Guiding Principles in Infant and Young Child Feeding - Part I

Chapter I-1 Breastfeeding and Infant Feeding Promotion for Achieving Sustainable Goals of Development

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“Economies are driven by the physical and mental health of individuals: Breastfeeding saves lives and promotes the health and well-being of mother and children”

CHAPTER OUTLINE

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Key Words: Infant feeding, indicators, protecting breastfeeding, sustainable development goals, health promotion, Islamic teachings

Global facts about infant feeding

- Globally in 2020, 149 million children under 5 were estimated to be stunted (too short for age), 45 million were estimated to be wasted (too thin for height), and 38.9 million were overweight or obese.
- About 44% of infants 0–6 months old are exclusively breastfed.
- Few children receive nutritionally adequate and safe complementary foods; in many countries less than a fourth of infants 6–23 months of age meet the criteria of dietary diversity and feeding frequency that are appropriate for their age.

Over 820,000 children’s lives could be saved every year among children under 5 years, if all children 0–23 months were optimally breastfed.

Breastfeeding improves IQ, school attendance, and is associated with higher income in adult life. (82, 95, 92)

Breastfeeding promotion and support is a mandate for achieving optimum health and well-being for children and future generations in many of the developed and developing countries.

Breastfeeding is a human right supported by the Convention of the human rights for protecting the child. (77) The International Code of Marketing of Breast-milk substitutes (ICMBMS) (48) protects breastfeeding by regulating the marketing tactics of companies that undermine women’s decision to breastfeed their children.

The Sustainable Development Goals (SDGs), also known as the Global Goals, include 17 goals that were adopted by the United Nations in 2015 as a universal call of action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity. Breastfeeding is one of the means and one of the most cost-effective and efficient interventions to achieve each and every goal of the 17 goals. (68) The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding was issued in August 1990 by 30 governments meeting in Florence, Italy. (92)

Introduction
Breastfeeding promotion and support is a mandate for achieving optimum health and well-being for children and future generations in many of the developed and developing countries. Countries around the world are struggling to meet the World Health Organization (WHO) recommendations for exclusive breastfeeding (EBF) during the first six months of life and continued breastfeeding for two years or more as recommended by the WHO and UNICEF, by implementation of interventions as the Baby-friendly Hospital Initiative (BFHI) at maternity level and the Integrated Management of Childhood Illness (IMCI) in the community.

In September 1990, the World Summit for Children endorsed the Innocenti Declaration and its operational targets became part of the Summits goals for the year 2000.

"Together, the Declaration and Plan of Action of the World Summit for Children and the Convention on the Rights of the Child constitute an ambitious but feasible agenda for the well-being of children to be achieved by the year 2000" (James Grant, ibid).

"The Innocenti Declaration sets four important operational targets

All Governments should have:

- appointed a national breastfeeding coordinator of appropriate authority, and established a multisector breastfeeding committee composed of representatives from relevant government departments, non-governmental organization, and health professional associations;
- ensured that every facility providing maternity services practices all the Ten Steps to Successful Breastfeeding; taken action to give effect to the principles and aim of all Articles of the International Code and subsequent relevant World Health Assembly Resolutions in their entirety;
- Enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement."

Much progress has been noted in improving infant feeding practices. Over 20,000 hospitals in 150 countries have become Baby-friendly and more than 60 countries have implemented the Code and Resolutions in legislation. Global breastfeeding rates had risen by at least 15%, but if the Innocenti goals were met in full one-fifth of all child deaths could be prevented - saving over 2 million children every year in addition to the 6 million deaths being prevented due to the protection afforded by breastfeeding. Practices in maternity facilities are core to improving breastfeeding rates, hence the Ten steps have been
revised to meet the challenges for protecting, promoting and supporting breastfeeding. \(^{(47)}\)

Breastfeeding protection, promotion and support are mandatory for preventing malnutrition and communicable diseases linked to malnutrition within the context of poverty and poor sanitation in developing countries and the COVID crises in developed and developing countries. Yet many challenges face breastfeeding promotion. Despite the Global efforts to promote breastfeeding and adequate complementary feeding, indicators for assessing breastfeeding and infant feeding status remain suboptimal. This has a negative influence on the health outcomes of children and mothers. In this coming section we review the status of breastfeeding practices through the universal indicators for breastfeeding and the support provided for breastfeeding in the countries of the EMR.

**I.1.1 Indicators for Assessing Breastfeeding and Infant Feeding**

EBF from birth to six months and continued breastfeeding (CBF) for two years are the two main indicators used to assess breastfeeding status at community level. \(^{(91, 92)}\)

The Baby-friendly Hospital Initiative (BFHI), which is a universal program developed by UNICEF and WHO to promote breastfeeding during pregnancy and at birth. The indicators of BFHI are based on “Ten steps” to successful breastfeeding initiation. Early initiation of breastfeeding (EIBF) is the most universally used indicator, since it is an indicator that influences child survival. \(^{(86, 101)}\)

The BFHI updated global criteria in 2009 \(^{(93)}\) were revised in 2018 and the BFHI indicators are currently based on the Revised Ten steps in 2018 and a guideline for national implementation for breastfeeding protection, promotion and support in health facilities providing maternity services. \(^{(93, 94, 102)}\)
The EBF and CBF indicators together with a set of BFHI monitoring tools are used to assess the state and effectiveness of implementation of the Ten steps of the BFHI are listed in Table (I.1.1). Indicators for assessing status and progress in breastfeeding promotion in countries are based on the WHO indicators for assessing infant and Young Child Feeding. (101)

**Table (I.1.1) Definitions of breastfeeding used in research for assessing the situation of breastfeeding at national level**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breastfeeding (EBF)</td>
<td>The infant has received only breastmilk from his/her mother or a wet nurse, or expressed breastmilk, and no other liquids or solids, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.</td>
</tr>
<tr>
<td>Early initiation of breastfeeding (EIBF)</td>
<td>Initiation of breastfeeding with the first hour after birth through immediate skin-to-skin contact between the mother and baby.</td>
</tr>
<tr>
<td>Predominant breastfeeding (PBF)</td>
<td>PBF is defined as intake of breastmilk with water based drinks (plain water, juice drinks, sugar water, and ritual fluids (in limited quantities) in the first six months of life (0-5 months of age). With the exception of fruit juice and sugar-water, no food-based fluid is allowed under this definition.</td>
</tr>
<tr>
<td>Full breastfeeding</td>
<td>This includes both exclusive breastfeeding and predominant breastfeeding.</td>
</tr>
<tr>
<td>Partial breastfeeding</td>
<td>Partial breastfeeding refers to a situation where the baby is receiving some breastfeeds but is also being given other food or food-based fluids, such as formula milk or weaning foods.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>The child is receiving breastmilk, either directly from the breast or expressed. This definition may include exclusive, predominant and partial breastfeeding.</td>
</tr>
<tr>
<td>Continued breastfeeding (CBF)</td>
<td>CBF at one year is the proportion of children 12-15 months of age who are fed breast milk. Continued breastfeeding at 2 years is the percentage of children fed breastmilk at 20-23 months of age.</td>
</tr>
<tr>
<td>Bottle-feeding</td>
<td>The child has received liquid or semi-solid food from a bottle with a nipple/teat. This term applies irrespective of the nature of the liquid or semi-liquid.</td>
</tr>
</tbody>
</table>
### Rooming in
Mothers and their newborn babies stay together in one room or one bed for 24 hours with separation not exceeding 1-2 hours for medical procedures.

### Artificial feeding
The baby who is artificially fed receives no breastmilk at all.

### Supplementary feeding
Supplementary feeds are feeds given to a baby under 6 months old to supplement his intake of breastmilk, where this is insufficient.

### Complementary feeding
Complementary feeding means the introduction of other foods and drinks after six months of age. These foods are in addition to an adequate intake of breastmilk.

### Introduction to solid, semi–solid or soft foods (ISSS) (6–8 mos.)
Percentage of children receiving solid, semi-solid or soft foods at ages 6 to 8 months.

### Minimal meal frequency (MMF)
MMF is the percent Breastfed and non-breastfed children 6–23 months of age who received solid, semi-solid and soft foods the minimum number of times or more (by age) during the previous day out of the total breastfed and non-breastfed children 6–23 months of age.

### Minimum dietary diversity (MDD)
MDD is defined as the percent children 6–23 months of age (breastfed and non-breastfed) who received foods from ≥ 4 food groups during the previous day out of the total children 6-23 months of age.

### Minimum acceptable diet (MAD)
MAD is the proportion of breastfed and non-breastfed children 6-23 months of age who had at least the minimum dietary diversity and the minimum meal frequency during the previous day out of the total breastfed and non-breastfed children 6-23 months of age.

## I.1.2. Global and Regional Status of Breastfeeding Protection
The Code of Marketing of Breastmilk Substitutes is a World Health Assembly (WHA) resolution that is intended to protect breastfeeding mothers and children from commercial activities of advertisement and marketing of the so-called “substitutes (foods, drinks or bottles or nipples) which can replace or interfere with breastfeeding.
All countries are requested to draft their own laws that cover all the articles of the Code and the subsequent resolution since 1981 which were released by the WHA in relation to protection of breastfeeding. (45)

The IBFAN (International Baby Food Action) is an international consumer protection network monitors the implementation of the national laws. IBFAN with other international organizations have issued a recent report on the status of the national implementation of the Code. (55) The findings from the global report showed that as of April 2020, 136 (70%) of 194 WHO Member States (“countries”) had enacted legal measures with provisions to implement the Code. Of these, 25 countries had measures substantially aligned with the Code; a further 42 had measures which are moderately aligned; 69 had only included some provisions and 58 had no legal measures at all. (62)

Box (I.1.1) illustrates the articles and items covered under each article for which the total scores that were used to measure the extent to which the national laws covered the articles under the Code in their entirety. The extent to which a country abides to the Code is given a score for each of the articles under the Code. This assists in quantitatively assessing the the extent to which national laws abide to the WHO Code.

Figure (I.1.1) Status of national measures on the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions, by country and by region*, 2016

<table>
<thead>
<tr>
<th>Article</th>
<th>Score (points)</th>
<th>Items measured under the article</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Scope:</td>
<td>20</td>
<td>Any milk or foods intended for feeding infants and children below 36 months of age.</td>
</tr>
<tr>
<td>Monitoring and enforcement</td>
<td>10</td>
<td>Identifies who is responsible for monitoring compliance, defines sanctions for violations, and requires that monitoring and enforcement should be independent, transparent and free from commercial influence.</td>
</tr>
<tr>
<td>Informational/ educational materials</td>
<td>10</td>
<td>Includes information in these material including the benefits and superiority of breastfeeding, maternal nutrition and preparation and maintenance of breastfeeding, the negative effect of these products (under the scope i.e. partial breastfeeding) on breastfeeding the difficulty to reverse the decision not to breastfeed, proper use of formula and for materials on infant milk formula their social and financial implications, their health hazards of inappropriate use and feeding, risk of contamination by lethal bacteria.</td>
</tr>
<tr>
<td>Promotion to the general public</td>
<td></td>
<td>Includes advertisement, promotional devices, and samples to the public, gifts to pregnant women and mothers, and contact with mothers.</td>
</tr>
<tr>
<td>Promotion in health care facilities</td>
<td>10</td>
<td>This type of prohibition explicitly includes display of products under scope, display of placards or posters concerning these products, distribution of any material provided by a manufacturer or distributor, use of health facility to host events, contests, or campaigns and use of personnel provided by or paid by manufacturers and distrubuters.</td>
</tr>
</tbody>
</table>
| Engagement with health workers and systems | 15 | - Overall prohibition of all gifts or incentives to health workers and health systems. If no overall prohibition (total three points), one point is given for each of the following specific types of gifts or incentives that are prohibited:  
  - Financial or material inducements to promote products within the scope  
  - Fellowships, study tours, research grants, attendance at professional.  
  - Conferences (where these are not prohibited but they must be disclosed to the institution, half credit is awarded, i.e. half point).  
  - Provision of free or low-cost supplies in any part of the health care system  
  - Donations of equipment or services (where donations are prohibited only if they refer to a proprietary product, half credit is awarded, i.e. one point).  
  - Product samples and product information restricted to scientific and factual matters. |
Labelling

Prohibition of nutrition and health claims
Required information on infant formula products—one-half point for each of the following six elements:
- The words “Important Notice”
- A statement on superiority of breastfeeding
- A statement on using only on the advice of a health worker
- Instructions for appropriate preparation
- Warning on health hazards of inappropriate preparation
- Warning that powdered formula may contain pathogens
- Prohibition of pictures that may idealize the use of infant formula on label of infant formula products

Required information for follow-up formula products—one-third point for each of the following three elements: (i) the recommended age for introduction of the product; (ii) the importance of continued breastfeeding for 2 years; (iii) the importance of no complementary feeding before 6 months.

Prohibited content for follow-up formula products (one point for each of the following four elements):
- Any representation suggesting use before 6 months.
- Images or text that discourages breastfeeding or compares to breastmilk.
- Messages that recommend or promote bottle-feeding.
- Professional endorsements.

Countries are classified by the World Health Organization (WHO) classification into six regions. They include the African region (AFR), the American region (AMR), The Eastern Mediterranean Region (EMR), The European Region (EUR), The South East Asia Region (SEAR) and the West Pacific Region (WPR). A study that analyzed the global data for identifying relationship between the status of EBF and the scores assigned to the articles of the Code (as shown above) with other health and nutritional indices was done for countries from different regions around the globe. Countries are listed in alphabetical order by region are shown in Box (I.1.2).

The continuity of EBF for six months was found to be highest in EMR (44.7%) and lowest in WPR (29.8%). The mean scores for the national laws that cover the Code were highest in the SEAR countries (68.7%) and lowest in EUR countries (43.3%) as shown in figure (I.1).
There was an evident relationship between percent EBF and score given to the national laws that cover the code with raised blood sugar (RBS) in these countries, overweight (Ovwt), obesity (Ob) and death from noncommunicable diseases (DNCD) in the countries examined on regional basis. The research found that there was a significant correlation between EBF with RBS, Ovwt, Ob and DNCD. Also they found significant associations between mean scores for national laws and RBS, Ovwt, Ob and DNCD. When analyzed by article it was shown that monitoring and enforcement, promotion to health workers and in health facilities were most significantly negatively correlated with RBS and DNCD i.e. the stronger the legislation and the higher the EBF were associated with lower the prevalence of RBS, Ovwt, Ob and DNCD.
I.3.1 Global and Regional Status of Early Initiation of Breastfeeding

According to UNICEF global data (2016) the progress in early initiation rates of breastfeeding within the first hour of birth (EIBF) has been slow over the past 15 years, with global rates increasing by just 14 percentage points overall. EIBF can reduce neonatal mortality by 22% (Edmonds, 2006). The trend is similar in Eastern and Southern Africa and Central and Eastern Europe and the commonwealth of Independent States (CEE/CIS), which have each experienced moderate increases of about 10 percentage points since 2000. The situations in East Asia and the Pacific and West and Central Africa show no improvement at all in the past 15 years. Nevertheless, trends is South Asia, have nearly tripled from 16 per cent in 2000 to 45 per cent in 2015. This progress is encouraging; But EIBF is still below 50 per cent in the region, leaving 21 million newborns waiting too long for the health benefits and comfort provided by breastfeeding. (See figure I.1.3)
Figure (I.1.3) Percent of newborns put the breast within one hour of birth by country and region, 2016.
Source: UNICEF global databases, 2016, based on MICS, DHS and other nationally representative sources, 2010-2016 (* denotes countries with older data between 2005-2009; data from these countries are not included in the regional aggregates except for China (2008) which is used for the East Asia and the Pacific and World averages). Countries shaded in dark grey have estimates from 2004 or earlier and are thus represented as having “no current data”; these countries are not included in the regional aggregates. *CEE/CIS does not include Russian Federation. Note: These maps are stylized and not to scale and do not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Sudan and South Sudan has not yet been determined. The final status of the Abyei area has not yet been determined.

EIBF can contribute to the reduction of neonatal mortality in order to support the achievement of the 2030 the Sustainable Development Goal (SDG) target to end preventable child deaths, and reduce neonatal mortality to at least as low as 12 per 1,000 live births.

I.1.3.2 Global and Regional Status of Exclusive Breastfeeding at Birth and 6 months
It is common in many parts of the world to give newborns foods or liquids other than breastmilk in the first few days of life. This is linked to traditions, cultural norms, family practices, and health system policies and procedures – many of which are not grounded in evidence. Milk formula, as well as other liquids or foods, can permanently alter the profile of good bacteria in the child’s gut. They deprive baby of the
immune rich colostrum and the increased risk of contamination leads to life threatening infections early in life.

In three regions, more than half of breastfed newborns receive liquids or foods other than breastmilk in the first three days of life.

![Graph showing percent of breastfed newborns receiving different types of liquids in the first three days of life by region, 2015.](image)

**Figure (I.1.4) Percent of breastfed newborns receiving breastmilk only, non-breastmilk based liquid foods, and milk-based liquids in the first three days of life by region, 2015.**

*Source: UNICEF global databases, 2016, based on MICS, DHS and other nationally representative sources.*

*Notes: Analysis is based on a subset of 72 countries with available data for feeding type in the first three days between 2010–2014 covering 47 per cent of the global population. Regional estimates are presented only where adequate population coverage (>50 per cent) is met. *Data represent newborns who were ever breastfed. No data on liquids consumed in the first three days of life were available for infants who were never breastfed. **Children in this category may also have been fed non-milk-based liquids. ***To meet adequate population coverage in each region, CEE/CIS does not include Russian Federation, Latin America and the Caribbean does not include Brazil, South Asia does not include India and East Asia and the Pacific does not include China. The “Total” is not labeled as a global figure as data were available for <50% of the global population. ****Other refers to mainly high-income countries not included within UNICEF program regions.*

Nearly two out of five breastfed newborns receive foods or liquids other than breastmilk in the earliest days of life, when their bodies are most vulnerable. Less than half of breastfed newborns in East Asia and the Pacific, the Middle East and North Africa and South Asia receive only breastmilk in the first three days of life. In East Asia and the Pacific, 42 per cent of newborns are given a milk-based liquid – such as infant formula or animal milk. Feeding newborns infant formula in the first three days of life is also common in Latin America and the Caribbean and CEE/CIS. In the Middle East and North Africa, 40 per cent of newborns receive non-milk-based liquids – such as plain water, sugar water or tea. In South Asia, both milk- and non-milk-based foods and liquids are commonly fed to newborns shortly after birth. The most common liquid given in the first three days after birth in West and Central Africa is plain water.
water, which can harbour pathogens and other substances that are life-threatening for newborns.

**Globally, just over two out of five infants are exclusively breastfed**

EBF for the first six months of life is the safest and healthiest option for children everywhere. It has great potential to save lives. In low- and middle-income countries, infants who received mixed feeding (foods and liquids in addition to breastmilk before 6 months) were up to 2.8 times more likely to die than those who were exclusively breastfed.1 The risk of dying was highest among those not breastfed at all; these infants had a 14-fold higher risk of mortality when compared with their exclusively breastfed peers.

Globally, just over 40 per cent – or two out of five – of the world’s infants under 6 months of age are EBF. The highest EBF rates are found in South Asia, where almost 60 per cent of infants under 6 months of age receive only breastmilk, followed by Eastern and Southern Africa, where 57 per cent of infants under 6 months of age benefit from this practice as shown in figure (I.1.5a).

Trends in EBF have shown increase in EBF by 10% over the past decade and a half from 2000 to 2015 as shown in figure (I.1.5b). Most of the regions showed some improvement the highest was in South Asia and South East Asia.
I.I.1.3.3 Global and Regional Status of Continued Breastfeeding

Continued breastfeeding (CBF) rates reflect frequent on-demand feeding for up to 12 months with introduction of foods after 6 months of age. Globally this indicator drops from 74 per cent at 1 year (for 12–15 month-olds), to 46 per cent at 2 years (for 20–23 montholds).

At all age intervals, rates of CBF are highest in Eastern and Southern Africa, West and Central Africa, and South Asia. The highest rates of CBF at 2 years are in South Asia, where nearly 70 per cent of these children are still breastfed. In East Asia and the Pacific, CEE/CIS and Latin America and the Caribbean, only half of all children are still breastfed at 1 year, and CBF rates drop to less than 30 per cent in all of these regions at 2 years.

Across all income levels, CBF is consistently associated with higher performance in intelligence tests among children and adolescents. This cognitive boost translates into improved educational attainment, increased long-term earnings and better productivity – with those children breastfed longer than 12 months benefiting most from these gains 5. In high-income countries, longer periods of breastfeeding may reduce a child’s risk of overweight and obesity.
Continued breastfeeding is also important for mothers; for every 12 months of breastfeeding in their lifetime, there is a 6 per cent reduction in the risk of breast cancer. Research also suggests that continued breastfeeding could improve birth spacing and potentially protect against ovarian cancer and type 2 diabetes.

Breastfeeding has great potential to reduce inequities. The impacts of continued breastfeeding on disease prevention, IQ, educational attainment and future earning potential can help bring even the poorest children closer to the same starting line as their wealthier peers.

The lower cognitive ability associated with not breastfeeding has economic costs. Globally, these losses are estimated at about $300 billion annually. High-income countries lose more than $230 billion annually due to low rates of breastfeeding, while low- and middle-income countries lose more than $70 billion annually.

Progress in CBF at 2 years is absent and has remained relatively unchanged since 2000. The only region to see an increase in continued breastfeeding over the 15-year period was CEE/CIS; and even with these gains only a third of children aged 20–23 months are currently breastfed.

Figure (I.1.6) Trends in per cent of children aged 20-23 months who are breastfed, by region, around 2000 and around 2015.
Source: UNICEF global databases, 2016, based on MICS, DHS and other nationally representative sources.
Notes: Analysis is based on a subset of 79 countries with comparable trend data covering 70 per cent of the global population (excluding China and Russian Federation) for around 2000 (1997-2003); and 71 per cent of the global population for around 2015 (2010-2016). Rates for 2015 may differ from current rates presented elsewhere as trends are based on a subset of countries with baseline data. Regional estimates are presented only where adequate population coverage (50 per cent) is met. * To meet adequate population coverage, East Asia and the Pacific does not include China and CEE/CIS does not include Russian Federation. **Other refers to mainly high income countries not included within UNICEF program regions.

I.I.4 Global and Regional Status of Complementary Feeding

Complementary feeding involves a complex set of behaviors: timely introduction of solid, semi-solid and soft foods; providing diverse food choices; feeding frequently; being responsive to children’s cues and preparing foods safely. Caregivers around the world face multiple barriers in feeding their children, such as limited access to adequate nutritious foods, economic constraints, family pressures, work demands and cultural norms and practices. To improve complementary feeding we need to do more than just provide children with enough food to eat; we need guarantees that nutritious complementary foods are available, affordable, safe and provided with care.

I.I.4.1 Introduction of Solids, Semi-Solids of Soft Foods (6-8 months)

In low- and middle-income countries, a substantial amount of growth faltering occurs between 6 and 23 months of age, and the evidence is clear that an inadequate diet during this period increases the risk of stunting and micronutrient deficiencies.

It is therefore critical that infants are introduced to their first foods on time, at 6 months of age. Introducing foods too late deprives children of the vital nutrients their bodies demand and leaves them vulnerable to malnutrition.

One out of every three infants is waiting too long for his or her first foods
Globally, more than one quarter of infants between 4 and 5 months of age are already consuming solid foods. Across all regions, a concerning number of infants are also already consuming solid foods between 0 and 3 months of age.

While approximately 80 per cent of all infants in Latin America and the Caribbean and East Asia and the Pacific are eating foods at 6 to 7 months, far too many are introduced to their first foods before 6 months of age.

Globally, one out of every four infants aged 8–9 months and nearly one in every five of those aged 10–11 months are still not receiving any solid foods. It is worrying that even at this late stage, far too many children have not yet been introduced to their first solid foods, jeopardizing their development and putting them at risk for undernutrition.

Trend data on the consumption of solid foods among infants 6-8-months old shows that the proportion of infants in this age group eating solid foods has improved in most regions since 2000. In Eastern and Southern Africa and CEE/CIS, the proportion of infants consuming solid foods at the recommended time has improved by roughly 20 percentage points in the past 15 years.
### I.1.4.2 Minimum Meal Frequency (6-23 months)

Minimum meal frequency as defined by WHO, breastfed children aged 6-8 months need to eat at least two meals or snacks a day, and those 9-23 months of age need to eat at least three meals or snacks a day. Non-breastfed children need to eat more frequently: at least four times a day from 6 months of age.

<table>
<thead>
<tr>
<th>MINIMUM MEAL FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only half of children 6 to 23 months of age are fed the minimum number of meals a day for their age.</td>
</tr>
</tbody>
</table>

Globally, even in the richest households, far too few receive a minimum meal frequency. Gaps exist between richest and poorest. In the poorest households in Eastern and Southern Africa, only a third of children are receiving the minimum number of meals. However, even in the richest households, in all regions, far too many infants and young children are not being fed even the minimum number of meals/snacks.

In one study from India, the odds of stunting were >60% higher in children 6-23 months old who were not fed the minimum number of times per day.

Global reports show that only one-half of all children aged 6-23 months are not being fed the minimum number of times a day during this critical period for growth and development. The three regions where stunting rates are highest, namely South Asia, West and Central Africa and Eastern and Southern Africa, have the lowest rates of all. While rates in Latin America and the Caribbean and East Asia and the Pacific are encouraging, approximately a quarter of infants and young children in these regions are not getting even the minimum number of meals or snacks their growing bodies need as shown in figure (I.1.8).
I.1.4.3 Minimum Diet Diversity (6-23 months)

To provide just the minimum level of diversity, as defined by WHO, children aged 6–23 months should eat food from at least four of the following food groups a day: grains, roots and tubers; legumes and nuts; dairy products; meats and fish; eggs; vitamin-A rich fruits and vegetables; and other fruits and vegetables.

Globally, less than one third of the world’s infants and young children are fed at least four food groups, leaving nearly 70 per cent at risk of undernutrition including micronutrient deficiencies.

Figure (I.1.8) Percent (unweighted) of children aged 6-23 months with minimum meal frequency, by country and region. Source: UNICEF global databases, 2016, based on MICS, DHS and other nationally representative sources, 2010-2016.

Only one in four infants and young children is eating food from the minimum number of food groups
The gap between the richest and poorest children for diet diversity is striking

Globally, less than one third of the world’s infants and young children are fed at least four food groups, leaving nearly 70 per cent at risk of undernutrition including micronutrient deficiencies.

In South Asia, West and Central Africa and Eastern and Southern Africa, the situation is dire: only one in five children aged 6–23 months is eating a minimally diverse diet. Of the regions with data, Latin American and the Caribbean and East Asia and the Pacific have the best rates of dietary diversity, with 72 per cent and 60 per cent of children between 6 months and 23 months of age receiving a minimally diverse diet, respectively.

Figure (I.1.9) illustrates that children from the poorest households suffer the worst rates of dietary diversity in all regions. In West and Central Africa, Eastern and Southern Africa and South Asia, only around one in six children in the poorest households is eating a minimally diverse diet. Even in the richest households, far too many infants and young children are not being fed a minimally diverse diet in any region.
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Figure (I.1.10) Percent (unweighted) of children aged 6-23 months with minimum diet diversity, by country and region
Note: Regional estimates are presented only where adequate population coverage (≥ 50 per cent) is met. *To meet adequate population coverage, East Asia and the Pacific does not include China. These maps are stylized and not to scale and do not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Sudan and South Sudan has not yet been determined. The final status of the Abyei area has not yet been determined.

I.1.3.4 Global and Regional Status of Minimum Acceptable Diet (6-23 months)

Minimum acceptable diet (MAD) is a composite indicator for feeding practices among 6-23-month-olds of minimum meal frequency and minimum diet diversity as defined by WHO. Evidence has shown that children eating a MAD have a significantly lower risk of both stunting and underweight.

Children’s meals need to be prepared safely and hygienically, and they need to be provided by responsive caregivers who interact with the children, encourage them to eat, and respond to their appetite and hunger cues. However, there are no current methods for measuring these complex components of feeding practices at the population level.

There are far too many children being deprived of a healthy diet around the world: only one in every six children is receiving a minimum acceptable diet. The situation is dire in West and Central Africa, Eastern and Southern Africa and South Asia, where
only around 10 per cent of children 6-23 months of age are fed a minimally acceptable diet. Rates are much higher in East Asia and the Pacific, with 41 per cent of infants and young children meeting the criteria.

Figure (I.1.11) Percent (unweighted) of children aged 6-23 months with minimum acceptable diet, by country and region.

Figure (I.1.12) Global status of infant and young child feeding indicators (Source UNICEF global databases, 2016, based on MICS, DHS and other nationally representative sources, 2010-2016). (UNICEF, 2016).
I.1.5 Status of Breastfeeding Promotion in the Eastern Mediterranean Region by Country

In this context we examine and compare the status of breastfeeding indicators in the countries of one the region of the Eastern Mediterranean (EMR) which includes 22 countries which mostly share the similar culture and language. In this region the prevalence of overweight and obesity are high in the middle and high income countries while prevalence of undernutrition and stunting are high in the low income countries in this region. Obesity is a known risk factor for high blood pressure (HBP) and cardiovascular disease (CVD). Obesity is on the rise and is a significant public health problem in the EMR, where one half of the countries have the highest rates of obesity in the world. (82) Breastfeeding is protective against later obesity. (53) Also EBF was found to be associated with lower adiposity and serum total cholesterol in children at 4 years of age. Likewise continued breastfeeding (CBF) for over 12 months was associated with lower adiposity. These data support the importance of EBF and CBF for later cardiometabolic health. (95) Breastfeeding, especially for longer duration is associated with higher intelligence and higher income status in later life. (96)

Death from CVD as HBP and coronary heart disease (CHD) is high globally and in the region and is linked to obesity. A study that compared EBF in the countries with high risk of death from CVD in 9 countries (Afghanistan, Egypt, Iraq, Iran, Morocco, Pakistan, Somalia, Sudan, Yemen) with 13 countries with low risk of death from CVD (Bahrain, Djibouti, Jordan, Lebanon, Libya, Kuwait, Qatar, Oman, Palestine, Saudi Arabia, Syria, Tunisia, United Arab Emirates, UAE) showed that there was a significant difference in the EBF rates, with higher risk in countries with low EBF. (4)

Global studies have demonstrated that longer breastfeeding duration was associated with a lower risk of CVDs, especially hypertension. (45, 56, 73) A study of a cohort of 0.5 million Chinese women showed that breastfeeding for 24 months or more was associated with lower risk of CHD by 18% and risk of stroke by 17% and that increasing the duration of breastfeeding for 6 months or more reduced risk for CHD and stroke even further. (85)
Another study in the EMR examined the relationship between early feeding practices, nutritional status and their association with RBS and neonatal mortality rate (NMR) and maternal mortality rate (MMR). They illustrated that RBS correlated significantly with obesity and overweight in adults (r=0.8, p=0.0001) and with NMR (r=0.6), p=0.002, MMR (r=0.7), p=0.0001. RBS was also associated with stunting in children under five years of age (CU5) (r=0.5, p=0.02) and prevalence of anemia in CU5 (r=0.4), p=0.05. Other interesting findings of the study were that RBS also correlated with total fertility rate TFR (r=0.6), p=P<0.001 and the Sustainable Development Goal Index at P<0.001. (39) Such findings put together indicate that promoting EBF and protecting breastfeeding through national laws that cover the Code in their entirety, could have a bearing on reduction of death from NCD, improving nutritional status of children and adults and reducing mortality rates in children and mothers. (1)

Hence the status of EBF and increasing the duration of breastfeeding through continued breastfeeding after introduction of foods at six months, for two years or more can substantially reduce the risk of death from CVD and other NCD, nutritional disorders and overall survival.

A diagrammatic comparison is made to illustrate differences between the 22 countries in relation to infant feeding practices (Figures I.1.13 to I.1.20). Countries show some progress in the EBF over the years, but CBF is decreasing and complementary feeding practices are border line or low especially in the low income countries (LIC). Some other aspects of breastfeeding protection related to maternity protection for supporting the working breastfeeding women are included in the discussion for each country.

**Afghanistan:** Afghanistan is classified by the World Bank as a LIC. EBF has increased from 43.3% to 58% in 2018. EBF increased by increasing wealth index. PBF was 69.2% and CBF for one year was 87.8% and for two years 69.2%. EIBF is 53.6%. Prelacteals are offered to one third (29.8%) of the newborns. ISSS at 6-8 months increased to 61% in 2015. Also MMF and MDD are 50.9% and 22.1% respectively, this explains the high rates of stunting (40.9%) and wasting (9.5%) despite the high CBF rates. (7, 8, 9)

**Bahrain:** Bahrain is a high income country (HIC). It has a problem of adult obesity which is 30% and one in every five youth is obese. EBF is 34% since
1995, no new data is available. EIBF is 39.3% Feeding prelacteals is common practice at 39.1%. CBF is reported to be 41% at one year. There are 6 Baby-friendly hospitals. 30.4% of children receive foods before 17 weeks of age, but by 27 weeks all babies have been introduced foods. Maternity leave is 45 days, fully paid by employer. Women in Bahrain have a strong status and are highly educated. (3)

Egypt: Egypt is a middle income country (MIC). EBF was 39.5% in 2014. No demographic survey has been done since then. Local surveys show that EBF has decreased particularly in urban populations. EIBF in Upper Egypt is 37.5% with high intake of prelacteals 69%. CBF to two years is 22%. MAD is 23.3%. It is highest in families from lowest and highest wealth quintiles and lowest in the middle class. Maternity leave has increased from 3 to 4 months as fully paid leave, but restricted for the first three children. (2)

Iran: It is a MIC. EBF is 53.1% in 2016 and CBF at one year is 84.2% and at 2 years is 51%. These rates have remained unchanged over the past two decades. EIBF is 68.7% while 466 out of a total 566 hospitals were accredited as Baby-friendly hospitals. The low EIBF rates are mainly due to lack of control over the private sector. ISSS at 6-8 months is 75.9%. Maternity leave has increased to 24 weeks (6 months), paid leave. (10, 65, 66, 77)

Iraq: Iraq is a MIC. EBF has decreased to 19.4% in but increased to 26% in 2018. EIBF was 42.8% and was higher in illiterate mothers (48%). There are Baby-friendly hospitals but progress is slow. CBF to two years is less than 5%. ISSS at 6-8 months is 85.1%. MMF was 76% and MDD was 45% resulting in a MAD of 34%. Trends in malnutrition are decreasing but stunting is 22.6%. Maternity leave is 14 weeks and is fully paid. (49, 76)

Jordan has recently been upgraded by the World Bank from an Upper Middle income country to an UIC. EBF has increased from 22.7% in 2012/13 to 25% in 2018. EIBF in 2012 was 18.6%. CBF into the second year does not exceed one third of the population. ISSS is 85.6% and MAD is 33.3% mainly due to low MDD which has shown a recent decline by almost one half between 2007 and 2012 from 67.2% to 38.8%. Stunting has decreased steeply to 7.8%. Maternity leave is fully paid for 10 weeks. (50, 51)
Kuwait: Kuwait is a HIC. Adult obesity is a public health problem being the highest in the region 38% and 8.7% and 6% in the under-fives in 2014 and 2015 surveys. EBF has increased from 2% in 2010 to 12% in 2015. EIBF is 10.5% and 55% are discharged from hospital on partial breastfeeding. CBF is reported as 21% at one year. Adnan hospital is the first and only designated Baby-friendly hospital in Kuwait. ISSS at 6-8 months is 65%. Maternity leave is 70 days, fully paid by employer in the public sector and 40 days in the private sector. (30, 31)

Lebanon: Lebanon is a MIC. EBF rate was 15% in 2009. EIBF is 41%. CBF for 12 months was 39%. BFHI ever designated hospitals are 18% and 10% in the past 10 years. Mothers, especially in urban areas, who were not breastfeeding, tend to introduce foods earlier than 4 months in Lebanon. Intake of meats is low, but fruits and cereals are high. Women are entitled to 10 weeks fully paid maternity leave. (41, 84)

Libya: Libya is a MIC. Recent studies for infant feeding are scarce. EBF for the first 4-6 months is 25.2%. EIBF in the first half an hour after birth is 44.3%. CBF for 12 months is 39%. There are no reported Baby-friendly hospitals. Women are entitled to 14 paid maternity leave. (2)

Morocco: Morocco is a MIC. EBF was 28% in 2010 and 31% in 2003/4. Bottle feeding rate was 46.2% in 2003/4. CBF for one year was 67% and has decreased to 25% in 2011. EIBF in 2011 was 26.8%. Thirty five hospitals were designated as Baby-friendly in 2007 but decreased to only five in 2016. ISSS is 90%. Maternity leave is fully paid and offered for 14 weeks. (2, 39, 40)

Oman: Oman is a HIC. EBF is 32.8%. EIBF is 71.1%. CBF for two years (20-23 months) is 48.5%. All hospitals and health centers in Oman were certified as Baby-friendly in 1999. Timely complementary feeding is 89.5%. Maternity leave is 14 weeks, fully paid by employer. (3, 11)

Pakistan: It is a LIC. Indices for breastfeeding have increased from 2011 to 2018. EBF is currently 48.8% and EIBF is 45.8%. CBF for one year is 68.4% and for two years is 56.5%. TISSS is 35.9%. Between 2011 NS 2018 indices of MDD has increased from 3% to 14.2%, MMF has decreased from 56% to 18.2% and MAD from 7 to 3.6%. One third of infants are offered bottle feeds, higher education and marketing are predisposing factors. In a country with the highest population in the region there are only 75 BFH of which 52 are present in Sindh.
which is the third largest province in Pakistan but ranks second by GDP second to Punjab. In Pakistan 40.2% of children aged under-five are stunted and 28.6% suffer from anemia. Maternity leave is 12 weeks fully paid leave in the public sector, with six weeks of compulsory maternity leave in all workplaces. This leave is offered to mothers and not to breastfeeding babies. Complementary feeding in Pakistan is poor and can explain the high rates of stunting and wasting despite a breastfeeding mean duration of 17 months. ISSS is 66.9%. MAD is low at 14.8% mostly due to the very low MDD (17.8%) compared to the MMF (62.7%). These are lower in rural, illiterate and poor populations. Disparities between provinces can be used as models for success stories in IYCF practices. (68, 69, 70)

Qatar: Qatar is a HIC. EBF is 29.3% and PBF is 38.1%. EIBF is 33.5%. CBF at 12-15 months is 65.0% and 31.9% at 20-23 months of age. Maternity leave is 40-60 days, fully paid by employer. (3)

Saudi Arabia: In Saudi Arabia EBF is 68.7%. EIBF is 23.2%. CBF is reported at one year is 1.8%. Formula feeding was introduced very early in life and was the cause for the steep decline in breastfeeding. Complementary foods were introduced to infants at 6 months by 81.5% of mothers. Maternity leave is 10 weeks paid in full or 50% depending on the employer. (12, 13, 14)

Somalia: Three in ten mothers in Somalia EBF. EIBF varies from 23.4% in 2009 to 80% in 2016. There are no Baby-friendly hospitals in Somalia. Adequate complementary feeding is very low (9%) challenged by the low MDD (15%). Consumption of iron rich foods is particularly low in Somaliland (22%) compared to central and south Somalia (60%). Maternity leave is 50% paid and is offered for 14 weeks after delivery. (2)

State of Palestine: In Palestine stunting has decreased to 7.4% in 2014. EBF is 38.1% in 2014. PBF is 49.5%. EIBF is 40.8% and is higher in rural areas but not influenced by wealth index. CBF into the second year is 31.7% but reached 11.5% at 20-23 months. ISSS is 78.2%, MMF is 58.4% and MDD is 24% so that MAD (14.7%) which is far below the recommended international level. There are no hospitals that are designated as BFH. Working mothers are entitled to 10 weeks paid maternity leave. (35, 71)
**Sudan:** Sudan is a LIC. EBF rate increased from 41.0% in 2010 to 54.6% in 2014 and PBF is 80%. CBF into the second year is 72.5%. MAD is 14.7% and is mainly related to low MDD caused by poverty. There are eleven hospitals that are designated as BFH but the latest estimate of EIBF in 2014 was 40.8%. Maternity leave is granted for 8 weeks (four weeks before and 4 weeks after confinement). (42, 43)

**Syria:** Syria is a MIC. Recent data is lacking since the last national survey in 2009. It is expected that the rate of stunting of 27.9% will double by the effect of political instability. EBF was 42.6% and PBF 58.9%, while breastfeeding continuity at 12 to 15 months was 63.9% but at 22-23 months fell steeply to 12.1%. EIBF was 32.4% in 2006 and 45.5% in 2009. The Baby-friendly hospitals have increased from 20 in 2004 to 35 in 2007, 2010 and 2015 but decreased to 25 in 2016. Working mothers are entitled to 10 weeks paid maternity leave. (33, 58)

**Tunisia:** In Tunisia EBF is 8.5% and PBF is 34%. However CBF in the second year is 33.9%. EIBF is only 39% despite the presence of 143 Baby-friendly hospitals in Tunisia. ISSS is 83.8% but MMF is 48.2% and iron deficiency anemia in under-five of age was reported 21.7%. Maternity leave is fully paid for 14 weeks. (2, 64)

**Yemen:** Yemen is a LIC with ongoing conflict. EBF is 9.7%. EIBF is 52.7%. CBF into the second year (12-23 months) is 33.9% and decreased by increasing level of education and wealth index. Complementary feeding practices are poor as shown by the low MAD is 15.4% caused by the low MDD of 21.3% and MMF of 58.5%. Maternity leave is 60 days, fully paid by employer. (33, 89, 103, 104)

The pattern of EBF remains more or less consistent for each country with little change in trends over the past 25 years. The change either decrease or increase was in the range of 5 to 10 points from one era to another. EBF which is Step 6 in the Ten steps of BFHI and is the summation indicator between hospital and community as it reflects EBF throughout the first six months, so it is an important indicator of how well breastfeeding promotion and protection and support is being achieved in both the hospital (at birth) and in the community (when the mother returns back home). However the patterns and trends in EBF for the EMR countries showed little improvement in this indicator over time,
indicating that there is a missing link between hospital practices and community initiatives.

Whereas EIBF showed a three-fold increase in Pakistan from (6% in 1990s to 20% in 2018) and two fold increase in Jordan (29.6% in 1990s to 67% in 2018) and Iraq (16% in 2000s to 32% in 2017). Oman remained high from the early 2000s to 2018 within the 70% to 80% (85% to 82%). While in the remaining countries the changes were not significant. EIBF is taken as an indicator of Step 4 of the “Ten steps” of the Baby-friendly Hospital Initiative (BFHI), which is one of the most important and challenging steps to achieve.

EIBF is one of the major challenges facing BFHI and is primarily influenced by hospital policies and routines. EIBF should be considered as standard practice in the birthing process and hospitals with birthing services should be mandated to implement it as standard medical care for any patient in labor irrespective of the mode of delivery or presence of complications in the mother and baby. In fact, many of the complications that arise in the infant as hypothermia (32) and severe illness in the newborn (76) or in the mother as bleeding, or hypertension (28) can be allied by placing the baby immediately after birth skin-to-skin on their mother’s bare chest and allowing the suckling process to begin. EIBF was shown to save lives of infants and neonatal mortality can be reduced by 22% if all babies are placed with their mother for one hour after birth. (52, 91) EBF in the first six months have beneficial effects on the baby and the mother. In the baby it reduces the toll of deaths from diarrhea (55) and respiratory tract infections. (25)

Continuity of breastfeeding at 12-15 months and at 20-23 months showed a drastic reduction in the patterns of breastfeeding over the second year. The discontinuation of breastfeeding in the second year coupled by poor feeding practices related to poverty, scarce resources and unawareness of the correct weaning practices both by health providers and mothers, place these children at risk of malnutrition, whether obesity or underweight or micronutrient deficiency states. However the marketing practices of infant milk formula companies and poor health practitioner practices are the main factor for reducing these indicators and thereby intervene with measuring the efficacy of the BFHI practices on EBF and CBF.
Figure 1.13. Exclusive Breastfeeding (0-5 mo) in the 22 countries of the Eastern Mediterranean Region

(UNICEF Health Global Database 2016).

Figure 1.14. Early initiation of Breastfeeding in 17 countries of the Eastern Mediterranean region

Figure 1.15. Predominant Breastfeeding in the Eastern Mediterranean region

Figure (I.1.3) shows the predominant breastfeeding rates (PBF) in 14 EMR countries.
Figure 1.16 Continued Breastfeeding at 12-15 months in the countries of the Eastern Mediterranean region

Figure 1.17 Continued Breastfeeding at 20-23 months in the 22 countries of Eastern Mediterranean Region

Figure 1.18 Timely introduction of solid, semi-solid and soft foods (6-8 months) in the Eastern Mediterranean region

1.1.6 Case Study: Breastfeeding Promotion Programs in Egypt

Egypt was the first country to release a ministerial decree in 1979 in support of the international code of marketing of breastmilk substitutes, by HE Dr. Mamdouh Gabr, Late Minister of Health and a pediatrician with strong support for breastfeeding. When the Innocenti declaration in 1991 Egypt was one of 123 flagship countries to adopt the BFHI and in 1992 Code was enforced in all hospitals and by 1995 the BFHI became a national program in the Ministry of Health. In 2014 the former Minister of Health & Population HE Dr. Maha El Rabbat released a Ministerial decree for making all health facilities that serve mothers and babies adopt the Ten steps to become Baby-friendly health facilities. Although Egypt has been taken by many countries in the region as a model for BFHI implementation, the marketing tactics from infant milk formula companies has continued to be the greatest challenge through political
pressure, media and promoting subsidization of infant milk formula. Lately the EBF and CBF in Egypt have declined to one third and one half over the past two decades. Hence protection of breastfeeding is a mandate if breastfeeding promotion will be effective.

1.1.7 Challenges to Breastfeeding Promotion

There were many success stories coming from countries in South America and Far East Asia and countries as New Zealand who attained BFHI status by making it a universal initiative both in the community and the hospitals.

In the EMR a similar success was seen in the Sultanate of Oman and Sharajah in the United Arab Emirates, where the universal coverage in the PHC and hospitals enabled them to achieve rates of CBF concomitant with high rates of BFHI coverage of births in the country. However success does not come without a challenge. Many other countries are trying their best to overcome such challenges to meet success.

In many developing countries there is a challenge for making hospitals work with the community for the continuum of support and ensuring continuity of breastfeeding.

The district health care approach was one of the tools used by the WHO to strengthen services that were common between medical and preventive services i.e. between hospitals and primary health care by strengthening referral systems, training specialists who work in both sites, disseminating breastfeeding promotion messages and strengthening health systems that are common between them.
The growth of noncommunicable diseases (NCD) and the challenges facing their prevention and management necessitate strong action to strengthen district health care systems to work efficiently for continuum of care with consistent communication messages, treatment protocols, interventions and policies for protection, promotion and support of breastfeeding.

The COVID-19 crises may impose unprecedented detrimental effects on communities and thereby a call for action to promote and protect breastfeeding should be a mandate in the global efforts to control this crisis.

**The Power of Media as a Challenge and Partner in Health**

Mass media has a powerful impact on public perceptions of health issues. The media provide information in a manner that creates and reinforces ideas about themes that appear acceptable and appealing to the common layman.

Mass media can be directed to disseminate and promote messages about safe infant feeding practices. Unfortunately mass media do not always promote a positive image of breastfeeding, even though it is the norm method of infant feeding with optimal health benefits.

A study carried out in the United Kingdom (UK) on media coverage for breast versus bottle feeding showed that media portrays implied that breastfeeding is problematic, funny, and embarrassing, and that it is associated with middle class or celebrity women. In contrast, bottle feeding is socially integrated, highly visible, unproblematic, and associated with “ordinary” families. The health benefits of breastfeeding and the risks of formula feeding were largely absent in routine media coverage. (44)
Bottle-feeding was used to symbolize babyhood. The benefits of breastfeeding and hazards of bottle-feeding were rarely mentioned. Moreover there were more articles about the drug passage through breastmilk and perceived milk insufficiency syndrome as being a cause for not breastfeeding.

In effect media makes it easy for mothers to give up early on breastfeeding. Media works on public health issues that face many mothers including “not enough milk” and prevailing poverty. Mothers think that they may need to have this milk in their homes “just in case” their milk is turned off in the middle of the night! These portrayals intensify the need for the artificial milk cans. Hazards of giving this one bottle of artificial formula and its effects on breastfeeding and baby’s health are hardly ever presented by media.

Offering one bottle to the baby a day is known to cause many problems. First it interferes with the normal cycle of demand supply, which is essential for milk production especially when introduced in the evening when the climax of hormone activity for breastmilk production is active. (37)

One bottle a day can also alter the bacterial flora of the gut that is necessary for optimal absorption and utilization of the essential and special nutrients and immune factors present in human milk that build the immune system of the growing baby and protect it from the exposure to lethal conditions. (72, 73, 74, 85)

Moreover offering bottles with nipples may cause some babies to reject feeding at their mother’s breast as they find it easier to feed from a bottle and with a teat and may even prefer the sweeter taste of artificial milk.

Formula milk is industrially processed milk that has undergone many biochemical changes to make into powdered milk that is reconstituted into a food called “infant milk formula” is a poor investment for the economy. (83)
I.1.8 Promoting Breastfeeding within the Context of the Sustainable Development Goals

The United Nations 17 Sustainable Development Goals

In September 2015, the General Assembly of the United Nations (UN) adopted the 2030 Agenda for Sustainable Development. This includes 17 Sustainable Development Goals (SDGs). The goals build on the vital principle of “leaving no one behind”, and emphasizes a holistic approach to achieving sustainable development for all. The SDGs are listed in Box I.1.3. All countries are requested to achieve the indicators set to meet the target intended at global level for all of these 17 goals. Countries are ranked by the score achieved in meeting these 17 goals as shown in table (I.1.2).

<table>
<thead>
<tr>
<th>GOAL</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: No Poverty</td>
<td>End poverty in all its forms everywhere (eradicate extreme poverty currently measured as people living on less than $1.25 a day.)</td>
<td></td>
</tr>
<tr>
<td>2: Zero Hunger</td>
<td>End hunger, achieve food security and improved nutrition and promote sustainable agriculture.</td>
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<tr>
<td>3: Good Health and Well-being</td>
<td>Ensure healthy lives and promote well-being for all at all ages.</td>
<td></td>
</tr>
<tr>
<td>4: Quality Education</td>
<td>Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.</td>
<td></td>
</tr>
<tr>
<td>5: Gender Equality</td>
<td>Achieve gender equality and empower all women and girls</td>
<td></td>
</tr>
<tr>
<td>6: Clean Water and Sanitation</td>
<td>Ensure availability and sustainable management of water and sanitation for all.</td>
<td></td>
</tr>
<tr>
<td>7: Affordable and Clean Energy</td>
<td>Ensure access to affordable, reliable, sustainable and modern energy for all</td>
<td></td>
</tr>
<tr>
<td>8: Decent Work and Economic Growth</td>
<td>Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.</td>
<td></td>
</tr>
<tr>
<td>9: Industry, Innovation and Infrastructure</td>
<td>Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation.</td>
<td></td>
</tr>
<tr>
<td>10: Reduced Inequality</td>
<td>Reduce inequality within and among countries.</td>
<td></td>
</tr>
<tr>
<td>11: Sustainable Cities and Communities</td>
<td>Make cities and human settlements inclusive, safe, resilient and sustainable.</td>
<td></td>
</tr>
<tr>
<td>GOAL 12</td>
<td>Responsible Consumption and Production</td>
<td>Ensure sustainable consumption and production patterns.</td>
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<td>---------------------------------------------------</td>
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<tr>
<td>GOAL 13</td>
<td>Climate Action</td>
<td>Take urgent action to combat climate change and its impacts.</td>
</tr>
<tr>
<td>GOAL 14</td>
<td>Life Below Water</td>
<td>Conserve and sustainably use the oceans, seas and marine resources for sustainable development.</td>
</tr>
<tr>
<td>GOAL 15</td>
<td>Life on Land</td>
<td>Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.</td>
</tr>
<tr>
<td>GOAL 16</td>
<td>Peace and Justice Strong Institutions</td>
<td>Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.</td>
</tr>
<tr>
<td>GOAL 17</td>
<td>Partnerships to achieve the Goal</td>
<td>Strengthen the means of implementation and revitalize the global partnership for sustainable development.</td>
</tr>
</tbody>
</table>

The SDGs are a unique toolkit for measuring development. High performance on the SDGs does not correlate fully with either of the two broadly-used measures of development: gross domestic product (GDP) per capita and the Human Development Index (HDI). The HDI is a composite index of life expectancy, education, and per capita income indicators, which are used to rank countries into four tiers of human development. A country scores higher if life span is higher, education level is higher, and gross national income (GNI (PPP) per capita is higher. The HDI that takes into account equality is termed as Inequality–adjusted HDI (IHDI). The IHDI is the actual level of human development as human development cannot be achieved when there is no equality. Breastfeeding is an equality issue as all children need to afforded the opportunity to reach their full potential of growth, development, health, and well-being through breastfeeding and adequate nutrition.

Table (I.1.2) presents the SDG scores of some countries in Africa and Asia which were discussed in the SDG report for the Arab region. It shows that a high GDP per capita does not automatically indicate a high regional ranking in the SDG index (a correlation of 0.34). However, there is a stronger correlation between SDG achievement and GDP per capita among the lower-performing 11 countries (0.87), which indicate a link between economic performance and
sustainable development outcomes. Breastfeeding rates can hypothetically increase the HDI by increasing IQ scores of children as adults. It can also improve the health and well-being of children and mothers. Lower EBF and continued breastfeeding indicates increasing inequality in this region for children under the age of five years. While the increasing rates of stunting and obesity are also indicative of inequality in the availability of adequate food and nutrition for this age group.

Strategies for promoting the achievement of SDGs and increasing IHDI are shown in Box I.1.3 which shows how breastfeeding promotion is linked with each of the 17 SDGs. Tables (I.1.3) and (I.1.4) present the health education messages that can be used within the cultural context of religious beliefs to promote the health and well-being for achieving the SDGs.

Table (I.1.2): SDG Achievement, GDP Per Capita and the Human Development Index in Arab countries in Africa and Asia

<table>
<thead>
<tr>
<th>Country</th>
<th>2019 SDG Index score</th>
<th>SDG Index rank</th>
<th>GDP per capita (PPP) 2018 US$</th>
<th>GDP per capita rank</th>
<th>HDI score 2017</th>
<th>HDI rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>66.69</td>
<td>1</td>
<td>15,622</td>
<td>9</td>
<td>0.754</td>
<td>8</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>66.17</td>
<td>2</td>
<td>74,943</td>
<td>2</td>
<td>0.863</td>
<td>1</td>
</tr>
<tr>
<td>Morocco</td>
<td>65.77</td>
<td>3</td>
<td>8,587</td>
<td>14</td>
<td>0.667</td>
<td>15</td>
</tr>
<tr>
<td>Tunisia</td>
<td>65.33</td>
<td>4</td>
<td>12,484</td>
<td>11</td>
<td>0.733</td>
<td>10</td>
</tr>
<tr>
<td>Jordan</td>
<td>65.28</td>
<td>5</td>
<td>9,348</td>
<td>13</td>
<td>0.735</td>
<td>9</td>
</tr>
<tr>
<td>Lebanon</td>
<td>63.09</td>
<td>6</td>
<td>13,058</td>
<td>10</td>
<td>0.757</td>
<td>7</td>
</tr>
<tr>
<td>Oman</td>
<td>62.84</td>
<td>7</td>
<td>41,435</td>
<td>6</td>
<td>0.821</td>
<td>5</td>
</tr>
<tr>
<td>Egypt</td>
<td>61.59</td>
<td>8</td>
<td>12,390</td>
<td>12</td>
<td>0.696</td>
<td>12</td>
</tr>
<tr>
<td>Kuwait</td>
<td>61.08</td>
<td>9</td>
<td>73,705</td>
<td>3</td>
<td>0.803</td>
<td>6</td>
</tr>
<tr>
<td>Qatar</td>
<td>60.57</td>
<td>10</td>
<td>126,598</td>
<td>1</td>
<td>0.856</td>
<td>2</td>
</tr>
<tr>
<td>Bahrain</td>
<td>59.82</td>
<td>11</td>
<td>47,220</td>
<td>5</td>
<td>0.846</td>
<td>4</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>59.72</td>
<td>12</td>
<td>55,120</td>
<td>4</td>
<td>0.85</td>
<td>3</td>
</tr>
<tr>
<td>Iraq</td>
<td>55.49</td>
<td>13</td>
<td>17,510</td>
<td>8</td>
<td>0.685</td>
<td>14</td>
</tr>
<tr>
<td>Libya</td>
<td>53.90</td>
<td>14</td>
<td>20,706</td>
<td>7</td>
<td>0.706</td>
<td>11</td>
</tr>
<tr>
<td>Mauritania</td>
<td>52.75</td>
<td>15</td>
<td>4,190</td>
<td>17</td>
<td>0.52</td>
<td>17</td>
</tr>
<tr>
<td>Sudan</td>
<td>52.11</td>
<td>16</td>
<td>4,759</td>
<td>16</td>
<td>0.502</td>
<td>19</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>51.86</td>
<td>17</td>
<td>n/a</td>
<td>n/a</td>
<td>0.536</td>
<td>16</td>
</tr>
<tr>
<td>Djibouti *</td>
<td>51.04</td>
<td>18</td>
<td>2,744*</td>
<td>19</td>
<td>0.476</td>
<td>20</td>
</tr>
<tr>
<td>Comoros</td>
<td>48.26</td>
<td>19</td>
<td>2,828</td>
<td>18</td>
<td>0.503</td>
<td>18</td>
</tr>
<tr>
<td>Yemen</td>
<td>46.89</td>
<td>20</td>
<td>2,571</td>
<td>20</td>
<td>0.452</td>
<td>21</td>
</tr>
<tr>
<td>Somalia</td>
<td>43.41</td>
<td>21</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

n/a: not available, HDI: Human development index,
The World Breastfeeding Week (WBW) is conducted annually under the leadership of WABA and UNICEF. In 2016 and 2017 the theme for the WBW was about Breastfeeding and the SDG. In 2016 it was “Breastfeeding: A key to sustainable development”. In 2017 “Sustaining breastfeeding together”.

**Box I.1.2 How Breastfeeding can promote the 17 Sustainable Development Goals**

Breastfeeding is free and does not impose any cost for the families.

Exclusive breastfeeding in the first six months of life and continued breastfeeding for two years ensures a highly nutritious food for children and contributes to ending hunger, malnutrition and obesity. Breastfeeding ensures food security.

Breastfeeding improves health, growth and development of children and child survival. It promotes maternal health on short and long term.
Breastfeeding and complementary feeding plays a critical role in preparing children for learning by promoting their intellectual and cognitive development.

Breastfeeding and complementary feeding plays a critical role in preparing children for learning by promoting their intellectual and cognitive development.

Breastfeeding ensures equity and gives every child, whether male or female their rights to a better beginning in life and protects them from the threats of formula feeding to rest the mother. On the contrary breastfeeding makes mothers more energetic so she can carry on her responsibilities at home and in her career to the very best.

Breastfeeding on demand provides all the needs of water and food to the infants even in hot and humid weather, on the contrary formula feeding needs continued access to clean water and hygienic preparation.

Breastfeeding saves on power as it does not require processing by industries and does not need heating so cuts down use of electricity and power.

Breastfeeding on demand provides all the needs of water and food to the infants even in hot and humid weather, on the contrary formula feeding needs continued access to clean water and hygienic preparation.

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Breastfeeding on demand provides all the needs of water and food to the infants even in hot and humid weather, on the contrary formula feeding needs continued access to clean water and hygienic preparation.
Breastfeeding is an environmentally friendly practice contrary to formula feeding.

Breastfeeding ensures the rights of the child and of women. Policies that support Baby-friendly health facilities promote family bonding and spread of peace.

The Global Strategy of Infant and Young Child Feeding promote partnerships between sectors for development.

**Promoting the Sustainable Development Goal for Health and Well-being**

**Figure 1.21** The contribution of other sectors to health and well-being

**Islamic Teachings for Promoting Health and Wellbeing (WHO, 1995)**

**أعمال الحياة الإسلامية لتعزيز الصحة العامة (منظمة الصحة العالمية - المكتب الإقليمي لشرق المتوسط (1995)**

<table>
<thead>
<tr>
<th>SDG#</th>
<th>Statement</th>
<th>Quran reference and Hadith (Prophet sayings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S3:</td>
<td>A well balanced diet is the basis for healthy nutrition</td>
<td>قال تعالى : ﴿ووضع الميزان ، ألا تطغوا فى الميزان ، وأقيموا الوزن بالقسط ، ولا تخسروا الميزان﴾ سورة الرحمن (7-9)</td>
</tr>
<tr>
<td>S4:</td>
<td>Choice of safe food and avoidance of hazardous foods, ensure health</td>
<td>قال تعالى : ﴿كلوا مما فى الأرض حلالاً طيباً ﴾ سورة البقرة (168)</td>
</tr>
<tr>
<td>S5:</td>
<td>Avoiding healthy diet without proper indication is against health and Islam does not favor it.</td>
<td>قال تعالى : ﴿ولا تحرموا طيبات ما أحل الله لكم ﴾ سورة المائدة (87)</td>
</tr>
<tr>
<td>S6:</td>
<td>A balanced diet is balanced in quantity, overeating is hazardous and leads to many health disorders as obesity and metabolic syndrome and is against Islamic teachings.</td>
<td>قال تعالى : ﴿وكلوا واشربوا ولا تسرفوا ﴾ سورة الأعراف (31)</td>
</tr>
</tbody>
</table>
Guiding Principles in Infant and Young Child Feeding

A balanced diet should be composed of a variety of foods that meet body needs for optimum growth and development including proteins, fats, sugar, minerals and vitamins (S#7).

Table (I.1.4) Islamic teaching that can be used to educate sanitation, oral and dental hygiene in line with Sustainable Development Goals

<table>
<thead>
<tr>
<th>SDG #</th>
<th>Guidance and source in Amman declaration</th>
<th>Quran reference and Hadith (Prophet sayings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S11</td>
<td>Drinking rain water is clean and safe, it is suitable for bathing, cleaning and drinking purposes.</td>
<td>Quran reference: ﴿أنزل من السماء لكم منه شراب﴾ (النحل 10) Hadith of Prophet: ﴿لا يبولن أحدكم فى الماء الراكد﴾</td>
</tr>
<tr>
<td>S12</td>
<td>Muslims should not pollute water especially stagnant water. It is prohibited to urinate or defecate or even wash up in still water.</td>
<td>Quran reference: ﴿وأنزلنا من السماء ماءً طهوراً﴾ (الفرقان 48) Hadith of Prophet: ﴿لا يغتسلن أحدكم في مستحمه ثم يغتسل فيه﴾</td>
</tr>
<tr>
<td>S14</td>
<td>Body care by washing up daily every part of the body especially the ears, feet, eyes, nose and especially the private parts (genitalia, urinary and defecation orifices).</td>
<td>Quran reference: ﴿إذا قمتم الى الصلاة فاغسلوا وجوهكم وأيدكم الى المرافق ﻟا تكونوا نظافة وراقة﴾ (المائدة 6) Hadith of Prophet: ﴿قصوا أظافيركم وادفنوا قلاماتكم﴾</td>
</tr>
<tr>
<td>S15</td>
<td>Hand washing after handling unclean objects, before and after meals and before prayers and cleaning &amp; cutting nails.</td>
<td>Quran reference: ﴿فلا يغسل رأسه وجسده﴾ (البقرة 233) Hadith of Prophet: ﴿إذا توضأت فمضمض﴾</td>
</tr>
<tr>
<td>S22</td>
<td>Dental hygiene by: Gargling for oral hygiene Cleaning the gums is required to prevent disease Cleaning teeth is a must for dental health and should be frequently practiced over the day.</td>
<td>Quran reference: ﴿أنبت لكم به الزرع والزيتون والنخيل والأعناب ومن كل الثمرات﴾ (النحل 66) Hadith of Prophet: ﴿قد حديثهم رضوان﴾</td>
</tr>
</tbody>
</table>
Conclusions and Recommendations

The global status of breastfeeding indicates that, although there is considerable progress in adoption of the Code by member states into country national laws, still the main constraint is that the national laws do not cover the Code and subsequent WHA in its entirety. Continued EBF for six months and breastfeeding with other foods (CNB) for two years or more, remains low in many regions with a maximum of 44%. Prolonging breastfeeding can reduce neonatal mortality and deaths from NCD. EBF is linked to obesity, hypertension, diabetes and CVD.

Globally status of infant and young child feeding indicate that just over 40 per cent – or two out of five – of the world’s infants under 6 months of age are exclusively breastfed, and there has been little progress over the past 15 years. Five out of seven regions with trend data have current rates around 30 per cent, and all of them have improved very little, if at all, in more than a decade.

From 6 months to age 2 and beyond: Continued breastfeeding during the period between 6 months and 2 years of age or beyond improves cognitive ability, translating into improved school performance, better longterm earnings and enhanced productivity. Globally, less than half of all children are still being breastfed at 2 years, and this rate has remained relatively unchanged since 2000. Continued breastfeeding rates drop from 74 per cent at 1 year to 46 per cent at 2 years. In nearly all regions, continued breastfeeding rates are highest among women from the poorest households.

Global status of complementary feeding indicators indicate that more infants are being fed solid foods at the recommended age than in the year 2000 – but one third still need to be covered. Only half of children 6 to 23 months of age are fed the minimum number of meals a day for their age. Minimum diet diversity is lowest among the youngest children: the age group for whom it is most critical. Globally, only 1 in every 6 children is receiving a minimum acceptable diet.

In the EMR countries there is progress in EBF and early initiation of breastfeeding, but complementary feeding practices are poor as indicated by
the indices of complementary feeding and the prevalence of stunting, wasting and obesity.

Promotion of breastfeeding can be used to achieve all the 17 SDGs particularly the goal of health and well-being. In a region like the EMR where religion plays an important role in shaping the culture of communities and influencing their beliefs and practices, the use of holy texts as from the holy books or prophet sayings can be used to influence behavior linked with health and well-being.

References and Further Readings


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Breastfeeding is an investment “A dose for the future”

Dr. Ayoub Al-Jawaldeh
Regional Adviser, Nutrition
WHO-EMRO
الجزء الأول من الدليل المتخصص في تغذية الرضع والأطفال الصغار
الفصل الأول
كيف يسهم تعزيز وضع الرضاعة الطبيعية في الصحة العالمية
ملخص
حقائق عالمية حول تغذية الرضع

على الصعيد العالمي في عام 2020، قدر أن 149 مليون طفل دون سن الخامسة يعانون من التقدم (أقصر من العمر)، و45 مليون طفل يعانون من الهزال (نحو الفئة بالنسبة للطول)، و38.9 مليون يعانون من زيادة الوزن أو السمنة.

حوالي 44% من الأطفال منذ الولادة وحتى سن 6 أشهر يرضعون رضاعة طبيعية فقط.

 Zahlمن من الأطفال ينهارون نفسيات فائقة كافية والمفيدة من الناحية التغذوية. في العديد من البلدان، يفوقون أقل من ربع الأطفال الذين تتراوح أعمارهم بين 6 و23 شهرًا معيار النمو الغذائي وتوزع التغذية المناسبة لأعمارهم.

يمكن إقاف حياة أكثر من 2000 طفل كل عام بين الأطفال دون سن الخامسة، إذا تم إرضاع جميع الأطفال من الولادة لحين بلغهم 6 أشهر من العمر. ينصح الرضاعة الطبيعية على تحسين الذكاء وأدائهم في الدراسة المدرسية والذين يرتبط بزيادة الدخل في حياة البالغين.

تعزيز الرضاعة الطبيعية ودعمها هو تفويض لتحقيق الصحة والرفاه الأمثل للأطفال والأجيال القادمة في العديد من البلدان المتقدمة والنامية. تناقل بلدان منطقة شرق البحر الأبيض المتوسط تكاليف مجاورات منظمة الصحة العالمية بشأن الرضاعة الطبيعية الحصرية خلال الأشهر الستة الأولى من العمر واستمرار الرضاعة الطبيعية لمدة عامين أو أكثر على النحو الموصى به من قبل منظمة الصحة العالمية، وبالتالي، يمكن إيقاف حياة أكثر من 2000 طفل كل عام بين الأطفال دون سن الخامسة، إذا تم إرضاع جميع الأطفال من الولادة لحين بلغهم 6 أشهر من العمر. ينصح الرضاعة الطبيعية على تحقيق الصحة والرفاه الأمثل لأطفالنا، مما يجعل من الضروري تجاوز هذه المشاكل للأطفال، مما يؤدي إلى التدخلات نظامية وفعالة في جميع البلدان.

الرضاعة الطبيعية هي حق من حقوق الإنسان تدعمه إتفاقية حقوق الإنسان لحماية الطفل. تحب المدونة الدولية تسويق بذات لام الرضاعة الطبيعية من خلال تنظيم الأساليب التشغيلية للشركات التي تقدر قرار المرأة بإرضاع أطفالها رضاعة طبيعية. تتضمن أهداف التنمية المستدامة، المعروفة أيضًا باسم الأهداف العالمية، 17 هدفًا تمتد إلى عام 2030 كنواة عالمي للعمل للقضاء على الفقر وحماية كوكب الأرض. تتمتع جميع البلدان بالسلام والأزهر بحلول عام 2020. الرضاعة الطبيعية هي إحدى الوسائل وواحدة من أكثر التدخلات فعالية من حيث التكلفة والفعالية لتحقيق كل هدف من الأهداف السبعة عشر.


وقد لوحظ تقدم كبير في تحسين ممارسات الرضاعة الضع. أصبح أكثر من 2000 مسئول في 100 دولة المدونة والقرارات في التشريعات. ارتقت معدلات الرضاعة

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الطبيعة العالمية بنسبة 15% على الأقل، ولكن، إذا تحققت أهداف إينيشنتي بالكامل، يمكن منع خمس وفيات الأطفال بالكامل - إذاً أكثر من مليون طفل كل عام بالإضافة إلى 6 ملايين حالة وفاة يتم منعها بسبب الحماية التي توفرها الرضاعة الطبيعية. تعتبر التحديات في مراقبة الأمومة أساسية لتحسين معدلات الرضاعة الطبيعية ومن ثم تتم مراجعة الخطوات العشر لمواجهة تحديات حماية وتعزيز ودعم الرضاعة الطبيعية.

حماية الرضاعة الطبيعية وتعزيزها ودعمها الزامية للوقاية من سوء التغذية والأمراض المعدية المرتبطة بسوء التغذية في سياق الفقر وسوء الصرف الصحي في البلدان النامية وأزمات فيروس كورونا في البلدان المتقدمة واللادمية. ومع ذلك، تواجه العديد من التحديات الترويج للرضاعة الطبيعية. على الرغم من الجهود العالمية لتشجيع الرضاعة الطبيعية والتغذية التكميلية الكافية، لا تزال مؤشرات الرضاعة الرضع دون المستوى الأعلى، وهذا له تأثير سلبي على النتائج الصحية للأطفال والأمهات.

تشير الحالة العالمية للرضاعة الطبيعية بين الأطفال تحت عمر عامين إلى أن ما يزيد قليلا عن 40 في المائة - أو أثنيا من كل خمسة - من أطفال العالم الذين يملأهم عن 2 أشهر يرضعون رضاعة طبيعية صحية، ولم يكن هناك نقص يذكر على مدار العشرين عاما الماضية. حسب من صغر سبع مناطق لديها بيانات عن التغييرات في معدلات الرضع في 2000 إلى 2015 وهي تبلغ حوالي 30 في المائة، وكلها تحتسب قليلا للغاية، إن لم تحصل على الإنتاجية، في أكثر من عدد من الزمان، من 2 إلى سن 2 وما بعد: معدل الاستمرار في الرضاعة الطبيعية خلال الفترة ما بين 6 أشهر و2 سنة أو ما بعد ذلك يحسن القدرة الإدراكية، ويؤدي إلى تحسين الأداء المدرسي، وتحقيق أرباح أفضل على المدى الطويل، وزيادة الإنتاجية. على الصعيد العالمي، لا يزال أقل من نصف جميع الأطفال تتمتع ودائع الرضاعة الطبيعية، ولكن الرضاعة الطبيعية عند عمر ستين مائة متدينة، وقد ظل هذا العدد دون تغيير نسبيا منذ عام 2000. تتضمن معدلات الاستمرار في الرضاعة الطبيعية من 74 في المائة في العام الأول إلى 64 في المائة في غضون عامين. في جميع المناطق تقريبا، تعد معدلات الاستمرار في الرضاعة الطبيعية هي الأعلى في المناطق الغنية.

تشير الحالة العالمية لمؤشرات التغذية التكميلية إلى أن عدد الأطفال الذين يتلقون أغذية صلبة في العمر الوليد يكبر مما كان عليه في عام 2000، ولا يزال ثلاثة يتوفرة إلى النغطية. يحمل نصف الأطفال الذين تتراوح أعمارهم بين 6 و12 شهرًا فقط على الحد الأدنى من الوجبات في اليوم المناسب لأعمارهم. دُرجة نموذج الغذائي هو الأدنى بين الأطفال العماني: النقطة الممزقة الأكثر أهمية بالنسبة لهم. على الصعيد العالمي، يتلقى طفل واحد فقط من بين كل ستة أطفال نظاما غذائيا مقبولا على الأقل.

وتشير حالة مؤشرات تغذية الرضع وصغار الأطفال في بلدان إفريقي شرق المتوسط أن الرضاعة الطبيعية الحصرية قد ارتفعت في معظم البلدان ولكن هناك مؤشرات التغذية التكميلية منخفضة كما أن الدعم المقدم لبرامج دعم وحماية الرضاعة الطبيعية ودعم المرأة العاملة يحتاج إلى المزيد من الدعم السياسي في بلدان إفريقي شرق المتوسط.

وتترتب هذه المؤشرات بأهداف العقد المستدام، وبالخصوص الهدف الذي يخص الصحة والغذاء، وتم عرض رؤى التوجيه الصحية المرتبطة بأنماط الحياة الإسلامية لتغيير الصحة التي أصدرتها منظمة الصحة العالمية (مكتب إفريقي شرق المتوسط) باعلان عماد في 1995.
الاستنتاجات والتوصيات

يشير الوضع العالمي للرضاعة الطبيعية إلى أنه على الرغم من إرادة المدونة من قبل الدول الأعضاء في القوانين الوطنية للبلد، إلا أن القيود الرئيسي لا يزال هو أن القوانين الوطنية لا تغطي المدونة والقرارات اللاحقة للمدونة لجمعية الصحة العالمية في مجملها. وأيضا على الرغم من الإنجازات التي حققتها مبادرة المستشفيات الصديق للطفل في تعميم الخطوات العشر لإنتاج الرضاعة الطبيعية في مراكز الولادة، إلا أن استمرار الرضاعة الطبيعية الحصرية لمدة ستة أشهر والرضاعة الطبيعية بأطعمة أخرى لمدة عامين أو أكثر، تظل منخفضة في العديد من المناطق بحد أقصى 44٪.

إن استطالة مدة الرضاعة الطبيعية تؤدي إلى خفض وفيات الأطفال والوفيات الناجمة عن الأمراض غير السارية وتقلل من السمنة وارتفاع ضغط الدم والسكري وأمراض القلب والأوعية الدموية. في بلدان منطقة شرق البحر الأبيض المتوسط، هناك تقدم في البدء الحصري والمبكر للرضاعة الطبيعية، ولكن ممارسات التغذية التكميلية ضعيفة كما هو مبين في مؤشرات التغذية التكميلية وانتشار التفزمة والهزال والسكرة في دول المنطقة.

يمكن استخدام تعزيز الرضاعة الطبيعية لتحقيق جميع أهداف التنمية المستدامة السبعة عشر، ولا سيما هدف الصحة والرفاه. كما أن في منطقة مثل منطقة شرق البحر الأبيض المتوسط حيث يلعب الدين دورًا هامًا في تشكيل ثقافة المجتمعات والتأثير على معتقداتهم وممارساتهم، يمكن استخدام النصوص المقدسة من الكتب المقدسة كالقرآن الكريم أو أحاديث الرسول صلى الله عليه وسلم للتأثير على السلوك المرتبط بالصحة والرفاه.
Importance of breastfeeding

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