrition services delivery sites?

Note: The following questions refer to a variety of health and nutrition programs. It may be easier to discuss each type of program separately (e.g., CDD) or in the order presented below. Additional questions pertinent to specific programs (EPI, CDD/ORT and family planning) are presented in sections f, g and h, respectively.

Do health facilities (visited by the assessment team) that provide maternity services and care for newborns practice the "Ten steps to successful breastfeeding"? (See Annex D.) This may be partially answered earlier for hospitals and large clinics but what about the PHC level?

Do peripheral salaried health care providers interviewed promote "optimal breastfeeding behaviors" as part of

- EPI activities
- diarrheal disease control or ORT activities
- family planning activities
- growth monitoring and counselling activities
- PL 480/WFP feeding program activities
- ARI activities?

d. Has supervision of breastfeeding activities been integrated at health and nutrition service delivery sites?

Are there supervisory responsibilities and checklists that include breastfeeding activities at the maternity services and newborn care facilities visited?

Are breastfeeding questions included in the supervisory checklists of peripheral salaried health and nutrition workers, to identify and deal with program issues, and report on breastfeeding promotion activities routinely as part of

- EPI activities
- diarrheal disease control or ORT activities
- family planning activities
- growth monitoring and counselling activities
- PL 480/WFP feeding program activities
- ARI activities?

e. Obstacles to breastfeeding in EPI programs

To what extent are the following found in EPI programs?

- Poor training and misinformation, e.g., "diminished response of oral polio vaccine among breastfed infants"
- Missed opportunities for support of breastfeeding during vaccination visits
- Failure to promote colostrum as "first immunization" and to recognize its role in enhancing the infant's cell-mediated immune response to BCG

f. Obstacles to breastfeeding in CDD and ORT programs

To what extent are the following found in CDD and ORT programs?

- Poor training and misinformation, e.g., "Breastfeeding should stop during diarrhea"
- Failure to promote exclusive breastfeeding from birth through 4-6 months to prevent early diarrhea
- Separation of breastfeeding mothers and infants in inpatient or outpatient wards during treatment
- Use of bottles and nipples to provide ORS to infants, exposing the child to pathogens if not sterile, and undermining the established breastfeeding relationship because of "nipple confusion"
- Emphasis to mothers only on administration of ORS, so that mother may forget to breastfeed in between and milk supply diminishes
- Oral rehydration often given for cases of mild diarrhea without dehydration, which can disrupt breastfeeding and expose child to pathogens, causing more harm than benefit
- Food-based ORS given to exclusively breastfed infants under 6 months of age, which may disrupt breastfeeding

g. Obstacles to breastfeeding in family planning programs

To what extent are the following found in family planning programs?

- Poor training and misinformation, e.g., "No family planning until breastfeeding stops; breastfeeding has no contraceptive effect"
- Use of combined oral contraceptives which contain estrogen, known to reduce breast milk, instead of progestin-only contraceptives and non-hormonal methods (e.g. lactational amenorrhoea method)
- Rewarding workers only for distributing contraceptives and not for promoting breastfeeding as a contraceptive
- Not counselling postpartum women on family planning and choice of contraceptives, including breastfeeding

i. To what extent has the private sector been involved in breastfeeding promotion?

Are private maternities and private newborn care facilities practicing the "ten steps" (Annex D)?

Are private pediatricians, OB/GYNs and self-employed midwives promoting "optimal breastfeeding" as part of preventive and/or curative activities?

B. Traditional health care providers

1. Patterns of prenatal care
   a. Type of provider; where and type of services provided; trained/untrained
   b. Breastfeeding counselling or nutrition counselling? Specify timing and content. Practitioners' advice (and rationale) to women. Anticipated results.

   Use interview checklist in Annex H.

2. Patterns of deliveries
   a. Type of attendant—trained/untrained
   b. Location of delivery (mother's household or other)
   c. Extent to which care is ongoing (mother seen before and after delivery) or at delivery only; link to formal health care system
   d. Breast examination
   e. Counselling for:
      maternal nutrition; infant nutrition
      breastfeeding techniques (and when given)
      use of colostrum
      maternal or infant illness
      breast problems
      Has the provider been given information about breastfeeding:
      What, by whom, what did they do?
   f. Use of ergometrine during third stage of pregnancy, labor or delivery (specify dose and duration)

3. Patterns of postpartum care
   a. Provider, location of service and time of service (within first hours, week or month of birth); trained/untrained, link to formal health system
   b. Concern of provider about mother and/or baby
   c. Inquiries about infant feeding/breastfeeding
      what they are concerned about
      content of counselling
   d. Breast examination
   e. Recommendation of fluids or foods for mother or infant

   Use interview checklist in Annex H.

4. Existence of a professional association
   a. policies
   b. activities

C. Conclusions

Refer to guidance given in Section I.1, Part D for writing this section.

D. Recommendations

Refer to guidance given in Section I.1, Part E for writing this section.

Suggested Sources of Information and Methods:

Bibliographic and health statistics search

A. Formal health services

Key informant interviews with:

- Ministry of Health officials (departments: planning, MCH, epidemiology, etc.)
- official representatives of other major health care systems (e.g., social security, private insurance, etc.)
- maternity hospital administrators or head physicians/nurses in obstetrics and pediatrics
- medical and nursing school faculty (current research and program activity)
- relevant professional groups or associations
- UNICEF re: Baby-Friendly Hospital Program
- A.I.D. re: Wellstart Program
- WHO

Observation and informal interviews with personnel in:

- hospital delivery rooms and maternity wards (including secondary and tertiary levels of care, urban, periurban and rural facilities, private and government facilities)
- health centers, MCH clinics and community childbirth facilities (community/primary level of care)
- community programs - growth monitoring, nutrition/food supplementation and community-based contraceptive distribution

B. Traditional health care providers

Key informant interviews with:

- medical anthropologists
- anthropologists
- traditional birth attendants
- trained midwives who work with traditional attendants

- traditional healer associations, etc.

Preliminary observation and informal conversations in communities with traditional birth attendants and traditional healers, if time permits.

5. *Training Programs for Health Care Providers*

Objective: To identify and describe existing training programs for key health care providers in the area of breastfeeding.

Use: To design priority training programs and materials in the area of breastfeeding.

Assessment Topics:

A. Formal health care providers

Identify practitioners who assist mothers with pregnancy, childbirth, neonatal and infant health care or breastfeeding specifically. These practitioners may include but are not limited to: physicians, nurses, nurse-midwives, midwives, community health workers, nutritionists, and pharmacists. Review the training programs for each type of practitioner, both pre-service and in-service:

1. Kind of training available: as part of pre-service/university education and as part of in-service training
2. For training in which breastfeeding/infant feeding/weaning mentioned:
   - number of training hours focusing on breastfeeding compared to total number of training hours
   - number of training hours focusing on breastfeeding versus supplementation
   - number of training hours focusing on interpreting/counselling in response to weight gain data, feeding during/following diarrhea and other infant illnesses and weaning
3. For special skills training (breastfeeding and weaning only):
   - number of hours, when given, etc.
   - clinical techniques
   - counselling techniques
   - growth monitoring
4. Content of curriculum and teaching materials: how up-to-date and accurate are materials and suggested protocols/norms for hospital and/or clinic-based interactions with mothers regarding breastfeeding?

   Use documents and interview checklists in Annex I.
5. Percent of provider-type trained (need to identify appropriate denominator)
6. Training of supervisors of those receiving training
7. Follow-up provided after training

   Begin with the people trained by WellStart or IBFAN and their subsequent training of others and the follow-up in-country. (A list of trainees should be provided to the consultant team.)
8. If training programs do not exist, where and how could one be initiated?
   - integration of breastfeeding training in existing training programs
   - creation of breastfeeding training programs

9. Has training strategy for breastfeeding been developed and approved, including pre-service and in-service/continuing education for all key interventions and in all sectors?

10. Are continuing education activities adequate?
    - continuing education policy defined
    - continuing education policy identifies national, regional and peripheral responsibilities
    - continuing education is consistent with findings of needs assessments

11. Are trainers qualified to train (have skills, information in substantive areas and know how to train)?

12. Is/are budget line item(s) for training consistent with magnitude of task?
    - government sponsorship
    - NGO sponsorship
    - private sector (industry) sponsorship

13. Do "needs assessments" form the basis for training activities?
    - facility assessments for quality of breastfeeding promotion have been carried out in the last 24 months in:
        - maternity care and newborn care services
        - EPI activities
        - diarrheal disease control or ORT activities
        - family planning activities
        - growth monitoring and counselling activities
        - PL 480/WFP feeding program activities
        - ARI activities
    - Have results of most recent needs assessments been used to modify training activities in:
        - maternity care and newborn care services
        - EPI activities
        - diarrheal disease control or ORT activities
        - family planning activities
        - growth monitoring and counselling activities
        - PL 480/WFP feeding program activities
        - ARI activities?

B. Training for traditional health care providers

Identify traditional practitioners who interact with mothers at any time regarding pregnancy, childbirth, neonatal/infant care or specifically breastfeeding. These practitioners may include but are not limited to traditional birth attendants, traditional healers, masseuses, and herbalists.

1. Access to training program (logistics and cost)

2. Content of training and teaching materials: how up-to-date and accurate are materials and suggestions on what should be included and how could interactions with mothers be conducted?

3. Percent of provider type trained (means identifying an appropriate denominator):
    - number of hours on breastfeeding compared to total number of training hours

- breastfeeding mentioned but not emphasized

4. Breastfeeding and growth monitoring and promotion skills training
   - clinical techniques
   - counselling techniques
   - needs assessment
   - interpreting/responding to weight data
5. Provision of educational materials during training
   - formats used (part of delivery kit, etc.)
   - informational content; up-to-date?
6. Supervisor training
7. Continuing education

C. Conclusions

Refer to guidance given in Section I.1, Part D for writing this section.

D. Recommendations

Refer to guidance given in Section I.1, Part E for writing this section.

Suggested Sources on Information and Methods

Review:

- Georgetown IISNFP breastfeeding curriculum for nurses
- IBFAN manual

Bibliographic search

- Documents describing training programs and/or reports from training activities

Key informant interviews with:

- Ministry of Health officials
- Ministry of Education officials
- medical, nursing and midwifery school faculty or administrators (interview leading public and private schools)
- representatives of any identified institutional sponsors of training programs (e.g., private sector, multilateral and bilateral donors, NGOs, etc.)
- professional associations (e.g., Ghana Midwives Association)

Interviews with trainees of special training courses, *if time available.*

6. *Information, Education and Communication Activities*

Objective: To describe and assess the effectiveness of current information, education and communication (IEC) activities.

Use: To determine their role or potential role in promoting breastfeeding.

Assessment Topics

A. Overall breastfeeding communication effort

Note: These questions refer to all health programs, public and private, as well as to any relevant non-health programs

1. Is breastfeeding the main theme of the communication program or is breastfeeding integrated within a broader focus or into a communication program for another topic?
2. Inter- and intra-*institutional* communication for planning IEC activities for breastfeeding (or more generally for MCH programs)

   degree of collaboration on breastfeeding IEC activities by different *health and nutrition programs* (e.g., MCH, STD, family planning, CDD, safe motherhood)

   message harmony enforced—by whom, how

   ntegration of mass media and interpersonal communications, i.e. message harmony, timing
3. Was a needs assessment (qualitative/quantitative KAP and media habits) the basis for planning? Describe.
4. The communication strategy

   scope: single focus "campaign" or comprehensive national, or regional program, or scattered efforts with groups/programs establishing own priorities

   designed with audiences specified and well segmented, including both program implementors, physicians, etc., as well as mothers and others
5. What are the specific objectives and what is the strategy to reach them?
6. Communication program monitoring and evaluation: Is there anything to show for the communication effort?
7. Sustainability

   campaign or long-term effort

   funds available—use of sponsorship by industry, professional associations, etc.

   presence of qualified communication professionals and adequate media resources

B. Communication regulation and policy

1. Government regulation of the mass media
2. Government or private media organizations' policies regarding public service announcements and/or message content (e.g., radio and TV stations)
3. Centralized or decentralized mass media system
4. Prohibition against exposing breast in TV or print

C. Specific IEC activities

1. Use of mass media to promote breastfeeding/infant feeding

   audience demographics (TV, radio, newspaper and magazines)

   directly (e.g., public service announcements/free time on radio or TV, commercial advertising on radio or TV, magazine and newspaper advertising, posters, brochures, billboards, etc.)

   inventory of recent activities: public relations, education on which themes, using what kind of format

   samples of existing materials

   process used to develop existing materials (formative research and pretesting)

   indirect media influences such as the depiction of infant feeding in TV drama (soap operas), radio drama, popular theater, etc.

   evaluation information/lessons learned

2. Interpersonal or face-to-face communication—timing of information given to mother and her likely receptivity

   hospital or clinic-based counselling

   - who transmits information?
   - materials
   - correct use of materials
   - evaluation information

   women's groups

   - who transmits information?
   - materials
   - correct use of materials
   - evaluation information

   other

3. Presence of a clearinghouse for up-to-date local and international information on breastfeeding/weaning and access to educational materials for a variety of audiences

D. Conclusions

Refer to guidance given in Section I.1, Part D for writing this section.

E. Recommendations

Refer to guidance given in Section I.1, Part E for writing this section.

Suggested Sources of Information and Methods:

Bibliographic search

Key informant interviews with:

- representative at government regulatory agency for communications
- MCH program coordinators in MOH or Ministry of Social Welfare
- health communications and/or health education program coordinators in MOH, and other institutions
- representatives within donor community, usually UNICEF and NGOs
- representative at leading advertising agency

7. *Community Outreach and Support Activities for Women*

Objective: To evaluate the importance of women's support groups for supporting breastfeeding.

Use: To identify the types of groups and activities which are effective in supporting breastfeeding and the potential gaps in this area.

Assessment Topics:

A. Support systems for women

1. Inventory different types of support systems for:
   - women in general
   - mothers with children
   - working women
2. Which of the support systems above is involved in any kind of breastfeeding support?
3. Within these systems, how is perinatal and ongoing breastfeeding support handled?
   - informal counselling
   - peer group pressure
   - formal group meetings
4. Looking at specific organizations, how do NGOs give ongoing support to breastfeeding?
   - mothers' clubs, promoters, community distributors or other mechanisms
   - home health visits
   - other?
5. How does the formal health system give ongoing support to breastfeeding?
   - Is there formal interest/commitment to breastfeeding mothers' support by health system?
   - Are breastfeeding mothers' support groups involved in formal MCH programs (e.g., nutritional supplements distribution program—coverage of lower SES women, clinic, hospital outreach, health worker training)?
6. What kind of training do those in the breastfeeding support network receive?
   - traditional, observational
   - apprenticeship
   - formal training course? Type? Who does training?
7. Are there formal breastfeeding mothers' support groups?
   - How are groups/meetings set up?
   - Who runs them?
   - How are groups organized?
   - Is there any coordination with BMSG networks?

- Is BMSG work funded or not?
- Sources of funds?
- Are counsellors/facilitators volunteers or paid?
- Who are the targets for breastfeeding mothers' support group work?

8. How is breastfeeding mothers' support tracked?

   Are any process evaluation indicators in place in formal health system/in breastfeeding mothers' support system?

   - Is there information on:
     - meetings, informal counselling, other activities
     - training
     - other services (documentation, referrals, education, etc.)

B. Conclusions

Suggestion: Refer to guidance in Section I.1, Part D for writing this section.

C. Recommendations

Refer to guidance given in Section I.1, Part E for writing this section.

Suggested Sources of Information and Methods:

Bibliographic search

Bibliographic search including the legislative review done by The Clearinghouse on Maternal Nutrition and Infant Feeding and ILO and IOCU documents.

Key informant interviews with:

- Ministry of Women's Affairs
- researchers (sociologists, economists)
- La Leche League representative
- local consumer group representative
- local breastfeeding promotion and support group representatives

8. *Financial Support for Breastfeeding Activities*

Objective: To identify the various sources of financial support for breastfeeding activities and the special focus or limitations of any given donor.

Use: This information will assist programmers to develop interventions designed to address the recommendations from the country assessment and/or other new breastfeeding activities.

A. Breastfeeding program costs borne by government

- trends in proportion of total government health budget devoted to breastfeeding activities (exclusive of other donor funds, ESF, PL-480 funds)
- trends in government share of total breastfeeding program budget (exclusive of other donor funds, ESF, PL-480 funds)
- trends in proportion of local, recurrent costs covered by government (exclusive of other donor funds, ESF, PL-480 funds)
- trends in funding over time corrected for inflation

B. Donor funding for breastfeeding

C. Experience with cost-recovery

D. Funding from private sources received for breastfeeding activities

E. Conclusions

Refer to guidance given in Section I.1, Part D for writing this section.

F. Recommendations

Refer to guidance given in Section I.1, Part E for writing this section.

Suggested Sources of Information and Methods:

Key informant interviews with:

Ministry of Health officials

UNICEF, WHO, PAHO, A.I.D. and other bilateral representatives

PVO and NGO representatives

9. Breastfeeding Country Score Sheet

(to be completed by consultant team)

Instructions: Please score each component area in terms of either breastfeeding programs or mothers who breastfeed.

1. Country background

A. Socio-demographic profile – no score

	high				*low*
B. Mortality (add nutritional status or morbidity?)	1	2	3	4	5
	poor				*good*
C. Nutritional status of under one year olds	1	2	3	4	5
	low				*high*
D. Contraception	1	2	3	4	5

2. Nature and magnitude of the problem of inadequate breastfeeding practices

	poor				*optimal*
A. Breastfeeding practices	1	2	3	4	5
	not supportive at all				*very supportive*
B. Mothers' knowledge & attitudes	1	2	3	4	5
C. Household and community members' KAP	1	2	3	4	5

3. Policy, legal and work environment

	not supportive at all				*very supportive*
A. National breastfeeding policy	1	2	3	4	5
B. Regulation of marketing and promotion of breast milk substitutes	1	2	3	4	5
C. Women's work environment	1	2	3	4	5

4. Health services

	not supportive at all				*very supportive*
A. Formal health services					
1. Prenatal care	1	2	3	4	5
2. Hospital/clinic deliveries	1	2	3	4	5
3. Immediate postpartum and infant care	1	2	3	4	5
4. Health staff's KAP	1	2	3	4	5
5. Integration of breastfeeding promotion in health programs	1	2	3	4	5
B. Traditional health care providers					
1. Prenatal care	1	2	3	4	5
2. Deliveries	1	2	3	4	5
3. Postpartum care	1	2	3	4	5

(This may not merit so much "weight.")

5. Training programs

	not well developed				*very well developed*
A. Formal health care providers (pre-service)	1	2	3	4	5
B. Formal health care providers (in-service)	1	2	3	4	5
C. Traditional practitioners	1	2	3	4	5

(This may need more "weight.")

6. Information, education & communication activities

		not supportive at all				*very supportive*
A. Overall effort		1	2	3	4	5
		strict				*lenient*
B. Regulation and policy		1	2	3	4	5
		not well developed				*very well developed*
C. Specific Activities:	mass media	1	2	3	4	5
	interpersonal	1	2	3	4	5
	clearinghouse	1	2	3	4	5

7. Support to women

1 2 3 4 5

8. Local financing and donor assistance

1 2 3 4 5

Total: All Sections _____

Highest Possible Total : 135

Section III

Recommendations

The purpose of this section is to provide a synthesis of all recommendations which have appeared in detail in the previous eight modules. The recommendations in this final section should relate to the overall assessment and provide a sense of priority. They should not be a mere re-listing of what has appeared before, either in detail or in number.

The team needs to remember that all the specific recommendations listed in areas 1-8 are important, but that in order to take action, program designers need to know which of them need attention first (the timing factor) and which need the most attention (the resource factor, regardless of timing). Therefore, the team needs to consider all of the conclusions and recommendations, and provide their judgment in the form of synthesized recommendations. "Synthesized" does not mean "generalized," as the recommendations listed in this part need to be clear and specific, but from a more macro point of view than those presented earlier.

The ratings given in the Country Score Sheet are one way of drawing overall conclusions for the assessment. The narrative in Section III should be a companion statement to the score sheet. The team can decide how best to organize the elements of this section. Several questions to help guide it. elaboration are:

> What are the most important issues? These are not necessarily those which appear as the headings of the eight major content areas of the Guide. In fact, they probably cut across these eight areas. For example, in one country a major issue may be the negative role of well-intentioned, but uniformed and poorly motivated health personnel, especially the more influential ones like pediatricians, gynecologists and obstetricians. In another country, a major issue may be the negative role of imported powdered milk which is distributed nationwide through government and NGO programs. In yet another, an overriding issue may be the effects of a long-running civil war and the collapse of the formal health infrastructure. These issues have probably already been identified in the course of responding to the questions in areas 1-8, but in this final section it is necessary to compare them and judge which are more important and therefore which deserve more immediate attention and how.
>
> Who are the most influential actors in the promotion of breastfeeding and what steps should they take next to further their work? What resources do they need? How can they influence the issues which the team has identified as having top priority for action?
>
> For each major issue which should be addressed, who are the actors and institutions which should be involved and how can each participate, given their individual mandates and current (or projected) resources?
>
> For any given group of top priority issues, which are those which can be addressed in the short-term and which in the long term (e.g., passing legislation to provide maternity leave)?

Annexes

Reference Materials and Checklists

Annex A

Warnings On Common Errors Made In Interpreting Breastfeeding Studies

from

Anderson, Mary Ann. *The impact of breastfeeding on infant and child morbidity and mortality,* paper presented at the Workshop on Child Health Priorities for the 1990s, Johns Hopkins University, 20-22 June 1991.

Sources of Bias in Association Between Breastfeeding and Morbidity and Mortality

There are many potential sources of bias when comparing mortality and infection rates between breastfed and other infants (Kramer, 1987). The most common sources of bias in breastfeeding and health impact studies fall into two major categories: (1) reverse causality, and (2) low comparability in socio-economic status between study groups. Reverse causality occurs in breastfeeding studies when the outcome being studies, e.g. death or illness, precludes or terminates breastfeeding, rather than the reserve, that is failure to breastfeed causing illness or death. Thus, while there is a causal relationship between breastfeeding and illness or mortality, the temporal sequence is the reverse of that hypothesized. Another example is low birth weight infants who are at increased risk of morbidity and mortality but who also are less likely to be breastfed (Barros et al., 1986). Reverse causality bias leads to an overestimation of the benefits of breastfeeding.

Socio-economic and demographic differences between mothers who breastfeed and those who bottlefeed are potential confounders because these factors are associated both with infant feeding practices and with morbidity and mortality. Thus, in many developing countries where breastfeeding is more common among the lower income, less educated population and bottlefeeding is practiced by the upper income, well-educated group, comparison of infant health outcomes by type of feeding, without controlling for these major socio-economic differences between them leads to an underestimation of the benefits of breastfeeding. In contrast, in the U.S., breastfeeding is practiced by well-educated middle and upper income groups and bottlefeeding is more common among lower income groups; thus comparison of health outcomes by these modes of infant feeding without controlling for socio-economic status could overestimate breastfeeding's benefits.

Because many older studies present spurious results due to the biases described above, this paper s review of the literature on infant and child morbidity and mortality reduction associated with breastfeeding will draw for the most part on well-designed, carefully controlled, more recent studies. A good illustration of analytical methods used to reduce bias and the impact of such statistical controls on the magnitude of infant mortality reduction associated with breastfeeding is a Malaysia study (Habicht, et al., 1986). Even after adequately controlling for potential reverse causality and confounding factors, this study and others still find the protective effect of breastfeeding to be highly significant (Millman and Cooksey, 1987; Kramer, 1987).

Breastfeeding and Weaning Patterns in Selected Countries From Demographic and Health Surveys, 1986–89 (For Last-Born Living Children)

Country	Percent of Children 0–4 Months				Percent of Children 7–11 Months			
	(a)* Breastfed Exclusively	(b) Breastfed + Plain Water	(c) Breastfed + Other Foods	(d) Any Breastfeeding	(e)* Breastfed + Solids No Bottle	(f) Breastfed No Solids	(g) Not Breastfed	(h)* % of Children 12-14 mos still Breastfeeding
Morocco	42	17	32	91	43	26	24	68
Tunisia	19	35	42	96	37	22	30	61
Botswana	37	26	33	96	73	12	7	79
Burundi	84	7	9	100	71	23	1	96
Ghana	2	61	37	100	45	36	1	97
Kenya	21	15	62	98	71	7	4	88
Liberia	14	27	57	98	50	23	17	69
Nigeria (Ondo)	1	21	76	98	24	53	7	79
Mali	8	68	23	99	51	44	1	91
Senegal	5	61	33	99	72	19	2	96
Togo	8	25	67	100	84	10	0	95
Uganda	63	6	31	100	74	19	6	90
Zimbabwe	9	39	51	99	88	3	3	90
Indonesia	36	3	57	96	83**	9	8	82
Sri Lanka	12	39	45	96	30	29	16	73
Thailand	4	21	65	90	48	10	24	63
Bolivia	55	4	38	97	39	24	15	71
Brazil (NE)	3	11	57	71	15	9	60	24
Colombia	18	5	63	86	13	12	52	36
Dom. Rep.	13	13	56	82	11	16	59	26
Ecuador	27	10	53	90	15	42	25	56
Mexico	33	1	38	72	20	13	48	35
Peru	31	4	57	92	24	23	26	66
Trin. & Tob.	10	6	62	78	12	4	62	33

*Columns (a), (e) and (h) represent the optimum infant feeding behaviors consistent with the goal of the A.I.D. Breastfeeding for Child Survival Strategy and should ideally be 100% for each country.
**Indonesia has no information on bottle feeding

Source: Demographic & Health Surveys, 1986–89.

Annex C

Summary of Definitions of Breastfeeding Terms

Category of infant feeding	Requires that the infant receive	Allows the infant to receive	Does not allow the infant to receive
Exclusive breastfeeding	Breast milk (including milk expressed or from wet nurse)	Drops, syrups (vitamins, minerals, medicines)	Anything else
Predominant breastfeeding	Breast milk (including milk expressed or from wet nurse as the predominant source of nourishment	Liquids (water-based drinks, fruit juice, ORS), ritual fluids and drops or syrups (vitamins, minerals, medicines)	Anything else (in particular, non-human milk, food-based fluids
Complementary feeding	Breast milk and solid or semi-solid foods	Any food or liquid including non-human milk	
Breastfeeding	Breast milk		
Bottle feeding	Any liquid or semi-solid food from a bottle with nipple/teat	Also allows breast milk by bottle	

Ref: World Health Organisation, CDD/SER/91.14. *Indicators for Assessing Breastfeeding Practices: Report of an Informal Meeting 11-12 June 1991*, Geneva, Switzerland.

Annex D

Ten Steps To Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in: allow mothers and infants to remain together, 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Annex E

Infant Formula Marketing Code

1. No advertising of these products to the public.
2. No free samples to mothers.
3. No promotion of products in health care facilities.
4. No company mothercraft nurses to advise mothers.
5. No gifts or personal samples to health workers.
6. No words or pictures idealising artificial feeding, including pictures of infants, on the labels of the products.
7. Information to health workers should be scientific and factual.
8. All information on artificial infant feeding, including the labels, should explain the benefits of breastfeeding and the costs and hazards associated with artificial feeding.
9. Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.
10. All products should be of a high quality and take into account the climatic and storage conditions of the country where they are used.

Annex F

Policy for Acceptance, Distribution and Use of Milk Products in Refugee Feeding Programmes

(Janet Nelson Staff) WFP

UNHCR/IOM/88/89
UNHCR/FOM/76/89

OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

GENEVA

Inter-Office Memorandum No. 88/89
Field Office Memorandum No. 76/89

To: All UNHCR Staff Members at Headquarters and in the Field

From: The Deputy High Commissioner

Ref: 593

Date: 25 July 1989

Subject: Policy for Acceptance, Distribution and Use of Milk Products in Refugee Feeding Programmes

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1. The attached policy document outlines instructions for the control of the use of milk products in refugee settings. You are hereby requested to undertake an evaluation of the assistance programme for refugees in your country and promote appropriate changes so as to secure the safe use of milk products in all programmes supported and co-ordinated by UNHCR.

2. These instructions have been endorsed by the Nutrition and Food Aid Units of the World Health Organization and by UNICEF. The World Food Programme has concurred with their application. They are to be implemented forthwith.

3. This policy stems from concern regarding the increased use of dried milk powder (particularly donated DSM) in refugee settings. DSM has been found to increase the risk of illness in young children who live in an unsanitary surrounding. Furthermore it discourages breast-feeding by promoting the alternative use of infant feeding bottles with serious implications for the health for young children.

4. Our current analysis points toward fourteen countries where DSM or milk formula are at present distributed in either general rations or to general groups: Algeria, Angola, Costa Rica, Djibouti, Ethiopia, Honduras, Hong Kong, Iran, Malaysia, Pakistan (Afghan repartriation) Somalia, Sudan, Swaziland and Vietnam. The composition of food rations in these, and any other countries distributing milk powder in the general rations will need to be reviewed and nutritionally comparable substitute items will have to be found.

5. A formal evaluation of achievement will be carried out in the first quarter of 1990.

Issues related to the safe use of milk products in feeding programmes in refugee settings

1. Introduction

Milk products, particularly dried skim milk (DSM), have become a commonly donated food item in relief operations. Because of documented evidence of the health risks associated with the indiscriminate distribution and use of milk products in feeding programmes in refugee settings, the United Nations High Commissioner for Refugees has introduced a policy regarding their use (see para 6.1. - 6.6. for specific guidelines).

2. Definition

For the purpose of this policy, the term "milk product" means any non-fresh milk product such as powdered, evaporated, condensed, or otherwise modified milk, including infant formula.

3. Nutritional value of milk

3.1. In general, milk is an excellent source of essential amino acids (proteins), calcium, vitamins B, and a number of trace elements. It is a limited source of iron—in fact, it inhibits the absorption of iron from other foods—and provides almost no vitamin C. Unless fortified, it is devoid of vitamin A when in skimmed form.

3.2. Breast-feeding is an unequalled way of providing complete hygienic food for the healthy growth and development of infants, and forms a unique biological and emotional basis for the health of both mother and child. In addition, the anti-infective properties of breast milk help to protect infants against disease, and there is an important relationship between breast-feeding and child spacing.

3.3. Breast milk alone satisfies the nutritional requirements of the normal infant for at least the first four months of life, and frequently up to six months. After this time, other foods become necessary to complement breast milk in order to meet the energy and other nutrient requirements of the infant. Ideally, as is still the case in many traditional cultures, breast-feeding will also continue well into the second year of life.

3.4. On a per kilogram basis, the energy and protein requirements of young children are considerably greater than those of the adult. There are also important qualitative differences in energy and nutrient requirements that are related either to the nutritional needs of children or to their particular physiological characteristics. Milk products such as DSM can help to meet these requirements if used safely. In feeding programmes in refugee settings, the safest use of dried milk products is as a mix with cereal flours.

3.5. Milk is rarely a part of the adult diet of refugee populations, except among pastoral nomads who depend on livestock to meet their nutritional needs. Dietary transition is a necessary adaptation process for such nomadic groups in refugee settings, and dried skim milk cannot be considered to be on a nutritional par with the fresh animal

milk that is a traditional component of this group's dietary intake.

4. Summary of the health hazards associated with the use of dry milk products in refugee settings

Problems with contamination

4.1. Water supplies are commonly inadequate, both qualitatively and quantitatively in refugee relief settings. Insufficient water means that containers and utensils used for mixing milk are often dirty, thus making secondary contamination highly probable. Milk powder that is reconstituted with contaminated water is an ideal medium for breeding harmful bacteria.

4.2. The immune system of a child below two years of age is not yet fully developed and consequently resists less well than the adult the effects of high bacterial food contamination. Acute diarrhoea and dehydration are the inevitable results of ingesting contaminated milk, and both of these conditions contribute to malnutrition.

Problems with reconstitution

4.3. Feeding children over-diluted milk powder as their main source of food will inevitably result in inadequate dietary intake and contribute to malnutrition. On the other hand, children who are fed under-diluted milk powder can become seriously ill due to dangerously high concentrations of sodium and protein; renal failure and death can result.

4.4. Different brands and types of milk powder carry different mixing instructions, which are rarely included on packaging in a language that is appropriate to refugee settings. Likewise, the possibility of proper instruction in, and monitoring of, reconstitution practices is extremely limited under these circumstances, especially during an emergency phase. Such activities only use up the valuable time of health workers who need to focus on more pressing health education issues.

Lactose intolerance

4.5. Until fully weaned, children secrete the digestive enzyme lactase, which is required to metabolize lactose in breast milk. Once breast-feeding is stopped, however, the enzyme ceases to be produced in many individuals in populations that are unaccustomed to drinking milk. If milk is given to persons who do not secrete lactase, diarrhoea can result.

Infant feeding

4.6. The hazards associated with using milk products for infant feeding are well documented. UNHCR supports the policy of the World Health Organization concerning safe and appropriate infant and young child feeding, in particular by protecting and promoting breast-feeding and encouraging the timely and correct use of complementary foods. The use of milk products in refugee settings must be in conformity with this policy.

4.7 It is reasonable to assume that the normal hazards associated with the use of breast-milk substitutes are considerably magnified in refugee settings. It is difficult to prevent the use of milk powder as a substitute for breast milk when it is distributed in a dry unmixed form as a part of general rations or in feeding programmes.

5. Studies of DSM use in refugee settings

5.1 Only two objective epidemiological studies have been undertaken to date regarding the effects of DSM use in refugee settings. The first, done by Bennet et al.[1] in 1961 in Uganda, found twice as much moderate malnutrition among two-year-old children where DSM was provided than in a similar camp where fresh cow's milk was available and no DSM distributed. Among three-year-olds, 10% were undernourished in the DSM-distribution camp compared with virtually no malnutrition found in this age group in the other.

5.2 A recent DSM Safety and Distribution Study in Pakistan[2] tested numerous samples of reconstituted milk and found that 75% had high aerobic plate-counts indicating dangerous levels of pathogenic bacteria. Secondary contamination from container handling was widely evident even after the water used in reconstitution had been boiled.

5.3 In addition, approximately 36% of respondents in this survey said they would use DSM for feeding breast-fed children, while some 60% said they would feed DSM to children under five years of age. Of the 114 respondents who were using DSM as a breast-milk substitute, 48% used a bottle and teat.

5.4 More substantive and illustrative data are required regarding the effects of the distribution of dried milk in both relief and development settings. All of the information that is available to date, however, clearly points to a need for systematic regulation and restriction of this commodity's distribution and use.

6. Guidelines for the safe use of milk products

6.1 Milk powder, both dried skim milk (DSM) and dried whole milk (DWM), may be used in reconstituted form only where it can be mixed carefully and hygienically in a supervised environment for on-the-spot consumption. On-the-spot feeding programmes should be conducted in enclosed areas where beneficiaries can be supervised and where the carrying away of reconstituted milk can be prevented.

6.2 In the above setting, DSM should always be mixed with oil in order to supply sufficient energy. Both DSM and DWM should be prepared with sugar to increase their energy content and improve palatability.

6.3. In most situations, DSM or DWM may be distributed in dry take-away form only if they have been previously mixed with cereal flours. Fortified bread, tortillas, porridge and the like made with milk are nutritionally valuable foods. Once milk powder has become part of a baked or fried food that remains dry, the risk of contamination on its account is negligible. The addition of milk powder in baked goods will also help to maintain their freshness. The possible misuse of milk powder for infant feeding is prevented if it is mixed with flour at a central point prior to its being distributed to beneficiaries.

6.4. The only possible exception to this will be distributions to groups who have traditionally used milk as a central component to their diet (e.g., nomadic populations). In such cases, proper usage must be monitored and if there is any indication of its use as a breast milk substitute (e.g., infant feeding bottles), distribution of milk powder should be discontinued.

1 Bennet, F.J., et al. *Refugees from Rwanda in Uganda* (1961).

2 *DSM Safety and Distribution Study, Pakistan.* World Food Programme, Pilgrim Associates (1987).

6.5. Infant-formula distribution should be discouraged in refugee relief settings, even in cases of difficult lactation. Relactation should be attempted by caring for and encouraging the biological mother. Failing this, wet-nursing should be considered as a first feeding alternative, and even supported with payment in kind if necessary.

6.6. When breast milk is not available, a suitable breast-milk substitute must be provided, together with clear instructions to those who need to use it, on proper hygienic mixing and use for feeding with a cup and a spoon. Infant-feeding bottles and teats should not be used under any circumstances. No infant formula should be given to children who are six months of age or older. Rather, instructions on appropriate weaning practices for this age group should be provided.

Policy of the UNHCR Related to the Acceptance, Distribution and Use of Milk Products[3] in Feeding Programmes in Refugee Settings

1. UNHCR will accept, supply and distribute donations of milk products only if they can be used under strict control and in hygienic conditions, e.g., in a supervised environment for on-the-spot consumption.
2. UNHCR will accept, supply and distribute milk products only when received in a dry form. UNHCR will not accept liquid or semi-liquid products, including evaporated or condensed milk.
3. UNHCR will accept, supply and distribute dried skim milk (DSM) only if it has been fortified with vitamin A.
4. UNHCR supports the principle that in general ration programmes, protein sources such as pulses, meat or fish are preferred to dried skim milk. UNHCR notes that DSM pre-mixed centrally with cereal flour and sugar is useful for feeding young children, especially if prepared with oil.
5. UNHCR will advocate the distribution of dried milk in a take-away form, only if it has been previously mixed with a suitable cereal flour, and only when culturally acceptable. The sole exception to this may be where milk forms an essential part of the traditional diet (e.g., for nomadic populations) and can be used safely.
6. UNHCR will support the policy of the World Health Organization concerning safe and appropriate infant and young child feeding, in particular by protecting, promoting and supporting breast-feeding and encouraging the timely and correct use of complementary foods in refugee settings.
7. UNHCR will discourage the distribution and use of breast-milk substitutes in refugee settings. When such substitutes are absolutely necessary, they will be provided together with clear instructions for safe mixing and for feeding with a cup and a spoon.
8. UNHCR will take all possible steps to actively discourage the distribution and use of infant-feeding bottles and artificial teats in refugee settings.
9. UNHCR will advocate that when donations of DSM are supplied to refugee programmes, the specific donors will be approached for cash contributions to be specially earmarked for operational costs of projects to ensure the safe use of this commodity.

[3] Any non-fresh milk product such as powdered, evaporated, condensed, or otherwise modified milk, including infant formula.

Annex G

Marketing of Infant Formula and Foods: Checklist

In selected stores, market places, and health facilities the consultant should ask key informants about what infant foods, breast milk substitutes, bottles and teats are marketed for infants – less than 4 months old, 5 to 7 months old, and 8 to 12 months old. (Attach all available ads, coupons, etc.)

A. Mass Media

1. Newspaper/Magazines

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

2. Posters/Flyers/Pamphlets

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

3. Radio

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

4. Television

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

5. Billboards

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

6. Other

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

B. Gifts

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

B. Gifts

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

C. Samples

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

D. Coupons

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

E. Tie-ins

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

F. Special Displays

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

G. Telephone

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

H. Other Information (i.e. mailings)

❑ general public ❑ preg.women mothers and families ❑ point of sale ❑ government hospitals, clinics ❑ private hospitals, clinics ❑ pharmacies ❑ other

This checklist is adapted from a Common Investigative Framework - CIF - developed by Labbok et al., WHO/Georgetown University, February 1991.

Annex H

KAP Survey of Health and Nutrition Staff: Checklist

Compile a KAP profile of staff at government and private facilities, facilities in major urban centers, and in more rural areas. Include training/teaching facilities. Make multiple copies of the checklist and use it to collect information.

1. What counselling is given to prepare pregnant women for infant feeding?
2. Women's preparation for breast or bottle feeding at delivery and postpartum. (Look at by delivery setting and attendant.)
3. Staff's attitude toward initiation of breastfeeding, including time of initiation, frequency and length of each feed, night feeds and exclusive versus partial breastfeeding.
4. Staff's attitude toward prelactal feeds.
5. Staff's attitude toward colostrum.
6. Staff's attitude toward breast milk substitutes immediately after delivery and late postpartum period (first week, first month...through 6 months.)
7. Staff's attitude toward other liquids (teas, water, juices) to supplement breast milk.
8. Staff's attitude toward the use of bottles.
9. Staff's attitude toward when and why other foods/liquids necessary.
10. Staff's attitude toward duration of breastfeeding.
11. Circumstances when staff believe women should not breastfeed (e.g., discouraged in specific social situations, when child or mother is ill, when breasts are engorged/hurt)
12. Appropriate breastfeeding behavior when baby is premature, LBW, sick with diarrhoea or has a cough/cold, and whether male or female.

Annex I

Training of Health Services Staff: Training Content Checklist

The consultant should use this checklist to assess the training content of government and private health care staff training. The curriculum of medical and paramedical staff working in the following programs should be included: newborn services and maternity care, pediatrics, family planning, nutrition, diarrheal disease control.

Infant feeding in the national context

1. ***Why is breastfeeding integral to child survival strategies?***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

2. ***Traditional patterns and current national trends in infant feeding***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

3. ***National food and health issues***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

4. ***National policies affecting infant feeding***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

5. ***Commercial practices in the country***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

6. ***Anatomy and physiology***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

7. ***Biochemistry and immunology***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

8. ***Antenatal preparation and giving birth***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

9. ***The first breastfeedings***

   ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

10. ***Nipple pain and position***

    ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

11. ***Breast problems and expression techniques***

    ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

12. ***Not enough milk and relactation***

    ❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

13. Sick and low birth weight babies

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

14. Special situations

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

15. The working mother

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

16. Maternal nutrition during lactation

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

17. Suckling problems and refusing the breast

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

18. Value of sustained breastfeeding during the second year

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

19. Growth of the baby and young child

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

20. Foods and feeding during the weaning interval

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

21. Breastfeeding and child spacing

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

22. Drugs and breastfeeding

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

23. Breastfeeding management during illness in mother or baby

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

Counselling

24. Observation of breastfeeds

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

25. Psychological factors in breastfeeding

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

26. Listening and learning from mothers—facts and feelings

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

27. Taking a history and making a diagnosis

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

28. Acceptance and support—building a mother's confidence

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

29. Running a mother support group

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

30. Communication skills

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

31. Choosing who needs to know what targets and messages

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

32. Leading group education: alternatives to the lecture method

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

33. Re-educating administrators and policy makers

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

34. Using mass media

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

35. The stages of change in ourselves and colleagues

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

36. Resource for continuing self-education

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

37. What is the International Code of Marketing?

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

38. Implementing the Code and closing loopholes

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

39. Code monitoring and health workers' responsibilities

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

40. Recommendations for a national plan

❑ Adequately Covered ❑ Not Adequately Covered ❑ Not Covered At All

This checklist is adapted from *"Lactation Management Topic Outlines"* by H. Armstrong, IBFAN. Kenya. 1990