World Health Organization

REGIONAL OFFICE FOR Africa

BACKGROUND PAPER

ON

BABY FRIENDLY HOSPITAL INITIATIVE IN THE CONTEXT OF HIV

SEPTEMBER 2003

Family and Reproductive Health Cluster

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This background paper was prepared by Rufaro Madzima for the IMCI Unit of DDC Division of the Regional Office for Africa of the World Health Organization, under the overall coordination and responsibility of Elizabeth Mason and Charles Sagoe-Moses

We acknowledge with thanks all the references and data sources used in compiling this background paper. We would also like to thank individuals and organizations in Botswana, Burkina Faso, Uganda, Zambia and Zimbabwe that assisted in the development of this paper.

Special thanks are extended to the Governments of Uganda and Zambia and the various institutions and officers who allowed and actively facilitated the consultant to visit their countries as part of the process to gather information for the paper; the WHO representatives who facilitated the mission.

It is our hope that the contents of this paper would go a long way to implementing and revitalising the Baby Friendly Hospital Initiative (BFHI) in this era of HIV and AIDS.

List of Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
BCG	Bacille Calmette-Guerin Vaccine
BFHI	Baby Friendly Hospital Initiative
BMFHI	Baby Mother Friendly Hospital Initiative
BOTUSA	Botswana and USA Project
CORPS	Community Resource Persons
GSIYCF	Global Strategy on Infant and Young Child Feeding
GTZ	Germany Technical Coorperation
HIV	Human Immunodeficiency Virus
IBFAN	International Baby Food Action Network
ILO	International Labour Organisation
IMCI	Integrated Management of Childhood Illnesses
IYCN	Infant and Young Child Nutrition
IYCF	Infant and Young Child Feeding
LLLZ	La Leche League of Zimbabwe
MBFHI	Mother Baby Friendly Hospital Initiative
MOH	Ministry of Health
MOHCW	Ministry of Health and Child Welfare
NGO	Non-Governmental Organisation
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
UDHS	Uganda Demographic and Health Survey
UNAIDS	United Nations
UNICEF	United Nations Children Fund
USD	United States Dollar
WABA	World Alliance for Breastfeeding Action
WHA	World Health Assembly
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Health Survey
ZILCA	Zimbabwe International Consultants Association

BABY FRIENDLY HOSPITAL INITIATIVE IN THE CONTEXT OF HIV AND AIDS: AFRICA REGION

EXECUTIVE SUMMARY

WHO recommends that exclusive breastfeeding be promoted up to 6 months from birth. Botswana, Uganda, Zambia and Zimbabwe have introduced policies that are in line with the WHO recommendation. Studies carried out between 2000 and 2003, show that Uganda reported the highest levels of exclusive breastfeeding rates in both urban and rural areas. Apart from Uganda the various studies from the countries showed a decline in exclusive breastfeeding rates.

The Global Strategy for Infant and Young Child Feeding which was adopted by the World Health Assembly and the UNICEF Executive Board in 2002 provides a framework of actions that are necessary to protect, promote and support infant and young child feeding. The operational targets defined in the strategy describe a minimum core of activities that governments and partners should implement in order to ensure adequate feeding, nutrition, health and development outcomes of children worldwide.

Finding ways of balancing BFHI and its original aims and goals with the threats from HIV and AIDS is a crucial aspect of the successful implementation of the Global Strategy on IYCF especially as countries develop comprehensive policies.

The need to revitalize the Baby Friendly Hospital Initiative (BFHI) has been a subject for discussion for some time now. BFHI implementation in a number of countries had slowed down from 1997. Mother to Child Transmission (MTCT) of HIV through breastfeeding has posed a challenge to the Baby Friendly Hospital Initiative. The greatest challenge has been in the implementation of the Ten Steps to Successful Breastfeeding in the context of HIV.

In order to establish and learn how countries are implementing or planning to implement BFHI in the context of HIV and AIDS, WHO decided to put together a background paper in preparation for a Review Meeting on the same topic. The lessons learnt from the review of five countries are meant to also prepare for the implementation of the Global Strategy in the Africa Region.

Individual country profiles on key issues and observations are presented in Annex 1.

Policy development

It is generally recognised that sustainable implementation of interventions to support infant and young child feeding requires a comprehensive policy, a coordinator and multi-sectoral committee. In the countries studied policy and intervention formulation and implementation is at various stages as outlined below.

- Developing of Policy Guidelines on Infant and Young Child Feeding in the context of HIV and AIDS Scaling up of the Prevention of Mother to Child Transmission (PMTCT)
- Developing strategies to integrate HIV and AIDS teaching in BFHI
- MBFHI Reactivation Strategy in Botswana
- Modifying the Ten Steps to Successful Breastfeeding to be sensitive to HIV and AIDS
- Adding Steps
- Training in Breastfeeding Counselling, HIV and Infant Feeding Counselling and PMTCT counselling
- Developing legislation of the International Code of Marketing of Breast milk Substitutes
- Development of a Training Strategy for Infant Feeding and HIV and AIDS

Coordination

BFHI National Coordinators were appointed between 1989 and 1994. In four countries the title was changed to "Infant and Young Child Nutrition Coordinator" and in Uganda there is a "Secretariat for the Infant and Young Child Nutrition Task Force". In all countries the national coordinators are government employees who also have other duties on general nutrition in addition to coordinating BFHI activities.

Stakeholder advocacy and consensus building meetings on Infant and Young Child Feeding were held in Zambia (June 2002) and Uganda (October 2002). The aims of these meetings were to develop a cohesive national strategy for infant and young child feeding issues which would be communicated to all stakeholders; to update, sensitise and advocate to stakeholders; share programme experiences and develop follow-up plans of action.

Coordination of the many activities that are initiated by different programmes, however, still remains a challenge especially as it relates to human and financial resources. These have often been verticalised and policies may not always reflect integration.

BFHI Objectives and Implementation Strategies of TEN STEPS

The Baby Friendly Hospital Initiative has been an important catalyst for breastfeeding action in the past decade. Political will and strong advocacy have led to improved quality of breastfeeding care for mothers and babies in all the countries under review. The basic principles of the BFHI are well recognised and respected in these countries. In all countries the initial objectives of the BFHI were to promote, protect and support breastfeeding and these have not changed but have incorporated HIV.
However some adaptation have been made in respect of the Hospital Self Appraisal Tool and hospital policies in Uganda, Zambia and Zimbabwe. The challenge now is to increase and extend the BFHI to activities that address the community component so as to be more integrated and better coordinated so as to strengthen BFHI beyond post-partum period.

BFHI Implementation and Achievements

Implementation of BFHI started between 1991 and 1994. Implementation was sustained up to 1995 in Uganda, 1994 in Botswana, 1998 in Zambia and 2001 in Zimbabwe. In Burkina Faso, the BFHI did not stop, only training in health facilities stopped due to a change in focus where training concentrated on community members to support lactating women. This training included counselling in HIV prevention.

By August 2002 a total of 110 health facilities had been designated as baby friendly in the five countries under review. Botswana is the only country that had conducted reassessments of facilities previously declared baby-friendly. In general HIV and AIDS was not considered as a hindrance to promoting, protecting and supporting breastfeeding, as most people are believed to be too poor to afford any other infant feeding options. The fight against HIV and AIDS through the discouragement of mixed feeding could positively influence exclusive breastfeeding. With a number of enabling factors in place in these countries, the progress and achievements for the BFHI in the context of HIV and AIDS could be achieved.

However, due to high staff turnover, training of staff in BFHI in the context of HIV has become necessary.

Integration of BFHI into Other Programmes and the Health Delivery System

Information gathered to date, indicates that there is a general interest in implementing BFHI as evidenced by the attempts made to integrate with HIV and AIDS. This is being done to ensure that BFHI implementation is revived. The five countries reviewed have achieved a satisfactory level of integration at national level. Special mention is made of progress in Uganda where a focal person is in place to co-ordinate Infant and Young Child Nutrition (IYCN). This has brought about close collaboration and facilitated progress towards the promotion, protection and support for BFHI in the context of HIV and AIDS.

The concept of a comprehensive strategy for Infant and Young Child Feeding (IYCF) approach was quite vivid as it was difficult at times to discuss BFHI outside the IYCF issues. The BFHI in these countries, has been integrated into the existing health provision systems in such programmes as Reproductive Health/ Safe Motherhood Initiative, Integrated Management of Childhood Illnesses, Prevention of Mother To Child Transmission of HIV, Nutrition, Growth Monitoring and Promotion. The experiences from these countries show that it is feasible for BFHI to be viewed as one element in the range of activities that are needed to strengthen health systems and empower communities to provide adequate support to breastfeeding mothers and babies.

Integration is desirable, as it will achieve standardization of messages, materials, and human resources. However there is need to acknowledge that there are some concepts that can be integrated and some that cannot. In addition, one has to guard against over

integration, as this is likely to leave out some critical concepts/messages especially in the BFHI context.

At national level, BFHI could stand alone to help ensure that some specific issues are addressed. In the case of new information and knowledge, this can be filtered down before integrated materials are developed. However at community and facility level, BFHI cannot continue to stand-alone. The integrated and concept approach is the best way forward, especially in view of decentralization where districts have become autonomous.

Community Based / Mother Support Groups

The establishment of mother support groups as an important avenue to increase coverage of skilled support was not considered strong apart from Burkina Faso where emphasis was placed on training community groups in exclusive breastfeeding support and HIV prevention. More effort is still required to strengthen this area in addition to reviving training in the health facilities and establishing links with communities and support groups.

A number of national and international level non-governmental organizations (NGOs) have often played crucial roles in the successes of the BFHI activities in all the countries under review. Unfortunately, this currently does not seem to be the same situation in some of the countries. The lack of activity is reported to be due to a number of reasons including the fact that most members have moved to other better paying jobs since most of them worked on a voluntary basis. Due to economic hardships, the leaders could not sustain voluntary work and groups have disintegrated, due to retirement, restructuring and deaths.

Some community-based organizations work with mother support groups in nutrition and community-based growth monitoring and promotion, which is the entry point for infant and young child feeding. One of the challenges faced by the community-based groups is that of confidentiality, especially when it comes to infant and young child issues in relation to HIV.

Pre-and In- Service Training and Capacity Building

Training of health workers in policy, lactation management skills, HIV and Infant Feeding is one of the key components of the BHFI as highlighted in Step 2.
Pre-service education in all the countries visited does provide students with some knowledge and skills necessary to promote, support and protect optimal infant and young child feeding. However, it was observed that most of the topics on breastfeeding and lactation management, infant and young child feeding were often covered in school under the human life cycle in both basic and applied sciences.

There is need therefore to review the curricula for medical, nursing, midwifery, allied public health and nutrition education programs to incorporate current issues on infant and

young child feeding and specifically BFHI and HIV. Zambia and Burkina Faso experiences are worth learning from, where some effort have been made to incorporate HIV and AIDS, PMTCT, General Nutrition and Infant Feeding issues in the pre-service curricula. If more such pre-service curriculum are reviewed it would go a long way to address the problems caused by high staff turnover and high costs for refresher courses.. For instance, in one country an 11- day course conducted for the Minimum Package for 25 health workers or a 10-day Breastfeeding Counselling, HIV and Infant Feeding Counselling currently costs on average USD24 000.00 at provincial level and USD8 500.00 at district level. In a 6-day (44-hour) combined course costs on average USD 5000.00 in another country.

The issue that is also of greatest concern in the countries visited and from various reports is the lack of follow –up of the trained trainers and counsellors. WHO recommends that newly trained health workers seeing mothers and infants should receive at least one follow-up visit within 4-6 weeks after training by an experienced and skilled supervisor. The support will enable them to make the necessary arrangements in their working environment and start implementing new knowledge and skills. Follow-up of trained breastfeeding and infant feeding counsellors has been conducted in Zambia and Zimbabwe with financial and technical support from WHO. Experience from the two countries show that this is an area that requires urgent attention. The trained counsellors often come across problems they cannot handle and for which they need extra support. In addition to in-service and pre-service training approaches, an alternative method has been explored for communicating essential breastfeeding knowledge and skills through distance learning in Uganda through the Health Management Development Centre (HMDC) in Mbale, a national training centre for health-workers on distance education programmes. The HMDC developed a National Health In-Service Training Strategy, which could be adopted countrywide. However, the modules need updating in order to incorporate BFHI in Context of HIV and latest information. Wide experiences on how pre-service training has integrated infant and young feeding issues could also be drawn from other countries.

All the five countries under review have conducted a reasonable number of in-service training or continuing education programs for health-care providers. The general observation from the BFHI meeting in Botswana is that, a lot of training has been taking place with some modifications in a number of countries. This was raised as a concern as quality is to be maintained.

A number of libraries visited do not have much on Infant feeding and HIV, nor BFHI. The available books range from 1974 to 1999 editions.

Scaling Up Plans

All countries under review are scaling up PMTCT programmes although at a different pace. Efforts generally are being made to incorporate infant feeding issues including BFHI in the scaling up. However, countries are at different levels of scaling up. This ranges from there being no clear plan for the BFHI expansion to a well defined National Strategic Plan; adaptation of IYCF materials to incorporate HIV and AIDS; and

the building of a national capacity for assessors in the context of HIV, training health workers on counseling for PMTCT, and integrating infant and young child feeding counseling.

Issues of Formula Supplies and Logistics

In countries where government provides, infant formula for the medically indicated cases is purchased through a purchasing vote. On a smaller scale such as at facility level, some non-governmental organizations are reported to be providing some form of free replacement feeding.

UNICEF had initially supported the procurement of the generic infant formula in Burkina Faso, Uganda, Zambia and Zimbabwe. This support has also been discontinued in the scale up phase of the program due to a number of factors that include high costs and logistical challenges. Another reason for discontinuing is that it is not considered easy for the majority of mothers to safely handle formula feeding. It was also noted that some of the mothers who benefited from the free generic formula were among those who could afford to purchase on their own as they had access to clean water.

In Burkina Faso confidentiality is regarded as a big concern since there are no adequate structures or mechanism to guarantee it. In the other countries, in order to ensure confidentiality, counselling is by trained counsellors. Mothers, who are HIV-positive and opt not to breastfeed, are given demonstrations on the preparation of other options away from other mothers and mostly this is done on an individual basis. In view of the intention by UNICEF to end free formula and the WHA Resolution of 1996 on ending free supplies, health workers were trained in Lactation Management Breastfeeding Counseling, HIV and Infant Feeding Counselling as well as implementation, interpretation and enforcement of the Code of Marketing of Breast milk Substitutes.

The cost of replacement feeding ranged from 30 to 142 .00 USD for 6 months as of April 2003.

Funding of BFHI

Botswana, Uganda, Zambia and Zimbabwe indicated that with the passage of time, the BFHI was no longer considered a priority by funding agencies. Botswana reported that there was lack of funding support from funding organisations including the UN for breastfeeding activities up to 1999. However this situation has improved in Botswana.

An Overview of Outstanding Issues

The subject of breastfeeding in general and BFHI in particular in the context of HIV and AIDS has been surrounded by a number of controversial issues which are regarded as still outstanding by the countries under review. Similar issues were highlighted by other countries during the Gaborone meeting of 2-4 June 2003 on the Context of HIV. The issues were expressed thus;

- Although BFHI forms the supporting base for counselling on HIV and Infant Feeding, it is not clear how the initiative is going to be revitalised and strengthened with special reference to human, financial and material resources.

- How to improve exclusive breastfeeding whilst at the same time reducing mixed feeding for mothers who are HIV-positive/-negative or of unknown status remains a challenge for all countries. Burkina Faso is concerned about the resistance to exclusive breastfeeding in the context of HIV and AIDS due to perceived risk of transmission.

- The issue of abrupt cessation of exclusive breastfeeding and how to manage the transition. Another issue is the use of Expressed Heat Treated Breast milk. For instance, it is said that expressing human breast milk is generally and culturally unacceptable. Are health workers willing and or convinced enough to be able to teach or recommend the method to mothers?

- Mixed messages that are still being sent to mothers and health workers in respect to BFHI and HIV, especially in areas where PMTCT activities are not being undertaken. For instance according to the WHA 2002 resolution, exclusive breastfeeding should be up to 6 months including HIV positive mothers who choose to breastfeed yet PMTCT recommends exclusive breastfeeding and abrupt weaning at 3 months. The HOW TO DO IT still remains a challenge?

- The practicalities of different infant feeding options need to be explored further as a lot of support is needed for the mothers and their families.

- Provision of nutrition supplements for HIV positive mothers. Is it feasible? How about the rest of the family?

- Stigmatisation of HIV positive mothers stopping the EBF at 4 months, or infants on replacement feeding and confidentiality issues.

- Towards implementation of Step 10: Follow up issues on how to make use of existing community based workers and community resource persons who have been trained under the different programmes and are often selected by the community, but are not necessarily trained in HIV counselling. Is counselling by these cadres feasible? How to handle the issue of confidentiality and stigmatisation? Will HIV-positive mothers come out in the open? Perhaps BFHI Step 10 could be used as an entry point to avoid stigmatisation and ensure confidentiality of those infected.

- The need for continued and sustained follow up of health workers after training of trainers (TOT), especially the counsellors. It is often assumed that when trainers are equipped with knowledge and skills, they would automatically pass these on. This perception is common in a number of countries. Funding is mentioned as a

constraint – the question is how can this be resolved in view of the high staff turnover?

- While continued and sustained follow up and support of HIV positive mothers is critical to invest in, but how feasible is it in view of limited human and financial resources!

- There is need for a pre-service curricula review as a long-term sustainable strategy, how to keep materials for in-service training up-to-date.

- The importance of ensuring gender balance i.e. involve partners / fathers and other family members in IYCF especially the BFHI. Perhaps BFHI and not PMTCT could be the entry point.

- The need to revise the Global Hospital Self Appraisal tool, External Assessors Tool and Reassessment Tool that are HIV sensitive.

1.0 INTRODUCTION

Breastmilk is a unique and ideal food for the growth and development of infants. It has a unique physiological and emotional influence on the health and well-being of the mother and child. For breastfeeding to be successfully initiated and established, mothers need active support from their families, community and the entire health system during pregnancy and after birth.

In recent years, several initiatives have been taken by international organisations and adopted by governments towards promoting, protecting and supporting breastfeeding by all mothers. These include:

- The International Code for Marketing of Breast milk Substitutes of 1982.
- The WHO/UNICEF Innocenti Declaration and the subsequent Baby Friendly Hospital Initiative (BFHI) launched in 1992;
- The WABA World Breastfeeding Week initiated in 1993;
- The ILO Convention on Maternity Protection;

These initiatives have been supported by several subsequent resolutions of the World Health Assembly (WHA) on the subject, especially in years 1994, 1996, 2001 (Exclusive breastfeeding up to six months), and 2002 (Global Strategy for Infant and Young Child Feeding). The Global Strategy for Infant and Young Child Feeding which has a component of BFHI was aimed at revitalising world attention to the feeding practices that have impact on the nutritional status, growth, development, health and thus the very survival of infant and young children.

The Innocenti Declaration calls for all maternity facilities to implement the "Ten Steps to Successful Breastfeeding" which are the foundation of the WHO/UNICEF Baby Friendly Hospital Initiative towards protecting, promoting and supporting breastfeeding. They summarise the maternity practices necessary to support, promote and protect breastfeeding.

Further to the Ten Steps, the Baby Friendly Hospital Initiative also encourages hospitals and maternity facilities to purchase all breast milk substitutes at full price, accepting no free or low cost supplies. In some countries the Baby Friendly Initiative has been implemented even in health centres that have a limited bed capacity. Important lessons have been learnt from the promotion of breastfeeding in general and the Baby Friendly Hospital Initiative in particular since its introduction by UNICEF and WHO in 1992.The BFHI concept applies not only to babies but to mothers also. This is regardless of the method of feeding of the baby. Therefore BFHI implementation can take place in countries where is high HIV prevalence.

In particular, the BFHI has been widely promoted and implemented. By 1998, BFHI had been well established in many countries. The WHO/UNCEF External Assessors Manual of August 1992 provides for the recognition of hospitals whose programmes encourage breastfeeding, and encouragement for similar programmes in hospitals, which have less

than optimal support to breastfeeding. The implementation of the BFHI Ten Steps is supported by the following tools:

1. Self Appraisal Tool
2. Internal Assessment Tool
3. External Assessors Tool
4. Reassessment Tool (prepared by WHO and Wellstart International)

Ten Steps to Successful Breastfeeding

Step 1: **Have a written breastfeeding policy that is routinely communicated to all health care staff.**

Step 2: **Train all health care staff in skills necessary to implement this policy.**

Step 3: **Inform all pregnant women about the benefits and management of breastfeeding.**

Step 4: **Help mothers initiate breastfeeding within a half-hour of birth.**

Step 5: **Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.**

Step 6: **Give newborn infants no food or drink other than breast milk, unless medically indicated.**

Step 7: **Practise rooming-in – allow mothers and infants to remain together – 24 hours a day.**

Step 8: **Encourage breastfeeding on demand.**

Step 9: **Give no artificial teats or pacifiers (also called dummies or soothers to breastfeeding infants).**

Step 10: **Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.**

Finding ways of balancing BFHI and its original aims and goals with the threats from HIV and AIDS is a crucial aspect of the successful implementation of the Global Strategy on IYCF especially as countries develop comprehensive policies.

The need to revitalize the Baby Friendly Hospital Initiative (BFHI) has been a subject for discussion for some time now. BFHI implementation in a number of countries had slowed down from 1997. Mother to Child Transmission (MTCT) of HIV through breastfeeding has posed a challenge to the Baby Friendly Hospital Initiative. The greatest challenge has been in the implementation of the Ten Steps to Successful Breastfeeding in the context of HIV.

In order to establish and learn how countries are implementing or planning to implement BFHI in the context of HIV and AIDS, WHO decided to put together a background paper based on experiences of five countries in the Africa Region in preparation for a Review Meeting on the same topic.

2.0 METHODOLOGY AND COUNTRY SELECTION

The information contained in this background paper was obtained from five countries, namely Botswana, Burkina Faso, Uganda, Zambia and Zimbabwe between January and May 2003. The countries were selected on the basis of their high HIV prevalence rates except for Burkina Faso which reports low rates and Uganda which has recorded a decline for comparison purposes. In addition consideration was made for inclusion of a Francophone country.

Due to the limited time in which this review had to be conducted, a few countries believed to be representative of the general status of BFHI implementation in the context of HIV and AIDS were selected.

Information gathering was through a structured questionnaire, country profile reports, and country visits to Uganda (25-29 March) and Zambia (22-25 April 2003). Detailed country reports are also available for these two countries.

Written responses to the questionnaire were received from Burkina Faso, Uganda and Zambia. Information on Botswana was obtained from reports shared at the " WHO/AFRO: Planning Meeting For The Implementation Of The Global Strategy For Infant and Young Child Feeding" held in Harare between 11-14 November 2002, at the "Regional meeting on Baby Friendly Hospital Initiative in the Context of HIV/AIDS, Gaborone, June 2-4 2003"**.** The consultant resides in Zimbabwe; therefore the required information was obtained in situ.

The preliminary results of this review were shared at the "Regional Meeting on Baby Friendly Hospital Initiative in the Context of HIV/AIDS, Gaborone, June 2-4 2003"**.** Comments received during this meeting and similar experiences recorded from other countries were therefore incorporated.

3.0 FINDINGS

3.1 HIV AND AIDS STATUS

The WHO/ UNICEF/UNAIDS policy statement on HIV and infant feeding states that mothers have a right to information and support that will enable them to make fully informed decisions about infant feeding. The statement also recommends that exclusive breastfeeding should be protected, promoted and supported for six months for women who are HIV negative or of unknown status.

In August 1999, IBFAN Africa also produced "Policy Guidelines on HIV and Infant Feeding" for the African region. In May 2002, IBFAN went on to produce pamphlets that were entitled "HIV and Infant Feeding " and "HIV and the Code: Information for Health Workers". In addition, IBFAN appended aspects on HIV and Infant Feeding to Section III of the Baby Friendly Hospital Initiative Reassessment Tool prepared by World Health Organisation and Wellstart International. However this modified reassessment tool is still in a draft form, but has been widely circulated for field-testing.

HIV infection among children is increasing, and in a number of countries including Botswana, Zambia and Zimbabwe, it is now one of the main causes of childhood deaths. Recent studies have shown more precisely the time at which HIV is passed from a mother to her infant during breastfeeding. However, there are considerable reported risks associated with not breastfeeding particularly in a resource-poor setting. This resulted in both policy-makers and health-workers being confused as to what messages to promote.

Of the five countries under review, Botswana, , Zambia and Zimbabwe rate among the countries with a high prevalence of HIV as shown in Table 1. However, Uganda and Burkina Faso rates are reported to have been declining over the last decade and the former demonstrate a tendency towards stabilisation. (PMTCT Report 2002)

Table 1: Proportion of HIV positives among pregnant women

Country	Antenatal Prevalence: HIV positive among pregnant women				
	1992	1995	2000	2001	2002
Botswana	18%			36.2%	35.4%
Burkina Faso				6.5%	
Uganda	30%		6.1%	6.5%	
Zambia				20.5%	
Zimbabwe	*14.3%	*19.4%	35%	29.5%	24.6%

* Figures are estimates arrived at through interpolation of figures for 1994 taken from districts.

3.2 BREASTFEEDING STATUS

Exclusive breastfeeding in addition to providing the best infant nutrition and growth, it protects infants against severe diarrhoea and acute respiratory infections. Studies in South Africa suggest that exclusive breastfeeding may protect infants against HIV, while mixed feeding of breast milk and other fluids and liquids, presents the greatest danger (Ref.) This is because addition of other foods or fluids may cause gut infections that could increase the risk of HIV transmission. WHO recommends that exclusive breastfeeding be promoted up to 6 months. Botswana, Uganda, Zambia and Zimbabwe have introduced policies that are in line with the WHO recommendation. Studies carried out between 2000 and 2003, show that Uganda reported the highest levels of exclusive breastfeeding rates in both urban and rural areas. According to the Uganda Demographic and Health Survey (UDHS) of 2000/1, exclusive breastfeeding at 0-3 months of age was 73.7%, and at 4-6 months it was 43.1%. In November 2001, Botswana reported that exclusive breastfeeding rates were significantly lower in urban (11%) than rural areas (32%) mainly due to the very early introduction of other fluids (ref). While more than 95 percent of infants in Zambia are breastfed during their first year of life, only 26 percent of infants 0-3 months old and 5 percent of infants 4-5 months of age are exclusively breastfed (LINKAGES SEPTEMBER 2002). In Burkina Faso, the exclusive breastfeeding rate for the 0-3 months age group is 5% (DHS 1998). Studies conducted in February 2003 in Zimbabwe, based on the National Health and Nutrition Survey as well as data from EPI Coverage showed that 21.0% of infant aged 0-6 months are exclusively breastfed in the preceding 24 hours (39.6% under 2 months, 19.0% 2-3 months, 7.7% 4-5 months). This represents a decline in exclusive breastfeeding compared with the 1999 ZDHS which were 60.7%, 21.7% and 11.5% respectively. Use of bottle-feeding is higher among those who are double orphans (both parents dead). There is some breastfeeding among the double orphans by relatives.

The countries under review accept that breastfeeding is the best method of feeding infants. Further, breastfeeding is deeply rooted in the traditional practices of these countries and is therefore widely promoted as the optimal way to feed infants. Apart from being the main source of nutrition for infants, the other known benefit of breast milk is that it provides protection of infants from diarrhoeas, pneumonia and other infections.

Nevertheless, mixed feeding i.e. breastfeeding combined with feeding of other foods or fluids in the first six months of life, is also widespread in all countries under study. For example, in Uganda 24.4% in 0-3 months and 54.0% in 4-6 months age groups. The most common reasons reported for mixed feeding in Uganda and Zimbabwe are due to the mother working away from home and the ‘not enough breast milk syndrome’.

The median duration of breastfeeding is relatively high with an average of 19 months in these countries (Botswana 18 months, Burkina Faso 18 months in 1988/99, Uganda 19 months in UDHS 2000/1, Zambia 20 months in ZDHS 1996, Zimbabwe 20 months in ZDHS 1999).

Establishing good breastfeeding practices in the first days is critical to the health of the infant and for breastfeeding success. According to WHO (1994), Safe Motherhood is the provision of high quality maternal health services during pregnancy, delivery and in the postpartum period to ensure optimum health of the mother and the infant. This means that the women have access to the information and care they need to safely go through pregnancy and childbirth. In addition, the newborn baby and mother should receive adequate care and support immediately after birth. This is covered in Steps 3, 4, 5 of the BFHI. The ideal situation is that mothers should be counselled to give birth at a health centre or hospital. Yet in three of the countries i.e. Burkina Faso, Uganda and Zambia only 30-35% of the deliveries take place in health facilities by skilled health care providers This low rate of hospital deliveries show that a substantial proportion of women do remain outside the delivery and post-partum health services for reasons that range from taboos, poor mobility, and preference to remain at home to the unavailability or inaccessibility of appropriate care. This could have a bearing on the Baby Friendly Hospital Initiative (BFHI). It could mean that mothers who are motivated already are the same ones who could be attending deliveries at health institutions. However, the women who attend antenatal care are generally more (Burkina Faso 61%, Uganda %, Zambia 95% and Zimbabwe 93 % (ZDHS 1999). Initiation of breastfeeding is on average 44% of babies breastfed within one hour of birth.

In Zimbabwe a national mother friendly childbirth strategy has been developed in the form of Reproductive Health Service Delivery Guidelines were developed and incorporate HIV and infant feeding issues. In 1994, Botswana launched the so-called Baby Mother Friendly Hospital Initiative (BMFHI). They deliberately included 'Mother' in the title of the programme so that maternal health and nutrition issues are addressed concurrently. The BMFHI principle is reportedly being implemented at hospital level. In Uganda, the concept of a MBFHI has been discussed, but there was still need for consensus on whether to adopt it or not. This is because its adoption would require a major change to the existing BFHI package to include other components towards making it MBFHI.
In Botswana the 2001 infant feeding practices study revealed that the adherence to exclusive formula feeding amongst HIV-infected women who choose to formula feed is seemingly good (89%), that exclusive breastfeeding rates among HIV-infected women who choose to breastfeed is poor (29%), and that exclusive breastfeeding rates among uninfected women at PMTCT sites is significantly lower than in mothers at non-PMTCT sites. There is evidence of significant spillover of formula feeding practices amongst uninfected mothers at PMTCT sites. Complementary feeding practices are generally poor at all sites. This shows that there is a need to support both HIV positive and negative mothers so that mothers may successfully practice feeding method chosen.

3.3 COUNTRIES RESPONSE TO HIV/AIDS AND INFANT/YOUNG CHILD FEEDING

In response to the HIV/AIDS epidemic the four countries for which information is available introduced a number of measures. These include:

(a) Development of Policy Guidelines on Infant and Young Child Feeding in the context of HIV/AIDS (Zimbabwe June 2000; Uganda September 2001; Burkina Faso; Zambia 2002 draft; Botswana 2002 draft)
(b) Development and legislation of the International Code of Marketing of Breast milk Substitutes (Zimbabwe law 1998; Uganda law; Zambia draft law 2002; Botswana draft law 2002)
(c) Developing strategies to integrate HIV/AIDS teaching in BFHI (Burkina Faso, Botswana, Uganda, Zambia, Zimbabwe);
(d) Development of Strategy on Training BFHI, BFC, HIV and AIDS (Zimbabwe June 2000)
(e) Training in Breastfeeding Counselling, HIV and Infant Feeding Counselling, PMTCT counselling (Burkina Faso, Botswana, Uganda, Zambia, Zimbabwe);
(f) Scaling up of the Prevention of Mother to Child Transmission (PMTCT) to involve all districts in the country (Botswana), increased number of sites (Uganda-23, Zambia –21, Zimbabwe 106; Burkina Faso 3)
(g) Development of a BMFHI National Strategic Plan (Botswana 2002)
(h) Add Steps (Uganda 1992 – have 12, plans for 13^{th}; Zambia 2002 – plans for 11^{th});
(i) Modifying the Ten Steps to Successful Breastfeeding to be sensitive to HIV/IDS (Zambia 2002, Uganda January 2003, Zimbabwe May 2003);

Information gathered, indicated that there is a general interest and appreciation of the challenges being faced in implementing the BFHI as evidenced by the attempts made to integrate with HIV/AIDS and other health related programmes such as Reproductive Health, Nutrition, Growth Monitoring and Promotion, IMCI. This is being done to ensure that BFHI implementation is revived. However, countries have approached it differently.

3.4 COORDINATION

BFHI National Coordinators were appointed between 1989 and 1994 (1989 in Burkina Faso, 1993 in Zambia and Zimbabwe, 1994 in Botswana). In the three countries the title has been changed to “Infant and Young Child Nutrition Coordinator” and in Uganda there is a “Secretariat for the Infant and Young Child Nutrition Task Force”. In all countries the national coordinators are government employees who also have other duties on general nutrition in addition to coordinating BFHI activities. For instance, the BFHI coordinator in Burkina Faso is also the IMCI focal person in the Family Health Division.

Stakeholder advocacy and consensus building meetings on Infant and Young Child Feeding were held in Zambia (June 2002).and Uganda (October 2002). The aims of these meetings were to develop a cohesive national strategy for infant and young child feeding issues which would be communicated to all stakeholders; to update, sensitise and advocate to stakeholders; share programme experiences and develop a follow-up plan of action. In Uganda the process led to the formation a multi-sectoral Infant and Young Child Nutrition (IYCN) Task Force (TF) under which is a component on the promotion and support of optimal Infant and Young Child Feeding (IYCF). BFHI is under this component. The IYCN Task Force is chaired by the Assistant Commissioner Health Services, Child Health. A member of the Uganda Lactation Management and Education

Team (ULMET) an NGO promoting, supporting and protecting Breastfeeding in the country chair the Promotion and Support component. This also has resulted in high integration at national level.

3.5 OBJECTIVES OF BFHI IMPLEMENTATION

In the three countries (**Botswana, Uganda and Zimbabwe**) the initial objectives of the BFHI were to promote, protect and support breastfeeding and these have not changed as but have incorporated HIV. In Botswana since 1992, BFHI included "mother" in recognition of the contributions of breastfeeding to maternal health, the Botswana cultural practice of "Botsetsi" and to make a deliberate effort towards improvement of maternal nutrition.

In **Zambia**, the initial objectives of BFHI were to improve knowledge and skills of health workers in lactation management; promote and support breastfeeding in order to improve child survival; and ensure that health facilities implement the Ten Steps to successful breastfeeding. The initial objectives in **Burkina Faso** were to promote good feeding practices in the general population, infants and lactating women in particular; strengthen the rights of the child; and promote exclusive breastfeeding. These have also not changed.

3.6 BFHI IMPLEMTANTATION STRATEGIES

Policy Guidelines on IYC in the context of HIV/AIDS were produced between June 2000 (Zimbabwe) and September 2001(Uganda). The policy documents for both countries are available in a bound form. The Uganda policy guidelines are more comprehensive as they include feeding of young children. Whereas the Zimbabwean guidelines are only for infant feeding as they are an implementing strategy for the National HIV/AIDS Policy Republic of Zimbabwe.

In Burkina Faso, the 10 Steps have not been revisited and the certification tool has not been changed.

The advent of HIV in **Botswana, Zambia and Zimbabwe** is said to have slowed down progress in the implementation of the Baby Friendly Hospital Initiative. In Zambia it is believed that most of the facilities have lost the BFHI status as a result of the MTCT during breastfeeding. The resulting confusion over breastfeeding messages in the context of HIV left health workers in a dilemma that was worsened by limited guidance from the UN agencies such as WHO, UNICEF and UNAIDS. **In Uganda**, HIV was not viewed as necessarily being the reason for the lack of momentum in the promotion of BFHI, but they identified such issues as lack of funding, lack of support visits, and individualization instead of institutionalization of BFHI implementation. However, there was no written policy on BFHI between 1998-2001, perhaps due to a lack of policy on BFHI in the context of HIV during this period. Now that a national policy is available, staff feel more confident. The 12 STEPS posters are available but they do not include the HIV. **Zambia and Zimbabwe** still face a high turnover of health workers, due to retirement, resignations and deaths. Hence the need to retrain and yet funds are limited.

Uganda originally adopted the 10 Steps and added 2 more in 1992 on immunisation and the Child Health Card. In 2003, the 12 Steps have since been modified to make them sensitive to HIV/IDS (see Annex 2). Implementation of the BFHI objectives and strategy in **Zambia** has since been revised to take into consideration the aspects of HIV positive mothers. A pilot project was redesigned to test the feasibility of integrating infant feeding and HIV counselling in the context of HIV. To date, there is an increased rate of exclusive breastfeeding in the general population as reported in Ndola where the LINKAGES Demonstration project was being implemented. In 2002, the Ten Steps and the Hospital Self-Appraisal Tool were revised and have also included are aspects of infant feeding in the context of HIV. (Annex 3). A Step 11, which is meant to encompass HIV and infant feeding is reported to be still in draft form. This was achieved through a Working Group.

In Zimbabwe as of May 2003, an attempt was made to modify the Self Appraisal BFHI Tool in the context of HIV (Annex 4). This was done through a participatory approach with a few health facilities previously designated as baby friendly and are also PMTCT sites. One health facility has since amended its hospital policy in view of these modifications (See Annex 5 example). The same modified tool has been communicated to 35 health facilities previously designated baby friendly and at the same time being PMTCT sites. Zimbabwe has included the changes on lactation management in the training of combined course on Breastfeeding, HIV and Infant feeding counseling of one pilot district.

3.7 BFHI IMPLEMENTATION AND ACHIVEMENTS

Table 2 shows the achievements on hospitals designated as baby friendly between 1992 and March 2003.

Implementation of BFHI started between 1991 and 1994 (i.e. in 1991 for Burkina Faso, 1992 for Uganda and Zambia, in 1993 for Zimbabwe and in 1994 for Botswana). Implementation was sustained up to 1995 in Uganda, 1994 in Botswana, 1998, Zambia and Zimbabwe. However, in Zimbabwe there was no total cessation as between 1999 and 2001 there was at least one hospital that was designated as baby friendly each year. In Burkina Faso, the BFHI did not stop as such. Only training in health facilities stopped due to a change in focus where training concentrated on community members to support lactating women. This training included counselling in HIV prevention. There are however new plans to revive training in the health facilities. There was no strategic plan for BFHI implementation; hence information on the number of hospitals targeted and designated by year could not be made available.

By August 2002 a total of 110 health facilities had been designated as baby friendly in the four countries under review. By 1998 Uganda had the least number; only 10 hospitals were trained and 2 designated as baby friendly. Botswana had assessed seven out of a total of 33 hospitals, which were also accredited as baby and mother friendly.

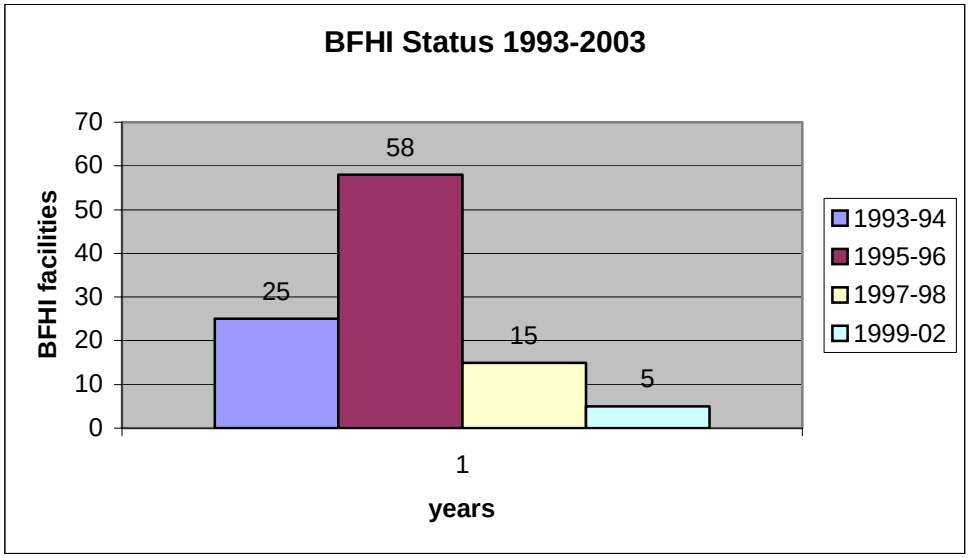
In 2003, Uganda supported by UNICEF has targeted 31 district hospitals for BFHI. These districts cut across PMTCT, IMCI and UNICEF. Zimbabwe also has set its target at 10 hospitals for assessment and 20 hospitals for reassessment with financial support from UNICEF where PMTCT has sites.

Table 2:Achievements: Hospitals designated as Baby Friendly, 1992 to April 2003:

Dates	Botswana (33 targeted)?	Burkina Faso (73 targeted) U	Uganda (434 targeted) U	Zambia (200 targeted)U	Zimbabwe (213 targeted)	Total
1992						
1993			2	2	2	6
1994	4		0	3	9	15
1995	0		0	31	9	40
1996	2		0	5	13	20
1997	1		0	5	4	10
1998		0	0	0	6	6
1999		0	0	0	1	1
2000		0	0	0	1	1
2001		0	0	0	2	2
2002		0	0	0	1	1
2003		0	0	0	0	0
Total	7	27 (37%)	2	46 (23%)	48 823%)	110

U = source was UNICEF 1999.

Figure I



3.8 LINKAGES/INTEGRATION

In Burkina Faso, PMTCT, Reproductive Health and IMCI are in the same Division under the same Director. One person coordinates IMCI and BFHI. Therefore planning is conducted jointly. The BFHI task force members are members of the IMCI working group at national level and participated in the IMCI training materials adaptation.
In **Uganda,** IMCI is represented on the IYCN Task Force. Although the nutrition component of the community IMCI is still regarded as weak, however its members are working hard to implement BFHI. Implementation of BFHI is also linked to the implementation of the PMTCT. With support from PMTCT, the IYCN Task Force has managed to sensitize all 56 districts in the country on BFHI. An IYCN training strategy has been developed that includes BFHI. The Task Force is in the process of developing training materials (drafts are still in their infancy and could not be shared with the Consultant). There is also integration of BFHI in the Support Supervision tool of PMTCT. BFHI is also included in the Integrated Infant and Young Child Counseling Courses.

Both **Zambia and Zimbabwe** with WHO adopted the IMCI feeding guidelines for children below 24 months. Both countries have incorporated replacement feeding in the first 6 months for HIV-positive infants. BFHI concepts, such as correct positioning and attachment, effective suckling, frequent longer breastfeeds day and night, promotion of exclusive breastfeeding, assessing a breastfeed, cup feeding are fully covered. Zambia has extended the issues of HIV-positive infants even up to 2 years. The community component of IMCI under UNICEF in Zambia was said not to have taken off since 2000. However there are plans to work more on it.

In **Uganda, Zambia and Zimbabwe** countries the Infant and Young Child Feeding Coordinator are members of the PMTCT Steering Committee/Partners' Forum and participate in the development of the combined courses for PMTCT and HIV, and Infant Feeding Counseling. In both countries again the trainers in PMTCT courses include those trained as Breastfeeding and HIV, Infant Feeding Counseling, and Lactation Management Trainers.

In **Botswana and Zimbabwe** the Child Health Card is being revised to make it HIV sensitive by the AIDS and TB Unit (PMTCT), RH Unit (IMCI and EPI) and Nutrition Unit and should be ready for use before end of year.

Reproductive health (RH) has multidimensional aspects and therefore collaboration with other stakeholders and sectors is crucial. Governments and other stakeholders aim at supporting programmes addressing issues contributing to good nutrition to ensure that the nutritional status of women, adolescent girls in particular is improved to prevent health problems. Burkina Faso, Zambia and Zimbabwe have gone a long way to integrate infant feeding issues into the Reproductive health programmes at national levels. In Uganda RH is a member of the Promotion and Support working group of the IYCN Task Force. However it seems to be more integrated at health facility level.

A number of **national and international level non-governmental organizations** (NGOs) have often played crucial roles in the successes of the BFHI activities in all these countries. Unfortunately, this currently does not seem to be the same situation in some of the countries. For instance, the breastfeeding support by the La Leche League of Zambia (LLLZ) and the Breastfeeding Association of Zambia (BAZ) that were more active in Lusaka especially at UTH are said to be no longer active. LLL is said to be more active in Kitwe- Copperbelt and to some extent in Lusaka. The lack of activity is reported to be due to a number of reasons including the fact that most members have moved to other paying jobs since most of them worked on a voluntary basis. Due to economic hardships, the leaders could not sustain voluntary work and groups have disintegrated, due to retirement, restructuring and deaths. A similar situation was found in Zimbabwe, where the breastfeeding support NGOs i.e. La Leche League of Zimbabwe (LLZ) and the Zimbabwe Infant Nutrition Network (ZINN) are no longer active. Only one member is still remaining in La Leche League. The International Consultants (ILCA) seem to have survived longer perhaps due to the fact that they charge a nominal fee for their service. In Uganda an NGO called ULMET operating only in Kampala is a member of the IYCN Task Force, and even chairs the Promotion and Support working group. Before the formation of the IYCN Task Force, the NGO equally experienced similar problems as in other countries.

In Zambia, the Zambia Integrated Health Programme (ZIHP) and the Zambia LINKAGES Integrated PMTCT Programme (ZALIPP) are also integrated within the District Health Management Teams breastfeeding activities and work closely with the NFNC. ZIHP works with community based organizations that include mother support groups in nutrition and community based growth monitoring and promotion, which is the entry point for infant and young child feeding. One of the challenges faced by the

community based groups in Zambia and those in Burkina Faso is that of confidentiality especially when it comes to infant and young child issues in relation to HIV.

3.9 SCALING UP PLANS

All countries under review are or planning scaling up PMTCT programs. Efforts generally are being made to incorporate infant feeding issues, BFHI included in the scaling up. However, countries are at different levels of scaling up.

There is no clear plan for the BFHI expansion in **Burkina Faso**. However, the thinking is to revive training in hospitals. Currently only one PMTCT center is functioning out of the three targeted. Negotiations are in the process with the World Bank to start expanding the PMTCT programme within 10 new districts per year. From 2003 to 2005, there are plans to expand in 2 districts per year. IMCI implementation has just started in three districts.

On the other hand in **Botswana**, a National Strategic Plan was written in June 2002 to include a review of the Terms of Reference and reactivation of the National Breastfeeding Authority; an update of the membership to BMFHI in the context of HIV/IDS; an adaptation of IYCF materials to incorporate HIV/AIDS; and the building of a national capacity for BMFHI assessors in the context of HIV.

In **Uganda**, the scale up plan includes capacity building of selected sites, the other components being: orienting of health workers to PMTCT, training laboratory staff on HIV testing, training health workers on counseling for PMTCT, and integrating infant and young child feeding counseling. Both IMCI and BFHI were being handled by the WHO Country office (the report is yet to be submitted to MOH). Currently, IMCI has not incorporated all BFHI concepts. The main component being incorporated is the promotion of exclusive breastfeeding for at least 6 months at community level. The question that still needs to be addressed is whether it is possible to incorporate all the BFHI concepts into IMCI.

PMTCT in **Zambia** is scaling up under different UN agencies and NGO's such as ZALIPP. Under the UN sponsorship, PMTCT is now expanding to cover 21 sites (6 sites were in the feasibility study); under ZALIPP four sites will implement the integrated approach.
As part of its scale up plan for BFHI, Zambia is replicating the Ndola Demonstration Project to four other districts. It is now referred to as the Zambia Linkages Integrated PMTCT Programme (ZALIPP). In general it was felt that BFHI is lagging behind the PMTCT scaling up plan. Hence the need to urgently include the concept in the PMTCT Scaling up strategy. Eighteen of the 46 health facilities once designated baby friendly are also the same districts were other programmes or agencies are operating from i.e. PMTCT (6), IMCI (11), LINKAGES (4), ZIHP (7) and RH (2).

In **Zimbabwe**, the PMTCT is expanding to an initial 107 sites and 35 of these sites are also health facilities that were previously designated baby friendly. Training in the

combined 44-hour Breastfeeding / HIV and Infant Feeding Counseling is targeted the those that are PMTCT sites.

3.10 HANDLING OF ISSUES OF FORMULA SUPPLIES AND LOGISTICS

Neither **Uganda** nor **Zimbabwe** has free infant formula supplied by the Government or by UNICEF. In Zimbabwe infant formula for the medically indicated cases is meant to be purchased through either the food or medicines provision purchasing vote. In contrast, **Botswana** is committed to providing free infant formula for 12 months for HIV-positive mothers opting to feed formula. Up to 97 percent of Batswana are said to have access to clean water and 84 percent use a sanitary means of excreta disposal.

On a small scale such as facility level, in Burkina Faso, Uganda and Zimbabwe, some non-governmental organizations are reported to be providing some form of free replacement feeding. For instance in **Uganda**, GTZ supplies fresh milk to HIV-positive mothers in those districts they operate in through payment of local farmers for the milk. In **Zimbabwe** one of the mission hospitals (Howard Mission Hospital) in Mazowe district does provide infant formula to HIV positive mothers for a period of only six months. This is district where commercial infant formula is hard to come by. Formula in **Burkina Faso** is currently purchased using PMTCT project funds in one center supported by the WHO-Italian project.

UNICEF had initially supported the procurement of the generic infant formula in **Burkina Faso, Uganda, Zambia and Zimbabwe.** However, the Uganda PMTCT Report for 2002 states that during the pilot phase of the program, HIV-positive mothers who after counseling opted not to breastfeed, as well as those who opted to exclusively breastfeed and then stopped before six months of age, were supported with generic infant formula to feed their babies for the first six months. Under UNICEF support in **Uganda**, the enrolment of mothers was stopped in September 2002 and thereafter procurement was only done to cover mothers who had already been enrolled. This support has also been discontinued in the scale up phase of the program due to a number of factors that include costs and logistical challenges. Another reason for discontinuing is that it is not considered easy for the majority of mothers to safely handle this option. It was also noted that some of the mothers who benefited from the free generic formula were among those who could afford to purchase on their own as they had access to clean water. In **Burkina Faso** as well it is reported that the provision of infant formula was stopped when it was realized that the policy was not being properly implemented in that country. Discussion are said to be in progress between the Ministry of Health and UNICEF to come to some solution.

In **Zambia** the handling of formula supplies and logistics is reportedly within the UNICEF supported PMTCT sites. UNICEF has since indicated that they would no longer supply free infant formula. The last issue was for those infants recruited in December 2002 and will be provided for up to one year. In other sites such as those supported by ZALIPP, mothers who opt to use infant formula are encouraged to buy it. If a donation is given, that has to be at least one-year's supply.

In Burkina Faso **confidentiality** is regarded as a big concern since there are no adequate structures or mechanism to guarantee it. In the other countries, to ensure confidentiality, counseling is by trained counselors. Mothers, who are HIV-positive and opt not to breastfeed, are given demonstrations on the preparation of other options away from other mothers and mostly this is done on an individual basis. In view of the intention by UNICEF to end free formula and the WHA Resolution of 1996 on ending free supplies, health workers were trained in Lactation Management Breastfeeding Counseling, HIV and Infant Feeding Counselling as well as implementation, interpretation and enforcement of the Code of Marketing of Breast milk Substitutes.

The **cost of replacement feeding** ranged from 30 to 142 .00 USD for 6 months as of April 2003(25-30 in Burkina, 142.00 in Zambia, in Zimbabwe locally manufactured infant formula is on average USD80.00 and purchased cows fresh and powdered milk is USD128.00 on average).

As part of the way forward for the PMTCT program in 2003, Uganda wishes to conduct an **investigation on the use of modified cow's milk** as a replacement feed for HIV positive mothers opting not to breastfeed their babies. This need for this investigation was also echoed during the discussions with the Commissioner for Infectious Diseases under which the PMTCT falls. *The results of their investigations could be of interest to other countries*

3.11 PRE-SERVICE AND INSERVICE TRAINING/CAPACITY BUILDING

Training of health workers in policy, lactation management skills, HIV and Infant Feeding is one of the key components of the BHFI as highlighted in Step 2.

Pre-service

Burkina Faso and Zambia do report some efforts that have been made to incorporate HIV/AIDS, PMTCT, and Nutrition in general and infant feeding issues in the pre-service curricula. For example in **Zambia**, the General Nurse Council of Zambia is reviewing the Enrolled Nurse Curriculum (draft 2003). The current curriculum has taken into account the increased disease burdens such as HIV/AIDS and the need for community involvement and participation in health care. Under the course title of Medicine and Medical Nursing content on HIV/IDS, VCT, PMTCT are adequately covered and well integrated in the rest of the curriculum depending on the subject under discussion. Under Public Health the topic on Community partnership in health is covered.

Nutrition is a course title on its own allocated 25 hours on theory during the first six months and in the second six months it is covered in other topics such as Medicine and Medical nursing II; course title Paediatrics and Paediatric Nursing; Integrated Reproductive Health. Chainama, which trains Medical Assistants, is reported to have incorporated PMTCT in their curriculum. Most schools are said to be reviewing their

curriculum to be sensitive to HIV/AIDS issues (Registered Nurses, General Nursing Council). This is a commendable development. Infant and Young Child Nutrition issues need to move in line with this trend.

If more such pre-service curriculum are reviewed it can go a long way to address the problems caused at the moment of high staff turnover, high costs for refresher courses. For instances, an 11 days course conducted for the Minimum Package for 25 health workers or a 10 days Breastfeeding Counselling, HIV and Infant Feeding Counselling currently costs an average of USD24 000.00 at provincial level and USD8 500.00 at district level in Zambia. In Zimbabwe the 6-day (44-hour) combined course costs on average USD 5000.00.

In Burkina Faso some BFHI components (10 steps, EBF) are reported to be taught in the school of nursing. It is reported that the training curriculum for nurses has been revised in collaboration with GHPIEGO to introduce the Reproductive Health. At the university, BFHI and Nutrition programmes have been introduced in the teaching of the last year of the curriculum. IMCI is expected to commence in 2004.

In the other countries where curricula have not been amended infant and young child issues are still being taught but a lot depends on the tutor. For example in **Zimbabwe and Uganda, the** tutors trained in Lactation Management, Breastfeeding and HIV and Infant Feeding counseling will make every effort to include such topics in their lectures especially for midwifery training. An average of 6 hours are allocated in the case of Zimbabwe. The training schools which are attached to a baby friendly hospital often have books that are more up to date, such as 'Helping Mothers to Breastfeed', etc. (e.g. Marondera Provincial Hospital and Training School for both General and Midwifery). In both countries (Uganda and Zimbabwe) the Medical Schools especially Departments of Peadiatrics do teach lactation management, breastfeeding and HIV in pregnancy.

Experiences on how pre-service training has integrated infant and young feeding issues could also be drawn from countries not included in this review..

In-Service Training

All the five countries under review have conducted a reasonable number of in-service training or continuing education programs for health-care providers. Such training is aimed at updating skills and knowledge of health-workers in infant and young child feeding and related topics. Refer to details in table 3. The general observation from the BFHI meeting in Botswana is that, a lot of training has been taking place with some modifications in a number of countries. This was raised as a concern as quality is to be maintained. Refer to Annex 8 for an example of course timetable that is a combined course.

With the increased need to support HIV positive mothers, the MOH in Uganda together with WHO and UNICEF decided to conduct an integrated training course in breastfeeding, HIV and infant feeding over a 6-day period. This is now known as the "Integrated Infant and Young Child Feeding Counselling Course". The aim of the course

is to equip the maternal and child health service providers with knowledge and skills to enable them to counsel and support mothers on how best to feed their infants and young children in the context of HIV/AIDS. The course covers six main broad areas which are:

1. Knowledge on Breastfeeding
2. Skills of Breastfeeding Management
3. Knowledge on HIV and Infant Feeding
4. Skills on HIV and Infant Feeding
5. Counselling
6. Implementation of optimal infant feeding practices

The general concern for in-service training in Uganda is that there have not been any refresher courses in BFHI for the 2 designated facilities, especially on BFHI in the context of HIV. Staff trained in PMTCT or IF/HIV counselling did not impart knowledge to the rest of staff- including students on attachment. Not even on the job training was conducted. A total of 16 people were trained under the Training of Trainers programme but there was minimum follow-up training at facility level. This has been attributed to a lack of funds. During the discussions it was suggested that the hospitals should try to include these training courses in the district plans in line with the on-going decentralisation policy.

One in-service training centre was visited in Uganda namely: - the Health Management Development Centre (HMDC) in Mbale. It is a national training centre for health-workers on distance education programmes. The HMDC developed a National Health In-Service Training Strategy, which could be, adopted countrywide. Also available at the HMDC is a Child Health module that incorporates the Uganda 12 Steps for BFHI and HIV/AIDS for Children. However, this module needs updating in order to incorporate BFHI in Context of HIV and latest information.

To date, **Uganda** has since 2001 trained a total of 115 HIV and Infant Feeding Counsellors, and has three national level Course Directors and 16 Trainers for Infant Feeding and HIV Counselling. A one-week long centrally co-ordinated course is conducted in collaboration with the Mwanamugimu Nutrition Unit at Makerere University and the Child Health Division of the Ministry of Health. This course is on integrated Infant and Young Child Feeding Counselling. It combines modules from the Baby Friendly Hospital Initiative Course, the Breastfeeding Counselling Course as well as the HIV and Infant Feeding Counselling Course. In 2002 the PMTCT reported that a workshop was conducted for 34 participants from selected sites. This complemented three similar workshops in 2001 that were attended by a total of 81 participants.

Zambia has plans to continue capacity building of health workers in health facilities in the area of PMTCT, BFHI, BFC and HIV and Infant Feeding Counseling (10 days).

PMTCT reports that training took place in three forms namely:

(1) PMTCT Minimum Package for 11 days, which includes a nutrition component, covered over a two-day period.

(2) A 10-days course on Breastfeeding Counselling, and HIV and Infant Feeding Counselling
(3) Laboratory Rapid Testing for Midwives.

In 1999 PMTCT in collaboration with WHO and UNICEF conducted the first national BFC, HIV and Infant Feeding Counselling course. From September 2002 PMTCT has trained about 150 health workers in BFC, 25 trainers and six course directors and 250 under the Minimum Package. Of concern however is the fact that most of these counsellors tend to regard infant formula as the only feasible option to HIV positive mothers. This could be due to the fact that is freely available from UNICEF support. However NFNC needs to conduct an inventory of who has been trained in what course and for how long.

Monze district under PMTCT have incorporated infant feeding issues in the training of lay counsellors, Traditional Birth Attendants (TBAs), peer educators, and community leaders, Kaluluchi breastfeeding and growth monitoring support groups and TBAs, reproductive health motivators. These are all cadres that could be encouraged to support Step 10 of BFHI and give support to HIV positive mothers on different options.

As part of the revitalisation strategy a national Baby Friendly Hospital Initiative Assessors Training Workshop was conducted for six days January/February 2002. Training of 22 cadres from the 17 facilities once designated baby friendly on BFHI and HIV. UNICEF supported the training financially and technical support was provided by LINKAGES.

Zimbabwe has invested in training counsellors in the combined Breastfeeding/ HIV and Infant Feeding Counselling Courses. Courses have also been conducted at national (2), provincial/city/central hospital (13), districts levels, as well as including the PMTCT program (5). Since year 2000 over 300 Breastfeeding/ HIV and Infant Feeding Counsellors have been trained. The WHO/IMCI and UNICEF/PMTCT programs supplied training materials. Funding has been from Government of Zimbabwe, WHO/IMCI, UNICEF and NGO's supporting PMTCT programs (KAPNEK, CESVI, ISPED). In the majority of cases this has been on a co-funding basis.

A number of libraries visited in Uganda and Zimbabwe do not have much on Infant feeding and HIV, nor BFHI. The available **books** range from 1974 to 1999 edition. For instance training materials at HMDC in Uganda were not very up to date. The latest being a 1999 edition. *Immediately required are supplementary materials for Tutors.*

Table 3: Record of In-service Training conducted by country 1992-May 2003

COUNTRY	BFHI UNICEF/ WHO 18-hours or 5 days	BFHI with HIV	40-hour Breasttfeeding Counselling	Breastfeeding, HIV and Infant feeding counselling (6-10 days) 2000 to May 2003	Number of BFC, HIV, IF counsellors followed-up	PMTCT Minimum package	Community level cadres

Botswana	37	NI	NI	200+ counsellors 133 training of trainers 24 managers received orientation	NI	NI	NI
Burkina Faso	NI	NI	NI	NI	NI	NI	500 women
Uganda	NI	NI	NI	115 IF counsellors 3 course directors 16 trainers	115 technical support	NI	NI
Zambia	346*	22 those previously trained in lactation management from baby friendly facilities	30*	150 IF counsellors 25 trainers 6 Course directors	63	250 from September 2002	NI
Zimbabwe	500+	16 from Rusape hospital	230 BFC counsellors 19 trainers	300 IF counsellors 37 trainers 10 course directors	8	1119 Nurse Midwives 233 trainers	NI
TOTAL				585 IF counsellors 78 trainers 19 course directors			

NI = no information could be obtained by the time this report was being finalised
* source is UNIICEF Programme Division: Baby Friendly Hospital Initiative, Case Studies and Progress Report, March 1999

3.12 FUNDING OF BFHI AND PMTCT PROGRAMMES

All countries under review regard the PMTCT as national priority. **In Botswana** government contributes over 90% of the required resources to the program. The remainder is guaranteed through the support from UNICEF and BOTUSA. In Zimbabwe government contributes through the 3% AIDS Levy, and UNICEF and other NGO's contribute some.

Botswana, Uganda, Zambia and Zimbabwe indicated that with the passage of time, the BFHI was no longer considered a priority by funding agencies. Botswana reported that there was lack of funding support from funding organisations including the UN organisations for breastfeeding activities up to 1999. In Uganda UNICEF support for BFHI by declined between 1995 and 2002. Government support had been mainly the production of materials and was therefore considered inadequate. In Zimbabwe UNICEF

funding for BFHI increased from (USD 1000.00) in 1999 to USD7820.00 in 2003 mainly for training of trainers, assessors, and for assessing and reassessing hospitals. WHO/IMCI committed USD30 000.00 for the infant and young child feeding activities in the 2002/2003 bi-annum budget. In addition, the Government of Zimbabwe has always funded Infant and Young Child Nutrition under its Nutritional Programmes, including BFHI. Before year 2000, SIDA funded 80% of the BFHI activities in Zimbabwe.

.

In Zambia, under WHO, funding of nutrition programmes was not a priority in the current bi-annum 2002/2003 budget. However, when annual plans are made, additional; funds are often sourced. Under IMCI and Reproductive Health some nutrition issues are included. For instance nutrition for the ill child. UNICEF has pledged to financially support the revitalisation of the BFHI, the Code and IYCF integrated with funds from the HIV/AIDS programme.

3.13.MONIITORING AND EVALUATION

Three countries (Uganda, Zambia and Zimbabwe) no hospitals have been re-assessed yet after the modifications to provide a basis of measuring level of success. In June 2002, Botswana reassessed nine facilities (7 hospitals and 2 national referral hospitals) using the WHO/UNICEF re-Assessment Tool but none met the criteria for BFHI. In Uganda, Zambia and Zimbabwe there are plans to conduct reassessments subject to availability of funds.

The issue of greatest concern in countries visited and from reports is the lack of **follow – up** of the trained trainers and counsellors. Follow-up of trained breastfeeding and infant feeding counsellors has been conducted in Zambia and Zimbabwe with financial and technical support from WHO. This is an area that requires urgent attention.

3.14. OUTSTANDING OR CONTROVERSIAL ISSUES SURROUNDING THE WHOLE SUBJECT OF BFHI IN THE CONTEXT OF HIV IN COUNTRIES UNDER REVIEW

- Coordination of the many activities that are initiated by the different programmes e.g. MPSI, IMCI, PMTCT, and LINKAGES.

- BFHI forms the supporting base for counselling on HIV and Infant Feeding, however it not clear how the initiative is going to be revitalised and strengthened with special reference to human, financial and material resources.

- What needs to be done to improve exclusive breastfeeding whilst at the same time reducing mixed feeding for mothers who are HIV-positive or negative or of unknown status remains a challenge for all countries. Burkina Faso is concerned about the resistance to exclusive breastfeeding in the context of HIV/AIDS (risk of transmission). Rates in Zimbabwe have gone down.

- There is the issue of abrupt cessation of exclusive breastfeeding and how to manage the transition? Another issue is the use of Expressed Heat Treated Breast milk? In Uganda for instance, it is said that expressing human breast milk is generally and culturally unacceptable. Are health workers willing / convinced enough to be able to teach or recommend the method to mothers?

- In Zambia mixed messages are still being sent to mothers and health workers in respect to BFHI and HIV, especially in areas where PMTCT activities are not being undertaken. Yet PMTCT recommends exclusive breastfeeding and abrupt weaning at 3 months versus at 6 months. The HOW TO DO IT still remains a challenge?

- In Uganda, modalities need to be worked out for managing BFHI as a priority in a decentralised system, e.g. promoting BFHI in district plans, use of Government funds and keeping staff motivated. Task Force members met during the mission indicated that the decentralisation policy where by districts have become autonomous bodies and nutrition in the context of the BFHI may not regarded as a priority.

- The practicalities of the different infant feeding options need to be explored further as a lot of support is needed for the mothers and their families.

- Nutrition Supplements for HIV positive mothers. Is it feasible? How about the rest of the family?

- Stigmatisation of HIV positive mothers stopping the EBF at 4 months, or infants on replacement feeding and confidentiality issues.

- Towards implementation of Step 10: Follow up issues on how to make use of existing community based workers and community resource persons (CORPS) who have been trained under the different programmes and are often selected by the community, but are not necessarily trained in HIV counselling. Is counselling by these cadres feasible? How to handle the issue of confidentiality and stigmatisation? Will HIV-positive mothers come out in the open? Perhaps BFHI Step 10 could be used as an entry point to avoid stigmatisation and ensure confidentiality of those infected. In Uganda guidelines on the community support for optimal infant and young child feeding have been developed; these will guide

the communities on how to establish and implement the community support for IYCF.

- The need for continued and sustained follow up of health workers after training of trainers (TOT), especially the counsellors. It is often assumed that when TOT are equipped with knowledge and skills, they would automatically pass these on. This is common in a number of the countries. Funding is mentioned as a constraint – the question is how can this be resolved in view of the high staff turnover?

- While continued and sustained follow up and support of HIV positive mothers is critical to invest in, but how feasible is it in view of limited human and financial resources!

- Another challenge as expressed by the Uganda Commissioner for Infectious Diseases is to establish nutritionally adequate alternative feeding options for HIV positive mothers. The outcome of current investigations could be shared with other countries in the Africa Region. The other challenge would be the provision of adequate micronutrients.

- There is need for a pre-service curricula review as a long-term sustainable strategy, how to keep materials for in-service training up-to-date.. *Lessons could be drawn from the Burkina Faso, Zambia experiences including other countries in the region*

- How to revive and sustain the activities of the Breastfeeding support NGO's in these countries.

- The need to revise the Global Hospital Self Appraisal tool, External Assessors Tool and Reassessment Tool that are HIV sensitive or sensitive to the changing environment.

4.0 SUGGESTIONS FOR THE WAY FORWARD

The recommendations and suggested way forward were derived from suggestions from the completed questionnaire as part of the responses by each country, from discussions made with the key informants, and during the debriefing meetings in countries visited. In addition the recommendations and suggested way forward and conclusion are aimed at encouraging debate, encourage concerted collective actions and guidance in the

implementation of BFHI in the context of HIV and AIDS especially in countries with high prevalence rates.

In addition, the Baby Friendly Hospital Initiative might have to respond to the changing environment.

4.1 COORDINATION

- There is a lot of commendable progress made through the integrated approach of BFHI into health related activities taken up by the different programmes in all the countries under review. The experiences from Uganda could be shared with other countries.

- A number of documents and materials are in the form of drafts. The Ministry of Health and especially in Botswana, Uganda, and Zambia should make every effort to ensure that drafts integrating the various materials such as the Code, Nutrition Policy (specifically for Zambia), Maternity Protection, are completed before the prevailing momentum and effort is lost. The technical aspects are almost complete. What is left mainly is the legal and policy aspects.

4.2 BFHI OBJECTIVES, IMPLEMENTATION STRATEGY

- HIV was not necessarily the main reason for the loss of momentum in the promotion of BFHI. Cited, as causes were such issues as lack of funding, lack of support visits, and the individualization instead of institutionalization of BFHI implementation

- HIV/AIDS is not considered as a hindrance to promoting, protecting and supporting breastfeeding, as most people are believed to be too poor to afford any other infant feeding options. The fight against HIV/AIDS through the discouragement of mixed feeding should positively influence exclusive breastfeeding. The Ndola Demonstration Project has reported this trend.

- Exclusive breastfeeding could minimize MTCT of HIV as shown by some studies. Unfortunately, exclusive breastfeeding is rarely practiced in these countries. However, Uganda is the only one among the four countries under review with a satisfactory rate of exclusive breastfeeding. Follow up of HIV-positive mothers is critical; especially those who choose exclusive breastfeeding to avoid mixed feeding. There is need establish what factors prevent exclusive breastfeeding. For example, the PMTCT Communication Strategies in Uganda and Zimbabwe could look at ways to address this and share experiences with the other countries.

- There is need to reassess facilities previously declared baby friendly. Due to a high staff turnover, training of staff in BFHI in the context of HIV has become necessary.

4.3 INTEGRATION

- IMCI feeding recommendations during sickness and health need to be updated to be more sensitive to HIV/AIDS e.g. Replacement Feeding in the first 6 months for Uganda.

- Generally observed is the trend that breastfeeding is now better promoted in the context of the PMTCT or the fight against HIV/AIDS. However, the now predominant message at health facilities for HIV positive mothers is to breastfeed for only up to 3 months. This leaves out the majority of mothers who are HIV negative for whom the message should be to breastfeed for up to 6 months.

- Antenatal, maternity and postnatal should be a focus for the BFHI integrated with PMTCT; hence, the Reproductive Health component should play an active role in the implementation of BFHI and PMTCT.

4.4 PRE- SERVICE AND IN-SERVICE TRAINING/ CAPACITY BUILDING

- The review of curricula and materials for pre-service and in-service in countries were this has not taken place needs to be conducted as a matter of urgency. For example, Uganda is currently reviewing its curricula for pre-service training schools and this opportunity should not be missed to incorporate the Infant and Young Child Nutrition (BFHI included) and PMTCT issues.

- Materials and information gathered and reviewed during the missions indicate that the various programmes i.e. IMCI, RH, PMTCT, UNICEF have some infant and young child issues incorporated depending on the programme focus. For instance, in Zambia the 'Making Pregnancy Safer Initiative' that has a focus on antenatal care, delivery and postnatal care have, BFHI concepts for Steps 1, 2, and 3. In addition, there is training conducted for a good number and varied community based cadres such as Traditional Birth Attendants (TBAs), Breastfeeding/growth monitoring promotion support groups, reproductive health motivators who could be used to facilitate BFHI Step 10. IMCI for example have a chart book which have been reviewed to make it sensitive to HIV/AIDS issues such as the 'Feeding Recommendations During Sickness and Health' does provide information on infant feeding options in Zambia and Zimbabwe. LINKAGES, ZIHP have training curriculum, which include BFHI concepts. *Therefore In-service training could be co-funded by IMCI, PMTCT, BFHI, and RH subject to coordinated planning.*

- There is a need to look at what training, who was trained and for how long nationally to be able to come up with a comprehensive training and follow-up strategy in each of the countries.

- WHO/AFRO and other UN Agencies should consider supplying countries with up to date educational materials on nutrition and related subjects for the tutors.

4.5 COMMUNITY SUPPORT

- In all countries there is need to revive training in health facilities and establish link with communities and support groups.

- Breastfeeding support and promotion NGOs such as La Leche League, Breastfeeding Association of Zambia (BAZ), Zimbabwe Infant Nutrition Network (ZINN) are reported to be no longer functional due to a number of reasons including the fact that most members have moved to other paying jobs since most of them worked on a voluntary basis. There is need to see to it that they are revived and strengthened as a matter of urgency. There is also need to strengthen funding of activities of NGO's promoting breastfeeding. In Uganda, for example ULMET needs to open branches at provincial and district levels.
-
- The importance of ensuring gender balance i.e. involve partners / fathers and other family members in IYCF especially the BFHI. Perhaps BFHI and not PMTCT could be the entry point.

4.6 MONITORING AND EVALUATION

- The trained counsellors often come across problems they cannot handle and for which they need extra support. Experience from two countries show that this is an area that requires urgent attention.

5.0 CONCLUSION

The five countries reviewed have achieved a satisfactory level of integration at national level. Special mention is made of progress in Uganda where a focal person is in place to co-ordinate IYCN. This has brought about close collaboration and facilitated progress towards the promotion, protection and support for BFHI in the context of HIV/AIDS. With a number of enabling factors in place in these countries, the progress and achievements for the BFHI in the context of HIV/AIDS could be achieved.

Integration is desirable, as it will achieve standardization of messages, materials, and human resources. However there is need to acknowledge that there are some concepts that can be integrated and some that cannot. In addition, one has to guard against over integration, as this is likely to leave out some critical concepts/messages.

At national level BFHI could stand alone to help ensure that some specific issues are addressed. In the case of new information and knowledge, this can be filtered down before integrated materials are developed. However at community and facility level, BFHI cannot continue to stand-alone. The integrated and concept approach is the best

way forward, especially in view of decentralization where districts have become autonomous.

In all the countries under study, plans have been developed to strengthen the Baby Friendly Hospital Initiative through training of assessors and integration into PMTCT. However, there is need to combine the acceleration of PMTCT activities with BFHI so that more hospitals become baby friendly in the context of HIV/AIDS and strengthen monitoring of the program.

Pre-service Education in all the countries visited does provide students with some knowledge and skills necessary to promote, support and protect optimal infant and young child feeding. It was observed that most of the topics on breastfeeding and lactation management, infant and young child feeding were often covered under the human life cycle in both basic and applied sciences. There is need therefore to review the curricula for medical, nursing, midwifery, allied public health and nutrition education program. Uganda and Zimbabwe are at the stage where curricula review is due (overdue for Zimbabwe but no fund for a review). A consultant from each country should be hired to assist with the review. This is a golden opportunity to integrate infant and young child concepts into the various curricula. The Zambia and Burkina Faso experiences are commendable and worth learning from.

6.0 REFERENCES

6.1 COMBINED

1. Madzima Rufaro C. December 2003. Questionnaire: Baby Friendly Hospital Initiative In The Context of HIV/AIDS: African Region: Response from Uganda, Barbara Tembo, January 2003; Response from Zambia, Wilson Siasulwe, NFNC, February 2003; Response from Burkina Faso, Youssof Gamatie, May 2003;
2. UNAIDS. 2002. Report on the global HIV/AIDS epidemic

3. UNICEF Programme Division. March 1999. Baby Friendly Hospital Initiative Case Studies and Progress Report
4. UNICEF. June 2003. Report of Meeting on Baby Friendly Hospital Initiative in the Context of HIV/AIDS, Gabarone (Draft)
5. WHO. June 2001. Status of Infant and Young Child Feeding in Sub-Saharan African: Situational Analysis.
6. WHO and UNICEF. August 1992. Baby Friendly Hospital Initiative, Part III, External Assessors Manual.
7. WHO/AFRO. November 2002. Planning Meeting For The Implementation Of The Global Strategy For Infant and Young Child Feeding held in Harare 11-14 November 2002.
8. WHO. 1982. The International Code for Marketing of Breast milk Substitutes
9. WHO/CHD. 1998. Evidence for the ten steps to successful breastfeeding (Revised).

➢

6.2 BOTSWANA

10. Hon Joy Phumaphi, Minister, Ministry of Health, Republic of Botswana: Launch of the Reactivation Campaign of The Baby Mother Friendly Hospital Initiative. Princes Marina Hospital. Keynote Address. 19th June 2002.
11. Mompati Kabo, 19 June 2002.. Family Health Division, Ministry of Health, Botswana. Baby Mother Friendly Hospital Initiative Reactivation in Botswana: National Strategic Plan. Presented at the Launch of the Reactivation Campaign,
12. Mompati Kabo. 2-4 June 2003. Procurement and Distribution of Free Formula for PMTCT- Bostwana Experience.
13. Morewane, D. 2-4 June 2003. Implementation of BMFHI in the Context of HIV/AIDS, Botswana Experience

6.3 UGANDA

14. Republic of Uganda, Ministry of Health: Sexually Transmitted Disease/ AIDS Control Program (STD/ACP): Prevention of Mother-to-Child Transmission of HIV: Annual Report for January – December 2002
15. Republic of Uganda, Ministry of Health and UNICEF: Policy Guidelines on Feeding of Infants and Young Children In The Context of HIV/AIDS. September 2001.
16. Republic of Uganda, Ministry of Health: Infant and Young Child Feeding Task Force, Promotion and Support Working Group: Planning Meeting on the Promotion and Support for Optimal Infant and Young Child Feeding, Hotel AFRICANA, Kampala, 7th March 2003.
17. Uganda Ministry of Health/AMREF Distance Education Programme: Child Health Course, Unit 4, Nutrition, July 1999.
18. Uganda Ministry of Health/AMREF Distance Education Programme: Child Health Course, Unit 17, HIV/AIDS in Children, July 1999.

19. UNICEF, Michael C. Latham and Pauline Kisanga: Current Status of Protecting, Support and Promotion of Breastfeeding in Four African Countries: Actions to Protect, Support and Promote of Breastfeeding in Botswana, Kenya, Namibia and Uganda, Based on a rapid review – 2 October-3 November, 2000. January 2001. 6th draft March 2001.
20. Republic of Uganda, Ministry of Health: Nutrition Section: Steps to successful breastfeeding; A Flipchart for Health Care Providers in Uganda, 2000.
21. Republic of Uganda, Ministry of Health: Integrated Infant and Young Child Feeding Counselling Course: Training Curriculum, February 2003.

6.4 ZAMBIA

22. Ministry of Health, Reproductive Health Unit. August 2000. Republic of Zambia First Draft, Reproductive Health Policy.
23. WHO, UNICEF, Republic of Zambia. 2003. Integrated Management of Childhood Illnesses.
24. General Nurses Council of Zambia. 2003. Revised Enrolled Nurse Curriculum
25. National Food and Nutrition Commission. March 2002. Report on National Baby Friendly Hospital Initiative Assessors Training Workshop. January 28 to February 2, 2002 at UTH.
26. Republic of Zambia, Ministry of Health. January 10, 2003. Draft Strategic Framework and Work plan for the Expansion of Integrated PMTCT Service in Zambia 2003-2005.
27. Ministry of Health, Central Board of Health of Zambia. October 2002. Integrated Reproductive Health: Plan of Action 2003-2005.
28. Kawesha E Chizema Dr of the Kalulushi District Health Board. Making Pregnancy Safer Pilot Project Sponsored by World Health Organisation: Report on Training Program for 2002.
29. WORLD LINKAGES. September 2002. Zambia Country Program Report.

6.5 ZIMBABWE

30. Madzima Rufaro C. September 2002. BFHI with the challenges of HIV/AIDS: Zimbabwe Experience. Paper presented at the WABA Forum 2, 23-27 September 2002 held in Arusha Tanzania.
31. Ministry of Health and Child Welfare, National Nutrition Unit, Zimbabwe. 12 June 2000. Infant Feeding and HIV/AIDS: Guidelines for Health Workers in Zimbabwe.
32. Ministry of Health and Child Welfare, Republic of Zimbabwe Reproductive Health Service Delivery Guidelines, Zimbabwe. 2001.
33. Ministry of Health and Child Welfare, AIDS and TB Unit. The Prevention of Mother to Child Transmission of HIV Programme 2002 Annual Report. Zimbabwe.
34. UNICEF, MOHCW, WHO. August 2002 final draft. Integrated Management of Childhood Illnesses (IMCI). Resource Manual.

35. WHO, UNICEF, MOHCW. March 2003 draft. Integrated Management of Childhood Illnesses: Proposed Manual for Community Based Workers.
36. Zimbabwe General Nurses (Training) Regulations 2000. Statutory Instrument 245 of 2000. CAP27:08

ANNEX 1: COUNTRY PROFILES ON KEY ISSUES AND OBSERVATIONS

BOTSWANA

Policies and Coordination

A "Baby Friendly Hospital Initiative Reactivation National Strategy Plan" is in place. The aim of the reactivation of the program is to ensure that all health care facilities and PMTCT centres become baby and mother friendly. This means that all health care facilities do not only protect, promote and support breastfeeding in accordance with the 'Ten Steps', but also broaden their scope of operation in order to ensure overall achievement of optimal infant and young child feeding practices in the context of HIV. Existing drafts include the National Policy on Infant and Young Child Feeding and the Regulations on the Marketing of Breastmilk Substitutes.

Objectives, Implementation Strategy of the TEN STEPS and Achievements

The Baby Friendly Hospital Initiative (BFHI) was introduced in 1992 and launched in 1994 as "Mother Baby Friendly Hospital Initiative" (MBFHI). The initiative included the "mother" in recognition of the contribution of breastfeeding to maternal health, in recognition of the Botswana cultural practice of "Botsetsi" and to make deliberate effort

towards improvement of maternal nutrition. A total of 33 health facilities were targeted for MBFHI implementation with seven designated as baby friendly by1997.

There are plans by the Ministry of Health in Botswana to revisit the 'Ten Steps' to incorporate HIV and AIDS issues. This would make it possible for health care providers to ensure that HIV positive mothers opting not to breastfeed would be fully supported towards optimal feeding for their infants themselves.

Integration

BMFHI has been linked to the PMTCT programme and training. Scaling up of PMTCT took place in all districts between July 2000 and November 2001. Breastfeeding counsellors, PMTCT counsellors and other health professionals have been trained afresh as Trainers. MCH has been linked to existing programmes such as MCH/FP, EPI, IMCI and Safe Motherhood. Hence, BMFHI committees in health facilities have got representatives of the different programmes.

Pre-and In-Service Training and Capacity Building

An in-service training strategy has been developed to integrate HIV and AIDS into MBFHI, BFC and IFHIVC. By 2002 a total of 133 trainers and over 200 health professionals had been trained in IYCF counselling course in the context of HIV and AIDS. However, the rapid turnover and shortage of staff in the Food and Nutrition Unit contributed negatively to the implementation of IYCF activities.

Counselling and Support on Infant Feeding Options

Training has taken place for Lactation Management, Code Documentation and Implementation, BFC, HIV and IFC.

Community Action, Knowledge and Skills at Lower Levels and Care

Stigmatisation is still being experienced by HIV positive mothers who are replacement feeding. Pre-lacteal feeds are still widely practiced. Although communities have been trained in how to form BMFHI committees and mother support groups, the 10th Step for BFHI remains a challenge. However there are plans to re-activate and form mother support groups in targeted hospitals.

Replacement Feeding and Logistics

Infant formula was found to be one of the most expensive components of the PMTCT program. Costs continued to rise with the expansion of the programme and demand for formula increased more than 5 fold.

UNICEF was not involved in procurement of commercial infant formula for the PMTCT program. The programme purchased formula using normal channels from the market by looking for 3 quotations. Botswana is committed to providing free infant formula for 12 months to babies born to consenting HIV-positive mothers opting to formula feed.

Resources

Lack of financial support from organizations including the UN organizations for breastfeeding activities up to 1999 is reported to be one of the factors that contributed negatively to the implementation of the BMFHI. Prioritisation of financial support from the Government and UN Organisations to HIV and AIDS also contributed negatively.

Monitoring and Evaluation

In June 2002 reassessments were conducted in all the seven health facilities that had been previously designated as baby friendly and two national referral hospitals. The WHO/UNICEF/Wellstart International BFHI Monitoring and Reassessment Tool to sustain progress was used. None of the facilities met the criteria. There are plans to reassess the targeted hospitals in 2003/2004 as centers of excellence.

A recent evaluation of the infant feeding practices in the PMTCT sites revealed that there were delays in instituting formula feeding by over one hour after birth for babies of HIV positive mothers who opted to feed formula. This finding emphasises the importance of ensuring that HIV/AIDS issues are incorporated in the BMFHI. Botswana suggested that since the 'Ten Steps' recommend initiation of breastfeeding within 'half hour of birth', this should be extended to formula feeding of babies as well.

Enabling Factors

- Support by Government of Botswana/Ministry of Health, UNICEF, and WHO on the BMFHI Strategic Plan and reactivation campaign
- UNICEF support of consultancy on IYCF activities.
- Support by UNICEF for accelerated action on BMFHI reactivation, training, policy development and regulations on the Marketing of Breastmilk Substitutes.
- Continued team/ consultations/ discussions between PMTCT and IYCF/BMFHI programmes, policy development, curriculum training development, training of PMTCT counselors, PMTCT Technical Advisory Committee
- Country position on recommended infant feeding method for infants born to HIV positive mothers, orientation of managers on BFC/BMFHI and HIV and Infant Feeding
- Increased financial resources

BURKINA FASO

Policies and Coordination

The BFHI coordinator in Burkina Faso is also the IMCI focal person in the Family Health Division.

Objectives, Implementation Strategy of the TEN STEPS and Achievements

The initial objectives have not changed.
The implementation of the BFHI started in 1991 and did not stop as such. There was no strategic plan for BFHI implementation; hence information on the number of hospitals targeted and designated by year could not be made available.
The 10 Steps have not been revisited and the certification tool has not been changed.

Integration and Scaling Up

PMTCT, Reproductive Health and IMCI are in the same Division under the same Director. Infant feeding issues have been integrated into the Reproductive Health programmes at national level. One person coordinates IMCI and BFHI. Therefore planning is conducted jointly. The BFHI task force members are members of the IMCI working group at national level and participated in the IMCI training materials adaptation.

Pre-and In-Service Training and Capacity Building

Some BFHI components; the 10 steps and Exclusive Breastfeeding) are reported to be taught in the school of nursing. It is reported that the training curriculum for nurses has been revised in collaboration with GHPIEGO to introduce the Reproductive Health. At the university, BFHI and Nutrition programmes have been introduced in the teaching of the final year of the curriculum. IMCI is expected to commence in 2004.

Counselling and Support on Infant Feeding Options

Training slowed down at health facility level due to a change of focus where training concentrated on community members to support lactating women. The training included counselling in HIV prevention. There are plans to revive training at health facility level.

Community Action, Knowledge and skills at Lower Levels and Care

There are plans to revise the Code to take into consideration the HIV and AIDS context and the guidelines related to infants born from HIV positive mothers. The guidelines have been adopted with exclusive breastfeeding being recommended up to 4 months followed up with replacement feeding. From 1998, there was a change in strategy. Burkina Faso stopped training in hospitals and shifted to training community members (women support groups). This strategy was thought to be more effective through provision of inter personal counselling. So far 500 women have been trained in counselling in exclusive breastfeeding.

Issues of Formula and Logistics

General provision of infant formula was stopped when it was realized that the policy and guidelines set were not being properly implemented. On a small scale, such as at one WHO-Italian PMTCT project free formula is reported to be provided

Monitoring and Evaluation

Nothing reported in this area.

Enabling Factors

- Low prevalence rate for HIV/AIDS
- Joint planning for PMTCT, Reproductive Health, IMCI and BFHI
- Training of 500 community members (women support groups), in exclusive breastfeeding counselling and HIV prevention; hence strengthening Step 10 of BFHI.

UGANDA

Policies and Coordination

Uganda has a multi-sectoral. Infant and Young Child Nutrition (IYCN) Task Force (TF) under which is a component on the promotion and support of optimal Infant and Young Child Feeding (IYCF) since Oct 2002. A working group to revitalise BFHI was set up by the TF. The IYCN Task Force is chaired by the Assistant Commissioner Health Services, Child Health. The Promotion and Support component is chaired by a member of the Uganda Lactation Management and Education Team (ULMET), an NGO promoting, supporting and protecting Breastfeeding in the country.

Objectives, Implementation Strategy of the TEN STEPS and Achievements

The initial objectives of the BFHI have not changed. The Ten Steps to Successful Breastfeeding have been adopted, including modifying of the 12 Steps of the Hospital Self Appraisal Tool to make them sensitive to the issues of HIV and AIDS (Annex 3). The TEN STEPS have been left in their original state. Modifications have been made in the subsections to include additional points which address HIV positive mothers who are not breastfeeding. Only Steps 2 and 8 have not been modified. In addition, Uganda makes reference to 12 STEPS instead of 10. Since 1992 two Steps have been added to provide for the immunisation of infants delivered in the health facility with BCG and Polio Vaccine and that a properly completed Child Health Card for every mother-infant pair are

issued at discharge. There are plans for an additional 13th Step to include provision of vitamin A on discharge.

BFHI implementation started in 1992 and was active up to 1995, with two health facilities designated as baby friendly

Integration and Scaling Up

Integration has been achieved at national level. At facility level, integration is not as high. The PMTCT programme has embraced the BFHI. With the scaling up of the PMTCT programme, BFHI is moving on with the scaling up plan. The implementation of BFHI is linked to the PMTCT implementation. With support from PMTCT, the Task Force has managed to sensitise all the 56 districts in the country on BFHI, developed a IYCN training strategy that includes BFHI, and are in the process of developing training materials. BFHI has also been integrated into the Support Supervision tool of PMTCT and the Integrated Infant and Young Child Counselling Courses. Twenty-three districts have at least one PMTCT site.
The challenge remains on development of strategies on how to manage the BFHI as a priority under the decentralized policy and promote inclusion of nutrition as well as BFHI in district plans and keep staff motivated. Integration of infant feeding issues and Reproductive Health is greater at health facility level.

Pre-and In-Service Training and Capacity Building

With the increased need to support HIV positive mothers, the MOH together with WHO and UNICEF conduct an integrated training course in BFHI, breastfeeding, HIV and infant feeding over a 6-day period. This is now known as the "Integrated Infant and Young Child Feeding Counselling Course". Since 2001 to date, Uganda has trained a total of 115 HIV and Infant Feeding counsellors, has three national level course directors and 16 trainers for Infant Feeding and HIV Counselling.

Counselling and Support on Infant Feeding Option

The general concern for in-service training is that there have not been any refresher courses in BFHI for the 2 designated facilities, especially on BFHI in the context of HIV. Staff trained in PMTCT or HIV and IF counselling often did not impart knowledge to the rest of staff and follow-up training at facility level minimum. Trained counsellors often face implementation constraints, such as transport, lack of funds and poor motivation. Plans are that the hospitals should try to include these training courses in the district plans in line with the on-going decentralisation policy.

Community Action, Knowledge and Skills at Lower Levels and Care

Studies carried out between 2000/1(UDHS) show that Uganda had high levels of exclusive breastfeeding rates in both urban and rural areas.
A Working Group on a Communication Strategy for PMTCT exists and has plans for a formative research as a basis for establishing interventions at community level. Guidelines on community support for optimal infant and young child feeding have been

developed to guide the communities on how to establish and implement community support for IYCF.
The community component of IMCI has been integrated with general exclusive breastfeeding promotion.

A major challenge is how to sensitise and involve male partners and the community at large. There is some resistance in community to accept any other feeding option, as breastfeeding is considered as the only mode of feeding acceptable by many. The same is said to apply regarding the effective involvement of the civil society organisations, which include NGOs, CBOs and the Private Sector. Despite it being discouraged, mixed feeding is reportedly still being practiced by some mothers. It is feared this could potentially erode success of the intervention.

Replacement Feeding and Logistics

There are no free supplies of infant formula anymore by the Government or UNICEF. On a small scale, one NGO supplies fresh cows milk to HIV positive mothers through payment of local farmers for the milk in districts in which they operate. During the pilot phase of the programme, HIV positive mothers were supplied with free generic infant formula procured with support from UNICEF. This was discontinued due to a number of factors that included costs, logistical challenges, and that the majority of mothers did not find it easy to safely handle this option. In addition, it was noted that some of the mothers who ended up benefiting from the free generic formula were those who could afford to purchase on their own and were those who had the clean water, etc.

The PMTCT programme wishes to conduct an investigational research into the use of modified cow's milk as a replacement feed for HIV positive mothers who would have opted not to breastfeed their babies.

Resources

The financial support in Uganda for BFHI by UNICEF ceased from 1995 to October 2002. Government support for the BFHI was mainly on material production. Government support is however considered to be inadequate. In October 2002 UNICEF made another financial commitment towards supporting the implementation of BFHI in the country.

Monitoring and Evaluation

Support supervision on 25 of the 56 districts was conducted in 1999 and found that most of the Steps except for Step 10 were being practiced. Re-assessment of designated health facilities using the WHO/Wellstart Tool remains a challenge.

Enabling Factors

- The review by UNICEF in January 2001 whose recommendations are being implemented;
- Policy guidelines on IYCF in the context of HIV and /AIDS, Multi-sectoral Task Force on IYCN (RH, PMTCT, IMCI, ULMET, UNICEF, WHO);
- Multi-sectoral Task Force on IYCN (Nutrition, RH, PMTCT, IMCI, ULMET, UNICEF, WHO)
- Chairmanship by Assistant Commissioner Health Services- Child Health which shows the high level placed by the Government for IYCN issues;
- ULMET chair-Promotion and Support component;
- Provision of funds from PMTCT to implement the BFHI and community component
- Sensitisation of 56 districts on BFHI and HIV;
- Training of midwives in PMTCT, HIV/IF counsellors;
- Renewed funding from UNICEF for BFHI;
- Integrated materials produced;
- The CORPS concept; and
- Designation of a Focal Person for IYCN, which brought up close collaboration and facilitated progress.

ZAMBIA

Policies and Coordination

A BFHI National Coordinator was appointed in 1993. Infant and Young Child Feeding (IYCF) issues are coordinated by a Nutritionist in the National Food and Nutrition Commission (NFNC). The Nutrition Specialist in the Central Board of Health (CboH) coordinates all nutrition programmes. Funds to the NFNC are channelled through CBoH. There are plans to move PMTCT from a separate Secretariat to the CBoH. The move to have the PMTCT programme under CboH is said to be commendable for sustainability of the programme.

In June 2002 a "Stakeholders' Advocacy and Consensus Building Meeting on Infant and Young Child Feeding" was conducted to develop a cohesive national strategy and develop a follow-up action plan for infant and young child feeding issues which would be communicated to all stakeholders. The Code of Marketing of Breastmilk Substitutes has been revised and will soon be law in order to enforce provisions in the Code.

Coordination of the many activities which are initiated by the different programmes such as MPSI, IMCI, PMTCT, LINKAGES remains a challenge.

Objectives, Implementation Strategy of the TEN STEPS and Achievements

The initial objectives of BFHI have not changed as such but have been made more sensitive to HIV. The implementation of the BFHI objectives and strategy has since been revised to take into consideration the aspects of HIV positive mothers. Ten Steps and the Hospital Self-Appraisal Tool have been revised and included are aspects of infant feeding in the context of HIV. This was achieved through a Working Group. A step 11 meant to encompass HIV and infant feeding for use in infant feeding within PMTCT is still in a draft form.

A pilot project was designed in Ndola under the LINKAGES Demonstration Project to test the feasibility of integrating infant feeding and HIV counselling in the context of HIV in existing health delivery system. An increased rate of exclusive breastfeeding in the general population in Ndola, has been reported.

Currently the strategy is to revitalise the 46 health institutions that were once designated as baby friendly. Ten health facilities have been targeted for 2003 subject to availability of financial support. As part of the revitalisation strategy, a 6-day training workshop for 22 participants was conducted to revive BFHI in the context of HIV/AIDS. This was meant to train National BFHI Assessors who will be used in the re-assessment of health facilities, which were previously declared baby friendly. UNICEF supported the training financially and technical support was provided by the LINKAGES project.

Integration and Scaling Up

PMTCT is scaling up under different UN agencies and NGO's such as ZALIPP. However, it was felt that BFHI is lagging behind the PMTCT scaling up plan. Hence it needs to be urgently included in the PMTCT Scaling up strategy As part of its scaling up plan for BFHI, the Ndola Demonstration Project is being replicated in seven other districts. It is now referred to as the Zambia Linkages Integrated PMTCT Programme (ZALIPP).

The Zambia Integrated Health Programme (ZIHP) and the Zambia LINKAGES Integrated PMTCT Programme (ZALIPP) are also integrated within the District Health Management Teams breastfeeding and community based growth monitoring activities and work closely with the NFNC.

The Infant and Young Child Feeding Coordinator from NFNC is a member of the PMTCT Steering Committee and participates in the development of the combined courses for PMTCT and HIV, and Infant Feeding Counselling. The trainers in PMTCT courses include those trained in Breastfeeding and HIV, Infant Feeding Counseling, and Lactation Management Trainers. Infant feeding issues have been integrated into the Reproductive Health programmes at national level.

Pre-and In-Service Training and Capacity Building

Zambia has gone a long way in integrating infant feeding issues in a number of documents including, the curriculum for Enrolled Nurses, the LINKAGES programme, the IMCI and MPSI.

From September 2002, PMTCT has trained about 150 health workers in BFC, 25 trainers and six course directors and 250 under the Minumum Package. Of concern however is the fact that most of these counsellors tend to regard infant formula as the only feasible option to HIV positive mothers. This could be due to the fact that it was freely available

National Baby Friendly Hospital Initiative Assessors Training Workshop was conducted for six days January/February 2002. Training of 7 cadres from the 17 facilities once designated baby friendly on BFHI and HIV.

There are plans to continue capacity building of health workers in health facilities in the area of PMTCT, BFHI, BFC and HIV and Infant Feeding Counseling (10 days). However NFNC needs to conduct an inventory of who has been trained in what course and for how long.

Counselling and Support on Infant Feeding Options

To ensure confidentiality, counseling is by trained counselors. Mothers who are HIV-positive and opt not to breastfeed, are given demonstrations on the preparation of other options away from other mothers and mostly this is done on an individual basis. Health workers were trained in Breastfeeding Counseling, Lactation Management as well as implementation, interpretation and enforcement of the Code of Marketing of Breastmilk Substitutes.

ZIHP works with community based organizations which include mother support groups in nutrition and community based growth monitoring and promotion which is the entry point for infant and young child feeding. One of the challenges faced by the community based groups in Zambia is that of confidentiality especially when it comes to infant and young child issues in relation to HIV.

There is a need for continued and sustained follow-up and support for HIV positive mothers. It was agreed that it is a critical area to invest in but there is doubt over its feasibility due to the limited human and financial resources.

A number of the materials and documents reviewed tend to equate infant feeding counselling, in the context of HIV, with supply of infant formula. Now that UNICEF free supply will come to an end, Zambia needs to think seriously on how to change the thinking of Health Workers trained as infant feeding counsellors under the PMTCT.

Community Action, Knowledge and skills at Lower Levels and Care

Breastfeeding Association of Zambia (BAZ) which has more activities in Lusaka, especially at UTH, is no longer active. The lack of activity is reported to be due to a

number of reasons, including the fact that most members have moved to other paying jobs, since most of them worked on a voluntary basis. Due to economic hardships, the leaders could not sustain voluntary work and groups have disintegrated. Other reasons include retirement, restructuring and deaths.

Monze district which is under PMTCT have incorporated infant feeding issues in the training of lay counsellors, TBAs, peer educators and community leaders, Kaluluchi breastfeeding and growth monitoring support groups and TBAs, reproductive health motivators. These are all cadres that could be encouraged to support Step 10 of BFHI and give support to HIV positive mothers on different options.

The once rising exclusive breastfeeding rates are reported to be on the decline nationally. Maybe other districts could learn from the Ndola Demonstration Project from which reports indicate an increase rather than a decrease.

Mixed messages are still being sent to mothers and health workers in respect to BFHI and HIV, especially in areas where PMTCT activities are not being undertaken.

The practicalities of the different infant feeding options need to be explored further as a lot of support is needed for the mothers and their families.

Replacement Feeding and Logistics

The handling of formula supplies and logistics is, reportedly within the UNICEF supported PMTCT sites. UNICEF has since indicated that they would no longer supply free infant formula. In other sites such as those supported by ZALIPP, mothers who opt to use infant formula are encouraged to buy it. If a donation is given, that has to be at least one-year's supply.

Resources

Under WHO, nutrition programmes were not a priority in the current bi-annum 2002/2003 budget. However, when annual plans are made funds could be sourced. Under IMCI and Reproductive Health some nutrition issues are included. For instance, nutrition for the ill child, breastfeeding and replacement feeding.

UNICEF has pledged to financially support the revitalisation of the BFHI, the Code and IYCF integrated with funds from the HIV/AIDS programme.
Reported high staff turnover, limited funding for BFHI, still remain a challenge.

Monitoring and Evaluation

There are plans to re-assess facilities and train of health workers in BFHI taking into account the prevention of MTCT of HIV. But this is subject to availability of funds.

Follow-up of trained breastfeeding and infant feeding counsellors has been conducted for 63 counsellors with financial and technical support from WHO. Continued and sustained follow up of health workers after training as trainers (TOT) especially the counsellors is still needed. The lack of funds for monitoring the work and follow-up training is a constraint.

Enabling Factors

- National Baby Friendly Hospital Initiative Assessors Training Workshop conducted for six days January/February 2002;
- Training of midwives in PMTCT, BFC and HIV/IFC;
- Pledges on funding from UNICEF for BFHI, CODE, Breastfeeding Counselling, HIV and Infant Feeding counselling training under HIVand AIDS and from WHO under IMCI and Reproductive Health;
- Incorporation of infant feeding issues in various programme plans and the Enrolled Nurses Curriculum;
- The training of community based groups by MPSI, PMTCT, ZIHP, and ZALIPP
- The Ndola Demonstration Project which has provided experiences from which other provinces and countries could learn from

ZIMBABWE

Policies and Coordination

HIV/AIDS Guidelines on Infant Feeding and HIV were produced in June 2000 as an implementing strategy for the National HIV/AIDS Policy of 1999. The National BFHI Coordinator was appointed in 1993 and the title is now Infant and Young Child Feeding Coordinator in line with the Global Strategy on Infant and Young Child Feeding.

Objectives, Implementation Strategy of the TEN STEPS and Achievements

The advent of HIV slowed down programme in the implementation.
As of May 2003, an attempt was made to modify the Self Appraisal BFHI Tool in the context of HIV (Annex 5). This was done through a participatory approach with a few health facilities previously designated as baby friendly and are also PMTCT sites. Modifications have been made on both the Steps and subsections where applicable. For an example, the term ‘infant feeding’ may replace ‘breastfeeding’. In addition a section on Health Facility Training Records for PMTCT, Lactation Management, Combined 44-hour course on BFC/HIV/Infant Feeding and IMCI has been added. One health facility has since amended its hospital policy in view of these modifications (See Annex 6 example). The same modified tool has been communicated to 35 health facilities previously designated baby friendly and at the same time being PMTCT sites.

A total of 48 (23%) of health facilities have been designated as baby friendly between 1993 and 2002. Although implementation was greatest between 1993 and 1998, there

was no total cessation as at least one hospital was designated each year between 1999 and 2002.

Integration

The IYCF National Coordinator is a member of the PMTCT Partners' Forum. The Child Health Card is being revised to make it HIV sensitive by PMTCT, Reproductive Health, IMCI and Nutrition. More effort has been put in integrating infant feeding issues into Reproductive Health programmes and IMCI at national levels.

Pre-and In-Service Training and Capacity Building

A Strategy linking BFHI, HIV and AIDS and Training for Infant Feeding was developed in June 2000. The main objective of the strategy is to link up and standardise training in Infant Feeding (Baby Friendly Hospital Initiative, Breastfeeding Counselling and HIV/AIDS and Infant Feeding Counselling) for health professionals and other extension agents.

The training gives different course outlines in order to cater for the different training needs, including those without previous training in breastfeeding, health workers who have been trained in BFHI and those trained in breastfeeding counselling. The duration of the BFHI course was extended from 18 hours to 22 hours to include three topics on the Infant feeding/HIV component running over a period of 3 days or in sessions of 1 or ½ days in the hospital setting.

The three topics under the Infant Feeding and HIV Counselling course are:

- "Overview of HIV and Infant Feeding and Prevention" (60 minutes);
- ,"Counselling for HIV Testing and for Infant Feeding Decision Process" (120 minutes), and
- "Integrated Care for the HIV-positive Woman and her Baby" (60 minutes)".

Zimbabwe has included the changes on lactation management in the training of combined course on Breastfeeding, HIV and Infant feeding counseling of one pilot district.

Counselling and Support on Infant Feeding Options

The country has invested in training counsellors in the combined Breastfeeding/ HIV and Infant Feeding Counselling Courses (Annex 7). Courses have also been conducted at national (2), provincial/city/central hospital (13), district levels, as well as including the PMTCT program (5). Since year 2000 over 300 Breastfeeding/ HIV and Infant Feeding Counsellors have been trained. The WHO/IMCI and UNICEF/PMTCT programs supplied training materials. Funding has been from Government of Zimbabwe, WHO/IMCI, UNICEF and NGO's supporting PMTCT programs (KAPNEK, CESVI, ISPED). In the majority of cases this has been on a co-funding basis.

Community Action, Knowledge and skills at Lower Levels and Care

Step 10 needs to be addressed in a more strategic and coordinated manner than the present situation. Community based counselors need to be trained to assist with the follow up of mothers. Efforts have been made to incorporate infant feeding issues into cIMCI community based workers manual.

Replacement Feeding and Logistics

Infant formula for the medically indicated cases is purchased through either the food or medicines provision purchasing vote. On a small scale such as at facility level, some non-governmental organizations are reported to be providing some form of free replacement feeding. One of the mission hospitals does provide infant formula to HIV positive mothers for a period of only six months. This is in an area where commercial infant formula is hard to come by.

Resources

Zimbabwe faces a high turnover of health workers, due to retirement, resignations and deaths. Hence the need to continuously train.
For the PMTCT programme, the government contributes through the 3% AIDS Levy, and UNICEF and other NGO's contribute a considerable amount.

Between 1996 and 1999, BFHI was no longer considered a priority by funding agencies. However, UNICEF funding for BFHI increased from (USD 1000.00) in 1999 to USD7820.00 in 2003 mainly for training of trainers, assessors, and for assessing and reassessing hospitals. WHO/IMCI committed USD30 000.00 for the infant and young child feeding activities in the 2002/2003 bi-annum budget. In addition, the Government of Zimbabwe has always funded Infant and Young Child Nutrition under its Nutritional Programmes, including BFHI. Before year 2000, SIDA funded 80% of the BFHI activities in Zimbabwe.

.

Monitoring and Evaluation

Follow-up of trained breastfeeding and infant feeding counsellors has been conducted with financial and technical support from WHO/AFRO. This is an area that still requires urgent attention.
One Provincial Hospital was reassessed and did not meet the criteria. This faced a lot of staff turnover. No hospitals have been re-assessed yet after the modifications to provide a basis of measuring level of success. There are plans to reassess 20 health facilities where PMTCT sites exist.

Enabling Factors

•National policy on infant feeding – 0 to 6 months exclusive breastfeeding
•National Infant Feeding Coordinator exist at national, provinces/city levels.

•Public Health Act – the Code of Marketing Breast milk Substitutes Regulations/law 46 of 1998
•Maternity Protection Regulations – 13 weeks and two half hour breaks until baby is 6 months
•3% Government levy towards HIV and AIDS programmes
•Government commitment to support training, material development, Guidelines for Health workers funded by government
•No free samples of formula in health facility- hospital purchase for medically indicated cases
•Infant Feeding Strategy for Training - June 2000

Annex 2: UGANDA DRAFT

BABY FRIENDLY HOSPITAL INITIATIVE SELF - ASSESSMENT TOOL

STEP I. Have a written breastfeeding policy that is routinely communicated to all health care staff.

1.1 Does the health facility have a written breastfeeding policy that addresses all the Twelve minimum Steps to Successful Breastfeeding in maternity services and protects breastfeeding?…….Yes ☐ No ☐

1.2 Is the breastfeeding policy available so that all staff who take care of mothers and babies can refer to it? ……..Yes ☐ No ☐

1.3 Is the breastfeeding policy posted or displayed in all areas of the health facility which serve mothers, infants and/or children?……..Yes ☐ No ☐

1.4 Does the policy prohibit group instructions in the use of Infant formula?…….Yes ☐ No ☐

1.5 Does the policy allow the Health Facility to receive free supplies of formula from manufactures?……..Yes ☐ No ☐

1.6 Does the policy support mothers who are HIV positive in infant feeding option of their choice?……..Yes ☐ No ☐

1.7 Does the policy promote, protect and support breastfeeding irrespective of HIV infection rate within the population?……Yes ☐ No ☐

STEP 2. Train all health care staff in skills necessary to implement this policy.

2.1 Are all staff caring for women and infants oriented in the breastfeeding policy of the hospital on their arrival?……..Yes ☐ No ☐

2.2 Is training on breastfeeding and lactation management given to all staff caring for women and infants within six months of their arrival?……Yes ☐ No ☐

2.3 Does the training cover all twelve minimum steps to Successful breastfeeding?…….Yes ☐ No ☐

2.4 Is the training on breastfeeding and lactation management at least 18 hours in total, including a minimum of 3 hours of supervised clinical experience?……..Yes ☐ No ☐

STEP 3. Inform all pregnant women about the benefits and management of breastfeeding

3.1 Does the health facility include an antenatal care clinic or antenatal inpatient ward?……..Yes ☐ No ☐

3.2 Are all pregnant women attending these antenatal services informed about the benefits and management of breastfeeding?……Yes ☐ No ☐

3.3 Are pregnant women attending antenatal services intending to use infant formula given instructions separately from the group?……..Yes ☐ No ☐

3.4 Are pregnant women informed about mother to child transmission of HIV Yes ☐ No ☐

3.5 Are VCCT service available?……Yes ☐ No ☐

3.6 Is confidentiality adhered to during counselling?…….. Yes ☐ No ☐

3.7 Are HIV position mothers given information on benefits and risks of breastfeeding?…… Yes ☐ No ☐

3.8 Are mothers who are HIV positive given information about the benefits and risks of artificial infant feeding?…….. Yes ☐ No ☐

3.9 Are mothers who are HIV positive counselled on infant feeding?…… Yes ☐ No ☐

3.10 Do pregnant mothers who are HIV positive make informed decision on infant feeding option before they are due to deliver?…… Yes ☐ No ☐

3.11 Are Antiretroviral treatment available?…….. Yes ☐ No ☐

STEP 4. Help mothers initiate breastfeeding within a half-hour of birth.

4.1 Are mothers who deliver normally given their babies to hold, skin-to-skin, within a half hour of birth?……. Yes ☐ No ☐

4.2 Are mothers who deliver by caesarean given their babies to hold skin-to-skin within a half hour after they are able to respond?…… Yes ☐ No ☐

4.3 Do the babies stay with their mothers, at this time, for at least 30 minutes?……Yes ☐ No ☐

4.4. Are the mothers offered help by a staff member to initiate breastfeeding?…… Yes ☐ No ☐

4.5 Do the staff assist the mothers who are HIV positive and have opted not

to breastfeed to also hold their babies skin to skin soon after delivery? Yes ☐ No ☐

4.6 Do the staff assist mothers who are HIV positive and opted not to breast in preparation of replacement feeds and also feeding the babies…….. Yes ☐ No ☐

4.7 Are mothers who are HIV positive supported in the infant feeding of their choice?…….☐….Yes ☐ No

4.8 Are the babies born to HIV positive mothers given antiretroviral treatment where indicated?……☐ Yes ☐ No

STEP 5. Show mothers how to breastfeed and how to maintain lactation, even if they **should be separated from their infants**

5.1 Does nursing staff offer mothers who are breastfeeding further assistance within 6 hours of delivery?……..……☐…Yes ☐ No

5.2 Are mothers continuously assisted to breastfeed their babies by the staff?……☐……Yes ☐ No

5.3 Are breastfeeding mothers shown how to correctly position and attach their babies for breastfeeding?…….☐ Yes ☐ No

5.4 Are breastfeeding mothers shown how to express their breast milk?……☐……..Yes ☐ No

5.5 Are mothers advised of where they can get any help on breastfeeding Issues, should they need it?……☐….Yes ☐ No

5.6 Are mothers of babies in the special care nursery helped to establish and maintain lactation by frequent expression of breastmilk?……☐Yes ☐ No

5.7 Are HIV positive mothers who opt not to breastfeed shown how to prepare or make a replacement feeding of their choice?…….. ☐ Yes ☐ No

5.8 Are the instructions on preparation of replacement feeds given privately and confidentially?…… ☐ Yes ☐ No

STEP 6. Give newborn infants no food or drink other than breastmilk, unless *medically* Indicated

6.1 Do breastfeeding babies received no food or drink Other than breastmilk unless medically indicated…… ☐ Yes ☐ No

6.2 Do staff have a clear understanding of what the few acceptable reasons are for prescribing food or drink other than breastmilk for breastfeeding babies…… ☐ Yes ☐ No

6.3 Do the staff assist babies born to HIV positive mothers to feed according to mothers choice using infant feeding guidelines?…… ☐ Yes ☐ No

STEP 7. Practice rooming-in allow mothers and infants to remain together-- 24 hours a day

7.1 Do mothers and infants remain together 24 hours a day, except for periods of up to an hour for hospital procedures or if separation is *medically* indicated?…… ☐ Yes ☐ No

7.2 Are HIV positive mothers who opt not to breastfeed allowed to stay In bed with skin to skin BUT NOT accessing the infant to the breast?…… ☐ Yes ☐ No

STEP 8. Encourage breastfeeding on demand.

8.1 By placing no restrictions on the frequency or length of breastfeeds, do staff show they are aware of the importance of breastfeeding on demand?…☐es ☐ No

8.2 Are mothers advised to breastfeed their babies whenever their babies are hungry or as often as their babies want to nurse? ……☐Yes ☐ No

8.3 Are mothers advised to wake their babies up for breastfeeding, should their babies sleep for long?……. ☐ ☐
Yes No

STEP 9. Give no artificial teats or pacifiers to infants

9.1 Are babies who have started to breastfeed cared for without any bottle feeds?……☐……Ye ☐
No

9.2 Are babies who have started to breastfeed cared for without using pacifiers (also called dummies or soothers)?……☐ ☐Yes
No

9.3 Do all mothers learn that they should not give any bottles or pacifiers to their babies?……. ☐ ☐
Yes No

9.4 Are mothers advised not to use cups with spouted covers if they should feed their babies with cups…… ☐ ☐
Yes No

STEP 10. Foster the establishment of mother support groups and refer mothers to **them on discharge from the health facilities**

10.1 Does the health facility give education to key family members so that they can support mothers and their infants at home?……..☐ ☐Yes
No

10.2 Are breastfeeding mothers referred to breastfeeding support groups, if any are available?……☐……Ye ☐
No

10.3 Does the hospital have a system of follow-up support for all breastfeeding mothers after they are discharged, such as early postnatal appointments ☐ ☐

Lactation clinic check-ups, home visits, or telephone calls, etc?…….Yes ☐ No ☐

10.4 Does the health facility network with traditional birth attendants and other Community Health Workers?……..……Yes ☐ No ☐

10.5 Does the health facility include TBAs and other Community Health Workers in infant and young child feeding activities?…….……Yes ☐ No ☐

10.6 Does the health facility provide information to the support Groups on mother to child transmission of HIV?……Yes ☐ No ☐

10.7 Does the health facility provide information to the support Groups on HIV and infant feeding?……..Yes ☐ No ☐

10.8 Does the health facility instruct these groups on how to provide extra Support to HIV positive mothers regardless of the feeding option?…… Yes ☐ No ☐

10.9 Are mothers, (especially the HIV positive) discharged with a proper And approved follow up care plan?……. Yes ☐ No ☐

STEP 11. Ensure that all infants delivered in the Health Facility receive BCG and Polio Vaccine before discharge

11.1 Does the health Facility give BCG and Polio o to all babies before discharge?……Yes ☐ No ☐

11.2 Are mothers advised to bring their babies for further immunization?….Yes ☐ No ☐

STEP 12. Issue a properly filled in child Health Card to every mother – infant pair at Discharge

12.1 Are all the health staff trained in proper filling and interpretation of

growth chart?…… ☐ Yes ☐ No

12.2 Are mothers given information/interpretation of their babies growth chart?…… ☐ Yes ☐ No

12.3 Are mothers advised to bring their babies together with the Child Health Card for further growth monitoring?…….. ☐ Yes ☐ No

Summary:

Does your health Facility follow all the 12 **STEPS** for promoting successful breastfeeding? Yes No

If no, what improvements are needed?

If improvements are needed, would you like some help? Yes No If yes, please describe:

This form is provided to facilitate a process of health Facility self-assessment. If a health facility wishes to invite assessment in order to be designated Baby Friendly, the completed from may be submitted in support of the application to the relevant national health authority and the WHO and UNICEF country programmes.

If this form indicates a need for substantial improvements in practices, health facilities are encouraged to spend several months in readjusting routines, retraining staff, and establishing new patterns of care, before repeating the self-appraisal process.

ANNEX 3
ZAMBIA, July 5, 2002 Hospital Self Appraisal Tool for the WHO/UNICEF Baby Friendly Hospital Initiative

Preamble

Overall, breastfeeding provides substantial benefits to both children and mothers. It significantly improves child survival by protecting against diarrhoeal diseases, pneumonia and other potentially fatal infections, while it enhances quality of life through its nutritional and psychosocial benefits. As a general principle, in all populations breastfeeding especially exclusive breastfeeding in the first six months after birth should continue to be protected, promoted and supported especially for women that are HIV negative, those of unknown status and those that are HIV positive but decide to breastfeed.

STEP 1. **Have a written infant and young child feeding policy that is routinely communicated to all health care staff**

1.1 Does the health facility have an explicit written policy for protecting, promoting and supporting breastfeeding that addresses all 10 steps to optimal infant feeding in maternity services?
…….
Yes No

1.2 Does the policy protect breastfeeding by prohibiting all promotion of group instruction for using breast milk substitutes, feeding bottles and teats?……. Yes
No

1.3 Is the infant feeding policy available to all staff who takes care of mothers and babies and can refer to it? …… Yes No

1.4 Is the infant feeding policy posted or displayed in all areas of the health facility which serve mothers, infants and/or children?
…… Yes
No

1.5 Is there a mechanism for evaluating the effectiveness of the policy?
……
Yes No

1.6 Does the policy address the issues of infant feeding in relation to PMTCT?
…… Yes No

1.7 Does the policy protect use of replacement feeding by prohibiting all promotion of and group instructions for using breastmilk substitutes,

except for HIV positive mothers who choose to use replacement feeds? ……. Yes No

STEP 2 Train all health care staff in skills necessary to implement this policy

2.1 Are all staff aware of the advantage of breast feeding and acquainted with the facility's policy and services to protect, promote and support breastfeeding?…….. Yes No

2.2 Are all staff caring for women and infants oriented to the breastfeeding policy of the hospital on their arrival? ……. Yes No

2.3 Is training on breastfeeding and lactation management given to all staff caring for women and infants within six months of their arrival? …… Yes No

2.4 Does the training cover at least eight of the ten Steps to Successful Breastfeeding and the protection of breastfeeding? ……. Yes No

2.5 Is the training on infant feeding at least 54 hours in total including a minimum of 16 hours of supervised practical experience? …….. ……. Yes No

2.6 Has the healthcare facility arranged for specialized training in infant feeding of specific staff members? ……. Yes No

2.7 Are all staff aware of risks of breastfeeding in the context of HIV transmission?…… Yes No

2.8 Are all staff caring for women and infants trained in appropriate use of replacement feeds? …… Yes No

Step 3. Inform all pregnant women about the benefit and management of breastfeeding

3.1 Does the hospital include an antenatal care clinic? Or an antennal Impatient ward?…….. Yes No

3.2 If yes, are most pregnant women attending these antenatal services informed about the benefits and management of breastfeeding? ……. Yes No

3.3 Do antenatal records indicate whether breast-feeding has been discussed with the pregnant woman? …….. Yes No

3.4 Is a mother's antenatal record available at the time of delivery? Yes No

3.5 Are pregnant women protected from oral or written promotion of and group instruction for artificial feeding? …… Yes No

3.6 Does the healthcare facility take into account a woman's intention to Breastfeed when deciding on the use of sedative, an analgesic, or an anesthetic, (if any) during labor and delivery? …….. Yes No

3.7 Are staff familiar with the effects of such medicaments of infant feeding? ……. Yes No

3.8 Does a woman who has never breastfed or who has previously encountered problems with breastfeeding and chooses to breastfeed receive special attention and Support from staff of the healthcare facility?……. Yes No

3.9 Are options on infant feeding discussed with HIV positive mothers? …….. Yes No

3.10 Are mothers supported in their infant feeding decision with further counseling and follow-up to make that decision as safe as possible? ……. Yes No

Step 4. Help mothers initiate breast feeding within a half-hour of birth

4.1 Are mothers whose deliveries are normal, regardless of their HIV status given their babies to hold, with skin contact, within a half hour of completion of the second stage of labor and allowed to remain with them for at least the first hour?

…… . Yes No

4.2 Are the mother offered help by a staff member to initiate breastfeeding during the first hour? ……. Yes No

4.3 Are mothers who have had caesarean deliveries given their babies to Hold, with skin contact within a half hour after they are able to respond to their babies? ……. Yes No

4.4 Do the babies born by caesarean stay with their mothers with contact at this time for at least 30 minutes? …… Yes No

4.5 Are mothers who are HIV positive and opt not to breastfeed shown how to prepare appropriate replacement feeds? …….. Yes No

Step 5 Show mothers how to breast-feed and how to maintain lactation, even if they should be separated from their infants

5.1 Does nursing staff offer all mothers further assistance with breast-feeding within six hours of delivery? ……. Yes No

5.2 Are most breastfeeding mothers able to demonstrate how to correctly position and attach their babies for breastfeeding? …….. Yes No

5.3 Are breastfeeding mothers shown how to express their milk or given information on expression and/or advised of where they can get help, should they need it? …….. Yes No

5.4 Are staff members or counselors who have specialized training in infant feeding available full-time to advise mothers during their stay in health care facilities and in preparation for discharge? …… …….Yes No

5.5 Does a woman who has never breastfed or who has previously encountered problems with breastfeeding and chooses to breastfeed receive special attention and support from the staff of the healthcare facility? ……. Yes No

5.6 Are mothers of babies in special care and have chosen to breastfeed helped to establish and maintain lactation by frequent expression of milk?

…… Yes No

5.7 Are mothers whose babies are on replacement feeds able to demonstrate correctly the preparation of the feeds?…… Yes No

5.8 Are mothers who are HIV positive told the risks of HIV transmission through breastfeeding? …….. Yes No

5.9 Are mothers who are HIV positive and opt to give replacement feeds told the risks of replacement feeds if not properly used? ….. Yes No

Step 6. Give newborn infants no food or drink other than breastmilk, unless medically indicated

6.1 Does staff have a clear understanding of what the few acceptable reasons are for prescribing food or drink other than breastmilk of infant feeding babies? (see acceptable medical conditions, Annex 1: The Global Criteria) …….. Yes No

6.2 Do breastfeeding feeding babies receive no other food or drink (than breastmilk) unless medically indicated?

Breast milk only……..Yes No
Some other food/drink……..Yes No

6.3 Are any breastmilk substitutes including special formulas which are used in the facility purchased in the same way as any other foods or medicines? ……. Yes No

6.4 Do the health facility and all health care workers refuse free or low-cost supplies of breastmilk substitutes, paying close to retail market price for any? ……. Yes No

6.5 Is all promotion for infant foods or drinks other than breastmilk absent from the facility…….. Yes No

Step 7. Practice rooming in allow mothers and infants to remain together 24 hours a day.

7.1 Do mothers and infants remain together (rooming in or bedding in) 24 hours a day, except for periods of up to an hour for hospital procedures or in separation is medically indicated? ……. Yes No

7.2 Does rooming in start within an hour of a normal birth? …… Yes No

7.3 Does rooming in start with an hour of when a caesarean mother can respond to her baby? ……. Yes No

Step 8. Encourage breastfeeding on demand

8.1 By placing no restrictions on the frequency or length of breastfeeding, do staff show they are aware of the importance of breastfeeding on demand? …….. Yes No

8.2 Are mothers who choose to breastfeed advised to breastfeed their babies whenever their babies are hungry and as often as their babies want to breastfeed?……. Yes No

8.2 Are the staff aware of how often a child on replacement feed is supposed to be fed according to the age of the baby and acceptable guidelines? ……. Yes No

Step 9: Give no artificial teats or pacifiers (also called dummies or soothers) to breast feeding

9.1 Are babies who have started to breastfeed cared for without any bottle feeds? …… Yes No

9.2 Are babies who have started to breastfed cared for without using pacifiers? ……Yes No

9.3 Do breastfeeding mothers learn that they should not give any bottles or pacifiers to their babies? …… ……Yes No

9.4 By accepting no free or low-cost feeding bottles, teats, or pacifiers do the facility and the health workers demonstrate that these should be avoided? …….. Yes No

Step 10. Foster the establishment of mother support systems and refer mothers to them on discharge from the hospital or clinic.

10.1 Does the hospital give education to key family members so that they can support the breast-feeding mother at home? ……. Yes No

10.2 Are all mothers, regardless of their HIV status referred to support systems, if any available? …….. Yes No

10.3 Does the hospital have a system of follow-up support for breast-feeding support groups, if any available? ……. Yes No

10.4 Does the facility encourage and facilitate the formation of mother-to-mother or health care worker-to-mother support systems?…… Yes No

10.5 Does the facility allow breastfeeding counseling by trained mother-support group counselors in its maternity services? ……. Yes No

10.6 Does the hospital have a follow up system and support for HIV positive mothers who opt to put their babies on replacement feeds?…. Yes No

ANNEX 4. 5TH MAY 2003: ZIMBABWE: Modified Health Facility Self-Appraisal Tool For Baby Friendly Hospital Initiative In Context of HIV/AIDS

Health Facility Data Sheet

Date_____,

_____

If no nursery for normal well newborns exists, write "non" space provided.
Name of the Health
Facility_____
Address:_____
_____

City, District, or Province_____
Country:_____
Name of District Medical Officer:_____
Telephone:_____
For the Facility:_____
Telephone:_____
For the Maternity Ward:_____
Telephone:_____
For the Antenatal Services:_____
Telephone:_____

Type of Facility: ☐ Government ☐ Public/Private (Mixed)
☐ Private

☐ Mission ☐ Teaching ☐ Other:_____

If health facility was designated baby friendly, indicate year:_____

Health Facility census data:

Total bed capacity:_____

_____in labour and delivery area
_____in the maternity wards
_____in the normal nursery
_____in the special care nursery
_____in other areas for mothers and children

Total deliveries in year 2002_____
_____were by Caesarean Caesarean rate_____%
_____were low birth weight babies (<2 500 g) Low birth weight rate_____%
_____were in special care Special care rate_____

Infant feeding data for deliveries from records or staff reports:
_____mother/infant pairs discharge in the past month
_____mother/infant pairs breastfeeding at discharge in the past month
_____%
_____mother/infant pair's breastfeeding exclusively from birth to
_____%
discharge in the past month
_____ mother/infant pairs exclusively infant formula feeding from birth to
_____%
discharge in the past month
_____mother/infant pairs exclusively modified animal milk feeding from birth to
_____%
discharge in the past month

_____infants discharged in the past month who have received at least one artificial feed since birth
_____%
_____infants discharged in the past month who have received infant formula since birth
_____%
_____infants discharged in the past month who have received modified animal milk

feed since birth
_____%

How was the infant feeding data obtained?

☐ From records ☐ Percentages are an estimate, provided by: _____

Health Facility Staff Training Records

1. Number of Staff members
   a) Nurses _____
   b) Paramedics _____
   c) Nurse Aides _____
   d) General Hands _____
   e) Doctors _____
   f) Others (specify) _____
   _____

2. Of these number of Staff members that have received training in the following:

Type of Course	Number of Staff Trained	Percent of total	Comments
PMTCT	Nurses		
	Paramedics		
	Nurse Aides		
	General Hands		
	Doctors		
	Others		

Type of Course	Number of Staff Trained	Percent of total	Comments
Lactation Management for at least 22 Hours theory and 3 hours of clinical practice	Nurses		
	Paramedics		
	Nurse Aides		
	General Hands		
	Doctors		
	Others		

Type of Course	Number of Staff Trained	Percent of total	Comments
Combined 44-hour course on Breastfeeding/ HIV and Infant Feeding Counselling with 8 hours of clinical practice and 4 hours of replacement feeding measurements, preparation and costing	Nurses		
	Paramedics		
	Nurse Aides		
	General Hands		
	Doctors		
	Others		

Type of Course	Number of Staff Trained	Percent of total	Comments
IMCI	Nurses		
	Paramedics		
	Nurse Aides		
	General Hands		
	Doctors		
	Others		

General Comments:

_____

_____

_____

STEP 1. Have a written infant feeding policy that is routinely communicated to all health care staff

1.1 Does the health facility have an explicit written policy for protecting, promoting and supporting breastfeeding that addresses all 10 steps to successful breastfeeding in maternity services?……Yes ☐ No ☐

1.2 Does the policy support and protect mothers who are HIV positive in infant feeding of their choice?…….. Yes No

1.3 Is the infant feeding policy available to all staff and can refer to it? ……Yes No

1.4 Is the infant feeding policy posted or displayed in all areas of the health facility: male and female wards, Outpatients Department, children's wards, maternity wards, antenatal care units, Rehabilitation unit, X-ray unit, offices etc?……... Yes No

1.5 Does the policy prohibit all promotion of group instruction for using breastmilk substitutes, feeding bottles and teats to protect breastfeeding and prevent spillover?……. …….. Yes No

1.6 Is there a mechanism for evaluating the effectiveness of the policy?…… Yes No

STEP 2 Train all health care staff in skills necessary to implement this policy

2.1 Are all staff aware of the advantage of breast feeding and acquainted with the facility's policy and services to protect, promote and support breastfeeding?…….. Yes No

2.2 Are all staff oriented to the infant feeding policy of the hospital? ……Yes No

2.4 Is training on lactation management and infant feeding given to all staff within six months of their arrival?…… Yes No

2.5 Is training on breastfeeding / HIV and infant feeding counseling given to all staff? …… Yes No

2.6 Does the training cover all of the Ten Steps to Successful Breastfeeding and the protection of breastfeeding? ……. Yes No

2.7 Is the training on lactation management at least 22 hours in total including a minimum of 3 hours of supervised clinical experience? …….. Yes No

2.8 Is the training on breastfeeding/HIV and infant feeding counseling at least 44 hours in total including 12 hours of practicals i.e. 8 hours of clinical practice and 4 hours of measurements, preparation, costing and use of replacement feeds? … Yes No

2.9 Is training on PMTCT given to all staff? …… Yes No

Step 3. Inform all pregnant women about the benefit and management of breastfeeding including Voluntary Confidential Counselling and Testing

3.1 Does the hospital have a Family and Child Health Services clinic? Or an antenatal inpatient ward?…….. Yes No

3.2 If yes, are all pregnant women attending these antenatal services informed about the benefits and management of breastfeeding with emphasis on exclusive breastfeeding? …… Yes No

3.3 Are pregnant women/ couples informed about MTCT of HIV? …….. Yes No

3.4 Are all pregnant women / couples attending antenatal care informed about the benefits of Voluntary Confidential Counseling and Testing? …… Yes No

3.5 Are HIV positive mothers /couples counseled on infant feeding options individually? …Yes No

3.6 Do antenatal records indicate whether breastfeeding has been discussed with the pregnant woman? …….. Yes No

3.7 Is a mother's antenatal record available at the time of delivery? Yes No

3.8 Are pregnant women protected from oral or written promotion of and group instruction for replacement feeding? …… Yes No

3.9 Does the healthcare facility take into account a woman's intention to breastfeed when deciding on the use of sedative, an analgesic, or an anesthetic, (if any) during labor and delivery? …… Yes No

3.10 Are staff familiar with the effects of such medicaments of breastfeeding? …… Yes No

3.11 Does a woman who has never breastfed or who has previously encountered problems with breastfeeding and chooses to breastfeed receive special attention and support from staff of the healthcare facility?……. Yes No

Step 4. Help mothers initiate infant feeding within an hour of birth

4.1 Are mothers whose deliveries are normal given their babies to hold, with skin contact, within a half hour of completion of the second stage of labor and allowed to maintain skin-to-skin contact for at least the first hour?……. Yes No

4.2 Are HIV positive mothers who have opted not to breastfeed supported and assisted to bond through skin-to-skin contact immediately after delivery? …… Yes No

4.3 Are the mother offered help by a staff member to initiate breastfeeding during the first hour? ……. Yes No

4.4 Are mothers who have had caesarean deliveries given their babies to hold, with skin contact within a half hour after they are able to respond to their babies? ……. Yes No

4.5 Do the babies born by caesarean stay with their mothers with contact at this time for at least 30 minutes? …… Yes No

Step 5 Show mothers how to breast-feed and how to maintain lactation, even if they should be separated from their infants

5.2 Does nursing staff offer all mothers further assistance with breastfeeding within six hours of delivery? ……. Yes No

5.2 Are most breastfeeding mothers able to demonstrate how to correctly position and attach their babies for breastfeeding? …….. Yes No

5.3 Are breastfeeding mothers shown how to express their milk or given information on expression and/or advised of where they can get help, should they need it? …….. Yes No

5.4 Are staff members or counselors who have specialized training in lactation management, breastfeeding/ HIV and infant feeding counselling available full-time to advise mothers during their stay in health care facilities and in preparation for discharge?…… …….Yes No

5.5 Does a woman who has never breastfed or who has previously encountered problems with breastfeeding and chooses to breastfeed receive special attention and support from the staff of the healthcare facility? ……. Yes No

5.6 Are mothers of babies in special care and have chosen to breastfeed helped to establish and maintain lactation by frequent expression of milk? …… Yes No

Step 6. Give newborn infants no food or drink other than breastmilk, unless *medically* indicated

6.1 Does staff have a clear understanding of what the few acceptable reasons are for prescribing food or drink other than breastmilk for breastfeeding babies? (see acceptable medical conditions, Annex 1: The Global Criteria) …….. Yes No

6.3 Do breastfeeding babies receive no other food or drink (than breastmilk) unless medically indicated?

6.3 Are any breastmilk substitutes including special formulas that are used in the facility purchased in the same way as any other foods or medicines? ……. Yes No

6.4 Do the health facility and all health care workers refuse free or low-cost supplies of breastmilk substitutes, paying close to retail market price for any? ……. Yes No

6.5 Is all promotion for infant foods or drinks other than breastmilk absent from the facility…….. Yes No

6.6 Are mothers who are HIV positive and have opted not to breastfeed, shown how to give replacement feeds of their choice? …… Yes No

Step 7. Practice rooming in allow mothers and infants to remain together 24 hours a day.

7.1 Do mothers and infants remain together (rooming-in or bedding-in) 24 hours a day, except for periods of up to an hour for hospital procedures or in separation if medically indicated? ……. Yes No

7.4 Does rooming-in start within an hour of a normal birth? …… Yes No

7.5 Does rooming-in or bedding-in start within an hour of when a caesarean mother can respond to her baby? ……. Yes No

7.6 Are mothers who are HIV positive and have opted not to breastfeed allowed rooming-in or bedding-in 24 hours a day? ……. Yes No

Step 8. Encourage breastfeeding on demand

8.1 By placing no restrictions on the frequency or length of breastfeeding, do staff show they are aware of the importance of breastfeeding on demand? …….. Yes No

8.2 Are mothers who choose to breastfeed advised to breastfeed their babies whenever their babies are hungry and as often as their babies want to breastfeed?……. Yes No

8.3 Are mothers who choose to breastfeed advised to wake up their infants if they should sleep too long (more than 3 hours), or when the mother's breasts are overfull? ..Yes No

8.4 Are the individual needs for infants not breastfeeding respected and responded to? …. Yes No

Step 9: Give no artificial teats or pacifiers (also called dummies or soothers) to infants

9.1 Are babies who have started to breastfeed cared for without any bottle feeds?
…….. Yes No

9.2 Are babies who have started to breastfed cared for without using pacifiers? …… Yes No

9.3 Do mothers learn that they should not give any bottles or pacifiers to their babies? …… ……Yes No

9.4 By accepting no free or low-cost feeding bottles, teats, or pacifiers do the facility and the health workers demonstrate that these should be avoided? …….. Yes No

9.5 Does the facility encourage cup feeding for non-breastfeeding infants? …Yes No

Step 10. Foster the establishment of mother support groups/systems and refer mothers to them on discharge from the hospital or clinic.

10.1 Does the health facility give education to key family members so that they can support the infant feeding mothers / families at home? …… Yes No

10.2 Are mothers referred to support groups/systems, if any available? …….. Yes No

10.3 Does the health facility have a system of follow-up support for infant feeding mothers after they are discharged, such as early postnatal or lactation clinic check ups, home visits, telephone? ……. Yes No

10.4 Does the facility encourage and facilitate the formation of mother-to-mother or health care worker-to-mother support groups/systems?…… Yes No

10.5 Does the health facility provide training in PMTCT, breastfeeding, HIV and infant feeding counseling to community based support groups? ……Yes No

10.6 Does the facility allow breastfeeding/ HIV and infant feeding counseling by trained mother-support group counselors in its maternity services? ……. Yes No

☐**Summary:**

Does your health facility follow all the **10 steps** for promoting and protecting successful infant feeding practices?……..Yes ☐ No ☐

If no, what improvements are needed?

_____

_____

If improvements are needed, would you like some help? Yes ☐ No ☐

_____

_____

This form is provided to facilitate a process of health facilities self-appraisal. If a health facility wishes to invite assessment or a reassessment in order to be designated Baby Friendly by the global criteria, the completed form may be submitted in support of the

application to the Provincial or National Nutrition Units. **The address for the National Nutrition Unit is: attention of the National Infant and Young Child Nutrition Coordinator, Ministry of Health and Child Welfare, Box CY 1122, Causeway, Harare on telephone (04) 792454.**

Annex 5: INFANT FEEDING POLICY – RUSAPE HOSPITAL, ZIMBABWE

AIM

To protect, promote and support infant feeding practices at Rusape Hospital.

POLICY

TRAINING ALL HEALTH WORKERS AT RUSAPE HOSPITAL

- All health workers should be trained on the importance of breastfeeding and its advantages.
- All health workers should be trained on:
    (a) Lactation Management (22 hours with 3 hours clinical practice)
    (b) Prevention of Mother to Child Transmission
    (c) Breastfeeding, HIV and Infant Feeding Counselling (44-hour course with 8 hours clinical practice and 4 hours practicals on milk measurements, preparation, use and costing).

- All health workers should be knowledgeable about the infant feeding policy.
- A staff training record should be kept.

HEALTH EDUCATION DURING PREGNANCY

Educate mothers on:

a) Nutrition
b) Importance of exclusive breastfeeding in the first six months of life
c) Dangers of mixed feeding
d) Advantages and benefits of breastfeeding and breast milk
e) Timely introduction of complementary feeding
f) Positioning and attachment at the breast
g) Manual expression of breast milk
h) Prevention of Mother to Child Transmission

- Mode of transmission of HIV
- Voluntary Confidential Counselling and Testing
- Antiretroviral
- Infant feeding options

i) Nutrition and HIV/AIDS
j) Side effects of drugs, smoking and drinking alcohol

DOCUMENTATION

- Document what has been taught pertaining to infant feeding to mothers on the ANC cards.
- Provide clients with leaflets and handouts.

PROMOTION OF INFANT FEEDING

- Initiate infant feeding to all newborn babies within 1-hour post delivery depending on the condition of both mother and baby.
- All mothers regardless of their HIV status should be supported and assisted to bond skin to skin immediately after delivery depending on the condition of the mother and baby (Caesar).
- Health workers should give assistance where necessary.
- Breastfeeding mothers are encouraged to feed their babies on colostrums that is rich in nutrients required by the baby.

POSITIONING, ATTACHMENET AND MAINTANANCE OF LACTATION

Good positioning and attachment of baby to the breast is important in prevention of breast conditions such as cracked or sore nipples, assuring enough milk and other breast conditions.

- Breastfeeding mothers should be in a comfortable position either sitting or sleeping.
- All breastfeeding babies should be breastfed on demand. The pre-term and the ill babies should be given expressed breast-milk by cup or nasogastric tube.
- Individual needs of babies not breastfed should be respected and responded to.
- Cup feeding should also be encouraged for non-breastfeeding babies.

EXCLUSIVE BREASTFEEDING

- All babies below the age of six months (6/12) should be exclusively breastfed, - i.e. giving breast milk only without any other food or fluids even water- unless medically indicated.
- Those babies not breastfed should be exclusively fed for the first six months with the chosen replacement feed /option.

ROOMING IN

- All mothers regardless of their of their HIV status should be allowed rooming-in / bedding-in with their babies for 24 hours a day.
- Mothers of admitted babies should be admitted to facilitate continuous breastfeeding except when the mother is critically ill.
- Avoid unnecessary separations of mother and baby except when medically indicated or during hospital procedures.

TIMELY INTRODUCTION OF COMPLEMENTARY FEEDING

- Mothers should be taught to prepare soft and nutritious foods which are locally available and given to the infants gradually in addition to breast milk or other forms of milk, from six months (6/12) of birth.
- Health education on complementary feeding should start at ANC.

SUPPLY OF BREASTMILK SUBSTITUTES (Code of Marketing of Breast milk Substitutes)

- All health workers should refuse free and low cost free supply of breast milk substitutes, bottles, teats and pacifiers/dummies/soothers from manufactures.
- Should the hospital require any breast milk substitutes, including special formulae, which are used in the health facility, these should be purchased in the same way as other foods and medicines.
- Feeding bottles, teats, pacifiers/dummies/soothers should not be given to infants.
- Advertising of artificial products is not allowed within the health facilities.

FOLLOW-UP SUPPORT

- Infant feeding mothers and their babies should be supported and followed-up.
- The existing community based support groups and systems should be strengthened, supported and involved in PMTCT and infant feeding follow-up.
- Networking amongst existing support groups and systems should be promoted.

WORKING MOTHERS

- Working mothers should be encouraged to express breast milk in clean containers. This milk is to be given to the babies during their absence by cup.

2003

ANNEX 6: EXAMPLE OF TIME TABLE FOR TBA' S TRAINING IN ZAMBIA FOR SAFE MOTHERHOOD INITIATIVE

DAY 8	
08:30-10:00	- Listening to baby's heart in womb/and cord care.
10:00-10:30	*T E A B R E A K*
10:30-13:00	- Child spacing (Family planning)
13:00-14:00	*L U N C H*
14:00-17:00	- Keeping drinking water safe to drink
DAY 9	
08:30-10:00	- **Putting the baby to the breast immediately after birth**
10:00-10:30	*T E A B R E A K*
10:30-13:00	- Controlling excessive bleeding after birth
13:00-14:00	*L U N C H*
14:00-17:00	- Group Discussion
DAY 10	
08:30-09:30	- Breech delivery
09:30-10:00	- Recognition of the baby who does not cry
10:00-10:30	**T E A B R E A K**
10:30-13:00	- Clearing the secretions from the mouth of the baby who does not cry – mouth to mouth breathing
13:00-14:00	**L U N C H**
14:00-17:00	- Group discussion
DAY 11	
08:30-10:00	- Weighing a new born baby, keeping baby warm
10:00-10:30	**T E A B R E A K**
10:30-13:00	- Recognition of congenital disease
13:00-14:00	**L U N C H**
14:00-17:00	- Group discussions

DAY 12	
08:30-10:00	- Recognition of Tetanus in the new born
10:00-10:30	**T E A B R E A K**
10:30-13:00	- **Breast engorgement and manual expression of breast milk**
13:00-14:00	**L U N C H**
14:00-17:00	- Group discussions
DAY 13	
08:30-10:00	- Recognition of pneumonia and dehydration
10:00-10:30	**T E A B R E A K**
10:30-13:00	- Preventing disease by immunization
13:00-14:00	**L U N C H**
14:00-17:00	- Group discussion
DAY 14	
08:30-10:00	- Educating the community
10:00-10:30	**T E A B R E A K**
10:30-13:00	- STIs
13:00-14:00	**L U N C H**
14:00-17:00	- Group discussion
DAY14	
08:30-10:00	- **HIV/AIDS**
10:00-10:30	**T E A B R E A K**
10:30-13:00	- Evaluation
13:00-14:00	**L U N C H**
14:00-17:00	- **Formation of practical groups and shifts**

ANNEX..7 KEY INFORMANTS

BOTSWANA

NAME	DESIGNATION
Mrs Kabo Mompathi	Head of Nutrition/MOH, IYCF Coordinator
Mrs Dikoloti Morewane	Local UNICEF Consultant -BMFHI

BURKINA FASO

NAME	DESIGNATION
Dr Youssof Gamatie	IMCI Officer and IYCF Coordinator

UGANDA

NAME	DESIGNATION
Barbara Tembo	Nutritionist, Child Health Division, Ministry of Health, Secretary of Task Force for IYCN member of the IYCN Protection, Regulations on the Marketing of Breastmilk Substitutes and Maternity Protection Convention working group.
Dr Saul Onyango	National Coordinator, STD/ACP, (PMTCT), Ministry of Health, Infant and Young Child feeding in HIV/AIDS working group chairperson
Mrs Ursula Wangwe	Principal Nutritionist/ Child Health Division, IYCF in Emergency Situation working group chairperson
Dr Charles Karamangi	Lecturer Makerere University, ULMET chair, Advocacy on IYCF working group chairperson
Dr	Commissioner, National Disease Control
Dr Walker	WHO Representative
Dr. Olive Sentumbwe-Mugisha	Reproductive Health/WHO, member of the Promotion and Support of IYCN working group
Dr. Geoffrey Bisoborwa	IMCI/ NPO , WHO
Margaret Keddi	Ministry of Education and Sports, Curriculum Development
Merrel Mattaisch	IMCI /WHO
Nakabiito Clemensia	Department of Obstetrics and Gynaecology
Orone-Kanya	Senior Nursing Officer, Nutrition Unit,

	Ministry of Health
J H. Inakioli	SPMO Mulago Hospital

ZAMBIA

NAME	DESIGNATION
Mr Wilson Siasulwe	IYCF Coordinator, Nutritionist for National Food and Nutrition Commission
Mr F Muwanga	Acting Director of the National Food and Nutrition Commission (NFNC)
Dr. Mwinga	IMCI/WHO
Mrs Patricia Kamanga	National Professional Officer/NUS, WHO Focal Point for Reproductive Health/ Women's Health and HRH
Dr M Siwale	Coordinator of the PMTCT Technical Working group
Ms Milika Zimba	Nutritionist/UNICEF
Mrs Nomajoni Ntombela	LINKAGES/AED Resident Representative
Mrs Tina Nyirenda	LINKAGES/AED Training Coordinator
Mrs Maureen Mzumara	LINKAGES/AED Training Coordinator
Ms Dilly Mwale	Nutritionist for National Food and Nutrition Commission
Ms Rose Lungu	Nutritionist for the Community Component at ZIHP

ZIMBABWE

NAME	DESIGNATION
Mrs Rufaro Madzima	IYCF National Coordinator, Nutritionist/MOHCW
Ms Margaret Nyandoro	Reproductive Health Coordinator/MOHCW
Mrs Cecilia Machena	IMCI Officer/MOHCW
Dr Agnes Mahomva	National Coordinator/PPMTCT/MOHCW
Mrs Pamela Morrison	Zimbabwe International Lactation Consultant/ BFHI Taskforce member
Mrs Barbara Tsiko	Clinical Instructor Harare Central Hospital School of Nursing, National Trainer for Breastfeeding, HIV and Infant Feeding Counselling courses
Mrs Ntaphe Mkandla	Senior Nursing Officer Gwanda Provincial Hospital, National Trainer and Course Director for Breastfeeding, HIV and Infant Feeding Counselling courses

Mrs Grace Zisengwe	Senior Sister/Rusape District Hospital, National Trainer and Course Director for Breastfeeding, HIV and Infant Feeding Counselling courses
Mrs Sabinah Tinarwo	Community Health Nurse/Rusape District, National Trainer and Course Director for Breastfeeding, HIV and Infant Feeding Counselling courses

ANNEX 8: ZIIMBABWE COMBIINED BFHI, BREASTFEEDING COUNSELLING AND HIV/INFANT FEEDING COUNSELLING COURSE TIMETABLE

ZIMBABWE COMBINED BFHI, BREASTFEEDING COUNSELLING AND HIV/INFANT FEEDING COUNSELLING COURSE: DATE: VENUE: PROVINCE: DISTRICT

TIMETABLE

TIME	**MONDAY 19**	**TUESDAY 20**	**WEDNESDAY 21**	**THURSDAY 22**
0800 – 0900	Welcome remarks, introductions and administrative announcements	Positioning baby at the breast	Not enough milk and crying	Overview of HIV and Infan Feeding
0900 – 1000	Introduction to the course and preparation for practical exercise **PRE-TEST**	Expressing breast milk	Not enough milk and crying exercise **(G)**	Counselling for HIV testing and for infant feeding decisions
1000 – 1030	**NUTRITION**	**BREAK**		
1030 – 1130	Why breastfeeding is important/ women's, nutrition, health	Clinical practice 1 **(G)**	Clinical practice 2 **(G)**	Clinical practice 3 **(G)**
1130 – 1230	How breastfeeding works	Clinical practice 1 **(G)**	Clinical practice 2 **(G)**	Clinical practice 3 **(G)**
1300 – 1400	**NUTRITION**	**BREAK**		
1400 – 1500	Assessing a breastfeed	Building confidence	Taking a breastfeeding history	Integrated care of HIV positive woman and her baby and BFHI Policy
1500 – 1600	Observing a breastfeed	Building confidence exercise **(G)**	Taking a breastfeeding history exercise **(G)**	Breastmilk options
1600 – 1630	**NUTRITION**	**BREAK**		
1630 – 1730	Listening and learning skills	Breastfeeding conditions and exercise	Low birth weight and sick children	Replacement feeding in the first 6 months+ BFHI, Acceptable Medical Reasonss
1730 – 1830	Listening and learning skills exercise **(G)**	Refusal to breastfeeding and helping a mother to relactate	Exercise **(G)**	Replacement feeding in the 6-24 months
1830 – 1900	Evaluation Day 1	Evaluation Day 2	Evaluation Day 3	Evaluation Day 4
	Trainer's Meeting	Trainer's Meeting	Trainer's Meeting	Trainer's Meeting

(G) = Small Groups