Republic of Namibia

Ministry of Health & Social Services

BABY FRIENDLY HOSPITAL INITIATIVE

Implementation Guideline

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BABY FRIENDLY HOSPITAL INITIATIVE

Implementation Guideline

Directorate: Primary Health Care Services

Division: Family Health Private Bag 13198 Windhoek
Tel: 061 203 2722/2712

Fax: 061 234 968

Email: doccentre@mhss.gov.na

Foreword

Malnutrition remains a public health problem in Namibia with 24% of the children under five years stunted (low height for age), 6 % are wasted (low weight for height) and 13% are underweight (low weight for age). The Government of the Republic of Namibia has over the years made great strides in the fight against malnutrition among children under five years. As part of the effort to improve child nutrition, the Baby Friendly Hospital Initiative (BFHI) is implemented.

The BFHI aims to promote, protect and support breastfeeding by giving every baby the best start in life by creating a health care environment that supports breastfeeding as the norm. It provides a framework that supports mothers to acquire the skills they need to breastfeed exclusively for the first six months, followed by complementary foods and continued breastfeeding for 2 years and beyond.

The International Code of Marketing of Breast-Milk Substitutes outlined in this guideline is a significant component of the BFHI. Compliance with the International Code of Marketing of Breast-Milk Substitutes is important for facilities providing maternity and new-born services, since the promotion of breast-milk substitutes is one of the largest undermining factors for breastfeeding. This situation means that ongoing concerted efforts will be required to protect, promote and support breastfeeding, including facilities providing maternity and new-born services.

As part of the Ministry of Health Social Services' effort to fight and end all forms of malnutrition, the BFHI guideline proposes a stepwise approach and a package of policies and procedures that facilities providing maternity and new born care services should implement to support, protect and promote breastfeeding.

Dr. Kalumbi Shangula, MP

I call upon all health workers to read and utilise the BFHI guidelines with the vision of improving the nutritional status of children.

Ministry of Health and Social Services
Office of the Minister

Dr. Kalumbi Shangula, MP
Minister

Preface

The first few hours and days of a newborn's life are a critical window for establishing lactation and for providing mothers with the support they need to breastfeed successfully.

Every child has the right to benefit from breast milk as it is the ideal food for babies and can satisfy all the infant's nutritional needs for the first 6 months of life. Breast milk provided by direct breastfeeding is the normal way to feed an infant. Scientific evidence overwhelmingly indicates that breast milk is nutritionally superior, offers substantial immunological and health benefits, facilitates mother-baby bonding, and should be promoted and supported to ensure the best health for women and their children.

The Baby Friendly Hospital Initiative focuses on providing optimal clinical care for new mothers and their infants. There is substantial evidence that implementing the Ten Steps to Successful Breastfeeding, significantly improves breastfeeding rates.

Health workers and the health-care systems are urged to comply with the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly resolutions in order to protect families from commercial pressures.

Families are most vulnerable to the marketing of breast- milk substitutes during the entire prenatal, perinatal and postnatal period when they are making decisions about breastfeeding. Additionally, health professionals themselves need protection from commercial influences that could affect their professional activities and judgement.

This guideline therefore, outlines the essentials of what it means to implement the BFHI in facilities providing maternity and new born services. The BFHI Implementation guideline

Ben Nangombe

provides valuable information and covers the necessary components from breastfeeding to the ten steps to successful breastfeeding, HIV and Breastfeeding, Maternal and Child health services, the International Code of Marketing of Breast-Milk Substitutes and the Baby Friendly Community Initiative.

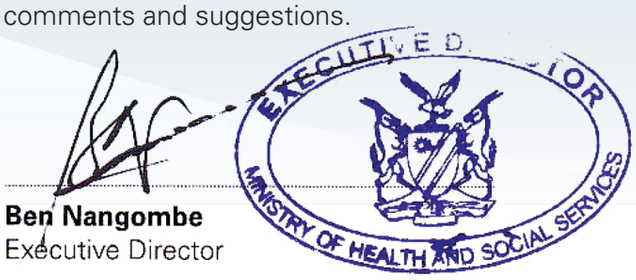
The development of these implementation guidelines for the Baby Friendly Hospital Initiative in Namibia was coordinated by the Directorate Primary Health Care, Food and Nutrition Subdivision.

These guidelines would not have been possible without the contributions of many individuals, agencies, and institutions. Special thanks are given to the following institutions without whom

this guideline document would not have been possible: The World Health Organization (WHO) and the World Food Programme (WFP) for their technical support and the United Nations Children's Fund (UNICEF) and European Union for their technical and financial contribution.

We also would like to acknowledge the contribution and many helpful insights, comments, and suggestions provided by nurses from the maternity and paediatric wards from various hospitals in the country during the drafting of this document.

Last but not least, our thanks go to the BFHI Technical Working Group for all their input, comments and suggestions.



Ben Nangombe
Executive Director

Acronyms and Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral Therapy
ARV	Antiretroviral drugs
BF	Breastfeeding
BFCi	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMS	Breast-Milk Substitutes
CBO's	Community-based organisations
CCN	Council of Churches in Namibia
EBM	Expressed Breast Milk
EPI	Expanded Programme on Immunisation
FBO's	Faith-based organisations
GMP	Growth Monitoring and Promotion
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
IMANA	Independent Midwives Association of Namibia
IUM	International University of Management
IYCF	Infant Young Child Feeding
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
MAWLR	Ministry of Agriculture, Water and Land Reform
MCH	Maternal Child Health
MDG	Millennium Development Goals
MHAISS	Ministry of Home Affairs, Immigration, Safety and Security
MHSS	Ministry of Health and Social Services
MICT	Ministry of Information, Communications and Technology
MoF	Ministry of Finance

MoJ	Ministry of Justice
MUAC	Mid Upper Arm Circumference
MURD	Ministry of Urban and Rural Development
NANASO	Namibia Network of Aids Service Organisations) representing Non- Governmental Organisations
NDHS	Namibia Demographic and Health Survey
NGO's	Non-Governmental Organisations
NHTC	National Health Training Centre
NPC	National Planning Commission
NSA	National Statistics Agency
NVP	Nevirapine
NUST	Namibia University of Science and Technology
PHC	Primary Health Care
PNC	Post Natal Care
SDG	Sustainable Development Goals
SUN	Scaling Up Nutrition
SUNCIP	Scaling Up Nutrition Country Implementation Plan
UNAM	University of Namibia
UNFPA	United Nations Population Fund
WFP	World Food Programme
FAO	Food and Agriculture Organization of the United Nations
UNAIDS	United Nations Programme on HIV/AIDS
USG	United States Government funded organisations e.g. (Centre for Disease Control (CDC) and United States Agency for International Development (USAID)
TWG	Technical Working Group
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organisation
WU	Welwitchia University

Glossary

Breast abscess:
is a painful fluctuant lump in the breast accompanied by fever that occurs following untreated mastitis or blocked duct.

Colostrum:
the first milk which is directly available after birth, is very concentrated, thick, sticky, and clear to yellowish in colour and has protective properties and provides immunity to the infant and remains available until "the milk comes in" within 2-3 days.

Engorged breasts:
is when the breasts are overfull with milk as a result of poor attachment and infrequent breastfeeding, which leads to infrequent or ineffective emptying of the breast.

Exclusive Breastfeeding:
means giving a baby only breast milk and no other liquids or solids- not even water. Drops of syrups consisting of vitamins, mineral supplements or medicines are permitted.

Low Birth Weight baby:
is a baby that weighs less than 2500 grams at birth.

Mastitis:
is an inflammation of the breast following unmanaged engorgement, cracked nipples or blocked duct, which leads to infection.

Mixed Feeding:
an infant younger than six months of age receiving other liquids and /or foods together with breast milk. This could be water, other types of milk or any type of solid food.

Neonate:
an infant 0-28 days old.

Pre-lacteal feeds:
pre-lacteal feeds are those foods given to new born before breastfeeding is established or before breast milk "comes in", usually on the first day of life.

Pre-term Baby (<37 weeks' gestation):
is diagnosed on the basis of period of gestation calculated from the last menstrual cycle of the mother.

Rooming-in:
is when the mother and the baby remain together in one room or bed for 24 hours a day.

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Chapter 1:
INTRODUCTION AND BACKGROUND

1.1 BACKGROUND AND RATIONALE

During the initial stages of infancy and early childhood, appropriate nutrition is essential to the development of the child to reach its full growth potential. The period from birth up to two years is a critical window for the promotion of optimal growth, health and behavioural development (PAHO & WHO, 2001). The direct concerns of poor nutrition during these formative years include significant morbidity and mortality and delayed mental and motor development. In the long-term, early nutritional deficits are linked to impairments in intellectual performance, work capacity, reproductive outcomes and overall health during adolescence and adulthood.

Breastfeeding brings clear short-term benefits for child health by reducing mortality and morbidity from infectious diseases. Skin to skin contact and initiation of breastfeeding within the first hour after birth are essential for the establishment of breastfeeding and for neonatal and child development (Himani, Baljit, K & Kumar P, 2011). The risk of dying in the first 28 days of life is 33% higher for new borns who initiated breastfeeding two to 23 hours after birth, and more than twice as high for those who initiated 1 day or longer after birth, compared to new borns who are put to the breast within the first hour after birth (Smith et al 2017).

Exclusive breastfeeding, defined as the practice of only giving an infant breast milk for the first 6 months of life (no other food or water) has the single largest potential impact on child mortality of any preventive intervention (WHO/UNICEF, 2014). It is part of optimal breastfeeding practices, which also include initiation within one hour of life and continued breastfeeding for up to two years of age or beyond.

However, globally, only 42 % of infant's initiate breastfeeding within the first hour after birth, 38% of infants under the age of six months are exclusively breastfed (United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring, 2019). Globally, research indicates that suboptimal breastfeeding practices by not practising exclusive breastfeeding, contributed to 11.6% (approximately 804 000 child deaths) of mortality in children under five years of age in 2011. The global trends also showed that at two years of age, 45% of children are still breastfeeding (WHO/UNICEF, 2014).

The Namibian Demographic and Health Survey (NDHS) 2013, indicates that 71% started breastfeeding within 1 hour of birth. Only 48% of children under the age of six months are exclusively breastfed, and 21% of infants continued breastfeeding up to two years. Additionally, 13% of children zero to 23 months are receiving the minimum acceptable diet. Despite efforts invested, the rate of adoption of recommended Infant and Young Child Feeding (IYCF) practices, including breastfeeding, is still low. The implementation of the BFHI approach is envisionaged to improve the knowledge and skills of health workers in the counselling and support of mothers during Antenatal Care (ANC), immediately after child birth, Post Natal Care (PNC) and other contact points.

The World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) in 2015 started a process of revising and updating the guidelines on the ten steps to successful breastfeeding by incorporating the new lessons learnt and scientific evidence. In 2018, the final version of the guidelines was produced after extensive consultation and comments from various implementers and policy makers globally. The document presents the first revision of the ten steps since 1989. Namibia therefore utilised this WHO/UNICEF updated version of the BFHI Guideline to revise its guideline by putting into perspective the local context.

1.2 JUSTIFICATION

In 2016, a review carried out on 58 studies on maternity and new born care, established that adherence to the ten steps influences rates of breastfeeding such as early initiation immediately after birth, exclusive breastfeeding and total duration of breastfeeding (Rafael Perez-Escamilla, Josefa. L. Martinez & Sofia Segura-Perez, 2016). The more of the ten steps of successfull breastfeeding are practiced, the more likely breastfeeding outcomes are improved (Rafael Perez-Escamilla, Josefa. L. Martinez & Sofia Segura-Perez, 2016). Also, avoiding supplementation of new borns with products other than breast milk has shown to be a crucial factor in shaping breastfeeding outcomes. Additionally, community care has also proved essential to preserving the heightened breastfeeding rates attained in facilities providing maternity and new born services (Rafael Perez-Escamilla, Josefa. L. Martinez & Sofia Segura-Perez, 2016).

Good nutrition builds a strong immune system, increases the children's chances of survival and protects them against infections. The first six months of a baby's life are crucial, children should be exclusively breastfed and most importantly initiated on the mothers' breast milk within one hour of birth (WHO, 2003). Breastfeeding helps provide children everywhere with the healthiest start to life. Early and exclusive breastfeeding helps children survive by supporting healthy brain development and improving cognitive development. It acts as the child's first vaccine by providing antibodies. It also reduces the burden of childhood and maternal illness, exclusive breastfeeding has a protective effect against obesity and certain non- communicable diseases later in life, lowering health care costs and creating healthier families. It contributes to child survival by protecting children during their critical first two years, as well as later in life. Breastfeeding benefits mothers, decreasing their risk of breast cancer, ovarian cancer, and diabetes. Breastfeeding is critical for achievement of many of the Sustainable Development Goals (SDG's). It improves nutrition (SDG), prevents child mortality and decreases the risk of non- communicable diseases (SDG), and supports cognitive development and education (SDG) (Hodin, 2017). Breastfeeding is also an enabler to ending poverty, promoting economic growth and reducing inequalities.

Recognising the crucial role of breastfeeding in global health and development, it is imperative that policies, strategies and guidelines are put in place to promote, protect and support breastfeeding. Namibia has developed regulations on the Code of Marketing of Breast Milk Substitutes to prevent companies from misleading mothers. The revision of the guidelines on the BFHI will further strengthen efforts towards the protection, promotion and support of breastfeeding at health facility and community levels. BFHI will strengthen and improve access to skilled breastfeeding counselling, foster community networks that support women in breastfeeding and improve the quality of maternity care to provide new mothers with breastfeeding support among others.

1.3 SITUATION OF BREASTFEEDING IN NAMIBIA

Namibia is a signatory to many World Health Assembly (WHA) resolutions on Infant and Young Child Feeding (IYCF). These include, The Convention on the Rights of the Child, Baby Friendly Hospital Initiative and the Millennium Development Goals just to mention a few. Since the endorsement of the Global Strategy for Infant and Young Child Feeding in 2002, Namibia has stepped up efforts to promote, protect and support breastfeeding.

1.3.1 Enabling Environment

The Government of Namibia is committed to the promotion and improvement of health and welfare of its people, especially children and women who are among the most vulnerable. As part of its efforts to improve maternal and child nutrition, the government has embarked on various policies and strategies such as Scaling Up Nutrition (SUN), Vision 2030, National Development Plans, Harambee Prosperity Plan, Zero Hunger strategy, optimal feeding strategies for children, to mention a few, which are all aimed at improving the living conditions of every Namibian.

Additionally, the specific objectives reflected in the Harambee Prosperity Plan, as well as the targets of SDG2 include:

- improving nutrition for the vulnerable and chronically hungry through ensuring adequate nutrition of pregnant and lactating mothers, as well as children under two years old, and providing nutrition supplementation and eliminating micro-nutrient deficiencies through fortification and other measures;
- reducing the vulnerability of the acutely hungry in disasters and shocks, through strengthening early warning and emergency response systems as well as social safety net programmes.

The Constitution of Namibia guarantees equal access by all communities to basic services including health, education and housing. Vision 2030 includes the objective to, "Ensure a healthy, food-secured and breastfeeding nation, in which all preventable, infectious and parasitic diseases are under secure control, and in which people enjoy a high standard of living, with access to quality education, health and other vital services, in an atmosphere of sustainable population growth and development" (Government of the Republic of Namibia. 2004).

Further, since independence, Primary Health Care (PHC) services have been the focal point of health services to communities in Namibia.

PHC services to support breastfeeding include:

- the promotion of proper nutrition and adequate supply of safe water
- maternal and child care, including family planning
- immunisation against the major infectious and vaccine preventable diseases
- basic housing and basic sanitation
- prevention and control of locally endemic diseases
- education and training concerning prevailing health problems in communities and the methods of preventing and controlling them
- appropriate treatment for common diseases and injuries
- community participation in health and social matters (CBHC initiatives)
- HIV/AIDS/STI's, Malaria and Tuberculosis prevention and control

As part of the development of these programs, focus has been placed on training and re-orientation of health workers in order to enable them to upgrade their knowledge and skills and to improve their attitudes towards communities.

The development of the BFHI is yet another milestone in the consolidation of the initiatives aimed at improving the survival, protection and development of children and women. The initiative will contribute significantly towards the improvement of the health status of women and children. Furthermore, the Ministry of Health and Social Services (MHSS) adopted 12 evidence-based high-impact nutrition interventions, of which breast feeding promotion and support, vitamin A supplementation, iron folic-acid supplementation for pregnant women and treatment of severe acute malnutrition are amongst the top five lifesaving nutrition interventions.

1.3.2 Namibia Demographic and Health Survey (NDHS)

The Namibia Demographic Health Survey (NDHS) 2013, showed malnutrition among children under five years, resulting in stunting (24%), wasting (6%) and underweight (13%) (NDHS,2013). Stunting is caused by various factors such as sub-optimal breastfeeding and complementary feeding practices, poor sanitation and hygiene, poverty, food insecurity, repeated exposure to infections and diseases and a poor health and social welfare system. Further, the poor nutrition status of mothers resulted in 13% of Namibian babies being born with a low birth weight (birth weight below 2.5 kg) (NDHS, 2013).

Table 1.1below shows breastfeeding trends in Namibia from 1992-2013 as outlined by the Namibian Demographic and Health Survey (NDHS). The NDHS, 2013, showed a decline from the year 2000 when 80% among those who delivered in a health facility and breastfed within one hour of birth, compared to 71% in 2013. It is recommended that the initiation of breastfeeding should be done immediately or within one hour after birth.

Table 1.1 Overview of breastfeeding trends in Namibia 1992-2013(NDHS)

Year	1992	2000	2006	2013
Median duration of breastfeeding	17.3 months	18.6 months	16.8 months	14.8 months
% exclusively breastfed from birth to 6 months	3%	4.1%	23.9%	48.5%
% babies who started breastfeeding within one hour of birth	52.3%	80.9%	71.3%	71.2%
Children breastfed at one year	73%	75.2%	69%	64%
Children breastfed at two years	13.4%	22.3%	28%	21%
Children ever breastfed	94.9%	95.1%	94%	95.7%

Additionally, the NDHS, showed that almost 96% of all children were breastfed at some point in their life but a minimal 21% benefit from continued breastfeeding up to the age of 24 months. Additionally, the NDHS 2013, indicated that 49% of the children were exclusively breastfed when most deliveries (87%) (NDHS, 2013) took place in health facilities in the country. This is contrary to the recommendation by UNICEF and WHO that infants under six months be exclusively breastfed and that they be given age appropriate solid or semi-solid complementary food in addition to continued breastfeeding from six months to at least 24 months.

Exclusive breastfeeding is the recommended feeding practice for infants during the first six-months of life because breast milk is not contaminated. Breast milk contains the mother's antibodies and all nutrients beneficial to the growth of infants in the first few months of life to provide immunity. Therefore, by reviving and implementing the BFHI in maternity wards in the country will ensure that all infants born in maternity facilities and their mothers are fully supported in breastfeeding.

This will increase breastfeeding rates which will in turn have a cascading effect by decreasing diarrhoeal episodes in infants under 6 months, reported at (12.2%) and six-11months (30.2%) (NDHS, 2013) and acute respiratory infections in infants aged less than six months, reported at (3.8%) and infants six-11months (7.9%) (NDHS, 2013). However, more needs to be done to protect, promote and support breastfeeding. One of the crucial key strategies in this regard is the implementation of the ten steps to successful breastfeeding, as well as compliance with the International Code of Marketing of Breast-Milk Substitutes.

The NDHS, 2013 reported that feeding children with feeding bottles is a relatively common practice in Namibia with 26% of children under six months using the bottle with a teat. The prevalence of bottle feeding is highest among children six-11 months (49-50%).

The International Code of Marketing of Breast-Milk Substitutes (the Code) was drafted and included in the Public and Environmental Health Act passed through Parliament (Act 1 of 2015), No. 5740, Windhoek, 18 May 2015.

Pre-lacteal feeding is defined as feeding newborns with anything other than breast milk before breast milk is initiated. Five regions across the country showed that more than 20%, (six regions more than 5% and two regions less than 5%) were fed pre- lacteal feeds. Pre-lacteal feeding is a barrier for implementation of optimal breast feeding practices and increases the risk of neonatal illness and mortality and should not be encouraged (NDHS, 2013).

1.3.3 Formative Assessment on Infant and Young Child Feeding (IYCF) and Care Practices

In 2014, a formative assessment on Infant and Young Child Feeding and Care practices was carried out in all 14 regions (MHSS, 2014). This assessment was undertaken in recognition that very little was known about how and what children were being fed, what were the barriers and facilitators to breastfeeding and what foods were available locally within the different regions that were suitable for children. Additionally, very little was known about breastfeeding practices, particularly the barriers to mothers exclusively breastfeeding for the recommended period from birth to six months of age. This assessment measured the current IYCF and care practices in the country against 12 ideal practices. These ideal practices e.g. all infants should be breast fed for the first time within one hour of birth, all infants should be exclusively breast feed for the first six months of life and all infants and young children should be fed on demand day and night, are also used as a benchmark to assess the adequacy and appropriateness of IYCF practices in developing countries (PAHO/WHO, 2001).

Key findings of formative assessment of IYCF and Care Practices:

- only 70% of infants initiated breastfeeding within the first hour after birth.
- infants were being fed water or other milks as early as two and three months of age.
- mothers reported their need to return to work within the child's first six months of life as the reason they were not able to exclusively breastfeed.
- there was also a strong and widely held belief or opinion that infants needed more than breast milk alone in the first six months of life, hence the reason for giving water, other milks and infant formula in addition to breast milk before the age of six months.

The overall formative assessment recommendations on IYCF and Care Practices stipulated the need to implement the BFHI in all health facilities providing maternity and new born services as well as developing a comprehensive communication strategy for IYCF and caring practices

CHAPTER 2:
INTRODUCTION TO THE BFHI GUIDELINE

2.1 PURPOSE OF THE BFHI

The BFHI was developed to protect, promote and support breastfeeding in health facilities by implementing good breastfeeding practices of term, pre-term, low-birth weight or sick infants and those admitted to neonatal intensive care units with the aim of reducing infant mortality and morbidity.

2.2 PURPOSE OF THE BFHI GUIDELINE

The BFHI has shown proven impact on infant outcomes (WHO/UNICEF, Baby Friendly Hospital Initiative, 2009). However, it is clear that an all-inclusive, multi-sector, multi-level effort to protect, promote and support optimal infant and young child feeding is of necessary. This should include legislative protection, social promotion and support for both health workers and the health system.

Therefore, the BFHI guideline is intended to:

- provide direction for the implementation of BFHI at all maternity and new born care services as an initiative to increase breastfeeding.
- ensure that the protection, promotion and support of breastfeeding is included in national policies, nutrition action plans, maternal and child health policies, strategies, standards of care and in hospital accreditations.
- integrate the ten steps into relevant national policy documents through governmental legislation, social security and labour law regulation, accreditation or certification in all health care facilities.
- ensure that the key clinical practices and global standards of the revised ten steps are written into the current standards of care and training curriculums for professional bodies/institutions such as nursing, midwifery, family and clinical medicine, obstetrics and gynaecology, paediatrics, neonatology, dietetics, nutritionists, anaesthesiology, psychologists, speech therapists, audiologists, teachers and other relevant occupations and groups.
- strengthen the quality-improvement aspects already present in the BFHI.
- streamline external assessments of BFHI into existing mechanisms that can be implemented sustainably.
- ensure that other supportive policy documents are developed such as the implementation of the International Code of Marketing of Breast-milk Substitutes.

2.3 SPECIFIC OBJECTIVES OF THE BFHI GUIDELINE

The specific objectives of the BFHI guideline are:

- to outline the BFHI implementation plan on the ten steps to breastfeeding and standards of care at national, regional and district level.
- to outline the role of the national BFHI technical working group (TWG).
- to provide guidelines for conducting regular internal monitoring as a crucial element to both quality improvement and ongoing quality assurance.
- to provide guidelines for conducting BFHI self, external and ongoing assessments and feedback.

2.4 WHAT THE BFHI GUIDELINE COMPLEMENTS

This BFHI guideline complements:

- theWHO Guidance on Implementation of BFHI: protecting, promoting and supporting breastfeeding in facilities providing maternity and new-born services (2018).
- existing standards for improving the quality of maternal and new-born care in health facilities.
- guidelines on the optimal feeding of low birth weight and pre-term infants andWHO recommendations.
- aspects of Baby Friendly Community Initiative (BFCI) are included within a broader context of support for breastfeeding in families, communities and the workplace.
- guidelines on HIV and breastfeeding on infants who are, or who have mothers who are living with HIV.
- guidelines on BFHI in emergencies.

2.5 THE INTENDED AUDIENCE FOR BFHI GUIDELINE

The intended audience of this document includes:

- all those who set policy for, or offer care to, pregnant women, families and infants
- governments;
- national managers of maternal and child health programmes in general, and of breastfeeding- and BFHI-related programmes in particular; health-facility managers at different levels (superintendents of hospitals, medical directors, nurses in charge of maternity and neonatal wards).

CHAPTER 3:
OVERVIEW OF THE BABY FRIENDLY HOSPITAL INITIATIVE

3.1 BFHI GLOBALLY

The BFHI was launched globally in 1991 by WHO and UNICEF following the 1990 Innocenti Declaration. The declaration advocated that governments develop national breastfeeding policies and implementation systems to support, protect and promote breastfeeding. The purpose of the BFHI is to promote breastfeeding in maternity wards worldwide. BFHI takes into consideration ten steps to successful breastfeeding.

The BFHI has been implemented in most countries with varying success in the level of implementation. A systematic review on new born care carried out in 2016 showed that adherence to the ten steps impacted the rates of breastfeeding, namely early initiation immediately after birth, exclusive breastfeeding and total duration of breastfeeding (Pérez- Escamilla R, Martinez JL & Segura-Pérez S, 2016). However, the implementation of BFHI has had its challenges too.

The major challenges faced were:

- the vertical and usually project-type implementation of the BFHI was an obstacle to the high coverage of the practices recommended in the ten steps and to the sustainability of these practices and monitoring of the initiative.
- the processes of providing technical assistance to facilities; training and maintaining assessors; implementing assessments and re-assessments required resources on an ongoing basis.
- full compliance with the Code of Marketing for Breast-Milk Substitutes (BMS) was a challenge for many facilities. Distributors of Breast-Milk Substitutes have often been found violating the Code by providing free or subsidised supplies to facilities or governments.
- inadequate staff at health facilities affeced capacity development
- step 10 of the original ten steps on fostering the establishment of breastfeeding support groups, proved very difficult to implement for most facilities providing maternity and new born services, since many did not have sufficient staff to work outside of their own facility.

3.2 BFHI IN NAMIBIA

In Namibia, the BFHI was launched in 1992. This initiative is a culmination of concerns and efforts aimed at promotion, protection and support of breastfeeding in order to improve child survival, protection and development.

The BFHI in Namibia initially certified more than 35 health facilities as baby friendly.

However, over the years all these health facilities are no longer certified as baby friendly and require to be revived once again to their original status. All public and private maternity facilities countrywide, need to be reassessed and supported for BFHI in order to improve implementation and to ensure that quality service delivery is sustained.

The BFHI will provide the opportunity for consolidating child survival, development and protection initiatives, aimed at creating a friendly environment for the child from birth, with an initial focus on

nutrition of the child. It has been established that immediate and uninterrupted skin-to-skin contact and initiation of breastfeeding within the first hour after birth are important for the establishment of breastfeeding, and neonatal and child survival and development.

In order to promote breastfeeding there must be a suitable environment for the mother and child at birth. Table 2.1 below states the possible factors that influence mothers not to breastfeed.

Table 2.1 Factors that influence mothers not to breastfeed

Lack of knowledge on the advantages of breastfeeding
Lack of adequate skilled support in breastfeeding (in health facilities and in the community)
Inadequate maternity leave legislation and other workplace policies that support a woman's ability to breastfeed when she returns to work
Inadequate public education on the benefits of breastfeeding
Overworked mothers
Caregiver and societal beliefs favouring mixed feeding (i.e. believing an infant needs additional liquids or solids before 6 months because breast milk alone is not adequate)
Promotion of infant formula, milk powder and other breast-milk substitutes

The Labour Act (1992 amended in 2007) states that employed pregnant women are entitled to three months' maternity leave (12 weeks). This short maternity leave duration makes it difficult for the mother to practice exclusive breastfeeding. Also, women on maternity leave are on half pay and this poses financial constraints on the family.

Furthermore, most workplace environments contribute to an additional burden as they do not provide breastfeeding corners for nursing mothers. Therefore, the BFHI aims to change this and explore opportunities to promote exclusive breastfeeding.

The aggressive marketing of breast-milk substitutes is a major hindrance to exclusive breastfeeding. However, the enactment of the Public and Environmental Health Act of Namibia, 2015, to regulate marketing of Breast-Milk Substitutes, is in line with the International Code of Breast-milk Substitutes (BMS), and will thereby protect, support and promote breastfeeding. The BFHI simply provides the starting point for greater achievements or fulfilments of the needs of children.

Therefore, in order to fulfil this desired objective of being friendly to the child, the following will need to be focused on:

- enable the child to get the natural protection and nutrition through breastfeeding.
- promote the role of the fathers, family and community.
- enable health workers, employers, leaders, planners etc., to develop new and positive attitudes towards mothers and children.
- promote interventions which impact on the health of women and children including immunisation, diarrhoea, family planning, good nutrition for mothers and children.
- promote the fight against child and women abuse, alcohol and drug abuse.
- ensure that there is increased allocation of resources to programmes with impact on the health and welfare of children and women.

Through the implementation of BFHI, Namibia will have affirmed the right of every child to be adequately nourished and protected from diseases that cause morbidity and mortality.

3.3 OVERALL AIM OF THE BFHI

The aim of the BFHI is to contribute to the development, survival and protection of the child in order to contribute to the reduction of severe to moderate malnutrition among children under five.

3.4 SPECIFIC OBJECTIVES OF THE BFHI

The specific objectives of the BFHI are outlined as follows:

- by the year 2030, 80% of all facilities providing maternity and new-born services in Namibia will be baby friendly according to the ten steps and standards of care.
- by the year 2030, 60% of all mothers will practice exclusive breastfeeding for six months.
- by the year 2030, 80% of health workers should be trained in BFHI and implement the minimum seven steps of the BFHI in facilities providing maternity and new born services.
- by the year 2030, 80% of health workers should be trained in the Code of Marketing of Breast-milk Substitutes in facilities providing maternity and new born services.
- by the year 2030, 80% of community health workers should be trained in lactation management (positioning, attachment, reinforcing benefits of exclusive breastfeeding in order to create a continuum of care for the mothers and their babies beyond the health facility to the household and community level.

CHAPTER 4:
THE TEN STEPS TO SUCCESSFUL BREASTFEEDING AND STANDARDS OF CARE

4.1 THE TEN STEPS

The ten steps to successful breastfeeding summarises a package of policies and procedures that facilities providing maternity and new born services should implement to support, protect and promote breastfeeding. The ten steps have been reworded while maintaining the basic theme of each step. The guidance separates the first two steps, which address the management procedures necessary to ensure that care is delivered consistently and ethically, from the other eight steps, which spell out standards for the clinical care of mothers and infants.

The updated ten steps and standards of care are set out below and should be implemented by facilities providing maternity and new born services in the country.

A. Management Procedures

Step 1a	Comply fully with the International Code of Marketing of Breast-milk Substitutes and World Health Assembly resolutions.
Step 1b	Have a written breastfeeding policy that is routinely communicated to staff and parents.
Step 1c	Establish ongoing monitoring and data-management systems.
Step 2	Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.

B. Key Clinical Practices

Step 3	Discuss the importance and management of breastfeeding with pregnant women and their families.
Step 4	Facilitate immediate and uninterrupted skin-to skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
Step 5	Support mothers to initiate and maintain breastfeeding and manage common breastfeeding difficulties.
Step 6	Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
Step 7	Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.
Step 8	Support mothers to recognize and respond to their infants 'cues for feeding.
Step 9	Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
Step 10	Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

The standards of care for each step were developed to ensure that the health care system and other relevant sectors support the recommendation of exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women the support that they require to achieve their breastfeeding goals, in the family, community and workplace.

The strict interpretation of how the ten steps to successful breastfeeding and standards of care to be applied in health facilities providing maternity and new born services, are outlined below:

Step 1: Facility Policy

Step 1a	Comply fully with the International Code of Marketing of Breast-milk Substitutes and World Health Assembly resolutions.

Standards of Care: Step 1a

- All health facilities should fully comply with the Namibian Code of Marketing Breast Milk Substitutes and relevant World Health Assembly (WHA) resolutions.
- At least **80%** of health professionals who provide antenatal, delivery and/or new born care can explain at least **two elements of the Code.**

All infant formula, feeding bottles and teats used in the facility have been purchased through normal procurement channels and not received through free or subsidized supplies.

- The facility should not display of products or items with logos of companies that produce breast-milk substitutes, feeding bottles and teats covered under the Namibian Code and regulations.
- All health facilities should not engage in any form of promotion of or any type of advertising of breast-milk substitutes, including distribution of any equipment or materials or discount coupons.

Health facility staff and health systems should avoid conflicts of interest with companies that market foods for infants and young children. Health professional meetings should never be sponsored by formula manufacturers and these manufactures should not participate in parenting education.

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The health facility must have a policy including the following:

- Not giving samples of infant formula, maternal supplements, feeding bottles or teats to mothers.
- Describes how it abides by the Code, including not accepting support or gifts from producers or distributors of products covered by the Code.
- Review and assess how policy is implemented and includes corrective measures, penalties or disciplinary actions when there is no compliance to the "Namibian Code of Marketing for Breast Milk Substitutes" in the facility.
- Include all eight key clinical practices of the Ten Steps, standards of care and regular competency assessment.

Step 1b	Have a written Breastfeeding policy that is routinely communicated to staff and parents.

Standards of Care: Step 1b

The health facility has a **written breastfeeding policy** that addresses the implementation of all eight key clinical practices of the Ten Steps, Code implementation, and regular competency assessment.

- At least **80% of clinical staff** who provide antenatal, delivery and/or new born care can explain at **least two elements of the breastfeeding policy** that influence their role in the facility.
- The policy should be visibly posted in all areas of the health facility which serves pregnant women, mothers and their families, infants, and children particularly in the maternity ward, all infant care areas, infant special care units, antenatal care (ANC) and postnatal care (PNC) services.
- The nurse manager for the institution and/or the senior nursing officer on maternity duty should be able to locate a copy of the policy when required.
- All nursing personnel in the maternity unit should be familiar with the policy. The updated policy should be timely communicated to all health staff, mothers and their partners.

- The policy should be available so that all staff can refer to it when required. The facility has a protocol for an ongoing monitoring and data-management system to comply with the eight key clinical practices (review of all clinical protocols or standards).
- The policy should be displayed in the six language(s) that is English, Oshiwambo, Otjiherero, Osilozi, Rukwangali and Damara/Nama most commonly understood by patients and staff.
- The needed information of the policy for the pregnant women and breastfeeding mothers and their families should be included in the Patient Charter.

Standards of Care: Step 1c

- Clinical staff at the facility meets at least every six months to review implementation of the system.
- Health facilities should aim for at least **80% early initiation and exclusive breastfeeding (current coverage to be considered when deciding on targets per facility).**

Health facilities should routinely collect information on the percentage of term infants who were put to the breast within one hour of birth during the facility stay. Therefore, it is absolutely important that maternal records make provision for recording latching time.

Health facilities should routinely collect information on the percentage of pre-term and term infants who are on exclusive breastfeeding during the facility stay.

Health facilities should ensure that the births of infants are registered using the e-birth notification system. This system helps with estimating birth registration rates and projections of the numbers of births each year.

Step 2: Staff Competency

Step 2	Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.

Standards of Care Best Practice: Step 2 (staff providing antenatal, delivery and/or newborn care services).

- At least **80% of health professionals** report that they have **received pre-service or in-service training on breastfeeding during the previous 2 years.**
  Conduct the 20-hour course or other breastfeeding courses as deemed necessary for maternity staff to strengthen the knowledge and skills of their staff towards successful implementation of the Ten steps to Successful Breastfeeding.
- Establishing options that can assist with strengthening knowledge and skills of maternity staff such as mentorship, job shadowing, short group meetings (quality improvement committee) or establishing a Centre of Excellence on the Ten steps to Successful Breastfeeding.
- At least **80% of health professionals are able to correctly answer three out of four questions on breastfeeding knowledge and skills to support breastfeeding.**

All health workers/staff who help mothers with breastfeeding should be assessed on their ability to:

- educate the mother on the importance of hand hygiene
- help and support a mother practically with positioning and attachment of the baby to breastfeed
- help a mother to initiate breastfeeding within the first hour after birth
- help a mother to express her breast milk and cupfeed her baby;
- help a mother to breastfeed a low-birth-weight baby or sick baby;
- help a mother who has breastfeeding problems/conditions or dealing with a baby who cries frequently or is refusing to breastfeed
- counsel a pregnant woman about breastfeeding
- counsel a mother about her own health
- implement the Code

Step 3: Antenatal Information

Step 3	Discuss the importance and management of breastfeeding with pregnant women and their families.

Standards of Care: Step 3

At least **80% of mothers who received antenatal care report having received prenatal counselling on breastfeeding.**

At least **80% of mothers** who received prenatal care at the facility are able to adequately describe what was discussed about **two of the topics mentioned below**.

A protocol for antenatal discussion of breastfeeding includes at a minimum:

- The importance of breastfeeding, exclusive breastfeeding for the first 6 months, the benefits of breastfeeding and management, the risks of giving formula or other breast- milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other foods are given
- immediate and sustained skin to-skin contact and early initiation of breastfeeding
- rooming-in and feeding on demand
- basics of good positioning and attachment
- recognition of feeding cues
- the risks of giving formula or other breast-milk substitutes, along with national and health-professional recommendations for breastfeeding.
- perception of not producing enough milk and how to address it.
- continuing breastfeeding when separated from the baby
- management of breast engorgement, inverted and cracked nipples and other breast conditions.
- health benefits of breastfeeding to the mother, baby and families
- family planning
- myths and misconceptions associated with breastfeeding
- maternity leave
- healthy lifestyle rights based approach to encourage women to demand quality services and to know what to expect during pregnancy, maternity leave, delivery in terms of dignity, autonomy, equality and safety.
- management of breast engorgement, inverted and cracked nipples and other breast conditions/problems that the mother may complain about
- health benefits of breastfeeding to the mother, baby and families

- antenatal breastfeeding counselling must be tailored to the individual needs of the woman and her family, addressing any concerns and questions they have. This counselling needs to be sensitively given and consider the social and cultural context of each family.

- women identified to be at risk for preterm delivery or birth of a sick infant (e.g.pregnant adolescents, high-risk pregnancies, known congenital anomalies) must be provided with specific information and counselling concerned with feeding a premature, low-birth-weight or sick baby.

Step 4: Immediate Postnatal Care

Step 4	Facilitate immediate and uninterrupted skin-to skin contact and support mothers to initiate breastfeeding as soon as possible after birth.

Standards of Care: Step 4

At least **80% of mothers or fathers of term infants report that their babies were placed in skin-to-skin contact with them immediately or within 5 minutes after birth and that this contact lasted 1 hour or more unless** there were documented medically justifiable reasons for delayed contact.

Early and uninterrupted skin-to -skin contact between mothers and infants to be facilitated and encouraged as soon as possible after birth and include the following:

- immediately after delivery dry the baby excluding the hands.
- put the baby skin to skin on the mother abdomen or chest with no clothing separating them for at least one hour after birth.
- cover both mother and baby with a dry cloth.
- cover the baby's head.
- apgar scoring and immediate care of new born can be done while baby is on mother's abdomen.
- put the baby on the breasts within first 30-50 minutes.
- all other routine care of the neonate can be done an hour later.

- mothers that are unable to initiate breastfeeding during the first hour after birth, should still be encouraged and supported to practise skin-to-skin contact and to breastfeed as soon as they can.

Caesarean section

- immediate skin-to-skin care and initiation of breastfeeding is feasible following a caesarean section with local anaesthesia (epidural).
- after a caesarean section with general anaesthesia, skin to-skin contact and initiation of breastfeeding can begin when the mother is sufficiently alert to hold the infant.
- mothers or infants who are medically unstable following delivery may need to delay the initiation of breastfeeding.
- post-caesarean section patients who had general anaesthesia can begin skin to skin contact and initiation of breastfeeding when the mother is sufficiently alert to hold the infant. Mothers or infants who are medically unstable following delivery may delay the initiation of breastfeeding e.g. distressed baby. However, they should still be supported to provide skin to-skin contact and to breastfeed as soon as they are able.

Pre-Term Babies / Low Birth Weight Babies

- skin-to-skin contact is particularly important for preterm and low-birth-weight infants if the baby does not need any urgent medical attention.
- kangaroo mother care should be the mode of care immediately for these babies who are stable after medical intervention.
- preterm babies may be able to root, attach to the breast and suckle from as early as 27 weeks' gestation. As long as the baby is stable, with no evidence of severe apnoea, desaturation or bradycardia, preterm infants can start breastfeeding.
- early initiation of effective breastfeeding may be difficult for preterm babies if the suckling reflex is not yet established and/or the mother has not yet begun plentiful milk secretion. Early and frequent milk expression is critical to stimulating milk production and secretion for preterm infants who are not yet able to suckle.
- mothers of preterm and low-birth-weight babies should be encouraged and supported to practice Kangaroo Mother Care because it involves early, continuous and prolonged skin-to-skin contact between the mother and the baby. Encourage fathers to participate in Kangaroo Mother Care.

- Mothers that are unable to initiate breastfeeding during the first hour after birth, should still be encouraged and supported to practise skin-to-skin contact and to breastfeed as soon as they can.

Step 5: Support with Breastfeeding

Step 5	Support mothers to initiate and maintain breastfeeding and manage common breastfeeding difficulties.

Standards of Care: Step 5

At least **80% of breastfeeding mothers of term infants** report that someone on the staff offered practical support and counselling with **breastfeeding within 6 hours after birth.**

- Mothers and fathers should receive practical support to enable them to initiate and maintain breastfeeding and manage common breastfeeding difficulties (information on breastfeeding and concrete skills should be taught to mothers).
- Staff should do direct observation of a feed to ensure that the infant is able to attach to and suckle at the breast and that milk transfer is happening.
- Mothers delivering by caesarean section, obese mothers and teenage mothers should be given additional help with positioning and attachment.

- At **least 80% of mothers of preterm or sick infants** report having been helped to **express milk within 1-2 hours after birth. Pre-Term Babies**

- Practical support is critical in order to establish and maintain the production of breast milk.
- Mothers of preterm babies may have health problems of their own and need motivation and extra support for milk expression.
- Most mothers of preterm infants are generally able to exclusively breastfeed at the breast, but the infants are at greater risk of jaundice, hypoglycaemia and feeding difficulties than full-term infants, and thus require increased vigilance.

Twins

- Mothers with twins also need extra support with regards to breastfeeding, especially for positioning and attachment.

- At least **80% of breastfeeding mothers of term infants** are able to **demonstrate how to position their baby for breastfeeding and that the baby can suckle and transfer milk.**

- At least **80% of breastfeeding mothers of term infants** can **describe at least two ways to facilitate milk production for their infants.**

- At least **80% of breastfeeding mothers of term infants** can describe **at least two indicators of whether a breastfed baby consumes adequate milk.**

- At least **80% of mothers of breastfed preterm and term infants** can **correctly demonstrate or describe how to express breast milk.**
- Health facility staff should teach mothers on how to express breast milk as a means of maintaining lactation in the event of being separated temporarily from their infants.

Step 6: Supplementation

Step 6	Do not provide breastfed new-borns any food or fluids other than breast milk, unless medically indicated.
Standards of Care: Step 6	
At least 80% of infants (preterm and term) received only breast milk (either from their own mother or from a human milk bank) throughout their stay at the facility.	
• At least **80% of mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situations.**	
• At least **80% of mothers who have decided not to breastfeed report that the staff discussed with them the safe preparation, feeding and storage of breast milk substitutes.**	
• At least 80% of term breastfed babies who received supplemental feeds have a • documented medical indication for supplementation in their medical record.	
• At least **80% of preterm babies and other vulnerable new born's that cannot be fed their mother's own milk are fed with donor human milk.**	
• At least 80% of mothers with babies in special care report that they have been offered help to start lacto genesis (beginning plentiful milk secretion) and to keep up the supply, within 1–2 hours after their babies' births.	
Mothers/family should be counselled on the importance of exclusive breastfeeding for the first 6 months of the baby's life, and how to establish a milk supply and to ensure that the infant is able to suckle and transfer milk from the breast.	
Mothers should be informed that exclusive breastfeeding means giving a baby only breast milk and no other liquids or solids- not even water. Drops or syrups consisting of vitamins, mineral supplements or medicines are permitted if prescribed.	
Mothers must also be supported and encouraged to express their breast milk to continue stimulating production of breast milk.	
In special circumstances, Mothers /caregivers who are feeding breast milk substitutes, by necessity must be taught about safe preparation and storage of formula and how to respond adequately to their child's feeding cues.	

Step 7: Rooming-In

Step 7:	Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.
Standards of Care: Step 7	
• At least **80% of mothers of term infants** report that their babies stayed with them since birth, **without separation lasting for more than 1 hour per separation instance.** • Observations in the postpartum wards and well-baby observation areas confirm that at least 80% of mothers and babies are together or, if not, have medically justifiable reasons for being separated. • Facilities should enable mothers and their infants to remain together after vaginal birth or caesarean section and to practise rooming-in throughout the day and night. Facilities should encourage and support fathers to have equal access to their infants. • At least 80% of mothers of preterm infants confirm that they were encouraged to stay close to their infants, day and night.	
When a mother is placed in a dedicated ward to recover from a caesarean section, the baby should be accommodated in the same room with her, close by. She will need practical support to position her baby to breastfeed, especially when the baby is in a separate cot or bed.	
If a preterm or sick infants need to be in a separate room to allow adequate treatment and observation, efforts must be made for the mother to recuperate postpartum with her infant, or to have no restrictions for visiting her infant. Mothers should have adequate space to express milk adjacent to their infants.	
Babies should only be separated from their mothers for justifiable medical and safety reasons; this will enable a mother to breastfeed for as much, as frequently and for as long as her baby needs it.	

Step 8: Responsive Feeding

Step 8	Support mothers to recognize and respond to their infants 'cues for feeding.

Standards of Care: Step 8

At least **80% of breastfeeding mothers of term infants can describe at least two feeding cues.**

- Mothers should be supported to practice responsive feeding as part of nurturing care.
- Regardless of whether infants are breast feed or not, mothers should be supported to recognize and respond to their infants' cues for feeding, closeness and comfort, and enabled to respond accordingly to these cues with a variety of options.

At least **80% of breastfeeding mothers of term infants report that they have been advised to feed their baby's as often and for as long as the infant wants (breastfeed their babies on demand).**

Step 9: Feeding Bottles, Teats and Pacifiers

Step 9	Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.

Standards of Care: Step 9

At least **80% of breastfeeding mothers of preterm and term infants report that they have been taught about the risks of using feeding bottles, teats and pacifiers.**

- There should be no promotion of feeding bottles, dummies, pacifiers or teats in any part of health facilities
- There should be no promotion of breast-milk substitutes or products that fall within the scope of the Code of marketing of breast milk substitutes in any part of health facilities.

Mothers should be shown on how to use a cup/spoon to feed the baby with expressed breast milk. Cups with spouts are not recommended, as they are difficult to clean.

- Staff should also inform mothers and family members of the hygiene risks related to inadequate cleaning of feeding utensils, so that they can make an informed choice of the feeding method.

For preterm infants, evidence does demonstrate that use of feeding bottles with teats interferes with learning to suckle at the breast. If expressed breast milk or other feeds are medically indicated for preterm infants, feeding methods such as cups or spoons are preferable to feeding bottles and teats.

Preterm infants who are unable to breastfeed directly, non-nutritive sucking and oral stimulation may be beneficial until breastfeeding is established. (Non-nutritive sucking or oral stimulation involves the use of pacifiers, a gloved finger or a breast that is not yet producing milk).

Step10: Care at Discharge

Step 10	Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

At least **80% of mothers of preterm and term infants report that a staff member has informed them where they can access breastfeeding support in their community.**

- Facilities need to provide appropriate referrals to ensure that mothers and babies are seen by a health worker 6 hours, 6 days, 6 weeks and 6 months after birth or based on MHSS updated circulars or guidelines to assess the general health and breastfeeding situation.
- Facilities need to identify appropriate community resources for continued and consistent breastfeeding support.
- Facilities should demonstrate that it coordinates with community services or/and mother-to-mother support groups that provide breastfeeding/breastfeeding support, including clinical management and mother-to-mother support.

CHAPTER 5:
IMPLEMENTATION OF THE BABY FRIENDLY HOSPITAL INITIATIVE

The BFHI implementation guidance from WHO/UNICEF (2018) forms the basis on how the BFHI will be implemented in the country. This chapter deliberates on the implementation of the BFHI which will take place as a **phased-in approach** in all facilities providing maternity and new-born care services in Namibia.

In order to scale up the BFHI coverage and to sustain the recommended practices over time the key responsibilities of the national BFHI programme will need to be implemented. All nine responsibilities are interconnected, and require integration into national policies and standards of care. These responsibilities are listed below and the implementation process for each of them explained in greater detail in this chapter:

5.1 KEY RESPONSIBILITIES OF A NATIONAL BFHI PROGRAMME

1. Establish National Technical Working Group.
2. Integrate BFHI (the Ten steps and standards of care) into relevant national policy documents and professional standards of care.
3. Ensure the competency of health professionals and managers in implementation of the BFHI.
4. Utilise internal and external assessment systems to regularly evaluate adherence to the ten steps and standards of care.
5. Develop and implement incentives and/or sanctions for recognition towards compliance or non-compliance with the implementation of BFHI (ten steps and standards of care).
6. Provide technical assistance to facilities that are implementing BFHI (the ten steps and standards of care).
7. Monitor implementation of the initiative.
8. Advocate for the BFHI to relevant audiences.
9. Identify and allocate sufficient resources to implement BFHI.

5.2 ESTABLISH A NATIONAL BREASTFEEDING COORDINATION BODY

National Leadership and Coordination
National leadership and coordination are critical to achieve 100% coverage and sustainability over time through continuous monitoring, communication, advocacy, and in securingfinancing. It is therefore important to establish a Technical Working Group (TWG) to provide national leadership and coordination to implement the programme effectively.

The purpose, scope of work and institutional arrangements of the national TWG will function through the Committee on Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition, and will consequently report back to the committee.

Purpose of the National BFHI Technical Working Group
The BFHI TWG will provide national leadership and coordination and ensure integration into maternal and child health programmes.

Membership of the BFHI Technical Working Group

The composition of the BFHI TWG will be multi-sectoral and will consist of representatives from the following ministries/ organisations:

Ministry of Health and Social Services (MOHSS):

- Primary Health Care division: Deputy Director – Chairperson
- National Focal Person on Infant and Young Child Feeding programmes- Deputy Chairperson

Ministry of Health and Social Services (MOHSS) will also include the following directorates/divisions:

- Directorate Special Programmes,
- Directorate Policy and Planning (Quality Assurance Division)
- Directorate of Health Information System and Research
- National Health Training Centre
- Ministry of Urban and Rural Development (MURD)
- Ministry of Home Affairs, Immigration, Safety and Security (MHAISS)
- Ministry of Information and Communication Technology (MICT)
- Ministry of Finance (MOF)
- Ministry of Justice (MOJ)
- Ministry of Agriculture, Water and Land Reform (MAWLR)
- Ministry of Gender Equality, Poverty Eradication and Social Welfare (MGEPESW)
- Ministry of Education, Arts and Culture (MOEAC)
- Ministry of Higher Education, Training and Innovation (MHETI)
- Ministry of Labour, Industrial Relations and Employment Creation (MLIREC)
- Ministry of Industrialisation and Trade (MIT)
- Ministry of Sport, Youth and National Service (MSYNS)
- National Planning Commission (NPC)
- National Statistics Agency (NSA)
- University of Namibia (UNAM)
- Namibia University of Science and Technology (NUST)
- Welwitchia University (WU)
- International University of Management (IUM)
- Independent Midwives Association of Namibia
- United Nations Organisations (UNICEF, WHO and UNFPA, WFP, FAO, UNAIDS)
- United States Government (USG) funded organisations e.g. (Centre for Disease Control (CDC) and United States Agency for International Development (USAID)
- Namibia Network of Aids Service Organisations (NANASO) representing Non- Governmental Organisations
- Private hospitals, Medi-Clinic, Rhino Park and Lady Pohamba Private Hospital
- Community-based organisations (CBOs)/Faith-based organisations (FBOs), Council of Churches in Namibia
- Consumer organisations or mothers' groups
- Private Dieticians and Lactation consultants

The membership list is not exhaustive; therefore, the BFHI TWG can add members as need arise. Additionally, the national focal person responsible for the implementation of Infant and Young Child Feeding programmes will be responsible overall for the BFHI implementation and will work closely with the BFHI TWG.

Individuals or organisations with a conflict of interest particularly companies that produce and/or market foods for infants and young children, or feeding bottles and teats, cannot be members of the BFHI TWG. The same applies to health professionals, researchers and others who have received funding from producers or distributors of products under the scope of the Code of marketing of Breast-Milk Substitutes ("Code").

Roles and Responsibilities of the BFHI TWG

- Planning, coordination, monitoring and evaluation of the BFHI, including organising training provision
- Disseminating information related to the BFHI
- Identifying and facilitating research priorities related to BFHI
- Supporting identified focal persons for the protection, promotion and support of breastfeeding at facilities providing maternity and new-born services
- Planning and coordinating activities to protect, promote and support infant and young child feeding that are not included in the BFHI
- Ensure that the national health information system includes a record of the feeding status on all contacts with children under 2 years of age
- Developing and implementing a monitoring and evaluation plan

BFHI TWG Meetings

- Meetings will be chaired by the Ministry of Health and Social Services
- The BFHI TWG shall meet regularly (at least quarterly) to review the progress on the planned BFHI activities
- Decisions will be made by consensus by the BFHI TWG. However, in emergency situations when decisions have to be made impromptu, the chair may make the final decision and thereafter inform all the BFHI TWG
- Meeting agendas and minutes will be provided by the Ministry of Health and Social Services (a secretariat will be formed)
- BFHI TWG Amendment, Modification or Variation
- The Terms of Reference may be amended, varied or modified in writing after consultation and agreement by the BFHI TWG.

5.3 INTEGRATING THE TEN STEPS INTO RELEVANT POLICY AND GUIDANCE DOCUMENTS

The ten steps and standards of care should be integrated into relevant national policy documents. The adherence by facilities to implementing the ten steps should be included in relevant guidelines, strategies, policies, standards, regulations, licensing and legislation (including the Code of Marketing of Breast-Milk Substitutes), social security and labour law regulations in order to strengthen quality services rendered to mothers and babies.

Regular assessment processes are also laid out in this guideline and will provide opportunities for incentives and recognition for facilities that adhere to most or all of the steps, set of clinical standards and specific management procedures. Such inclusion will facilitate the allocation and sourcing of funds to implement BFHI activities.

The key clinical practices and global standards of the revised ten steps should be written into the standards of care for professional bodies. At a minimum, standards for nursing, midwifery, family medicine, obstetrics, paediatrics, neonatology, dietetics and anesthesiology should be laid out as the basics of care for all newborns. The national protocols for feeding of infants of mothers who are living with HIV, as well as protocols for the use of donated human milk, also need to be incorporated into these standards.

A relevant guidance document for incorporating the key clinical practices into standards of care is the "Standards for improving quality of maternal and newborn care in health facilities" (WHO, 2016), could be used as a resource document in addition to these guidelines and other standards and relevant policies and guidelines in the MOHSS.

5.4 ENSURING COMPETENCY OF HEALTH PROFESSIONALS AND MANAGERS

Health Professional Competency Building

The competency of health professionals and managers in implementing the ten steps to breastfeeding and the training of the 20-hour BFHI course is a critical component in the successful implementation of the initiative. Health workers at all levels of the health-care system should have adequate knowledge, competence and skills to implement recommended practices and procedures for the protection, promotion and support of breastfeeding in facilities providing maternity and newborn services. Facility managers, nurses in charge, hospital administrators, directors and medical superintendents need to have an adequate understanding of breastfeeding and the BFHI so that they can guide and oversee BFHI implementation at the facility level.

The 20-hour BFHI course (WHO & UNICEF, 2009), the revised ten steps, breastfeeding counselling, the protection, promotion and support of breastfeeding, as well as health-workers responsibilities under the international and subsequent WHA resolutions and any other relevant training (including on-line or electronic courses) for midwifes and doctors should be:

- integrated into pre-service training curricula for all professions that will interact with pregnant women, deliveries and newborns. This should include adequate time for theoretical, clinical, administrative as well as practical sessions.
- teaching staff at tertiary institutions involved in education and training should be equipped with the appropriate qualifications, education and experience, in order to include, adapt or develop the new materials and curricula.
- the WHO Model chapter for textbooks for medical students and allied health professionals is a useful basis and could be used as a resource document in addition to these guidelines. (WHO, 2009).

These training sessions are an essential investment for long-term, sustainable capacity- strengthening and will improve quality of service delivery.

Additionally, individual facilities have the responsibility to:

- assess competencies and ensure that all of those who work at a facility have appropriate knowledge and skills when these are found to be substandard.
- train health workers on the 20-hour BFHI course, the revised ten steps, breast- feeding counselling, the protection, promotion and support of breastfeeding, as well as health-worker responsibilities under the Code (WHO, 1981;) and any other relevant training for midwifes and doctors.
- ensure that these training sessions could be done through regular in-service training and on the-job refresher training sessions until competencies, knowledge and skills are met.
- that these training need to be competency based, focusing on practical skills rather than only on theoretical knowledge.
- ensure that skills assessment will require direct observation. As a result, some one-to-one learning and competency-based assessment will still be needed.
- ensure that staff at health facilities should be able to do mentoring and conduct competency assessments.

It is the responsibility of the IYCF national programme officer with the assistance of the BFHI TWG to ensure that capacity building and appropriate training material development is done through:

- training of trainers who will subsequently coordinate training at regional and district levels and ensure that this training will be integrated with other on-going PHC training activities.
- training of health workers in various health facilities (in-service training).
- training of employers and employees.
- training of child minders.

- training of community health workers and traditional birth attendants.
- training of members of the community including women's groups.
- training of religious and community leaders.
- training of mother's support groups.
- Improvement of basic training of health workers in the various training institutions to include BFHI and its standards (pre-service curriculum).

5.5 UTILIZING INTERNAL AND EXTERNAL ASSESSMENTS

5.1.1 Internal Assessment

Facilities providing maternity and newborn services need to develop internal monitoring mechanisms to ensure adherence to the ten steps of breastfeeding and to the standards of care. Facilities should first go through a process of self-assessment using a self-assessment tool found in Annex 1 of this document before an external assessment is undertaken to recognise the facility as baby-friendly.

The awareness, knowledge, skills, as well as adaptation of the maternity and new-born care facilities of the BFHI should first be created among the staff of the health facility, before self-assessment can be done/evaluated. This should include clinical assessment as well as administrative assessment. The ten steps, standards of care and the "Code", which are explained in previous chapters of this guideline, and the attached self-assessment tool should be used as a step by step guide to assess the facility.

This process provides the facility and staff with the opportunity to critically assess them whether they are:

- strategically displaying the BFHI policy statement issued by the Ministry of Health
- and Social Services and ensuring that all staff members are aware of it.
- displaying IEC materials in appropriate languages.
- having a written outline about breastfeeding which is given to mothers and fathers.
- fully implementing as health promotion material and adhering to the ten steps and standards.
- adhering to the International Code of Marketing of Breast-Milk Substitutes.
- training staff according to training Guidelines developed by the BFHI TWG.
- collecting data of services provided.

The above-mentioned should be done in addition to the self-assessment tool and will assist the facilities to reflect on the effectiveness of their breastfeeding programme before moving on to external assessment. After the initial self-assessment, the facility can share the results with the district and regional health teams through which the regional PHC director will then notify the national BFHI TWG through the Directorate of Primary Health Care/Division of Family Health, and request external assessment. The facility may also request a **Certificate of Commitment** before external assessment is carried out.

5.1.2 External Assessment

External assessment is critical for quality assurance to validate adherence to the ten steps and quality assurance, whilst also providing feedback to each facility on areas for improvement. It is thus important to maintain ongoing external assessment processes (including assessments and re-assessments).

This assessment can be integrated with other processes for example:

- supportive supervisory visits
- inspection for licensing of facilities
- quality-assurance processes or any process that could include external assessment.
- vertical stand-alone assessment can also be done if preferred, depending on availability of resources.

The primary purpose of external assessment should be:

- to facilitate technical assistance and correction of inappropriate practices. Each facility should be assessed by assessors:
- who are designated by the TWG and who do not come from the same facility or include TWG members themselves
- staff members from other regions/districts that possess the knowledge and skills to conduct the assessment

The Hospital **external assessment tool and guideline** for external reassessment can be used and can be requested from the national level when facilities are ready.

Facilities that are assessed to be baby-friendly can be rewarded with incentives or other forms of recognition that are applicable. External assessment should review documentation on all of the key clinical practice indicators, including the sentinel indicators. If data is regularly collected by facilities, it can be reviewed by the external review team to assess consistent adherence to the clinical steps. The assessment should include some element of validation of the facility's monitoring data via interviews with staff, pregnant women and mothers, at least for some period of time.

In addition, indicators of adherence to the critical management procedures should be assessed with standard indicators, using the suggested list of indicators for these management practices, and their means of verification. The methods of verification include observation, interviews with clinical staff and review of records.

The BFHI TWG should notify the facility on when an assessment of the facility is to be conducted and also be informed on the results of the assessment. Facilities need to be assessed and re-assessed on a continuous and regular basis.

The depth and frequency of the external assessments depends on the quality and frequency of internal monitoring, and determine which information is reported to higher levels.

Some focus areas for assessment at facility level might include:

- Breastfeeding policy and guidelines: A clearly written breastfeeding policy and guideline that is routinely communicated to staff and parents and displayed in appropriate languages.
- Staff competency: Health facility staff should have sufficient knowledge, competence and skills to support women to breastfeed.
- Antenatal information: pregnant women and their families should be counselled about the importance, benefits and management of breastfeeding.
- Immediate postnatal care: Early and uninterrupted skin-to-skin contact and rooming-in between mothers and infants should be facilitated.
- Support to mothers: Health workers showing mothers practically to initiate and maintain breastfeeding and manage common breastfeeding difficulties.
- Supplementation: Do not provide breastfed new-born's any food or fluids other than breast milk, unless medically indicated for the first 6 months..
- Code of Marketing of Breast-Milk Substitutes: Complying fully with International Code of Marketing of Breast-Milk Substitutes.
- Active responsive feeding: Support mothers to recognise and respond to their infants' cues for feeding.
- Care at discharge: Coordinate discharge so that parents and their infants have timely access to ongoing support and care.
- IEC materials and job aids: Availability of IEC materials in appropriate languages and job aids for patients and health workers at facility.

These might not include all areas but should be focused on in addition to the hospital external assessment attached to this guideline. If the assessment cannot be performed, spot checks may be used and be reported on.

5.6 DEVELOPING AND IMPLEMENTING INCENTIVES AND SANCTIONS FOR COMPLIANCE

5.1.3 Incentives

Incentives should form part of the implementation process in order to ensure that facilities providing maternity and newborn services make the necessary changes to fully protect, promote and support breastfeeding. These incentives should be performance based.

Incentives for change in public and private facilities may be different. Several options or suggestions for incentivising with the BFHI implementation are stated below.

Different types of incentives may be implemented depending on the:

- facility
- implementation phase
- resources available

The BFHI TWG will recommend and implement the incentives as well as having the option to select one or more of the incentives if necessary.

Proposed Incentives

Certification as baby friendly facility - Adherence to the ten steps and standards of care can be done as a requirement upon licensing, registration and/or renewal of a facility providing maternity and newborn services. It can be included in performance contracts both in the public and private sector.

Recognition of excellence - This can be done through awarding a certificate or award when facilities who are providing maternity and newborn services have been assessed as baby friendly. This may be done when facilities partly or fully comply or state their intention to implement the programme.

Performance-based financing - This can be done when facilities providing maternity and newborn services meet the ten steps and standards of care after having been externally assessed, provided funding is available. Facilities identified as having more deficiencies in practices might receive a lower rate of reimbursement per delivery, compared to those in full compliance with all the ten steps and standards.

5.1.4 Sanctions

Sanctions should form part of the implementation process in order to ensure that facilities providing maternity and newborn services make the necessary changes to fully protect, promote and support breastfeeding. These sanctions in public and private facilities may be different. Sanctions can be applied according to government policies, guidelines and appropriate legislation depending on non-compliance at the time of implementation e.g. penalties, rejecting of withholding license to practice or accreditation etc.

5.7 PROVIDING TECHNICAL ASSISTANCE TO FACILITIES

Where resources are constrained, it may be necessary to phase in technical assistance over time, with a clear plan to achieve national coverage in a set period of time. A variety of strategies which facilities could target first are:

- a strategic geographic focus, such as starting with one facility in each region, would ensure that throughout the country all facilities have a nearby facility to view as a role model in implementing the recommended policies and practices.
- focusing first on facilities that are most likely to comply with the recommendations
- e.g. facilities previously certified as "Baby-friendly" or who have shown interest on implementation. Facilities could provide early wins and demonstrate to other facilities the feasibility of the recommendations.

- large facilities are also an important early target because the health of a large number of mothers and babies can be improved with changes in a single place.
- ensuring that the training curriculum of nurses and doctors may be particularly effective so that new health professionals are well-grounded in the ten steps before they are assigned to facilities throughout the country.

Monitoring Implementation of the Initiative

- individual health facilities need to monitor their activities in protecting, promoting and supporting breastfeeding, as well as feeding behaviours.
- national level bodies should monitor health facility activities and breastfeeding outcome indicators using the ten steps, clinical practices and BFHI programme activities. There is need to develop a monitoring tool that will capture data and compile data at national level.
- routinely collected data from the national Health Information System (HIS) and private facilities on maternity and new born services, can be used to document the overall percentage of babies experiencing recommended care, or the percentage of facilities that are meeting a given threshold for acceptable practices.
- results of internal and national level monitoring can be used to inform assessments.
- indicators from the ten steps should be integrated into the existing household surveys (Household Census, Income and expenditure surveys, NDHS, etc).

5.8 ADVOCATING FOR THE BFHI TO RELEVANT AUDIENCES

The national TWG will need to undertake ongoing communication and advocacy efforts to ensure sustained implementation of the BFHI through existing policies, strategies and communication tools. A communication plan should include identification of the key audience, key communication channels, existing knowledge and attitudes, development and adaptation of key messages, etc.

5.9 IDENTIFYING AND ALLOCATING RESOURCES FOR SUSTAINABLE FUNDING OF BFHI

Funding for the protection, promotion and support of breastfeeding in facilities providing maternity and new born services should primarily come from government resources. Donors should channel resources through the government:

- the activities need to be incorporated into regular government budget processes so that they can be funded in a sustainable way.
- governments need to ensure that strategies and activities are designed in such a way that they can be funded by the government in a sustainable manner.
- while the BFHI should be the government's responsibility, additional funders may be needed if the national budget cannot sustain the initiative because of competing priorities or inadequate resources.
- external funding sources, such as international donors, foundations, NGOs, or the private sector may be necessary, either for specific interventions related to the BFHI or for ongoing operational costs.
- funding sources for the BFHI cannot have a conflict of interest with breastfeeding and should never be accepted from companies that market foods for infants and young children, or market feeding bottles and teats.

5.10 QUALITY IMPROVEMENT

Quality improvement is a management approach that health workers can use to reorganise care, to ensure that patients receive good-quality health care. Quality improvement helps to improve sustainability, since standard processes require fewer external resources or additional staff. The BFHI-related aspects can be combined with other quality-improvement initiatives that are already ongoing in the area of newborn or maternal and child health at the facility.

Regardless of what model of quality improvement is used, key principles of quality improvement are central:

- the triad of planning, improvement and control is central to the approach: Implementing teams need guidance on how to move through quality improvement steps.
- active participation of the main service providers or front-line implementers: A team of staff members in the facility should review their own practices and systems and decide on the processes or actions that need to be changed.
- engagement of leadership personnel: Facility administrators, heads of medical departments and need to be convinced of the importance of the protection, promotion and support of breastfeeding and achieving high rates for the early initiation of and exclusive breastfeeding. Front-line implementers should be encouraged to adapt practices where needed, and facilitate and actively support necessary changes Facility managers play a pivotal role in implementing the critical management procedures.
- measurement and analysis of progress over time: Using data to identify where problems are occurring, allows a more focused approach to solving them. The team needs to decide on the key indicators to measure, in addition to the two sentinel indicators.

5.11 INFORMATION, COMMUNICATION AND EDUCATION (IEC), HEALTH EDUCATION AND SOCIAL MOBILISATION

IEC materials and Target Groups

Posters, leaflets, booklets etc. will be developed and disseminated to specific target groups such as mothers, fathers/husbands, caregivers, public opinion leaders, grandparents, youth, community development workers, agricultural extension workers, community groups, youth organisations, trade unions, employers, schools, trade, finance, customs, justice, women affairs, etc. These materials should be displayed in the facility as well as translated into appropriate languages.

Social Mobilisation

The IEC/health promotion directorate in the Ministry of Health and Social Services in collaboration with various sectors will facilitate the BFHI social mobilisation activities. Information should be disseminated in all languages through radio, local newspapers, television (especially for urban targets), folk songs, drama etc. At the community level, community resource persons including community health workers and traditional birth attendants, should be involved in promoting BFHI. Further, religious organisations, women groups and breastfeeding support groups should help to disseminate the relevant information to various target groups.

CHAPTER 6:
SPECIAL CONSIDERATIONS IN INFANT YOUNG CHILD FEEDING

The main incentive of the BFHI is to ensure that mothers and newborns receive appropriate care before and during their stay in a facility providing maternity and newborn services, so that they can successfully breastfeed in accordance with international recommendations. Breastfeeding should be integrated at all levels and standards of care and at key contact points with the system, i.e. family planning, ante-natal care (ANC), delivery, post-natal Care (PNC), expanded programme of immunization (EPI), integrated management of neonatal and childhood illness (IMNCI).

6.1 BREASTFEEDING FOR IMPROVING QUALITY OF NEW-BORN CARE IN HEALTH FACILITIES

Antenatal Care

Antenatal Care (ANC) is a potentially important entry point for delivering core interventions to improve maternal nutrition. By encouraging pregnant women to improve maternal dietary intake during pregnancy can contribute to improved birth outcomes. During antenatal care all pregnant women need basic information about breastfeeding during group health education talks and during individual counselling with health workers. The breastfeeding information should be documented at facility level and begin during the first or second ANC visit so that there is time to discuss any challenges if needed.

The following topics should be covered during ANC visits and recorded for assessment purposes:

- benefits of breastfeeding for mother and baby.
- importance of early skin to skin contact to promote bonding and importance of early initiation of breastfeeding.
- importance of exclusive breastfeeding on demand and rooming-in.
- breastfeeding and HIV.
- importance of maternal nutrition throughout pregnancy and post-partum.
- practical demonstration of correct positioning and attachment and hand expression of breast milk.
- encourage mother to bring partner/support person.
- the importance of PNC, growth monitoring and promotion (GMP) and EPI.
- pre-test and post-test counselling: All mothers and partners with unknown HIV-status should be counselled and tested for HIV.
- individual counselling for PMTCT.
- importance of support groups: at this point it is very important for the mother to identify a family member or a friend who is likely to give her support.

Post Natal Care (PNC)

Post-natal care is the health care and follow-up given to a mother and the newborn immediately following delivery and up to 6 weeks or 42 days or appropriate number of days, after delivery. The following should be undertaken:

- early and uninterrupted skin- to- skin contact within one hour of birth between mother and infants should be facilitated.
- early initiation of breastfeeding and rooming-in.
- mothers should receive practical support to enable them to initiate and maintain breastfeeding and manage common breastfeeding difficulties.
- show mothers good positioning and attachment at the breast.
- direct observation of a feed should be done by health worker to ensure that baby is able to latch and suckle at the breast.
- mothers should be coached on how to express breast milk and feed baby per cup

- mothers should be taught about the importance of colostrum.
- strengthen support to mothers to practice exclusive breastfeeding for 6 months.
- encourage mothers not to give artificial teats or pacifiers (also called dummies and soothers) to breastfeeding infants.
- advise mothers to breastfeed on demand, day and night and to wake up babies for breastfeeding if they sleep too long.
- ensure that mothers on ARVs have been counselled on the use of ART/ARVs during the breastfeeding period.
- provide Vitamin A supplementation for the mother if included in national guidelines.
- the mother should be given the date for next appointment.

Mothers discharge from health facility

Make sure that the mother demonstrates and understands:

- correct positioning and attachment.
- the importance of exclusive breastfeeding and the dangers of mixed feeding.
- the dangers of using artificial teats and bottles.
- that the baby should decide the length and frequency of feeds.
- what to do if they think that they do not have enough milk.
- the importance of eating a variety of food including traditional food.
- that the mother should drink extra fluids regularly throughout the day.
- that she should get regular exercise and rest.
- that mothers should avoid alcohol, tobacco, excessive caffeine and other self- medications whilst breastfeeding.
- the dangers of becoming HIV-infected while breastfeeding because of the significant increased risk of Mother to Child Transmission (MTCT) during that period, and advise mothers to use condoms in addition to other methods of family planning.
- the importance of regular follow up visits for routine child health, GMP, EPI, etc.
- make sure that the mother has received vitamin A supplementation after delivery.
- refer mother to support groups or members of her family for support.
- give follow-up date after delivery
- ensure the mother has received counselling on the use of ARVs during breast- feeding period for herself and the baby.

Care of mother and baby after delivery

- provision of basic needs e.g. food, pain relief, hygiene.
- assess maternal nutritional status and provide information on appropriate nutrition
- observe breastfeeding and support with positioning and attachment and assist mother if necessary.
- promote and educate the mother on exclusive breastfeeding for the first six months regardless of HIV status.
- in HIV exposed infants start NVP (as per PMTCT guidelines) on the use of Nevirapine (NVP) prophylaxis or as per national guidelines.
- examine the breasts.
- provide information on nutrition, HIV and AIDS, family planning, immunizations and IYCF counselling, follow up visits at six days, six weeks and six months, etc and post-natal care visits. Offer HIV counselling and testing for breastfeeding mothers who have tested negative previously or have unknown HIV status. Establish the infant's HIV status.
- follow up breastfeeding progress and provide advice to the mother accordingly, reinforce relevant information. Check feeding and provide IYCF counselling mother/ care giver appropriately.
- advise mother to bring baby to the nearest facility if needed. Check baby's mouth for oral thrush and refer/treat accordingly at any visit.
- weigh the infant, plot weight on the health passport and refer for further medical care if infant shows signs of growth failure at any visit. Provide to mother/care giver.
- advise the mother on the use of family planning methods and to practice safer sex.
- emphasise the dangers of mixed feeding.
- assess the mother's adherence to ART if HIV infected.
- emphasise continuation of family planning method in addition to condoms.
- mothers should continue breastfeeding on demand, day and night.

6.2 NUTRITION MANAGEMENT OF LOW BIRTH WEIGHT (LBW) AND PRE-TERM BABIES

Nearly 75% of neonatal deaths occur among low birth weight neonates. Even after recovering from neonatal complications, some low birth weight babies remain more prone to malnutrition, recurrent infections, and neuro developmental handicaps. LBW may be due to either prematurity or intra uterine growth restriction and results in a baby who is small for gestational age (SGA). At times the new born may be both premature and SGA. Pre-term babies also have distinct physical features which help in their recognition.

Low Birth Weight babies (LBW)

Low birth weight babies can be categorised in 3 groups;

- extremely low birth weight- less than 1,000 g
- very low birth weight- between 1-1.5 kg
- low birth weight 1.5-2.5 kg

6.1.1 Nutrition management of low birth weight babies weighing between (2-2.5 kg birth weight)

- babies with a birth weight of two kg or above are usually strong enough to breast feed and maintain their body temperature.
- their mothers usually need additional support for exclusive breastfeeding. These babies must be kept warm at all times.
- check and record the blood glucose level of all low birth weight babies three hourly for the first 24 hours.
- all low-birth-weight babies are at risk of infection and infection control should be closely observed.
- the mother and the family, under the supervision of a health care worker, can manage an otherwise healthy LBW new-born with a birth weight of two kilogram or above, at home.

6.1.2 Nutrition management of a low birth weight babies weighing between (1.5-2.0 kg birth weight)

- babies weighing below two kilogram should be admitted to a premature/neonatal unit.
- feed babies within 30 minutes of birth with Expressed Breast Milk (EBM) with cup or nasogastric tube. The mother should express her own milk into a sterile container
- these babies have a higher risk of developing complications.
- babies with complications should be managed accordingly.
- the baby should be monitored closely for the first 24 hours or first few days to assess feeding ability, fluid intake, the presence of any danger signs and vital signs checked. If the baby remains stable.
- low birth weight should be given kangaroo mother care (KMC) starting soon after birth and ensured at all times, day and night.
- many of these babies will be able to suckle at the breast. Babies who can suckle should be breastfed.
- those who cannot breastfeed should be given expressed breast milk with a cup/ spoon. When the baby is sucking well at the breast and gaining weight, increase breastfeeds and reduce the cup feeds.
- in order to promote lactation, and enable the baby to learn to suck, all babies more than 1.5 kg and 32 weeks gestational age, feeding by cup, spoon or tube, should be put on the breast for five-10 minutes before each feed. This should be done with caution as these babies can easily aspirate.

6.1.3 Nutrition Management of low birth weight babies weighing between (1.0-1.5 kg Birth Weight)

These babies have the highest risk of feeding problems and necrotizing enterocolitis.

- Day one- give 25 ml/kg/day of enteral feeds, preferably expressed breast milk and 55ml/kg/day IV/fluids. The feeds should be given via a gastric tube.- If the baby cannot tolerate enteral feeds, give IV fluids at 80 ml/kg per day.

- Day one-5- Increase feeds everyday by 25mls/kg/day if tolerated.
- Adjust IV fluids so that total intake is according to the table below.
- Try to be fully enteral by 5-7 days.
- Start enteral feeding when the condition of the baby is stable –the baby is able to maintain the suck and swallow routine without increasing respiratory distress and there is no abdominal distension or tenderness, bowel sounds are present, meconium passed and no apnoea.
- Use a prescription chart to calculate exact amounts for feeding and the timing of feeds.
- Check blood sugar every six hours until enteral feeds are established.

Table 3.1 below provides information on feeding.

Table 3.1 Feeding Chart

Total Intake (Enteral and Intravenous) mls/kg/day				
Day 1	Day 2	Day 3	Day 4	Day 5
80	90	100	120	150

1.1.4 Other feeding considerations for LBW and pre-term babies:

Breast milk is the preferred milk because it has a high electrolyte and protein content necessary for rapid growth of the baby, the antibodies and other anti-infective factors in mother's milk are very necessary for the survival of a premature baby.

Birth weight, gestation age, respiratory rate and effort, presence or absence of sickness and individual feeding efforts of the baby, determine the decision as to how a LBW neonate should receive fluids and feeds. The gestational age is one of the most important determinants as coordinated sucking and swallowing does not develop until about 34 week's gestation.

The following should be observed by the mother and health worker:

- is the baby able to breastfeed effectively when offered the breast?
- does the baby root to the breast, attaches well and sucks effectively?
- is the baby able to suck long enough to satisfy needs and gaining weight?
- is the baby able to accept feeds by alternative methods?
- when offered cup feeds, the baby opens the mouth, takes milk and swallows without coughing/ spluttering
- the baby is able to finish the required amount per feed.

It is useful for all mothers to know how to express their milk (Refer to 2011 Infant and Young Child Feeding Guidelines, page 27-28).

Expression of breast milk is required in the following situations:

- to maintain milk production and for feeding the baby who is premature, low birth weight or sick and cannot breast feed for some time.
- where mother and baby are separated due to poor maternal condition (e.g. mother is in the intensive care unit for observation but is able to express).
- to relieve breast problem e.g. engorgement.

6.3 CUP FEEDING

Baby should be awake and held sitting semi-upright on caregiver's lap. Put a small cloth on front of chest to catch drip of milk.

How to cup feed

- Put a measured amount of milk in the cup.
- Hold the cup so that the pointed tip rests on the baby's lower lip.
- Tip the cup to pour a small amount of milk at a time into the baby's mouth.
- Allow the baby to feed at his own pace, ensuring small/weak babies have time to rest and breathe between spurts of drinking. Avoid pouring milk into the baby's mouth.
- Make sure that the baby has swallowed the milk already taken before giving any more.
- When the baby has had enough, he or she will close her mouth and will not take anymore. Do not force the baby to feed.

6.4 OPTIMAL FEEDING IN PRE-TERM AND SMALL FOR DATE BABIES

The key measure of optimal feeding is the weight pattern of the baby. Table 4.1 shows points to consider for Pre-Term LBW and Small for Date Babies on adequacy of nutrition.

Table 4.1 Adequacy of Nutrition

Condition	Measure of Optimal Feeding
Pre-term LBW	Loses up to 10 percent cumulative weight loss during the first week of life Birth weight is usually regained by the end of 2 weeks of life. (May be longer in very premature babies). **Observe for:** Inadequate feeding – insufficient breast milk, inadequate amounts prescribed if tube or cup fed (has the amount been increased appropriately?) mother sick so unable to come to every feed, or- phan. Structural abnormality e.g. cleft palate/lip Persistent hypothermia due to low environmental temperature, which diverts energy from growth to heat production (may be a sign of underlying sepsis). Baby should not have appreciable weight loss at all and gains weight early.

6.5 KANGAROO MOTHER CARE (KMC)

- Kangaroo Mother Care (KMC) is care of a small baby who is continuously carried in skin-to-skin contact by the mother/guardian and exclusively breastfed (ideally). It is the best way to keep a small baby warm and it also helps establish breastfeeding.
- KMC can be started in the hospital as soon as possible. Initiate Kangaroo Mother Care for all LBW babies less than 2,000g, continuous KMC for stable babies and intermittent KMC for sick babies.
- While the baby is recovering from an illness, the mother/guardian can begin to hold the baby in skin-to-skin contact for short periods of time (minimum of 1 hour at a time).
- Once the baby's condition is stable and the baby does not require special treatment (e.g. oxygen or IV fluid), the mother can begin continuous KMC.
- Before initiating KMC, counsel the mother on KMC. Ensure that the room temperature is at least 25 °C.

While the mother/guardian is holding the baby, describe to her each step of KMC, demonstrate, and then allow her to go through the steps herself. The steps are as follows:

- place the baby on the mother's chest:- place the baby in an upright position directly against the mother's skin:
- ensure that the baby's hips and elbows are flexed into a frog-like position and the baby's head and chest are on the mother's chest, with the head in a slightly extended position.
- place the baby on the mother's chest under the mother's clothes and cover with a pre-warmed blanket:
- use a soft piece of fabric (about 1 square metre), folded diagonally in two and secured with a knot; make sure it is tied firmly enough to prevent the baby from sliding out if the mother stands, but not so tightly that it obstructs the baby's breathing or movement.
- after positioning the baby, allow the mother to rest with the baby, and encourage her to move around when she is ready.
- provide counselling on kangaroo mother care, newborn danger signs and general hygiene.
- support the mother/guardian in putting and maintaining baby in KMC position.
- mothers should be encouraged to do kangaroo mother care at home when discharged from hospital.
- where a mother cannot manage follow-up visits and there are no follow-up services in the community, delay discharge until the baby is at least two kilograms.

6.6 NUTRITION DISCHARGE CRITERIA OF THE LBW/PRE-TERM BABY

A well LBW baby can be discharged when:

- baby is fully breast fed or breastfeeding supplemented by EBM by cup and gaining adequate weight for 3 consecutive days. Refer to KMC discharge sheet.
- ensure Vitamin K has been administered and recorded.
- first immunisation has been received and recorded.
- ensure HIV exposure status is known and recorded in the passport.
- if the LBW/pre-term baby is not sick, the immunisation schedule is the same as for term babies.
- Follow-up schedule (at home or as close to home as possible).

Counselling for care of LBW at home:

- Counsel on exclusive breastfeeding, keeping baby warm and to seek health care early if any of the danger signs are identified between postnatal care visits. Ask the parent to repeat the danger signs so that you know they have remembered them.
- Inform mother about postnatal care visits.

6.7 HIV AND BREASTFEEDING

Breastfeeding is a fundamental pillar of child survival and the best way of feeding an infant. Studies have shown that breastfeeding provides distinctive biological, immunological and psychological benefits for both mother and child. The risk of HIV transmission during breastfeeding can be minimised by exclusive breastfeeding for six months and the use of Anti-Retroviral (ARV) prophylaxis during the breastfeeding period.

6.1.5 Breastfeeding when a mother is HIV negative or of unknown status:

- mothers should be counselled to exclusively breastfeed their infants for the first six months of life and to introduce appropriate complementary foods while continuing breastfeeding for 24 months or beyond.
- mothers should be counselled **NOT** to practise mixed feeding before the age of six months.
- mothers whose HIV status is unknown should be offered HIV counselling and testing.
- breastfeeding mothers with a negative HIV status should be encouraged to test regularly six weeks after delivery and thereafter, every six months until cessation of breastfeeding.

6.1.6 Breastfeeding when a mother is HIV positive (her infant is uninfected or of unknown HIV status):

- these mothers should exclusively breastfeed their infants for the first six months of life and then introduce appropriate complementary foods while continuing to breastfeed for 24 months and beyond.
- all HIV infected mothers should be on Anti-Retroviral Therapy (ART) during the breastfeeding period.
- all HIV infected mothers not yet on ART should be counselled and initiated on lifelong treatment.
- all infants should receive Nevirapine (NVP) prophylaxis until 4 weeks after the mother's viral load is < 40 copies/ml or 4 weeks after cessation of breastfeeding, whichever happens first.
- breastfeeding should stop only once a nutritionally adequate and safe diet without breast milk, can be provided.

6.1.7 Breastfeeding when the Infant is HIV Infected:

- these mothers should exclusively breastfeed their infants for the first six months of life and then introduce appropriate complementary foods while continuing to breast feed for 24 months and beyond.
- Nevirapine (NVP) prophylaxis for these babies should be stopped and ART initiated.

6.8 DANGERS OF MIXED FEEDING

Mixed feeding means an infant younger than 6 months of age is given other liquids and/or foods together with breast milk. This could be water, other types of milk or any types of solid food. Exclusive breastfeeding is difficult for mothers to comply with, despite widespread promotion and support, and therefore requires that health workers counsel mothers appropriately.

- When infants are below the age of six months, introduction of any foods or liquids, even water while the baby is taking breast milk can damage the developing gastrointestinal (GI) tract hence allowing HIV, to pass through to the blood.
- The potential for irritation of the GI tract increases the risk for inflammation, allergies, and increased permeability, which allows foreign molecules to pass through to the blood, including HIV.

Exclusive breastfeeding helps to maintain a healthy gastrointestinal tract, which can then act as a protective barrier to infectious agents.

6.9 IMPORTANT CONSIDERATIONS FOR HEALTH WORKERS

- Mixed feeding for infants under the age of six months should be avoided at all times because it carries the risk of HIV-transmission to the baby (mothers who are HIV positive and death or illness from diarrhoea or other infections (all mothers, irrespective of HIV status).
- Risk of HIV transmission to the infant will be higher with mixed feeding during the first six months than the risk from exclusive breastfeeding.
- Mixed feeding during the first six months should be avoided even if the mother is on ART and/ the baby is on ARV's or ART.

Table 5.1 Summary of breastfeeding recommendations in the context of HIV

Age	Mother is HIV negative or of unknown status	Mother is HIV positive (and her infant is uninfected or of unknown HIV status)	Infant is HIV infected
< 6months	- Exclusive breastfeeding from birth until 6 months	- Exclusive breastfeeding from birth until 6 months - Mothers should be on lifelong Anti-Retroviral Therapy (ART) - Infants should receive Nevirapine (NVP) prophylaxis until 4 weeks after the mother's viral load is < 40 copies/ml or 4 weeks after cessation of breastfeeding, which ever happens first.	- Exclusive breastfeeding from birth until 6 months - Nevirapine (NVP) prophylaxis for these babies should be stopped and ART initiated
≥ 6months	- Introduce appropriate complementary foods while continuing breastfeeding for 24 months or beyond.	- Introduce appropriate complementary foods while continuing to breastfeed for **24 months and beyond** -- Breastfeeding should stop only once a nutritionally adequate and safe diet without breast milk can be provided	- Introduce appropriate complementary foods while continuing to breastfeed for 24 months and beyond

BREASTFEEDING IN SPECIAL SITUATIONS

When to use heat-treated expressed breast milk

Mothers known to be living with HIV may consider expressing and heat-treating breast milk as an interim feeding strategy:

- in special circumstances, such as when the infant has low birth weight or is otherwise ill in the neonatal period and unable to breastfeed; or
- when the mother is unwell and temporarily unable to breastfeed or has a temporary breast health problem such as mastitis; or
- to assist mothers in stopping breastfeeding; or
- if antiretroviral drugs are temporarily unavailable.

Heat-treating breast milk is a way to destroy the HIV in breast milk while retaining the important nutrients and protective agents in the breast milk. It is also called flash heating. The expressed breast milk should then be given to the baby with a cup until cracked nipples have healed and breastfeeding can safely resume. In order to heat-treat breast milk, the mother must have adequate access to and supply of fuel and clean cooking supplies to prevent contamination.

Teach the mother how to safely heat-treat breast milk

- Always wash all utensils that you will use to express and heat-treat your breast milk with clean water and soap. It is best to boil these utensils after washing to make sure that they are clean.
- Express breast milk into a clean cup. Be sure to empty both breasts.
- Put all the milk you have expressed in a heat resistant glass (not plastic) jar.
- Place the jar of milk in a small pan of water. Make sure the water is about two fingers above the level of milk so that all the milk will be heated well.
- Heat the water on a very hot fire or on the highest level of your stove until the water reaches a rolling boil (when the water has large bubbles). Do not leave the water to boil too long as this will damage some of the nutrients in the milk.
- Remove the jar of milk from the boiling water immediately after the water comes to a boil.
- Place the jar in a container of cool water, or let it stand alone to cool until it reaches room temperature.
- Protect the milk as it cools and during storage by placing a clean lid or small plate (saucer) on it.
- Store the heat-treated milk in a clean, covered container in a cool place and use it within 1 hour.
- Feed heat-treated milk to the infant with a cup.
- Heat-treated breast milk can be stored for about 8 hours at room temperature or up to 24 hours in a refrigerator.

If the mother is unable to breastfeed for medical reasons such as advanced HIV disease, severe pulmonary TB or breast cancer, formula milk should be prescribed, but ONLY until the infant is 6 months old, and ONLY after a full assessment of the socio-economic situation has been conducted and the family is found to be eligible.

An HIV – positive status is not a medical reason for inability to breastfeed.

6.10 STOPPING BREASTFEEDING

Stopping breastfeeding gradually

- Mothers should be informed that stopping breastfeeding should be done gradually.
- Stopping breastfeeding abruptly can be traumatic for both the baby and mother and can result in growth failure, malnutrition, diarrhoea and an increase in viral load in the breast milk.
- Mothers should be informed on the ideal ways to gradually stop breastfeeding which are as follows:
- While still breastfeeding the baby should be taught to drink expressed breast milk from a cup.
- Replace one breastfeed with one cup-feed using expressed breast milk, increase the frequency of cup feeding every few days while reducing the frequency of breastfeeding.
- Mothers should stop putting the baby to the breast as soon as both the mother and the child are accustomed to frequent cup feeding. Replace the expressed breast milk with whole animal fresh milk.
- Mothers should be informed that infants may seek additional comforting during the gradual stoppage of breastfeeding but they should find other ways to comfort them such as massaging, carrying, rocking, singing and talking.
- Mothers should be advised notto re-start breastfeeding once stopped.
- Re-starting breastfeeding increases the chance of passing HIV infection to the baby.
- Mothers should be advised that if their breasts become engorged when stopping to breastfeed, the milk should be expressed by hand and discarded.

Prevention of breast engorgement when stopping to breastfeed

- The mother needs to express just enough milk to keep her breasts comfortable and healthy during this process. Stopping to breastfeed quickly can lead to engorgement, mastitis and if left untreated, an abscess will develop.

Breast engorgement can be treated as follows:

- the breast should be supported with a well supporting bra or cloth
- apply warm or cold compresses to reduce swelling and express just enough milk to relieve discomfort.
- too much milk expression may stimulate milk production.
- prescribe Paracetamol or Ibuprofen to relieve pain
- avoid pharmacological treatments such as Stilboesterol, Bromocriptine (Parlodol) and Cabergoline that reduce milk supply.

Breast health management

Cracked nipples, mastitis and breast abscesses increase the risk of HIV transmission through breast milk. Health workers should demonstrate correct positioning and attachment techniques to prevent the development of cracked nipples and counsel on how to prevent and manage other types of breast problems such as mastitis, breast abscesses and blocked ducts.

Refer to 2011 National Infant and Young Child Feeding Guidelines, MHSS, page 28-31

6.11 FEEDING AN HIV-POSITIVE SICK CHILD

- During periods of illness, breastfed infants and young children should continue breastfeeding
- Sick children need to eat frequent, small meals to enhance recovery

6.12 BREASTFEEDING FOLLOW UP

Health workers should follow up on HIV positive mothers and their exposed infants to offer breastfeeding counselling and support.

Breastfeeding counselling, support and follow-up should be provided:

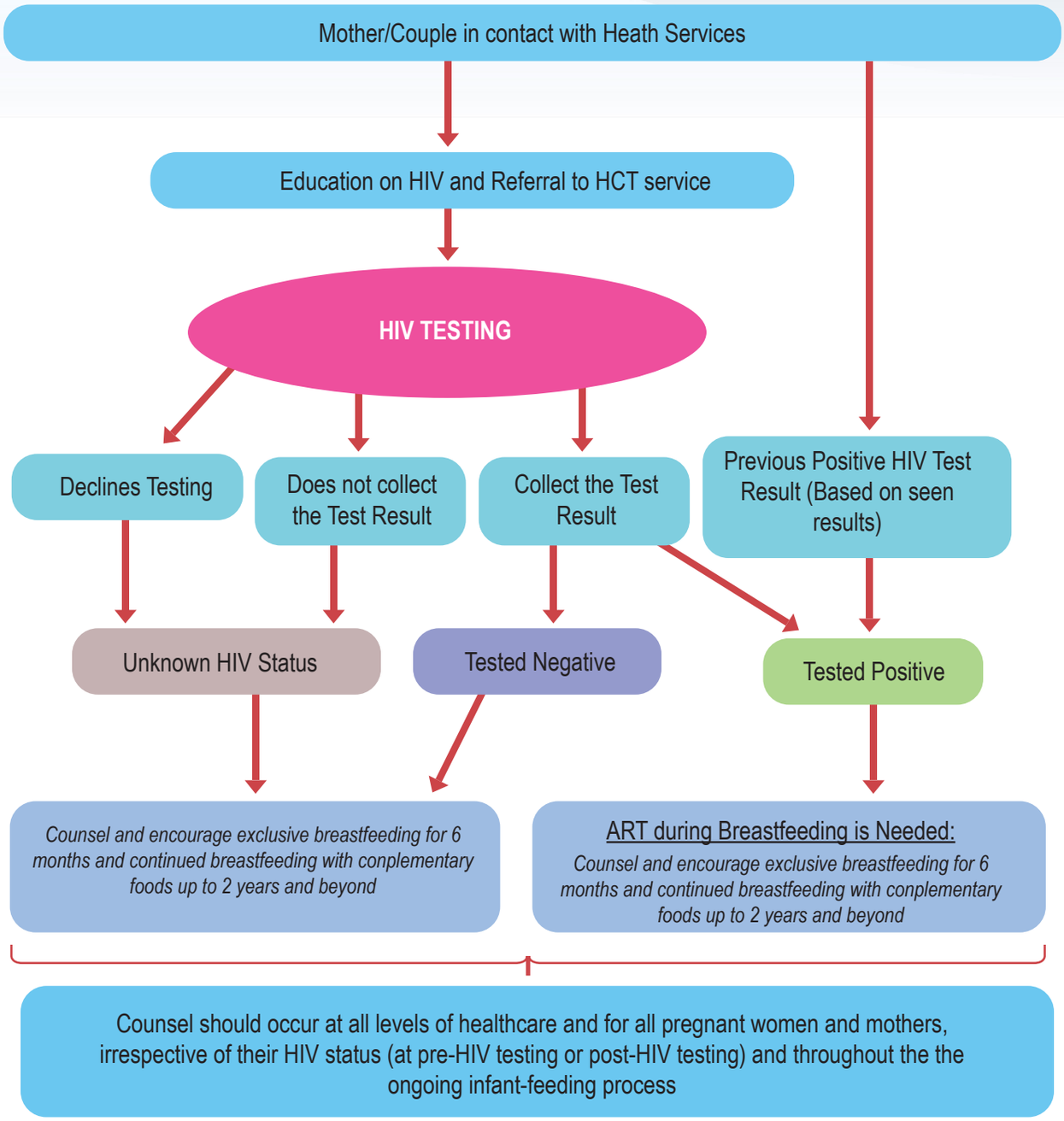
- during pregnancy-first and follow-up antenatal care visits;
- at delivery
- during the postnatal period-at six days, six weeks and thereafter every month until 24 months of age.
- during each visit the health worker should assess and counsel on sustainability of exclusive breastfeeding, timely introduction of complementary feeding at six months with continued breastfeeding.
- during each visit the health worker should assess the child's health and look for signs of infection such as oral thrush, persistent diarrhoea, failure to thrive, ear discharge, enlarged lymph nodes or recurrent pneumonia.
- health workers should identify and establish community support to refer mothers for follow-up to community health workers, home based care givers, traditional birth attendants, to mention a few, who can integrate breastfeeding support as part of their activities.

Counselling on breastfeeding

Health workers should give breastfeeding counselling to:

- all mothers and their partners during antenatal, labour and post-natal care; it requires well-trained health workers and a comfortable environment that ensures privacy for the mother and her partner.
- all health workers involved in maternal and child health care should undergo training on infant and young child feeding, including counselling.

Figure 5.1 below shows a scheme for counselling on feeding for different conditions and status as per current national guidelines.



6.13 THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES AND RELEVANT WORLD HEALTH ASSEMBLY RESOLUTIONS (WHA)

The International Code of Marketing of Breast-Milk substitutes was adopted in 1981 by the World Health Assembly (WHA) in response to poor breastfeeding practices which were negatively affecting the growth, health, development of children and were a major cause of morbidity and mortality in infants and young children. The International Code of Marketing of Breast-Milk substitutes is a significant component of the BFHI and is a set of recommendations and WHA resolutions aimed at regulating the marketing of breast-milk substitutes, feeding bottles and teats in order to protect, promote and support breastfeeding.

Namibia is a signatory to the International Code of Marketing of Breast-Milk substitutes and therefore incorporated parts of it into the Public and Environmental Health Act of 2015. The Act of 2015 provides for the enforcement and monitoring of legislation related to the International Code of Marketing of Breast-Milk substitutes and subsequent relevant World Health Assembly resolutions aimed at protecting breastfeeding by ensuring the proper use, marketing and distribution of breast-milk substitutes.

Families are most vulnerable to the marketing of breast-milk substitutes during the entire prenatal, perinatal and postnatal period when they are making decisions about breastfeeding. The WHA has called upon health workers and the health-care systems to comply with the International Code of Marketing of Breast-Milk substitutes and subsequent relevant WHA resolutions (the Code), in order to protect families from commercial pressures. Compliance with the Code is important for facilities providing maternity and new-born services, since the promotion of breast-milk substitutes is one of the largest undermining factors for breastfeeding. Health professionals themselves need protection from commercial influences that could affect their professional activities and judgement.

The Hospital and Health Worker's Responsibilities under the Code
The Criteria referred below refers to the Code as it applies to maternity and new born services and related areas.

Article 6 and 7 of the code relate to the health care system and health workers. Article 6.2 states that 'No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of the code'. The following is the hospital and health worker's responsibilities under the code:

Encourage and protect breastfeeding
Health workers involved in maternal and infant nutrition should make themselves familiar with their responsibilities under the code, and be able to explain the following:

- the importance and superiority of breastfeeding
- hazards associated with artificial feeding
- the role of maternal nutrition in breastfeeding
- the preparation for and maintenance of breastfeeding
- the negative effect on breastfeeding by introducing partial bottle feeding
- the difficulty of reversing the decision not to breastfeed

Health workers should ensure that:

- no employees of manufacturers or distributors of breast-milk substitutes, bottles, teats or pacifiers have any direct or indirect contact with pregnant women or mothers with infants in maternity wards or new born services.

Health workers should ensure that health facilities are NOT used for:

- display of products within the scope of the code, for placards or posters
- ensure that packages of Breast-Milk Substitutes and other supplies purchased by the health facility are not on display or visible to mothers.

Health workers should ensure that they do NOT:

- receive free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events from manufacturers or distributors of breast-milk substitutes, bottles, teats or pacifiers.

Health workers should refuse samples of:

- infant formula or other products within the scope of the code, or of equipment or utensils for their preparation or use, unless necessary for the purpose of professional evaluation or research at the institutional level.

Health workers should NOT pass any samples to:

- pregnant women, mothers of infants and young children, or members of their families.
- Samples of infant formula should not be given to mothers on discharge.

Health facilities should NOT allow:

- the display of posters or other materials provided by manufacturers or distributors of breast-milk Substitutes, bottles, teats and dummies or any other materials that promote the use of these products.

Health facilities should NOT allow:

- any direct or indirect contact between employees of these manufacturers or distributors and pregnant women or mothers.

Health workers should disclose any contribution made by:

- a manufacturer or distributor of breast-milk Substitutes, bottles or teats for fellow- ships, study tours, research grants, attendance at professional conferences, or the like to the management of health facility.

Health facilities can purchase the small amounts of breast-milk Substitutes needed for the minority of infants who:

- require them e.g. orphans in the maternity wards and hospitals through normal procurement channels and not through free or subsidised supplies.

Heath facilities will NOT display:

- posters or other materials provided by manufacturers or distributors of breast-milk substitutes, bottles, teats and dummies or any other materials that promote the use of these products.

Heath facilities will ensure that there is No distribution of:

- samples or gift packs with breast-milk substitutes, bottles or teats, or of marketing materials for these products to pregnant women or mothers or members of their families.

For more information on the International Code of Marketing of Breast-Milk Substitutes refer to the Public and Environmental Health Act (Act 1 of 2015), and the International Code of Marketing of Breast-Milk Substitutes, 1981.

6.14 SUPPORTING BREASTFEEDING IN EMERGENCIES

Emergencies such as droughts, floods, earthquakes, wars and epidemics are characterised by population displacement and food insecurity. In such situations the care and feeding of infants are often compromised and can seriously threaten breastfeeding practices and consequently child nutrition, health and survival. Therefore, in emergencies, emphasis should be on protecting, promoting and supporting breastfeeding.

Breastfeeding is lifesaving because human milk is not only the perfect nutrition for infants but it also contains antibodies that fight infection and disease, preventing bacteria and pathogens from attaching to the infant's intestines. Besides, breastfeeding helps keep infants warm, lowers pain levels in infants, and lowers stress levels to calm traumatised infants and mothers.

It is therefore important that breastfeeding mothers are supported to breastfeed their new born infants in emergencies by ensuring that:

- initiation of breastfeeding starts within one hour of birth.
- the mothers practice exclusive breastfeeding for the first six months of life and continue breastfeeding to two years of age or beyond.
- key health interventions such as skin-to skin contact, kangaroo mother car, 'rooming in' are part of maternity care (in order to keep mothers and infants together),
- the ten steps to successful breast Feeding are integrated in maternity services.
- ensure access to HIV services as appropriate, including nutritional support when indicated

In emergency situations, the Code is especially important for:

- controlling donations,
- preventing the distribution of unsuitable products
- preventing companies from using emergencies to increase market share or for public relations.

However, there are certain situations where breast-milk substitutes may be needed, WHA

6.1.8 (1994) operative paragraph 2(3) recommends that donated supplies be given only if all of the following conditions apply:

- infants have to be fed on breast-milk substitutes
- the supply is continued for as long as the infants concerned need it
- the supply is not used as a sales inducement for example there should be no display, and companies should not use the donation to promote the brand, company names or logos.

Therefore, the International Code of Marketing of Breast-Milk substitutes states that:

- when breast-milk substitutes are required in an emergency response, these should ONLY be purchased because unregulated donations can undermine breastfeeding as mothers and their children become reliant on them
- health workers should participate in monitoring the International Code of Marketing of Breast-milk substitutes and report violations to the relevant authorities to ensure that emergencies are not exploited for commercial interests.

CHAPTER 7:
Baby Friendly Community Initiative (BFCI)

Increasing the exclusive breast-feeding rates in the country entails that the community is involved by reaching out to the mothers in their own communities when they leave the hospital, even if they do not deliver at the hospital. This intervention known as the Baby Friendly Community Initiative (BFCI) was developed as an extension of the 10th step of BFHI. The BFHI 10th step emphasises the support for breastfeeding mothers after they leave the hospital.

7.1 OBJECTIVES OF BABY FRIENDLY COMMUNITY INITIATIVE (BFCI)

- to protect, promote and support breastfeeding for healthy mothers and babies through compliance to the International Code of Marketing of Breast-Milk Substitutes
- to increase the percentage of babies who are breastfed
- to increase the duration of exclusive breastfeeding
- to sustain breastfeeding after six months alongside introduction of complementary foods

BFCI underlines the formation of community support groups and mother-to-mother support groups that motivate the participation of men, the introduction of income generating activities, such as kitchen gardens. Community level involvement in breastfeeding initiatives consists of health care workers, community health workers, family members, relatives and friends, peers, community development workers, traditional health practitioners, breastfeeding advocates such as grandmothers, community and religious leaders and local media.

7.2 MAIN FEATURES OF THE BFCI

- community involvement
- breastfeeding, adequate complementary feeding maternal nutrition, early childhood development, and hygiene
- formation and training of mother support groups at the village level
- close links to the health facility
- training messages on Infant and Young Child Feeding (IYCF), maternal nutrition, environmental sanitation, personal hygiene etc.

7.3 BENEFITS OF BFCI

- creating linkages between maternal and infant nutrition.
- creates linkages between the health facilities and communities.
- integrated with environmental, personal hygiene and sanitation practices.
- includes sustainable income generating activities.
- includes men as important actors of breastfeeding decisions.
- involves a larger community integrated group.
- addresses the environmental issues that affect breastfeeding beyond the mother.
- offers sustainability through community engagement. Members of the community are not likely to move away on transfer as do health care providers, who are often transferred from one health facility to another, which causes loss of follow-up and low sustainability of programs.
- drawing resources of the entire community.
- provides governments with an entry point for other community development and health care policy frameworks and programs.
- messages are developed based on traditional knowledge and practices of the local communities.

7.4 KEY ACTORS OF THE BFCI

In order to achieve the objectives of the BFCI in Namibia the following key actors will need to play positive roles, as outlined.

7.1.1 Policy Makers/Planners

Policy makers should be sensitised on the need to ensure that the objectives of this initiative are achieved. Policy guidelines have been formulated to promote breastfeeding from birth. Further, awareness should be created for the need to support the implementation of the International Code of Marketing of Breast-Milk Substitutes. The infant food manufacturers should be discouraged from donating or providing low-cost breast-milk Substitutes to health facilities. All planners should bias their planning towards women and children and make their plans baby and mother friendly. For example, there should be allocation of more funds for programmes which impact on the health and nutrition status of women and children.

7.1.2 The role of the employers and employees

The employer plays an important role in promoting this initiative since the working mother spends a good part of her day at work. Opportunities for breastfeeding at work can be provided and the mothers encouraged to breastfeed during tea times and lunch hours. Further, there should be facilities for lactating mothers who want to express their milk and store it for later use at home. Employees should be understanding and supportive to their breastfeeding colleagues in the workplace. In the workplace baby friendly corners should be established with active participation of the employees, especially the breastfeeding, working mother.

7.1.3 The role of the family and the community

The family is very important in the implementation of this initiative. The mother needs support by the members of the family especially the husband/father. The nutrition of the mother should be improved. She should get enough time to rest and to breastfeed her child. All members of the community should support and promote breastfeeding as well as other MCH/FP interventions.

7.1.4 The role of the father

Fathers have an important role to play in ensuring a friendly environment at home for the mother and the child. Fathers should ensure that a happy environment is created at home by providing support and love, by being physically involved in the care of the mother and the baby and taking them to health facilities for health care interventions. This includes family planning, immunisation, appropriate treatment for diarrhoea and ARI and growth promotion.

Fathers should ensure that there is enough food and rest for the mother during pregnancy and lactation. They can help to reduce the workload for the mother within the household e.g. participating in the care of other small children, playing with them and caring for older children including doing homework with those attending school. In addition, when fathers and mothers plan together for the birth of a child, children will be enabled to breastfeed for long period and have a better chance to develop and achieve their full potential.

7.1.5 The Role of Non-Governmental Organisations

These organisations need to support and implement the initiative. They are very important because they reach the population at grassroots level. The Non-Governmental organisations (NGO's) should:

- promote the establishment and training of breastfeeding support groups especially at the community level.
- create awareness among employers and employees on the need for the promotion of breastfeeding for working mothers.
- disseminate information on breastfeeding and promote good nutrition.
- advocate for the implementation of an International Code of Marketing of Breast- Milk Substitutes

7.1.6 The Role of Infant Food Industry

Awareness should be created among industries in order to apply the International Code of Marketing of Breast-Milk Substitutes adopted by the WHO assembly in 1981. The Code should be seen in the context of the following:

- overall public and professional education;
- support of women and women's organisations;
- revitalisation of health care system interest regarding infant and young child feeding;
- and general uplifting of infant and maternal health.

7.1.7 The role of health workers

Medical doctors, nurses and all workers in health facilities need to be aware of the initiative and promote it. It is only through the commitment of the health workers that this initiative can be achieved. The attitudes of health workers towards the mother and the baby will need to be improved so that they can see the mother and baby in the context of this new initiative. Positive attitudes can improve maternal and child care. Pregnant mothers are very sensitive and should be treated with respect.

It is therefore essential to train health workers and give them knowledge and skills which will enable them to provide improved care for the mother and child.

The health workers should undertake the following:

- immediately after the birth of a child the health worker must ensure that bonding between the mother and the baby is achieved.
- the health worker should be aware of the Ten Steps to Successful Breastfeeding and promote them.
- provide education to mothers before, during and after delivery, as well as provide adequate public education on breastfeeding and nutrition.
- promote exclusive breast-feeding for six months.
- ensure that there is no distribution of free and low-cost infant formulae in hospitals and clinics.
- reduce missed opportunities for immunisation for children and women of child bearing age with the focus on pregnant women.
- promote family planning.
- promote good maternal care and nutrition.
- promote good attitudes in all health facilities towards the mother and the baby.
- encourage positive attitudes of the public towards the acceptance of breast-feeding.
- involve the father in the care of pregnant, as well as lactating mothers, and encourage fathers to support breastfeeding, immunisation, family planning and other MCH interventions.
- educate members of the community to be involved in protection, promotion and support of breast-feeding.
- establish conditions conductive to successful breast-feeding by creating baby friendly corners in health facilities.
- integrate baby and mother friendly activities into all PHC programs.
- prescribe no medication to suppress breast-milk unless medically indicated.

7.1.8 The role of other line-ministries

In order to ensure the success of this initiative all sectors have various roles to play. The involvement of various government ministries in the BFHI and BFCI is essential in order to address the various problems affecting the ability of the mother to breastfeed. This has an impact on the general nutritional status of the mother and the child. All sectors will therefore, need to co-ordinate their efforts in a number of areas including the following:

- dissemination of information on breastfeeding, nutrition, immunisation, family planning etc.
- establishment of baby friendly corners and promotion of breastfeeding at the workplaces.
- at the community level various sectors should work together with NGOs to promote breastfeeding and good nutrition. Further, they should promote the role of the father in various interventions aimed at improving the health and welfare of mothers and children.
- promoting interventions at community level which decrease the workload of the mother and time spent in undertaking the various activities e.g. fetching firewood and water, reaching clinics etc.

7.5 BABY FRIENDLY CORNERS

In order to promote breastfeeding for mothers while they are away from the home environment, it is necessary to establish baby friendly corners especially at work places with the following objectives:

- to enable working mothers to practise exclusive breastfeeding for 6 months.
- to provide facilities for lactating working mothers to express breast milk and store it for their babies who are left at home.
- to enable working mothers whose child minders are occasionally absent, to come to duty with their infants "just for the day".
- to enable lactating mothers while attending meetings, seminars and conferences to be with their children and have a friendly environment which enables them to breastfeed and provide the necessary care for their infants.
- to facilitate the dissemination of information on various child survival interventions including immunization, ORS, breastfeeding etc.

7.1.9 Making Baby Friendly Corners Work

Baby friendly corners are not crèches and should be viewed as "holding ground" and as an extension of the home environment and not an equivalent of a crèche where children are left to be cared for by others.

The working parent, as well as co-workers, have to participate actively in the creation of baby friendly corners and they need to be sensitised to appreciate the need for such a corner which is of benefit not only for the breastfeeding child but for the working mother as well.

A baby friendly corner is a place of convenience to the working mother or a lactating mother attending a meeting, a seminar or a conference. It is therefore necessary for those who organise meetings, seminars and conferences to ensure that there is a room or a corner designated as a "baby friendly corner" to encourage those who wish to attend such meetings with their breastfeeding babies, to do so.

Employers have an important role of ensuring that baby friendly corners are established as a welfare initiative to support lactating mothers. These corners would inevitably make it easier for the working, lactating mother who is motivated to practise exclusive breastfeeding for the recommended period of 6 months. It makes it possible for the lactating mother whose child minder is away for the day to come, for example, to work with her child and therefore avoid having to take leave often in order to look after the child at home.

A baby friendly corner should be simple and should have only basic requirements as follows:

- access to toilet facilities.
- a table to facilitate easy changing of nappies.
- a few chairs for the mothers.
- mattresses for the mother to rest on during and after feeding especially during lunch breaks.
- a few cots for the infants.
- a wash basin or a sink.
- where possible, there should be a fridge for storing the expressed breast milk for infants left at home.
- the lactating mother who is already providing complementary feeding to her child should bring her own food for the child.
- at the work places an arrangement could be made whereby lactating mothers could collectively employ a child minder to look after their infants. Appropriate training could be conducted for such child minders.
- IEC materials should be available in all corners.
- toys for babies should be brought from home and additional toys provided.

7.1.10 Recognition of Baby Friendly Corners

Ministry of Health and Social Services, Food and Nutrition Sub-division, will promote the establishment of the baby friendly corners. A certificate of commitment to the promotion, protection and support of breastfeeding should be given to the employers who have accepted to have a baby friendly corner established primarily by the workers but with support from the employers.

Environmental health inspectors will be encouraged to visit these corners to ensure that they meet public health standards.

7.1.11 Age of Infants to be accommodated at baby friendly corners

It is necessary to limit the age of children to be accommodated at the baby friendly corners especially at the early stages. In every work place it is necessary for the workers and the employers to agree on the main objectives of the baby friendly corner. It makes sense to focus initially on the promotion of exclusive breastfeeding and to provide additional care to the infants under one year of age. Further, it is inevitable that older children would have further needs including playgrounds, toys appropriate for their age, etc.

Baby friendly corners do not replace crèches and therefore mothers who prefer to have their children in crèches should continue to do so, as long as they remember that they can express their own breast milk. The expressed breast milk should be sent to the crèches for the purpose of promoting exclusive breastfeeding for six months or for feeding of the older children who have to be given appropriate complementary feeding.

7.1.12 Baby Friendly in the Home Environment

The success of the Baby Friendly Community Initiative will depend largely on the creation of a friendly environment at home to support the mother during pregnancy as well as during the lactation period.

The following will need to be done at the home/family level:

- sensitisation of fathers to enable them to support breastfeeding as well as other child survival interventions including immunisation.
- dissemination of information packages at the household level on the following:
- nutrition/breastfeeding
- immunisation
- correct management of diarrhoea and ARI
- family planning
- sanitation
- promotion of adequate child spacing in the family.
- ensuring use of locally available foods for complementary breastfeeding.
- discouraging bottle-feeding.
- reduction of the mother's workload. Efforts should be made to reduce the time spent by mothers to fetch water, visit health facilities, food production for the household etc.

ANNEX 1:
ACCEPTABLE MEDICAL REASONS FOR BREAST MILK SUPPLEMENTATION

A small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently. These conditions, which concern very few mothers and their infants, are listed below together with some health conditions of the mother that, although serious, are not medical reasons for using breast-milk substitutes. Whenever stopping breastfeeding is considered, the benefits of breastfeeding should be weighed against the risks posed by the presence of the specific conditions listed.

Acceptable medical reasons for infants who should not receive breast milk or any other milk except specialised formula:

- infants with classic galactocemia: a special galactose-free formula is needed.
- infants with maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed.
- infants with phenylketonuria: a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring).

Infants for whom breast milk is best but who may need other supplements in addition to breast milk for a limited period:

- severely ill babies, babies in need of surgery, and very low birth weight infants (less than 1,000 grams) are kept in a special care unit in the maternity ward. Their feeding will be individually decided, given their particular nutritional requirements and functional capabilities, though breast milk is recommended whenever possible.

These infants in special care are likely to include:

- infants with very low birth weight or who are born pre-term, at less than 1000g or 32 weeks gestational age.
- infants with severe dysmaturity with potentially severe hypoglycaemia, or who require therapy for hypoglycaemia, and who do not improve through increased breastfeeding or by being given breast milk.

Babies that are well enough to be with their mothers on the maternity ward, have very few indications for supplements. In order to assess whether a facility is inappropriately using fluids or Breast-Milk Substitutes, the following should be considered:

- Maternal conditions that may justify temporary avoidance of breastfeeding:
- infants whose mothers have severe illness (e.g. psychosis, eclampsia, or shock).
- infants with inborn errors of metabolism (e.g. galactocemia, phenylketonuria, maple syrup urine disease).
- infants with acute water loss, for example during photo-therapy of jaundice, whenever increased breastfeeding cannot provide adequate hydration.
- infants whose mothers are taking medication which is contraindicated when breast feeding (e.g. cytotoxic drugs, radioactive drugs, and anti-thyroid drugs other than propylthioracil).
- infants whose mothers have died.
- infants who have been abandoned

Maternal conditions during which breastfeeding can still continue, although health problems may be of concern:

- breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started.
- hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter.
- hepatitis C.
- mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition.
- tuberculosis: mother and baby should be managed according to national tuberculosis guidelines.
- substance use:
- maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
- alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby. Mothers should be encouraged not to use these substances, and given opportunities and support to abstain.

When breastfeeding has to be temporarily delayed or interrupted, mothers should be helped to establish or maintain lactation, for example through manual or hand-pump expression of milk, in preparation for the moment when breastfeeding is resumed.

ANNEX 2:
SELF- ASSESSMENT TOOL

Maternity/Newborn facility

General information on hospital and senior staff:

Hospital name and address: _____

Name and title o Medical Superintendent or Administrator: _____

Telephone or extension:_____

mail address: _____

Total number of hospital beds:_____Total number of hospital employees: _____

Information on antenatal services:

The Hospital has antenatal services (either on or off-site) ☐ Yes ☐No

The hospital is: [tick all that apply]

☐ a maternity hospital
☐ a general hospital
☐ a teaching hospital
☐ a tertiary hospital
☐ a government hospital
☐ a privately-run hospital
☐ Other (specify): _____

[if "No", skip all but the last question in this section]

Name and title of the Nurse in charge of antenatal services/clinic:_____

Telephone or extension: _____E-mail address: _____

What percentage of mothers delivering at the hospital attends the hospital's antenatal clinic? _____%

Does the hospital hold antenatal clinics at other sites outside the hospital? ☐ Yes ☐ No

[If "Yes"] Please describe when and where they are held: _____

Are there beds designated for high-risk pregnancy cases? ☐ Yes ☐ No

[if "Yes"] _____

Are there beds designated for high-risk pregnancy cases? ☐ Yes ☐ No

How many? _____

What percentage of women arrives for delivery without antenatal care? _____% ☐ No Don't know

Information on labour and delivery services:

Are there breastfeeding and/or HIV and infant No feeding committee(s) in the hospital? ☐ Yes ☐ No

Name and title of the maternity ward and registered

Nurse-In-Charge: _____
Telephone or extension:_____E-mail address: _____

Information on maternity and related services:

Name and title of the registered nurse in charge of maternity services: _____

Telephone or extension:_____

Number of post-partum maternity beds:_____

Average daily number of mothers with full term babies in the post-partum unit(s): _____

Does the facility have unit(s) for infants needing special care (LBW, premature, ill, etc.)? ☐ Yes ☐ No

[if "Yes"] Name of first unit: _____

Name of nurse(s) of this unit: _____
Average daily census: _____

Are there areas in the maternity wards designated baby observation as well? ☐Yes ☐No

[If "Yes"] Average daily census of each area: _____

Name of head of these areas: _____

Staff responsible for breastfeeding/infant feeding:

The following staff members have direct responsibility for assisting women with breastfeeding (BF), feeding breast-milk substitutes (BMS), or providing counselling on HIV and infant feeding: [tick all that apply]

	BF	BMS	HIV		BF	BMS	HIV
Nurses				Paediatricians			
Midwives				Obstetricians			
NICU nurses				Lay/peer counsellors			
Dieticians				Other staff (specify):			
Nutritionists				.....			
Lactation consultants				.....			
Physicians				.....			

Are there breastfeeding and/or HIV and infant feeding committee(s) in the hospital? ☐Yes ☐No

If "Yes", Please describe: _____

Statistics on births:

Total births in the last year:_____of which:

_____% were by C-section without general anaesthesia

_____% were by C-section with general anaesthesia

_____% infants were admitted to the NICU or similar units

Statistics on infant feeding:

Total number of babies discharged from the hospital last year:_____of which:

_____% were exclusively breastfed (or fed human milk) from birth to discharge.

_____% received at least one feed other than breast milk (formula, water or other fluids) in the hospital because of documented medical reason. (if a mother knew she was HIV positive and made an informed decision to replacement feed, this can be considered a medical reason).

_____% received at least one feed other than breast milk without any documented medical reason. [Note: the total percentages listed above should equal 100%]

The hospital data above indicates that at least 75% of the babies delivered in the past year were exclusively breastfed or fed human milk from birth to discharge, or, if they received any feeds other than human milk this was because of documented medical reasons: ☐Yes ☐No

[Note: add the percentages in categories one and two to calculate this percentage] _____%

Statistics on HIV/AIDS:

Percentage of pregnant women who received testing and counselling for HIV: _____%

Percentage of mothers who were known to be HIV-positive at the time of babies' births: _____%

Data sources:

Please describe sources for the above data: _____

_____

_____

_____

_____

_____

STEP 1a. Comply fully with the International Code of Marketing of Breast-milk Substitutes and World Health Assembly resolutions.

	YES	NO
1.1 Does the healthcare facility refuse free or low-cost supplies of breast-milk substitutes, purchasing them for the wholesale price or more?		
1.2 Is all promotion for breast-milk substitutes, bottles, teats, or pacifiers absent from thefacility, with no materials displayed or distributed to pregnant women or mothers?		
1.3 Are employees of manufacturers or distributors of breast-milk substitutes, bottles, teats, or pacifiers prohibited from any contact with pregnant women or mothers?		
1.4 Does the hospital refuse free gifts, non-scientific literature, materials or equipment, money or support for in-service education or events from manufacturers or distributors of products within the scope of the Code?		
1.5 Does the hospital keep infant formula cans and pre-prepared bottles of formula out of view, unless in use?		
1.6 Does the hospital refrain from giving pregnant women, mothers and their families any marketing materials, samples or gift packs that include breast-milk substitutes, bottles/teats, pacifiers or other equipment or coupons?		
1.7 Do staff members understand why it is important not to give any free samples or promotional materials from formula companies to mothers?		

Standards of care - Step 1a

All infant formula, feeding bottles and teats used in the facility have been purchased through normal procurement channels and not received through free or subsidised supplies.

The facility has no display of products covered under the Code or items with logos of companies that produce breast-milk substitutes, feeding bottles and teats, or names of products covered under the Code. The facility has a policy that describes how it abides by the Code, including procurement of Breast-Milk Substitutes, not accepting support or gifts from producers or distributors of products covered by the Code and not giving samples of breast-milk substitutes, feeding bottles or teats to mothers.

At least 80% of health professionals who provide antenatal, delivery and/or new-born care can explain at least two elements of the Code.

STEP 1b. Have a written infant feeding policy that is routinely communicated to staff and parents

	YES	NO
1.1b Does the health facility providing maternity and newborn care services have a clearly written breastfeeding/infant feeding policy that addresses the implemen- tation and monitoring of all 8 key clinical practices of the Ten Steps of successful breastfeeding?		
1.2b Does the health facility providing maternity and newborn care services regularly carry out competency assessments on its health staff of the 8 key clinical practices of the ten steps of successful breastfeeding?		
1.3b Are all nursing personnel in the maternity unit familiar with the breastfeeding/ infant- feeding policy?		
1.4b Is the breastfeeding/infant feeding policy available so all staff who take care of- mothers and babies can refer to it?		
1.5b Is the summary of the policy posted in language(s) and written with wording most commonly understood by mothers and staff?		

1.6b Is there a mechanism for evaluating the effectiveness of the policy?		
1.7b Are all policies or protocols related to breastfeeding and infant feeding in line with current evidence-based standards?		
1.8b Is a summary of the breastfeeding/infant feeding policy, including issues related to the 10 Steps, and support for HIV-positive mothers, posted or displayed in areas of the health facility which serve mothers, infants, and/or children?		

Standards of care - Step 1b

- The health facility has a written infant feeding policy that addresses the implementation of all eight key clinical practices of the Ten Steps, Code implementation, and regular competency assessment.
- Observations in the facility confirm that a summary of the policy is visible to pregnant women, mothers and their families.
- A review of all clinical protocols or standards related to breastfeeding and infant feeding used by the maternity services indicates that they are in line with BFHI standards and current evidence-based guidelines.
- At least 80% of clinical staff who provide antenatal, delivery and/or new-born care can explain at least two elements of the infant feeding policy that influence their role in the facility.

STEP 1c. Establish ongoing monitoring and data-management systems

	YES	NO
1.1c Does the healthcare facility routinely collect information on the percentage of term infants who were put to the breast within one hour of birth during the facility stay?		
1.2c Does the healthcare facility routinely collect information on the percentage of pre-term and term infants who are on exclusive breastfeeding during the facility stay.		
1.3c Does the healthcare facility ensure that the births of infants are registered using the e-birth notification system?		
1.4c Does the healthcare facility ensure that mothers are interviewed before discharge using the Maternal Exit Discharge Form (preferably by a person not directly in charge of their care)?		

Standards of care - Step 1c

- The facility has a protocol for an ongoing monitoring and data-management system to comply with the eight key clinical practices.
- Clinical staff at the facility meet at least every 6 months to review implementation of the system.
- Health facilities should aim for at least 80% early initiation of breastfeeding and exclusive breastfeeding.

STEP 2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.

	YES	NO
2.1 Are all staff members caring for pregnant women, mothers, and infants oriented to the breast feeding / infant feeding policy of the hospital when they start work?		
2.2 Are staff members who care for pregnant women, mothers and babies aware of the importance of breastfeeding and acquainted with the facility's policy and services to protect, promote, and support breastfeeding?		

2.3 Does the health facility have options that can assist with strengthening knowledge and skills of maternity staff, such as mentorship, job shadowing, short group meetings?		
2.4 Is the training for clinical staff at least 20 hours in total, including a minimum of 3 hours of supervised clinical experience?		
2.5 Does the training cover all the Ten Steps to Successful Beastfeeding and the International Code of Marketing of Breastmilk Substitutes?		
2.6 Do staff members who care for pregnant women, mothers and babies have sufficient knowledge, competence and skills to support women to breastfeed?		
2.7 Is training for non-clinical staff sufficient, given their roles, to provide them with the skills and knowledge needed to support mothers in successfully feeding their infants?		
2.8 Is training also provided for all or designated staff who are caring for women and infants, on feeding infants who are not breastfed, and supporting mothers who have made this choice?		
2.9 Are clinical staff members who care for pregnant women, mothers, and infants able to answer simple questions on breastfeeding promotion and support and care for non-breastfeeding mothers?		
2.10 Are non-clinical staff such as care attendants, social workers, and clerical, hous keeping and catering staff able to answer simple questions about breastfeeding and how to provide support for mothers on feeding their babies?		
2.11 Has the healthcare facility arranged for specialised training in lactation management of specific staff members?		

Standards of care - Step Two

- At least 80% of health professionals who provide antenatal, delivery and/or new-born care report they
- At least 80% of health professionals who provide antenatal, delivery and/or new-born care services report receiving competency assessments in breastfeeding in the previous 2 years.
- At least 80% of health professionals who provide antenatal, delivery and/or new-born care are able to correctly answer three out of four questions on breastfeeding knowledge and skills to support breastfeeding.

STEP 3. Discuss the importance and management of breastfeeding with pregnant women and their families.

	YES	NO
3.1 Does the hospital include an antenatal clinic or satellite antenatal clinics or in-patient-antenatal wards? *		
3.2 If yes, are the pregnant women who receive antenatal services informed about the importance and management of breastfeeding?		
3.3 Are women identified to be at risk for pre-term delivery or birth of a sick infant (e.g. Pregnant adolescents, high-risk pregnancies) provided with specific information and counselling concerned with feeding a premature, low-birthweight or sick baby?		
3.4 Does antenatal education, including both oral and written form, cover key topics related to the importance and management of breastfeeding?		
3.5 Are pregnant women protected from oral or written promotion of and group instruction for formula feeding?		

3.6 Are the pregnant women who receive antenatal services able to describe the risks of giving supplements while breastfeeding in the first six months?		
3.7 Are the pregnant women who receive antenatal services able to describe the importance of early skin-to-skin contact between mothers and babies and rooming-in?		
3.8 Is a mother's antenatal record available at the time of delivery?		
3.9 Do health workers have conversations on breastfeeding with the mother from the first or second antenatal visit, so that there is time to discuss any challenges, if necessary?		

**Note: If the hospital has no antenatal services or satellite antenatal clinics, questions related to Step 3 and the Global Criteria do not apply and can be skipped.*

Standards of care - Step Three

If the hospital has an affiliated antenatal clinic or in-patient antenatal ward:
A written description of the minimum content of the breastfeeding information and any printed materials provided to all pregnant women that is available.

The antenatal discussion covers the importance of breastfeeding, the importance of immediate and sus- tained skin-to-skin contact, early initiation of breastfeeding, rooming-in on a 24-hour basis, feeding on cue or baby-led feeding, frequent feeding to help assure enough milk, good positioning and attachment, exclu- sive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other foods are given.

A protocol for antenatal discussion of breastfeeding includes at a minimum: The importance of breastfeeding;

- Global recommendations on exclusive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other foods are given;
- The importance of immediate and sustained skin to-skin contact;
- The importance of early initiation of breastfeeding;
- The importance of rooming-in;
- The basics of good positioning and attachment;
- Recognition of feeding cues

At least 80% of mothers who received ante-natal care report having received prenatal counselling on breastfeeding.
Monitoring success of step 3 entails that at least 80% of mothers who received prenatal care at the facility can adequately describe what was discussed about two of the topics mentioned above.

STEP 4. Facilitate immediate and uninterrupted skin-to skin contact and support mothers to initiate breastfeeding as soon as possible after birth.

This Step is now interpreted as:

Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognise when their babies are ready to breastfeed and offer help if needed.

Standards of care - Step Four

Out of the randomly selected mothers with vaginal births or caesarean sections without general

anaesthesia in the maternity wards:

- At least 80% confirm that their babies were placed in skin-to-skin contact with them immediately or within five minutes after birth and that this contact continued without separation for an hour or more, unless there were medically justifiable reasons.
- (Note: It is preferable that babies remain skin-to-skin even longer than an hour, if feasible, as they may take longer than 60 minutes to be ready to breastfeed)
- At least 80% of mothers of term infants report that their babies were put to the breast within 1 hour after birth, unless there were documented medically justifiable reasons.

STEP 5. Support mothers to initiate and maintain breastfeeding and manage common breastfeeding difficulties.

	YES	NO
5.1 Do staff offer all breastfeeding mothers further assistance with breastfeeding their babies within six hours of delivery?		
5.2 Can staff describe the types of information and demonstrate the skills they provide- both to mothers who are breastfeeding and those who are not, to assist them in successfully feeding their babies?		
5.3 Are staff members or counsellors who have specialised training in breastfeeding and lactation management available full-time to advise mothers during their stay in healthcare facilities and in preparation for discharge?		
5.4 Do the staff offer advice on breast care to mothers with babies in special care who have decided not to breastfeed?		
5.5 Are breastfeeding mothers able to demonstrate how to correctly position and attach their babies for breastfeeding?		
5.6 Are breastfeeding mothers shown how to hand express their milk or given information on expression and advised on where they can get help, should they need it?		
5.7 Do mothers who have never breastfed or who have previously encountered problems with breastfeeding receive special attention and support from the staff of the healthcare facility, both in the antenatal and post-partum periods?		
	YES	**NO**
5.8 Are mothers, who have decided not to breastfeed, shown individually how to prepare and give their babies feeds and asked to prepare feeds themselves, after being shown how?		
5.9 Are mothers with babies in special care who are planning to breastfeed helped within 6 hours of birth to establish and maintain breastfeeding by frequent expression of milk and told how often they should do this?		
5.10 Do facilities providing maternity and new born services assist first-time mothers and mothers who have not breastfed before extra support?		
5.11 Are mothers who delivered by caesarean section, obese mothers, teenage mothers and mothers struggling with positioning and attachment given additional help?		

Standards of care - Step Five

- At least 80% of breastfeeding mothers of term infants report that someone on the staff offered assistance with breastfeeding within 6 hours after birth.
- At least 80% of mothers of pre-term or sick infants report having been helped to express milk within 1-2 hours after birth.
- At least 80% of breastfeeding mothers of term infants can demonstrate how to position their baby for breastfeeding and that the baby can suckle and transfer milk.
- At least 80% of breastfeeding mothers of term infants can describe at least two ways to facilitate milk production for their infants.

- At least 80% of breastfeeding mothers of term infants can describe at least two indicators of whether a breastfed baby consumes adequate milk.
- At least 80% of mothers of breastfed pre-term and term infants can correctly demonstrate or describe how to express breast milk.
- Mothers delivering by caesarean section, obese mothers and teenage mothers should be given additional help with positioning and attachment.

STEP 6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.

6.1 Are mothers/family counselled on the importance of exclusive breastfeeding for the first 6 months of the baby's life?		
6.2 Are babies breastfed, receiving no food or drink other than breast milk, unless there were acceptable medical reasons or fully informed choices?		
6.3 Does the facility take care not to display or distribute any materials that recommend feeding breast-milk substitutes, scheduled feeds, or other inappropriate practices?		
6.4 Do mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options, and helped them to decide what was suitable in their situations?		
6.5 Are all clinical protocols or standards related to breastfeeding and infant feeding in line with BFHI standards and evidence-based guidelines?		
6.6 Are mothers supported and encouraged to express their breast milk to continue stimulating production of breast milk?		

Standards of care - Step Six

- At least 80% of infants (pre-term and term) received only breast milk (either from their own mother or from a human milk bank) throughout their stay at the facility.
- At least 80% of mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situations.
- At least 80% of mothers who have decided not to breastfeed report that the staff discussed with them the safe preparation, feeding and storage of Breast-Milk Substitutes.
- At least 80% of term breastfed babies who received supplemental feeds have a documented medical indication for supplementation in their medical record.
- At least 80% of pre-term babies and other vulnerable newborns that cannot be fed their mother's own milk are fed with donor human milk.
- At least 80% of mothers with babies in special care report that they have been offered help to start lactogenesis II (beginning plentiful milk secretion) and to keep up the supply, within 1–2 hours after their babies' births.

STEP 7. Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.

	YES	NO
7.1 Do the mother and baby stay together and/or start rooming-in immediately after birth?		
7.2 Do mothers who have had Caesarean sections or other procedures with general anaesthesia stay together with their babies and/or start rooming-in as soon as they are able to respond to their babies' needs?		
7.3 Do mothers and infants remain together (rooming-in or bedding-in) 24 hours a day, unless separation is fully justified?		

Standards of care - Step Seven

- At least 80% of mothers of term infants report that their babies stayed with them since birth, without separation lasting for more than 1 hour per separation instance.
- Observations in the post-partum wards and well-baby observation areas confirm that at least 80% of mothers and babies are together or, if not, have medically justifiable reasons for being separated.
- At least 80% of mothers of pre-term infants confirm that they were encouraged to stay close to their infants, day and night.

STEP 8. Support mothers to recognise and respond to their infants' cues for feeding.

	YES	NO
8.1 Are breastfeeding mothers taught how to recognise the cues that indicate when their babies are hungry?		
8.2 Are breastfeeding mothers encouraged to feed their babies as often and for as long as the babies want?		
8.3 Are breastfeeding mothers advised that if their breasts become overfull, they should also try to breastfeed?		

Standards of care - Step Eight

Out of the randomly breastfeeding selected mothers:

- At least 80% of breastfeeding mothers of term infants can describe at least two feeding cues.
- At least 80% of breastfeeding mothers of term infants report that they have been advised to feed their babies as often and for as long as the infant wants.

STEP 9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.

	YES	NO
9.1 Are breastfeeding babies being cared for without any bottle feeds?		
9.2 Have mothers been given information by the staff about the risks associated with feeding milk or other liquids with bottles and teats?		
9.3 Are breastfeeding babies being cared for without using pacifiers?		
9.4 Are mothers demonstrated to on how to use a cup/spoon to feed the baby with e pressed breast milk?		
9.5 Do health facility staff ensure appropriate hygiene in the cleaning of cup/ spoons?		

Standards of care - Step Nine

- At least 80% of breastfeeding mothers of pre-term and term infants report that they have been taught about the risks of using feeding bottles, teats and pacifiers.
- STEP 10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

	YES	NO
10.1 Do staff discuss plans with mothers who are close to discharge on how they will feed their babies after returning home?		
10.2 Does the hospital have a system of follow-up support for mothers after they are dis- charged, such as early postnatal or lactation clinic check-ups, home visits, telephone calls?		
10.3 Does the hospital provide appropriate referrals to ensure that mothers and babies are seen by a health worker 6 hours, 6 days, 6 weeks and 6 months after birth or based on MHSS updated circular?		
10.4 Does the hospital providing maternity and newborn services identify appropriate com- munity resources for continued and consistent breastfeeding support?		
10.5 Is printed material made available to mothers before discharge, if appropriate and feasible, on where to get follow-up support?		
10.6 Are mothers encouraged to see a health care worker or skilled breastfeeding support person in the community soon after discharge (preferably 2-4 days after birth and again in the second week) who can assess how they are doing in feeding their babies, and give any support needed?		
10.7 Does the facility allow breastfeeding/infant feeding counselling by trained moth- er-support group counsellors in its maternity services?		

Standards of care - Step Ten

- At least 80% of mothers of pre-term and term infants report that a staff member has informed them where they can access breastfeeding support in their community.
- The facility can demonstrate that it coordinates with community services that provide breast feeding infant feeding support, including clinical management and mother-to-mother support.

ANNEX 3:
QUESTIONNAIRE FOR MOTHER'S (LEAVING MATERNITY FACILITIES)

A. WHEN BOOKING TO HAVE YOUR BABY AT THE HOSPITAL		
	YES	**NO**
1. Did you attend ante-natal care to prepare you for childbirth and breastfeeding?		
2. How many times did you attend the ante-natal clinic?(Check one option)		
• More than 6 times		
• Less than 6 times		
• Not at all		
If not all, state reasons why not?		
3. Were you encouraged to breast feed?		
4. Was the facility's policy explained to you regarding:		
• labour management		
• rooming-in		
• breastfeeding		
5. Were you shown around the facility?		
6. Were you given an opportunity to ask any questions you might have had?		
7. Were the questions answered satisfactory?		
If NO, explain		

8. Were you asked to bring along with you?		
• bottle		
• dummy		
• both		
• none of the above		
9. Were you encouraged to bring the father of the baby or some other supportive person with you for the labour?		

	YES	NO
B. ON ADMISSION TO THE HOSPITAL		
1. What was the attitude of the person who admitted you?		
• friendly and caring		
• offhand		
• unapproachable		
2. Were procedures explained to you satisfactorily e.g. enema, shaving, examination etc? If NO, explain		
C. DURING LABOUR		
1. Were you allowed to have partner/friend or relative with you?		
2. How did you feel regarding your labour management?		
• in control		
• not in control		
3. Were you able to use your own techniques for managing contraction e.g. positions, showers, etc.		
4. Did you feel the staff took account of what you said or requested?		
5. Did you feel?		
• over-managed?		
• left alone too much?		
6. How many health workers assisted you? (excluding shift changes)		
• one person		
• one team		
• many new faces		
7. Were you required to wear a foetal monitor?		
8. Was the reason to wear the foetal monitor explained to you clearly?		
9. While supporting you in labour were you reminded to empty your bladder regularly?		
• Were you assisted to do this, if required?		
• Were you assisted to do this, if required?		
• Drink something to maintain energy levels? (Provided a normal birth was anticipated)		

	YES	NO
D. DURING BIRTH		
1. During the birth, how do you recall the atmosphere?		
• calm and supportive		
• calm and supportive		
• rushed and noisy		
2. Were you informed of your progress during birth e.g. how much of the head could be seen?		
3. Was the father/partner/relative encouraged to observe the progress of the birth?		
4. Did you have an episiotomy?		
Did the doctor/midwife explain why it was necessary? Were you informed before it was done?		
5. Where was the baby placed immediately after birth?		
• on your lower abdomen		
• on the bed near your feet		
• elsewhere		
Explain		
6. Were you encouraged to touch your baby?		
7. How long after the birth was your baby given to you?		
• Immediately		
• after a few minutes		
• half an hour later		
• more than one hour later Explain		
....		
Were you encouraged and assisted to put the baby to the breast before leaving the delivery room?		
Were you happy with the way your baby was handled after the birth?		
In the case of a caesarean birth, were you given the opportunity to see or touch your baby immediately on regaining consciousness?		

	YES	NO
E. IN THE POST-NATAL WARD		
1. Was your baby given water, formula or any other liquid?		
2. Were you offered assistance with breastfeeding?		
3. Were you worried about a lack of milk for the first few days after the birth?		
• If YES, was the importance and function of colostrum explained to you?		
• If YES, was breast milk production explained to you?		
4. Were you encouraged to breastfeed on demand?		
If NO, explain		
5. Was any time limit set on the baby's suckling per breast? e.g.		
• 5 minutes per breast		
• 10 minutes per breast		
• no time limit		

6. Did your baby room in with you?		
• day time only		
• day and night		
• not at all		
7. Were you at any time advised to use a bottle or formula?		
If YES, explain		
8. If, for MEDICAL reasons, the baby had to be given water, formula or any other liquid, how was it administered?		
• with a cup, teaspoon, or dropper		
• with a bottle		
• given by yourself		
• given by health worker		
9. In the case of being unable to feed your baby immediately, were you encouraged and shown how to express milk for the baby?		
10. Was the father/partner or relative supporting you allowed access to visit you and the baby outside visiting hours?		

	YES	NO
11. Did your baby have photo-therapy (under the lights)		
• Were you allowed access to the baby at all times?		
• Was the baby given any other liquid between feeds?		
• If you requested that no water be given, was this done?		
12. Were you show how to bath the baby?		
13. Were you encouraged to have plenty of physical contact with your baby?		

F. ON DISCHARGE		
1. Were you advised to continue exclusive breastfeeding for six months?		
2. Were you advised to attend a clinic regularly to monitor your baby's weight and development progress?		
3. Were you given an immunizsation schedule and was the importance of having your baby immunised explained to you?		
4. Were you advised how to contact breastfeeding support groups and encouraged to do so should you have questions or problems?		

ANNEX 4:
TEN STEPS TO SUCCESSFUL BREASTFEEDING IN LAY TERMS

	Hospitals Support mothers to breastfed by…	Because
1. Hospital Policies	• Not promoting Infant Formula bottles or teats • Making breastfeeding care standards practice • Keeping track of support for breastfeeding	Hospital policies help make sure that all mothers and babies receive the best care
2. Staff Competency	• Training staff on supporting mothers to breastfeed • Assessing health workers knowledge and skills	Well-trained health workers provide the best support for breastfeeding
3. Ante-natal Care	• Discussing the importance of breastfeeding for babies and mothers • Preparing women on how to feed their babies	Most women are able to breastfeed with the right support
4. Right care after birth	• Encourage skin to skin contact between mother and baby soon after birth • Helping mothers to put their baby to the breast right away	Snuggling skin to skin helps breastfeeding get started
5. Support mothers with breastfeeding	• Checking positioning attachment and suckling • Giving practical breastfeeding support • Helping mothers with common breastfeeding problems	Breastfeeding is natural, but most mothers need help at first
6. Supplementing	• Giving only breast milk unless there are medical reasons • Prioritising donor human milk when a supplement is need	Giving babies formula in the hospital makes it hard to get breastfeeding going
7. Rooming-in	• Letting mothers and babies stay together day and night • Making sure that mothers of sick babies can stay near their baby	Mothers need to be near their babies to notice and respond to feeding cues
8. Responsive feeding	• Helping mothers know when their baby is hungry • Not limiting breastfeeding times	Breastfeeding babies when- ever they are ready helps everybody
9. Bottles, Teats and Pacifiers	• Counselling mothers about the use and risks of feeding bottles and teats	Everything that goes in the baby's mouth needs to be clean
10. Discharge	• Referring mothers to community resources for breastfeeding support • Working with communities to improve breastfeeding support services	Learning to breastfeed takes time

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