MINISTRY OF HEALTH

UGANDA POLICY GUIDELINES ON INFANT AND YOUNG CHILD FEEDING

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FOREWORD

The critical value of optimal infant and young child feeding was recognized a long time ago and during the last two and half decades tremendous effort has been directed towards the promotion, protection and support of such optimal feeding. The indisputable benefits of breastfeeding have been proven time after time and breastfeeding has remained the optimal mode of infant and young child feeding. Challenges do exist, however, especially since the discovery that HIV is transmitted through breastfeeding. While the transmission of HIV from mothers to their babies accounts for about 15% of all the HIV infections in Uganda, it is the main mode of transmission of the virus to children and is responsible for more than 90% of the HIV infections in this age group. Feeding in other exceptionally difficult circumstances poses similar challenges.

The Government of Uganda has put in place several policies and programmes in its attempt to promote optimal infant and young child feeding. Directly related to infant and young child feeding was the "Policy Guidelines on the Feeding of Infants and Young Children in the Context of HIV/AIDS" disseminated in 2001. Since that time, however, additional information has become available on infant and young child feeding. Data from large cohort studies in Cote D'Ivore, South Africa and Zimbabwe suggests that exclusive breastfeeding for up to six months is associated with a three to four fold decreased risk of HIV transmission compared to non-exclusive breastfeeding. In addition, early cessation of breastfeeding (before six months) is associated with an increased risk of infant morbidity (especially diarrhoea) and mortality in HIV-exposed children in completed (Malawi) and ongoing studies (Kenya, Uganda, and Zambia).

In view of this and other recent developments such as The Global Strategy for IYCF, the Framework for Priority Action, "early infant diagnosis" and "access to care and treatment of HIV/AIDS" an urgent need to formulate a comprehensive IYCF policy in Uganda has arisen.

This policy document is intended for use by planners, managers and implementers who are involved in the provision of maternal and child health as well as reproductive health services. It gives guidance on the appropriate IYCF practices in most situations in the country.

I therefore call upon all stakeholders in IYCF to take and utilize these policy guidelines to maximum advantages.

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ACRONYMS

AFASS	Acceptable, Feasible, Affordable, Sustainable and Safe
ANC	Antenatal Care
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Drugs
BMS	Breast Milk Substitutes
BFHI	Baby Friendly Health Facility Initiative
CRC	Convention on the Rights of the Child
EBM	Expressed Breast milk
ELISA	Enzyme Linked Immuno-Sorbent Assay
ENA	Essential Nutrition Actions
FAO	Food and Agricultural Organisation
HC IV	Health Center IV
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IBFAN	International Baby Food Action Network
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
MAM	Moderate Acute Malnutrition
MDGs	Millennium development goals
MTCT	Mother-to-Child Transmission of HIV infection
MUAC	Mid Upper Arm Circumference

NCHS	National Centre for Health Statistics
NGO	Non Governmental Organization
PCR	Polymerase Chain Reaction
PMTCT	Prevention of Mother-to-Child Transmission of HIV infection
RF	Replacement Feeding
SAM	Severe Acute Malnutrition
UDHS	Uganda Demographic and Health Survey
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on Children
UNAIDS	United Nations AIDS Programme
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
VCCT	Voluntary Confidential Counselling and Testing

EXPLANATION OF TERMS

AFASS	**Acceptable:** The mother perceives no significant barrier(s) to choosing a feeding option for cultural or social reasons or for fear of stigma and discrimination. **Feasible:** The mother (or other family member) has adequate time, knowledge, skills, and other resources to prepare feeds and to feed the infant as well as the support to cope with family, community, and social pressures. **Affordable:** The mother and family, with available community and/or health system support, can pay for the costs of the replacement feeds—including all ingredients, fuel and clean water—without compromising the family's health and nutrition spending. **Sustainable:** The mother has access to a continuous and uninterrupted supply of all ingredients and products needed to implement the feeding option safely for as long as the infant needs it. **Safe:** Replacement foods are correctly and hygienically stored, prepared, and fed in nutritionally adequate quantities; infants are fed with clean hands using clean utensils, preferably by cups.
Breast Milk Substitute	Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.
Bottle feeding	Feeding from a bottle, whatever its contents, whether expressed breastmilk, water, infant formula or another food or liquid.
Cessation of breast feeding	Completely stopping breastfeeding, including suckling.
Complementary feeding	Giving a child both breast milk or breastmilk substitute and other solid or semi-solid foods. In this document this definition has been used interchangeably with supplementary feeding).

Complementary food	Any food, whether manufactured or locally prepared, used as a complement to breast milk or breast milk substitute.
Exceptionally Difficult Circumstances	Special and difficult situations where families require extra attention in order to feed their children optimally.
Exclusive breastfeeding	Feeding a child only breastmilk and no other liquids or solids, not even water, with the exception of prescribed drops or syrups consisting of vitamins and mineral supplements or medicines.
HIV-negative	Refers to people who have taken an HIV test and who know that they tested negative, or to young children who have tested negative and whose parent(s) or guardians know the result.
HIV-positive	Refers to people who have taken an HIV test and who know that they tested positive, or to young children who have tested positive and whose parent(s) or guardians know the result.
HIV status unknown	Refers to people who either have not taken an HIV test or do not know the results of the test they have taken.
Infant	A baby from birth to 12 months of age
Infant feeding counselling	Counselling on breastfeeding, complementary feeding and, for HIV-positive women, on HIV and infant feeding.
Low birth weight	A birth weight of less than 2500gm, whether pre-term of small for dates.
Mixed feeding	Feeding both breast milk and other foods or liquids.
Normal circumstances	Refers to the majority of children that are not exposed to HIV or other exceptionally difficult circumstances
Physical support	Presence, companionship and sharing responsibilities in a given setting

Relactation	Re-establishing breastfeeding after a mother had stopped, whether in the recent or distant past.
Replacement Feeding	The process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients the child needs, until the child is fully fed on family foods. Replacement feeds do not include black coffee/tea, fruit juices, diluted milk.
Rooming in/Bedding in	When the mother and her baby stay in the same room/bed.
Young child	A person from the age more than twelve months up to the age of 5 years (sixty months).

EXECUTIVE SUMMARY

The feeding of infants and young children is a crucial factor in determining the health, nutrition, survival, growth and development of the individual. Children, have the right to health and nutrition as stipulated in the Convention on the Rights of the Child (CRC). Furthermore, caretakers have the right to full information to decide on how to feed their children and to ensure suitable conditions that support their decisions. Over the past 25 years, infant and young child feeding (IYCF) has received increasing attention and several global instruments have guided formulation and implementation of policies and programmes in this area. At national level, a lot of effort has been put into the promotion, protection and support of optimal IYCF spearheaded by the Ministry of Health in collaboration with other partners and stakeholders. Several national policies and guidelines provide information and guidance on IYCF and counselling and support is available in many health facilities. Despite these impressive efforts in promoting protecting and supporting optimal IYCF and the progress that has been made in HIV prevention in Uganda:

- IYCF practices are not optimal as evidenced by a timely breastfeeding initiation rate of 32%, an exclusive breastfeeding rate of 60% and a timely complementary feeding rate of 75%.
- Malnutrition is prevalent with stunting at 32%, wasting at 5% and underweight at 20%.
- The infant mortality rate stands high at 88 per 1000 live births.
- Challenges exist with feeding of HIV-exposed, malnourished, low birth weight, orphaned children, and children in other exceptionally difficult circumstances.
- None of the current policies addresses the issue of IYCF in its totality. Those that touch on the issue give inadequate information and recommendations.

It is against this background and in line with the Global Strategy for IYCF that the Ministry of Health and its partners developed this policy guidelines on IYCF in order to provide the framework for enhancing the nutrition, health, growth and development of infants and young children, as well as strengthening care and support for their parents/caretakers to achieve optimal IYCF. This document provides guidance on the feeding of infants and young children as follows:

a) Feeding the Child under " Normal" circumstances
b) Feeding the Child Who is Exposed to HIV

c) Feeding the Child in Other Exceptionally Difficult Circumstances

Policy Statements

Policy statement 1

All HIV negative mothers and those of unknown HIV status shall be counselled and supported to exclusively breastfeed their infants for the first six months of the child's life.

Policy statement 2

Parents shall be counselled and supported to introduce adequate, safe and appropriately fed complementary foods at six months of the child's age while they continue breastfeeding for up to 2 years or beyond.

Policy statement 3

Pregnant women and lactating mothers shall be appropriately cared for and encouraged to consume nutritious foods.

Policy statement 4

4a) Service providers shall establish the HIV status of all pregnant women and lactating mothers.
4b) All pregnant women and lactating mothers shall be encouraged to confidentially share their HIV status with service providers and key family members in order to get appropriate IYCF services.

Policy statement 5

Exclusive breastfeeding shall be recommended for HIV infected women for the first six months of the child's life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.

Policy statement 6

Children born to mothers living with HIV shall be tested for HIV infection at 10 weeks of age.

Policy Statement 7

Malnourished children shall be provided with appropriate nutrition supplements, rehabilitation support and follow up.

Policy Statement 8

Mothers of children who are born with low birth weight but can suckle shall be encouraged to breastfeed, unless there is a medical contra-indication. Mothers of low birth weight children who cannot suckle well shall be encouraged and assisted to express breastmilk and give it by cup.

Policy Statement 9

Mothers, caretakers, and families, shall be counselled and supported to practice optimal IYCF in emergencies and other exceptionally difficult/special circumstances.

Implementation of these policy guidelines will be in line with the Global Strategy for IYCF and relevant national policies and guidelines. Several strategies will be employed, including, but not limited to: advocacy, capacity building, Information, Education and Communication, care and support, counselling, integration, coordination and collaboration, growth monitoring and promotion as well as resource mobilisation. Monitoring and evaluation at all levels will be done to ensure that implementation of the policy and guidelines are proceeding well and that the desired results are being achieved.

CHAPTER ONE: *OVERVIEW OF INFANT AND YOUNG CHILD FEEDING*

1.1 Importance of optimal Infant and Young Child Feeding

The feeding of infants and young children is crucial in determining the health, nutrition, survival, growth and development of the individual. Nutrition is a key element of the child's right to health as stipulated in the Convention on the Rights of the Child (CRC). Children have a right to adequate nutrition and access to safe and nutritious food. In addition, women have the right to full information to decide the feeding choice of their children and to appropriate conditions that support their decisions. In spite of this recognition, the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) estimate that of the 10.9 million annual deaths among children below five years of age, 60% are related directly or indirectly to malnutrition[79].

Data from the Uganda Demographic and Health Surveys (UDHS) leaves us in no doubt that malnutrition is prevalent in Uganda. According to the 2000/2001 UDHS, stunting was at 39%, wasting at 4% and underweight at 23% among the under-five year olds[51]. The more recent UDHS 2006 offers no consolation: stunting was at 32% wasting was at 5% and underweight at 20% among children in the same age bracket[52]. This rate of malnutrition contributes to over half of the high infant mortality rate of 88 per 1000 live births[51].

The risk of HIV transmission through breastfeeding poses a dilemma on infant feeding particularly in a developing country like Uganda where HIV prevalence remains a public health concern and where breastfeeding is the norm and critical for child survival. Previously it was also not possible to provide wide spread early diagnosis of HIV in children so as to make specific recommendations on infant feeding. Recent advances in provision of services for early diagnosis of HIV in children and increased availability of antiretroviral therapy have made it possible to determine HIV status of children and provide them with early appropriate care including counselling on IYCF.

HIV exposed children are at high risk of morbidity and mortality due to recurrent and chronic illness. Studies suggest that about 66% of infected children die before their 3rd birthday if there is no intervention. With early HIV diagnosis, these children will be able to access appropriate care and treatment. HIV exposed children are faced with nutritional challenges particularly in the first six months of life when breast milk is critical for optimal growth and development. Safe infant

feeding plays a key role in the Prevention of Mother-to-Child Transmission of HIV infection (PMTCT).

Given the importance attached to infant and young child feeding, the World Health Assembly (WHA) adopted a Global Strategy for Infant and Young Child Feeding in the year 2000[79]. The Strategy aims to improve the nutritional status, growth and development, health and nutrition, and therefore the survival, of infants and young children through optimal feeding.

It becomes imperative, therefore, that service providers, parents, relatives and communities are provided with guidance and support to be able to implement optimal infant and young child feeding practices.

1.2 Review of Global Instruments

Over the past 25 years, infant and young child feeding has received increasing attention and several global instruments have guided formulation and implementation of policies and programmes in this area.

Several international instruments[21, 64, 68, 69, 76, and 77] have stressed the need and obligation to support the health and nutrition of children through optimal feeding, reduce impediments to optimal feeding and ensure food security. They call upon countries to foster opportunities for all women to combine child bearing, breastfeeding and child rearing roles and empower them to optimally feed their children.

The International Code of Marketing of Breast-milk Substitutes [68] adopted by the World Health Assembly (WHA) in 1981 and the subsequent WHA Resolutions seek to contribute to the provision of safe and adequate nutrition for infants and young children by protecting, promoting and supporting breastfeeding and ensuring that Breast-Milk Substitutes (BMS) are not marketed or distributed in ways that may interfere with breastfeeding. T***he Innocenti Declaration*** [76] of 1990 called on all governments to empower all women to breastfeed their infants exclusively for the first 4 to 6 months, and thereafter to continue breastfeeding for 2 years or beyond while providing appropriate complementary feeds. In 1991, *WHO* and UNICEF launched ***The Baby Friendly Hospital Initiative (BFHI)*** [76] whose objective is to create an environment that supports breastfeeding through implementation of the ***Ten Steps to Successful Breastfeeding.***

In 2001, the ***Report of an Expert Consultation on the Optimal Duration of Exclusive Breastfeeding***[78] firmly recommended exclusive breastfeeding for the first 6 months of life for the general population. This provided a firm foundation for the ***Global Strategy for Infant and Young Child Feeding*** which recommends, for the general population, exclusive breastfeeding for the first six months of life, with adequate and safe complementary feeding from the age of six months and continued breastfeeding for up to two years or beyond. The Global Strategy also takes cognizance of children in exceptionally difficult circumstances, including those born to HIV-positive women. The ***HIV and Infant Feeding: Framework for Priority Action***[80] recommends to governments the key priority actions, related to infant and young child feeding, that cover the special circumstances associated with HIV/AIDS.

The Millennium Summit 2000[63] committed itself towards a world in which sustaining development and eliminating poverty would have the highest priority. ***Millennium Development Goal*** No. 4 requires national policies and programmes which will lead to the reduction of child mortality by two-thirds by 2015. Ensuring optimal IYCF is one of the key strategies for achieving this goal.

At the United Nations General Assembly Special Session on Children (UNGASS)[64] 2002, some 180 nations agreed to "A world fit for children" with a strong future agenda focused on four key priorities, including promoting healthy lives for children. In the drive towards "A world fit for children", the country must strive to foster optimal IYCF.

The 2003 publications ***"HIV and infant feeding: Guidelines for decision-makers"*** and ***"HIV and infant feeding: A guide for health–care managers and supervisors"***[61,62] by UNICEF, UNAIDS, WHO and UNFPA provide guidance to decision-makers, health care managers and supervisors on issues that need to be considered in relation to IYCF in the context of HIV/AIDS.

The Consensus Statement[82] from the WHO HIV and Infant Feeding Technical Consultation of October 2006 recommends that the appropriate infant feeding option for the HIV-infected mother should depend on the woman's health status and take into account the local situation.

Similar statements have also been made over the years by the International Baby Food Action Network (IBFAN) Africa Region. In addition, IBFAN Africa has supported or participated in the development of policies and guidelines on the feeding of infants and young children in the Region in general and in Uganda in particular.

A study of all these recommendations, policies and guidelines has provided useful background to the development of this Policy Guidelines on Infant and Young Child Feeding in Uganda.

1.3 Review of Current National Policies and Guidelines

The child's right to an adequate diet is entrenched in the ***Children's Statute*** of 1996 while the ***Food Safety Law*** and the ***Food Safety (Marketing of Infant and Young Child Foods) Regulations***[30] provide the legal framework for protecting the child against undesirable foods. The maternity protection aspect of the Employment Act 2006, on the other hand, seeks to safeguard the working mother's infant feeding role.

The ***Uganda Food and Nutrition Policy***[22] promotes the recommended IYCF practices which are also stressed in the ***National Health Policy***[27] and The ***National Policy Guidelines and Service Standards for Reproductive Health Services***[28]**.**
Further guidance on IYCF is given in ***The Baby Friendly Health Facility Initiative (BFHI)*** and ***Health Facility Practices Policy*** of October 1999, the ***Integrated Management of Childhood Illness (IMCI) Feeding Guidelines***, the ***Vitamin A Supplementation Guidelines*** and ***A Guide for Health Workers: Facts to know about Breastfeeding,*** Ministry of Health, 1998.

The recognition of HIV/AIDS in Uganda since the early 1980s has led to formulation of policies to mitigate the impact of the HIV/AIDS epidemic. The revised MOH ***Policy Guidelines for Prevention of Mother-to-child Transmission of HIV*** 2006 stresses the indisputable benefits of breastfeeding which result into greatest protection against infant morbidity and mortality during the first six months of life. The guidelines go on to acknowledge that breastfeeding is however associated with transmission of the virus to the baby. Given the need to reduce this risk of transmission, the policy stipulates that mothers living with HIV and their partners shall be counselled on infant feeding to enable them make appropriate choices. Where replacement feeding is acceptable, feasible, affordable, sustainable and safe, this should be the mother's choice.

As part of the process of scaling up access to services for comprehensive HIV/AIDS care for both adults and children, the Government of Uganda has put in place a programme for early diagnosis of HIV among infants and children less than 18 months old[34]. This provides an opportunity for getting children into care and treatment, including counseling and support for safe infant feeding.

In conclusion, a lot of effort has been put into the promotion, protection and support of optimal IYCF both at international and national levels. Several national policies and guidelines provide some information and guidance on IYCF and counselling and support is available in many health facilities. Despite these impressive efforts made by the Government and other stakeholders in promoting protecting and supporting optimal IYCF and the progress that has been made in HIV prevention in Uganda, there is still a deficiency in the policy framework on IYCF in general and HIV and infant feeding in particular. None of the policies addresses the issue of IYCF in its totality because even those that touch on the issue, the information and recommendations are inadequate. Hence the need for this comprehensive policy guidelines on infant and young child feeding.

1.4 Justification

Optimal IYCF is essential for child growth, survival and development. Under normal circumstances, exclusive breastfeeding during the first six months is the most economical, safest, most optimal feeding mode critical for the infant's nutrition and survival. Breast milk alone, however, becomes inadequate for the child's requirements from six months of age, and therefore other foods must be introduced at that time, while breastfeeding continues to two years or beyond. When the mother is infected with HIV, there exists a 15-25% risk of the infection being transmitted to the child through breastfeeding and this poses a great challenge to parents and health workers alike.

At the national level, a lot of effort has been put into the promotion, protection and support of optimal IYCF spearheaded by the Ministry of Health in collaboration with other partners and stakeholders. Several national policies and guidelines provide some information and guidance on IYCF and counselling and support is available in many health facilities. Despite these impressive efforts in promoting protecting and supporting optimal IYCF and the progress that has been made in HIV prevention in Uganda we find that:

- IYCF practices are not optimal as evidenced by a timely breastfeeding initiation rate of 32%, an exclusive breastfeeding rate of 60% and a timely complementary feeding rate of 75%[52].
- Malnutrition is still prevalent with stunting at 32%, wasting at 5% and underweight at 20%[51]. According to UDHS 2001, micronutrient deficiencies remain a challenge especially

among women and children: vitamin A deficiencies and iron deficiency anaemia stood at 52% and 30% amongst women and at 28% and 65% in children respectively.

- The infant mortality rate stands high at 88 per 1000 live births[51]
- Challenges exist with feeding of HIV-exposed, malnourished, low birth weight, orphaned children and children in other exceptionally difficult circumstances.
- There is still a deficiency in the policy framework on IYCF and support for its implementation.
- In particular, the provision of IYCF counselling, support and follow up for HIV positive mothers remains one of the greatest challenges..

Up to now there has been an existing policy on infant and young child feeding in the context of HIV/AIDS and several other national policies which do not address the entire spectrum of IYCF. The deficiencies in the policy framework are likely to hamper resource mobilization and service provision. In view of this and in view of recent information and developments such as The Global Strategy for IYCF, the Framework for Priority Action, "early infant diagnosis" and "access to care and treatment of HIV/AIDS" there is an urgent need to formulate a comprehensive IYCF policy in Uganda.

This comprehensive policy guideline is designed to cover the entire spectrum of IYCF taking into account recent developments, and they are meant to provide the framework for enhancing the nutrition, health, growth and development of infants and young children, as well as strengthening care and support for their parents/caretakers to achieve optimal IYCF.

1.5 Policy goal and objectives

1.5.1 Goal

The aim of the Policy Guidelines on IYCF is to provide the framework for enhancing the nutrition, health, growth and development of infants and young children, as well as strengthening care and support for their parents/caretakers to achieve optimal infant and young child feeding.

1.5.2 Objectives

The specific objectives of the Policy Guidelines are to:

- Promote, protect and support exclusive breastfeeding for the first six months of life.
- Ensure adequate and safe complementary feeding from six months of the child's age while breastfeeding continues for two years or beyond.
- Contribute to PMTCT while promoting optimal IYCF in HIV-exposed children.
- Strengthen care, support and follow up for pregnant women, mothers and caretakers to practice optimal IYCF.
- Enhance optimal IYCF in other exceptionally difficult circumstances
- Advocate for appropriate interventions that promote and support the practice of optimal IYCF for all women including working mothers.
- Contribute to the prevention/reduction of childhood and maternal malnutrition, illness and death.

CHAPTER TWO: *POLICY ISSUES*

2.1 Introduction

This Chapter details the various policy issues, the justification for including them and the accompanying policy statements. Implementation action points or guidelines for the various policies are also outlined. The policy issues have been divided into three categories pertaining to:

- Child under "normal" circumstances
- Child exposed to HIV/AIDS
- Child in other exceptionally difficult circumstances.

2.2 Feeding the Child under "Normal" circumstances

2.2.1 Introduction

Optimal IYCF is fundamental for the nutrition, health, survival, growth and development of the child. Feeding practices are one of the major determinants of the health and nutritional status of children. Breastfeeding is a traditional practice in Uganda and the majority of mothers initiate and maintain breastfeeding for long periods [23, 24, 25, 29]. Breast milk contains all the nutrients required by an infant for the first six months of life. In addition, breastfeeding has multiple other benefits including: protection from illness, psychological, child spacing and economic benefits to mothers, children, families and communities. Further, breastfeeding improves the health of mothers by decreasing the risk of bleeding after delivery, promoting child spacing, preventing breast and ovarian cancers. Breastfeeding also offers substantial monetary savings for the nation through its economic and ecological benefits[17].

Under normal circumstances, an infant should be exclusively breastfed for the first 6 months of life. Thereafter, complementary foods should be introduced while breastfeeding continues for up to 2 years or beyond. Mothers and families require information and support in order to achieve optimal IYCF practices.

2.2.2 Aim and objectives

This section of the policy guidelines aims at ensuring optimal IYCF under "normal" circumstances.

The objectives are to:

- Protect, promote and support exclusive breastfeeding for the first six months and continued breastfeeding up to 2years and beyond:
    - Eliminate all use of prelacteal feeds
    - Increase exclusive breastfeeding 0-6 months from 60% to 75%
    - Increase the timely complementary feeding rate from 75% to 85%.

2.2. 3 Policy issues

2.2.3.1 Policy issue 1

Promote exclusive breastfeeding for the first six months of the child's life.

Justification

The multiple benefits of breastfeeding have already been mentioned in this document. Exclusive breastfeeding for the first six months maximizes all these benefits. However, only 60% of babies are exclusively breastfed for 6 months according to UDHS data[52]. In addition, smaller scale studies or surveys continue to indicate that early introduction of liquids, in particular water or other traditional herbal drinks, is more common than reflected by UDHS, in addition to late initiation of breast feeding. For instance, Engebretsen et al. (BMC Paediatrics 2007) reported that whilst breastfeeding was practiced by 99% of mothers in Mbale district, only 7% and 0% practiced exclusive breastfeeding by 3 and 6 months respectively and prelacteal feeding was given to 57% of the children. The authors concluded that the use of prelacteal feeds and early introduction of other food items before 6 months is the norm.

It is increasingly being recognised that even among women of unknown HIV sero-status the benefits of breastfeeding far outweigh the risks of not breastfeeding.

For breastfeeding to be successful, it should be initiated soon after delivery. This early initiation also helps bonding between the mother and her infant as well as preventing postpartum hemorrhage. UDHS data[57] however, reveals that only 32% of mothers initiate breastfeeding within one hour of delivery.

There is evidence that rooming in/ bedding in is important for the purposes of practicing breastfeeding on demand, bonding, and the baby's temperature control. In some of the health facilities in Uganda, babies are separated from their mothers[31].

Mothers' confidence in breastfeeding can easily be undermined by inappropriate marketing and distribution of BMS. This can be prevented by complying to the Food Safety (Marketing of Infant and Young Child Foods) Regulations 2005.

Policy statement 1

All HIV negative mothers and those of unknown HIV status shall be counselled and supported to exclusively breastfeed their infants for the first six months of the child's life.

Implementation

Implementation of this policy will require that mothers are counselled/educated on the benefits and importance of breastfeeding during pregnancy and that the counselling is continuous throughout the period of lactation. The HIV status of the woman should be established at the earliest contact with the service providers so that IYCF decisions can be taken appropriately.

This policy requires that the following recommendations are implemented:

- Rooming in/bedding in for all mothers and newborn infants
- Mothers are supported to initiate early contact with the newborn baby for at least half an hour combined with initiation of breastfeeding within the first hour
- Mothers are encouraged to feed their babies colostrum or "first milk" and to appreciate its benefits.
- Mothers are counselled to breastfeed frequently on demand, both by day and night. This should result into at least 8 feeds within a 24 hour day.
- Strengthen information and communication on the importance of avoiding prelacteal feeds such as water, glucose water, teas, and herbal preparations for newborn babies.
- Mothers should be supported to position and attach the baby to the breast correctly, and mother to completely empty one breast before offering the second, to ensure the baby gets the rich hind milk and avoid breast problems.
- Mothers should be counselled/educated to continue and even increase the frequency of breastfeeding when the mother or the child is sick. Where the infant is unable to suckle, expressed breast milk (EBM) should be fed by cup or tube.

- Mothers should be counselled/educated on how to identify breastfeeding difficulties, including breast conditions, and the need to promptly seek medical care.

This policy position requires that all health facilities offering maternity services implement the Baby Friendly Health Facility Initiative (BFHI) and be certified Baby-friendly. . Further, key essential nutrition actions (ENA) messages should be promoted at all relevant contact points such as at ANC and post natal visits. In addition to the promotion of key family care practices at community level, scale up of the promotion of exclusive breastfeeding should be supported through strengthening community initiatives using multiple communication channels and strengthening linkages between health facilities and surrounding communities. Lastly, implementation and monitoring of the Food Safety (Marketing of Infant and Young Child Foods) Regulations 2005 must also go hand-in-hand with this policy position.

2.2.3.2 Policy issue 2

Promote timely, adequate, safe and appropriately fed complementary foods with continued breastfeeding up to 2 years or beyond

Justification

Breastmilk becomes inadequate for the baby's nutritional requirements after 6 months when other foods become necessary[78,79]. To ensure that children's requirements are met, complementary foods should be timely, adequate, safe and appropriately fed. Appropriate complementary feeding depends on accurate information and skilled support from the family, community and health care system. All children should be started on complementary feeding at 6 months with continued breastfeeding up to the time the baby is 24 months or beyond. However, only 75% of infants 6 to 10 months of age were receiving complementary foods[51]. The complementary feeds should also be given in adequate amounts and variety to meet the nutritional needs of the baby, and should be safely handled during storage, preparation and feeding. When liquid foods are being given, cup feeding is safer than bottle-feeding and is recommended for feeding infants and young children. Feeding bottles with teats or cups with spouts increase the risk of diarrhea. Cups are safer as they are easier than bottles to clean with soap and water. With cup feeding there is more attention to the infant, which helps to enhance psychosocial stimulation. Bottle-feeding is still a challenge with 5% of babies being bottle fed[51].

Infants and young children are not fed adequately when they are sick. Conversely these children may not be fed when their mothers fall sick. When a sick baby stops breastfeeding/ feeding, s/he loses more weight and takes longer to recover. Sick infants and children need to be fed even more frequently than usual to meet their requirements.

Micronutrient deficiencies are common among Ugandan children as evidenced by a high prevalence rate of anaemia of over 60%, and low serum retinol of 28%[50]. This makes micronutrient supplementation and food fortification essential for all children.

Policy statement 2

Parents shall be counselled and supported to introduce adequate, safe and appropriately fed complementary foods at six months of the child's age while they continue breastfeeding for up to 2 years or beyond.

Implementation

To implement this policy, the following are key recommendations:

- Complementary feeds (soft semi-solid feeds) are introduced at six months and breastfeeding continues until two years of age or above
- Promote the use of a variety of nutritious, locally available foods for infants and young children.
- Parents/caretakers should be encouraged to feed liquid foods using clean cups without spouts and not bottles or teats.
- The child's food should be of the right consistency (thickness) and nutrient density (especially energy and micronutrients). The frequency of feeding should be consistent with the child's age.
- Increase the number of times the child is fed and the amount of complementary foods as s/he gets older. The appropriate number of feedings depends on the energy density of the local foods and the usual amounts consumed at each feeding.
- Parents should all be encouraged to practice active feeding: interacting with the baby during feeding.
- Parents should be encouraged to practice high standards of hygiene when handling the baby's food, and maintain sanitation and food/water safety.

- Parents must also be encouraged to ensure that their children receive vitamin A supplements every six months starting at 6 months of age, and de-worming medicines every six months commencing at one year of age, in addition to consuming micronutrient fortified foods. Iron supplements should be given from 2 months of age but only to those with evidence of anaemia and the dose should be in line with National Anaemia Policy 2002.
- When a baby falls sick, the mother should be counselled and supported to feed the child even more frequently than usual. When the child is recovering s/he should be given extra fluids and an extra meal.
- Lastly, for mothers to achieve the optimal duration of breastfeeding, they should be counselled and supported to space births two to three years apart.

2.2.3.3 Policy issue 3

Promote adequate care and intake of nutritious foods for pregnant women and lactating mothers.

Justification

Care and support is needed for the optimal reproductive performance of pregnant women and lactating mothers. This care and support can be offered by the health care system, male partners, families and communities. Community based networks offering mother-to-mother support and trained breastfeeding counsellors working within or closely with the health care system have an important role to play in this regard.

In many communities in Uganda pregnant women and lactating mothers do not receive adequate support from their male partners, relatives and the communities. The physical, psychological, financial and other material supports to these women are crucial in determining the pregnancy and lactation outcome as well as the health and nutrition of the children. Men are the decision makers in the families and control resources. Therefore, involving them in health will increase health service utilization including family planning and provision of financial and material support. Relatives and communities are also an important source of support for pregnant women and lactating mothers.

Policy statement 3

Pregnant women and lactating mothers shall be appropriately cared for and encouraged to consume nutritious foods.

Implementation

Implementation of this policy requires that:

- Health and nutrition education, supportive counselling on feeding and nutritional and psychosocial support and follow-up should form part of the woman's comprehensive care.
- Education/support is given to pregnant and lactating women to eat a variety of foods and have one additional meal every day. Communication shall stress the importance of using iodized salt for cooking all household meals.
- Iron and folic acid should be provided for all pregnant women and lactating mothers. A vitamin A capsule should be given to newly delivered mothers within 8 weeks.
- Pregnant women should be de-wormed and given presumptive malaria treatment once during the second and third trimesters to prevent anaemia. In addition, pregnant women and lactating mothers and their children should sleep under insecticide treated nets.
- Where possible, food supplementation can be given to women of poor nutritional status. Community awareness should be created to encourage means to reduce heavy work load, as well as cultural and gender inequities which impair women's reproductive performance. In addition, male partners, relatives and communities need to be encouraged to provide physical, moral, psychosocial, financial and other material support to pregnant women and lactating mothers.
- Counselling and support is provided for women (and partners) to practice family planning.

This policy is applicable to all pregnant women and lactating mothers, including those living with HIV and those in other exceptionally difficult circumstances.

HIV positive women should be counselled to:

- Increase their energy intake by 10% (i.e. one additional snack per day) if they are asymptomatic or 20-30% (which is 2 or 3 snacks a day) if they are symptomatic.
- Have their weights monitored frequently and seek medical care immediately their weights reduce significantly (e.g. by 10% or more).
- Be aware of and manage drug-food interactions for those on ART.

2.3 Feeding the Child who is exposed to HIV

2.3.1 Introduction

HIV/AIDS in Uganda is predominantly caused by HIV-1 type of virus. Mother-to-Child Transmission of HIV (MTCT) accounts for the vast majority of new infections in children[49, 53, 54, 65].

Infants can acquire HIV from their infected mothers during pregnancy, at the time of delivery, or after birth through breastfeeding[1, 4, 6, 7, 11, 39, 40, 46]. Transmission through breastfeeding accounts for 15 to 25% of MTCT[6,11,49]. The risk of HIV transmission through breastfeeding is increased by factors which include high maternal viral load; low maternal immune status; prolonged breastfeeding for more than six months; mixed feeding; breast conditions (e.g. abscesses, mastitis, cracked nipples); and mouth sores in the infant[40, 59, 60, 70] .The risk of MTCT of HIV through breastfeeding appears to be greatest during the first months of infant life but persists as long as breastfeeding continues.[40] It is estimated that more than 20,000 children in Uganda are infected with HIV annually through MTCT if there is no intervention. This large number of HIV-infected infants is due to a combination of the high prevalence rate of HIV among pregnant women and the high fertility rate[54]. HIV exposed children are at high risk of morbidity and mortality due to recurrent and chronic illness. Studies suggest that about 66% of infected children die before their 3rd birthday if there is no intervention[15, 16, 46, 84]. The key strategies in PMTCT include routine counselling and testing for HIV during pregnancy; short course Nevirapine for HIV-infected pregnant women and their infants; and appropriate infant feeding. Recent developments including greater access to long-term antiretroviral therapy, and early diagnosis of HIV in children have improved care and treatment of HIV exposed and infected children[2, 34, 42]. In particular, early diagnosis of HIV in children has made it possible to classify HIV exposed children into three categories namely:

- HIV Exposed but not HIV infected
- HIV Exposed and HIV infected
- HIV Exposed but with unknown HIV status

These categories are useful for deciding appropriate care and treatment for HIV exposed children, including infant and young child feeding.

2.3.2 Aim and objectives

This section of the policy guidelines aims at ensuring optimal feeding for the infant and young child exposed to HIV.

The objectives are to:

- Promote optimal feeding for the HIV exposed infant and young child
- Reduce HIV transmission through breast-feeding.

2.3. 3 Policy issues

2.3.3.1 Policy issue 4

Promote routine counselling and HIV testing of pregnant women and lactating mothers.

Justification

Knowing the HIV status of pregnant and lactating mothers will facilitate identification of HIV exposed children in order to decide on the most appropriate care including feeding of these children.

Policy statement 4

4a) Service providers shall establish the HIV status of all pregnant women and lactating mothers.

4b) All pregnant women and lactating mothers shall be encouraged to confidentially share their HIV status with service providers and key family members in order to get appropriate IYCF services.

Implementation

Implementation of this policy shall be in conjunction with the PMTCT policy of routine counselling and HIV testing for all pregnant women and lactating mothers, especially for the purpose of getting appropriate IYCF services.

2.3.3.2 Policy issue 5

Promoting optimal IYCF among HIV exposed children while preventing transmission of HIV through breastfeeding.

Justification

Exclusive replacement feeding (RF) eliminates MTCT of HIV through breast milk while offering acceptable nourishment for the child. However, exclusive replacement feeding caries the risk of diarrhoea, pneumonia and malnutrition unless it is **acceptable, feasible, affordable, sustainable and safe (AFASS).** In situations where RF is not AFASS, breastfeeding is recommended.

Policy statement 5

Exclusive breastfeeding is recommended for HIV infected women for the first six months of the child's life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.

Implementation

Implementation of this policy requires the following actions.

- HIV-infected pregnant women and lactating mothers should be counselled on the infant feeding options available to them. Hence the need to scale up and strengthen quality infant feeding counselling, support and follow up of HIV infected mothers nationally.
- The counselling should:
  - Be done by IYCF counsellors who have undergone the MOH approved Integrated Infant and Young Child Feeding Counselling Training Course
  - Make use of the MOH approved IYCF counselling tools/job aides
  - Take into account the MOH recommended feeding options.

- The Ministry of Health recommended feeding options are:
  - **Exclusive breastfeeding for six months** followed by replacement feeding, if AFASS, in conjunction with timely, adequate and safe complementary feeding.
  - Exclusive breastfeeding for six months followed by timely, adequate, safe and appropriately fed complementary foods in addition to continued breastfeeding up to 2 years if RF is not AFASS.
  - **If AFASS, exclusive replacement feeding for first 6 months followed by timely, adequate and safe complementary feeding and continued replacement feeding.**
  - **RF may be with:**
    - Infant formula
    - Animal milk
- It is essential to emphasize to HIV positive women that whether it is breastfeeding or RF, it must be **exclusive** for the first six months with NO mixed feeding. Where mothers opt for replacement feeding, the marketing, procurement and distribution of BMS must comply with the Food Safety (Marketing of Infant and Young Child Foods) Regulations, 2005.
- All HIV positive mothers who opt for RF should be educated and counselled to feed their infants using cups and not feeding bottles with teats or cups with spouts.
- If a mother starts on RF and it is no longer AFASS before 6 months, she should be counselled and supported to either make it AFASS again or to re-lactate.
- Where replacement feeding is not AFASS even at 6 months, the mother should be counselled and supported to:

- continue breastfeeding, up to 2 years, with complementary feeding, or
- Improve replacement feeding to become AFASS. This will require strict follow up and assessment of mother and baby and may require extra support outside of existing health services.

- All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.
- Whatever the feeding decisions, health services should be supported to follow up all HIV exposed infants and continue to offer infant feeding counselling and support.
- If an HIV-exposed child falls sick, regardless of the mode of feeding, s/he should be fed even more frequently than usual in order to meet that child's nutritional requirements. If the child has the symptoms of AIDS the energy intake should be increased by 20-30% and if the child is losing weight the energy intake should be increased by about 30% to 50%.
- Counselling, support and where possible follow up must also be provided for the parents to introduce complementary foods from 6 months of the child's age.
- Ensure that the children receive micronutrient supplements as previously outlined in this document.
- Give ¼ tablet of iron and ¼ tablet of folic acid to infants on RF with animal milk.
- Parents/caretakers of children on ART should be counselled on drug-food interactions and advised on approaches to manage dietary related symptoms such as diarrhea, vomiting, as well as problems related to mouth sores, oral thrush and swallowing.

2.3.3.3 Policy issue 6

Early diagnosis of HIV infection among the exposed infants and young children

Justification

Early diagnosis of HIV infection among the exposed infants and young children allows for the opportunity to provide appropriate treatment, follow up care and support for the affected children, including IYCF counselling. Unfortunately, when parents learn that the child is HIV-free, they are likely to want to change the child's mode of feeding from what is recommended.

Policy statement 6

Children born to mothers living with HIV shall be tested for HIV infection at 10 weeks of age.

Implementation

Implementation of this policy shall be in conjunction with the PMTCT policy of early diagnosis of HIV among infants and young children. As a general principle, children exposed to HIV will be tested for HIV at 10 weeks of age. However, exposed children who are not breastfeeding may be tested at 6 weeks.

During the testing at 10 weeks:

- All mothers should get additional counselling support and follow up for infant feeding with each mother's situation re-assessed and RF recommended only if it is AFASS.
- Mothers who had opted for breastfeeding should be supported as much as necessary to continue breastfeeding if RF is still not AFASS.

2.4 Feeding the Child who is in Other Exceptionally Difficult Circumstances

2.4.1 Introduction

In line with the Global Strategy for IYCF consideration must be given to infants and young children in other exceptionally difficult circumstances, including the malnourished and low birth weight children. These infants and young children require special attention and practical support to ensure optimal IYCF.

Malnutrition in Uganda remains a problem with pockets of famine and hunger especially in the north east and areas of insecurity. There are high levels of childhood under-nutrition contributing to 40% of deaths among children. Malnutrition can be classified into two main categories: moderate and severe which require management and rehabilitation in supplementary and therapeutic feeding programmes, respectively.

Malnutrition among women also remains prevalent and contributes to low birth weight[51]. In Uganda, 10% of all babies are low birth weights[51]. Low birth weight babies are at particular risk of infections and malnutrition as well as learning disabilities.

Other categories of children in exceptionally difficult circumstances include children in emergency situations, children whose mothers are very ill, dead or otherwise absent, infants rejected by their mothers, those of mothers who are alcoholic and/or drug abusers, orphaned children, abandoned children, displaced children, street children, children in refugee settlement and foster institutions.

Exclusive breastfeeding is very important for infant nutrition and health in difficult circumstances because it is cheap, safe, acceptable and affordable to many families and shall be promoted as the number one IYCF option in such circumstances. If alternative feeding becomes necessary, the following critical issues must be addressed:

- Assessment to find out who is eligible for alternative feeding.
- Procurement and distribution of alternative feeds.
- Minimizing the risk of use of BMS.

2.4.2 Aim and objectives

This section of the guidelines aims at ensuring optimal feeding for infants and young children in other exceptionally difficult circumstances. The objectives are to:

- Promote the effective management of malnourished and low birth weight infants and young children.
- Promote and support optimal feeding for infants and young children in emergencies and other special circumstances including infants unable to breastfeed and on BMS.

2.4.3 Policy Issues

2.4.3.1 Policy issue 7

Treatment, care and support for moderately and severely malnourished infants and young children.

Justification

Whilst promotion of optimal IYCF practices amongst other interventions aims to prevent child malnutrition from arising, it is important that clear IYCF policies are highlighted if malnutrition manifests. Firstly, it is necessary to identify malnutrition or the risk of malnutrition early in order to prevent further deterioration and provide an opportunity to counsel mothers/caretakers on appropriate practices.

Once identified, moderately or severely malnourished children will require nutritional supplements (i.e. supplementary ration for moderately malnourished or therapeutic feeds for severely malnourished), rehabilitation and ongoing nutrition support.

On going nutrition support includes providing mothers or caregivers of these children with relevant information on appropriate infant and young child feeding.

Children often become malnourished because their mothers/caretakers have not been very successful with breastfeeding or they have encountered some difficulties with particular practices. They need information and guidance. In addition, a high association has been established between the severely malnourished and HIV/AIDS (~30-40%).

Policy Statement 7

Malnourished children shall be provided with appropriate nutrition supplements, rehabilitation, support and follow up.

Implementation

Implementation of this policy requires that:

- Malnourished children receive extra attention both during the early rehabilitation phase and over the longer term to prevent a recurrence and to minimize the effects of chronic malnutrition.
- Efforts should be made to build capacity of hospital staff to recognise and manage cases of severe or moderate malnutrition when they arise.
- Dietary supplements required by these children must be provided.
- Mothers of these children should be counselled and supported to continue frequent breastfeeding and, where appropriate, re-lactate.
- Nutrition education and support on appropriate complementary feeding practices is required with an emphasis on the use of existing community structures to disseminate messages.
- Health and community workers actively pursue growth screening of all children for early detection of malnutrition. Furthermore, families and communities should be encouraged to take their children for regular growth screening including weighing and/or use of Mid Upper Arm Circumference (MUAC).
- Malnourished children should receive treatment and care according to the National Guidelines on Management of Moderate and Severe Malnutrition and the Guidelines on Integrated Management of Acute Malnutrition.
- Where available, moderately malnourished children should be recruited into supplementary feeding programs and appropriate counselling and support provided to mothers depending on the assessed cause of the malnutrition.

- Treatment and care of the severely malnourished can take place in health institutions or in communities as recommended in the National Guidelines on the Integrated Management of Acute Malnutrition.
- Micronutrient supplementation should be in accordance with the National Guidelines on the Management of Severe Malnutrition. Iron should not be provided until Phase II when the malnourished child has began recovering and growth has resumed. Folic acid can be provided throughout all phases. Vitamin A supplementation should be provided on admission and at discharge.
- In addition, mothers/caretakers of severely malnourished infants and young children should be offered psychosocial support since these children tend to be lethargic and thus need to be stimulated in order to boost their responses including their appetite.
- Lastly, mothers/caretakers of malnourished children should be encouraged to undergo routine HIV counselling and testing and/or linkages should be established between HIV clinics and nutrition rehabilitation for the malnourished.

2.4.3.2 Policy issue 8

Promote increased breast milk intake among low birth weight babies

Justification

Low birth weight infants can be either pre-term or small for dates. The best food for low birth weight babies is their own mother's milk unless medically contraindicated. Small for dates newborn babies are usually able to suckle effectively from the breast. Pre-term babies may be unable to suckle strongly at the breast at first but they can be fed on expressed breast milk by tube or cup and helped to establish full breastfeeding later. In order for the mother of a low birth weight baby to be able to express milk effectively, she needs skilled counselling and support. In addition, low birth weight infants need more of some nutrients than breast milk can provide.

Policy Statement 8

Mothers of children who are born with low birth weight but can suckle shall be encouraged to breastfeed, unless there is a medical contraindication. Mothers of low birth weight children who cannot suckle well shall be encouraged and assisted to express breastmilk and give it by cup.

Implementation

Babies less than 30 weeks gestational age usually need to be fed by nasogastric tube;

- Give expressed breastmilk by tube. The mother can let her baby suck on her clean finger while he/she is having the tube feeds. This probably stimulates his digestive tract, and helps weight gain.
- If possible, let the mother hold her baby and give him skin-to-skin contact against her body for part of every day from this age. Skin-to-skin contact enhances bonding, and helps the mother to produce breast milk, and so it helps breastfeeding.

Babies between about 30-32 weeks gestational age can take feeds from a small cup, or from a spoon.

- Try to give cup feeds once or twice a day while a baby is still having most of his feeds by tube. If he takes cup feeds well, you can reduce the tube feeds and eventually remove the tube.
- Another way to feed a baby at this stage is by expressing milk directly into the baby's mouth.

Babies of about 32 weeks gestational age or more are able to start suckling on the breast.

- Let the mother put her baby to her breast as soon as he is well enough. He may only root for the nipple and lick it at first or he may suckle a little.
- Continue giving expressed breast milk by cup or tube, to make sure that the baby gets all that he needs.
- When a LBW baby starts to suckle effectively, he may pause during feeds quite often and for quite long periods. For example, he may take 4-5 sucks, and then pause for up to 4 or 5 minutes. It is important not to take him off the breast too quickly. Leave him on the breast so that he can suckle again when he is ready. He can continue for up to an hour if necessary. Offer a cup feed after the breastfeed. Or offer alternate breast and cup feeds.
- Good attachment may make effective suckling possible at an earlier stage. The best positions for a mother to hold her LBW baby at her breast are:
    - across her body, holding him with the arm on the opposite side to the breast;
    - the underarm position.

In both of these positions, she supports her baby's body on her arm and supports and controls his head with her hand. This is important with LBW babies, but not with larger babies.

Babies from about 34-36 weeks gestational age or more (sometimes earlier) can often take all that they need directly from the breast. However, supplements from a cup continue to be necessary occasionally.

All low birth weight babies should be followed up and weighed regularly to make sure that they are getting all the breast milk that they need for adequate growth.

All low birth weight babies should be provided with ¼ tablet of iron daily since they are at higher risk of iron deficiency and iron deficiency anaemia, Iron supplements should begin at 2 months and continue until the infant is on complementary feeding. This should be in conjunction with measures to prevent and control malaria. . It is recommended not to give folic acid supplements.

Policy Issue 9

Optimal IYCF for children in emergencies and other difficult/special circumstances

Justification

The children under this category are those in emergency situations, orphans, children in foster care and children born to adolescent mothers, mothers suffering from physical or mental disabilities, drug or alcohol dependence or mothers who are imprisoned or part of disadvantaged or otherwise marginalized populations. In emergency situations, children are among the most vulnerable victims. Uncontrolled distribution of breast milk substitutes mainly in refugee or other camp situations increases the already high risk of diarrhoeal disease and malnutrition.

The best food for all infants in exceptionally difficult circumstances is their own mother's milk unless medically contraindicated, given the multiple benefits that accrue from breastfeeding. Only when the mother is absent or otherwise unable to breastfeed should artificial feeding be resorted to. Under exceptionally difficult circumstances, when the mother is un-available, artificial feeding becomes necessary. However, the cultural expectations, health workers' knowledge, skills and experiences may present barriers to understanding and supporting the use of artificial feeds. All these call for a special and supportive environment for the health, community and emergency workers, as well as the families, in order for them to support

appropriate infant and young child feeding as required. These special needs also include additional food, water, shelter and health care services.

In difficult circumstances including emergencies, the resources needed for safe use of artificial feeds such as water and fuel are also usually scarce. There is an overall need to minimize the risks and dangers of artificial feeding to infants and their families under difficult circumstances.

Policy Statement 9

Mothers, caretakers, and families, shall be counselled and supported to practice optimal IYCF in emergencies and other exceptionally difficult/special circumstances.

Implementation

Implementation of this policy requires that health care providers, community and emergency workers give more attention to mothers, caretakers and families of children in exceptionally difficult circumstances so as to empower them to implement optimal IYCF.

- Give guidance for identifying infants who need to be fed with BMS, ensuring that a suitable substitute is provided and fed safely for as long as needed by the infants concerned.
- Ensure that whenever BMS are required for social medical reasons, for example, for orphans or in the case of HIV positive mothers, they are provided for as long as the infants concerned need them.
- The use of BMS shall be accepted in exceptionally difficult circumstances when the child's mother is not available but the marketing and distribution of the BMS must be controlled in accordance with the Food Safety (Marketing of Infant and Young Child Foods) Regulations 2005.
- Emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, adequate, safe and appropriately fed complementary foods consistent with the age and nutritional needs of older infants and young children.
- Strengthen education and communication to ensure that children continue to be fed when they or their mothers fall sick. The feeding should be even more frequent during illness and when the child is recovering.
- Ensure that health workers have accurate and up to date information about infant feeding policies and practices, and that they have the specific knowledge and skills required to support caregivers and children in all aspects of IYCF in difficult circumstances.

- Adopt the Baby Friendly Hospital Initiative and other forms of protection and promotion of breastfeeding and provide support to prevent spillover of artificial feeding for those for whom breastfeeding is the best option.

CHAPTER THREE: *IMPLEMENTATION, MONITORING AND EVALUATION*

3.1 Implementation Strategies

Implementation of these policy guidelines will be in line with the Global Strategy for IYCF and relevant national policies and guidelines.

Implementation of the section on Feeding of Infants and Young Children exposed to HIV will require wide access to HIV Counselling and HIV Testing services, strengthening prenatal, delivery, postnatal care and family planning programmes, and care services for parents and HIV exposed children. As part of the PMTCT Programme all pregnant and postnatal clients of unknown status will be offered HIV testing while the programme on Early HIV diagnosis and care for infants also takes effect. In addition, children will be identified through well and sick child clinics including immunisation clinics, postnatal clinics, paediatric in-patient clinics, nutrition rehabilitation units, and wards for children with diarrhoeal diseases.

3.1.1 Advocacy

Advocacy for optimal IYCF will be crucial for the successful implementation of this policy. Advocacy will be done at various levels including at international, national, district and community levels. Key issues to be targeted in the advocacy include exclusive breastfeeding, complementary feeding, replacement feeding, overcoming stigmatisation, and supporting working mothers to optimally feed their infants and young children.

3.1.2 Capacity building

Capacity building in terms of improving the facilities, up-grading the infrastructure and providing necessary skills for health and community workers will be a key strategy.

Training and education (in service and pre-service) of health care providers in the benefits and management of breastfeeding, re-lactation, and the use of replacement feeding and all other aspects of optimal IYCF will be stressed. Similarly, community based workers will need training and education on IYCF.

Staff of nutrition rehabilitation centres requires knowledge and skills on appropriate psychosocial counselling and support. Capacity building to strengthen utilization of data captured for IYCF including malnutrition and low birth weights in Health Management Information System (HMIS) will also be necessary.

Disasters and emergencies can occur any where any time and when least expected. Most often the decision makers, health and community workers are caught unaware and depend on support from the development partners and humanitarian agencies that come with their own guidelines and practices. On going training and sensitization of health workers prior to emergencies makes them prepared and less likely to be influenced by the agencies that come in to respond and help. In addition, health workers shall be trained or sensitized on preparedness and support for IYCF in difficult circumstances.

Therefore, the need to promote training/sensitization of the relevant workers at national and district levels in preparedness and support for IYCF in difficult circumstances must be borne in mind.

3.1.3 Information Education and Communication (IEC)

During implementation, the IEC strategy will be employed to create awareness on all aspects of optimal IYCF. This will involve the use of print and electronic media.

Community mobilization will be a key intervention in the implementation of these policy guidelines. Creation of awareness at the community level is essential to ensure implementation of optimal infant feeding practices. Community leaders, village health teams and community resource persons will be sensitized to promote and support optimal infant and young child feeding. Communities will be encouraged and supported to initiate and/or strengthen community based support groups which will promote and support optimal IYCF among other activities. Parents, families and communities will be given information on production, storage, preparation and utilization of food through demonstrations according to different cultures. All IEC materials on IYCF should carry messages which are harmonized.

IEC materials on the management and prevention of low birth weight and malnutrition in infants and young children will need to be reviewed or developed.

3.1.4 Care and support

Care and support services will be offered to the pregnant women and lactating mothers to enhance their reproductive performance. Mothers with poor nutritional status will be offered food supplements where possible in addition to other services.

Male partners and other influential relatives can be an important source of support for the pregnant women and lactating mothers. Besides financial, psychosocial and physical support,

they can help in reducing the women's workload and removing cultural and gender imbalances which would otherwise impede mothers' ability to practice optimal IYCF. Effort will be made to sensitise men and encourage them to participate in the health and nutrition activities of the children.

Key areas for implementation are promotion of parental love, nutrition services, health care services, and education. Of particular significance is the pprovision of nutrition support and care during pregnancy and post natal period to prevent low birth weights.

Nutrition support for women, which should target especially those of reproductive age, includes provision of information on proper nutrition, iron/folic acid supplements, additional food supplementation and promotion of immediate and exclusive breastfeeding.

Post natal follow up and care for the mothers and infants for both ordinary and PMTCT mother/baby pairs needs to be strengthened.

Pregnant women and lactating mothers can further be supported by creating an enabling environment in the health facilities, homes, communities and places of work. Ensuring that all maternity units are baby-friendly, enforcement of the Employment Act 2006 and other laws and regulations which govern maternity protection, establishment of breastfeeding corners and baby/mother friendly communities and work places are all essential elements of this enabling environment.

3.1.5 Counselling and follow up

Counselling services will be strengthened to empower parents and families to make informed decisions about infant and young child feeding. The parents and families will then be supported to implement their decisions so that optimal IYCF is achieved. Additional counselling and support will be offered to mothers working outside their homes to enable them practice optimal IYCF. The use of cup feeding will be promoted in the feeding of infants and young children who receive EBM or BMS.

Counselling of parents and sensitization of the communities about feeding of sick infants and young children will be done. When mothers fall sick they will be encouraged and supported to continue feeding their infants and young children.

3.1.6 Integration, Coordination and Collaboration

Strategic linkages will need to be forged with the different departments, programmes and policy guidelines to achieve maximum impact during implementation of these guidelines. Coordination and collaboration enhances the effective participation of key stakeholders, maximises the use of resources, provides guidance and sets standards of achievement. The MOH will be the principal implementer of this policy. However, given the multi-sectoral nature of the interventions required, other important stakeholders will be involved as recommended in the section of roles and responsibilities.

Harmonization of messages and integration of infant and young child feeding in initiatives targeting women and children such as BFHI, IMCI, HIV and Reproductive Health interventions, will be actively pursued. Use shall be made of the Essential Nutrition Actions (ENA) approach as a means of ensuring IYCF promotion at the various key contact points (*ANC, Delivery, Post Natal/family planning, Immunization, growth monitoring/well child and sick child consultations*) in addition to non health contact points such as schools and at community level. It will be important to strengthen the use of community based health workers, peer counsellors, mother support groups and links with agricultural and other extension workers in the promotion of optimal IYCF.

Any agency/partner involved in procurement, management, distribution, targeting and use of BMS and related products by children in difficult circumstances shall do so in accordance with the Food Safety (Marketing of Infant and Young Child Foods) Regulations 2005.

3.1.7 Strengthening growth monitoring and promotion including screening and referral

In order to conduct growth monitoring and promotion at the health facility and community levels, it will be necessary to build the capacity of facility health workers, community based health workers and leaders of mother support groups on growth monitoring and counselling. The traditional form of growth monitoring using weight for age can work alongside the use of MUAC for easier identification of the malnourished. Once identified, malnourished children should be appropriately referred for treatment and rehabilitation.

3.1.8 Resource mobilization

Implementation of this policy will require human, material and financial resources. The MOH in collaboration with other key stakeholders will endeavor to solicit for and mobilize resources, which are necessary for the implementation of this policy.

3.2 Monitoring and Evaluation

Monitoring and evaluation at all levels will be done to ensure that implementation of the policy guidelines is proceeding well and that the desired results are being achieved. Both process and outcome indicators will be assessed, some routinely while others will require periodic surveys and researches.

3.2. 1 Indicators

The following indicators shall be used for monitoring and evaluating the policy guidelines.

3.2.1.1 Percentage of mothers initiating breastfeeding within one hour of birth

3.2.1.2 Percentage of mothers rooming in/bedding in with their newborn babies

3.2.1.3 Percentage of babies 0-6 months receiving no other food or fluid apart from breast milk

3.2.1.4 Percentage of children started on complementary foods at 6 to 10 months

3.2.1.5 Percentage of mothers who continue to breastfeed at 20-23 months

3.2.1.6 Percentage of infants receiving feeds using bottles

3.2.1.7 Number of trained infant and young child feeding counsellors

3.2.1.8 Number of mothers individually counselled on infant and young child feeding

3.2.1.9 Percentage of infants and young children with:

- Underweight
- Stunting
- Wasting
- Anaemia
- Low serum retinol

3.2.1.10 Percentage of HIV positive mothers practicing exclusive RF at 3 and 6 months

3.2.1.11 Percentage of HIV positive mothers practicing exclusive breastfeeding at 3 and 6 months

3.2.1.12 Percentage of children under 6 months in difficult circumstances who are being exclusively breastfed when their mothers are available.

3.2.1.13 Number of children under 6 months in difficult circumstances who are being fed on breast milk substitutes.

3.2.1.14 Percentage of children 6 to 59 months in difficult circumstances who received multi micronutrient supplements.

3.2.1.15 Number of health workers trained in preparedness and support for IYCF in difficult circumstances at national and district levels.

3.2.1.16 Number and gravity of violations of The Food Safety (Marketing of Infant and Young Child Foods) Regulations.

3.2. 2 Sources of information

For the purposes of monitoring and evaluation, information will be obtained through:

- HMIS
- Support supervision reports
- BHFI assessments
- District nutrition surveys
- UDHS
- Monitoring for compliance with and violations of the Regulations
- Other surveys and researches

3.3 Roles and responsibilities

3.3.1 Government of the Republic of Uganda (Executive, Legislative and Judiciary):

- Ensure that infant and young child feeding is a priority in the nation's agenda.
- Provide support for laws, regulations, policies, strategies and programs dealing with infant and young child feeding.
- Ensure compliance with the laws and regulations on infant and young child feeding where these exist.

3.3.2 MOH:

- Act as the principal implementer and coordinator of all the interventions aimed at achieving the goal and objectives of this policy

- Strengthen the nutrition unit by providing it with adequate human, material and financial resources to spearhead implementation and coordination of this policy
- Facilitate the training of health professionals and all others who work with women, care givers and the children on infant and young child feeding, malnutrition, low birth weight, BFHI, and preparedness and support for IYCF in difficult circumstances to ensure competence in these areas
- Disseminate and monitor The Food Safety (Marketing of Infant and Young Child Foods) Regulations 2005
- Conduct a needs assessment to identify children in difficult circumstances
- Undertake training/sensitization of health workers on monitoring and evaluating the impact of using alternative feeds
- Facilitate access to replacement feeds where appropriate
- Support Growth Promotion Monitoring
- Develop and/or review guidelines on the management of malnutrition and low birth weights
- Recruit, empower and employ Regional Nutritionists and Hospital dieticians to strengthen management of severe malnutrition nationally
- Develop guidelines or tools on appropriate IYCF counselling
- Harmonize nutrition related materials on IYCF and develop appropriate IYCF communication strategy
- Harmonize and integrate existing nutrition intervention packages
- Review and/or revise malnutrition indicators in HMIS in addition to strengthening HMIS data reporting and utilization.

3.3.3 Health Care Providers:

- Create awareness on VCCT and provide these services.
- Encourage use of antenatal care and strengthen antenatal care services so that they can provide information about prevention of HIV infection; and offer referral for HIV counselling and testing and other interventions to reduce mother-to-child transmission. These should be provided in addition to the basic package for obstetric care.
- Provide IEC and counselling on infant feeding for all pregnant women and mothers. This includes support and counselling about breast-feeding for mothers who are HIV

negative or of unknown status and counselling about replacement feeding for women who are HIV positive

- Support HIV positive women in their choice of feeding method, whether they choose breast-feeding or replacement feeding. This should include advice on how to access replacement feeds where appropriate
- Prevent any "spill-over" effect of replacement feeding which may undermine breast-feeding among HIV negative women and those of unknown status. In this regard there should be no group counselling/education on replacement feeding
- Integrate all interventions for prevention of MTCT of HIV into reproductive and child health services
- Conduct sensitisation and mobilisation of the community for the activities related to infant feeding.

3.3.4 Hospital level:

- Manage malnourished children and provide nutrition supplements, where possible.
- Provide IYCF counselling for all mothers in addition to special support to mothers of malnourished and low birth weight children
- Support outreaches and community mother support groups to conduct growth monitoring including screening and referral and IYCF promotion and education
- Provide follow up of children and mothers/caretakers.

3.3.5 Lower level health facilities:

- Conduct growth monitoring and promotion both at health facility level and at outreaches to be able to identify the malnourished and to appropriately counsel mothers/caretakers
- Support and strengthen links with community health workers to promote IYCF and growth monitoring including screening and referral of the malnourished
- Manage low birth weight babies appropriately and provide mothers with the necessary support
- Provide IYCF counselling for all mothers in addition to special support to mothers of malnourished children and low birth weight children
- Support outreaches and community mother support groups to conduct growth monitoring including screening and referral and IYCF promotion and education.

3.3.6 Ministry of Education and Sports:

- Take steps to ensure that primary, secondary and tertiary institutions incorporate infant and young child feeding issues into their curriculum
- Orient education managers at all levels on optimal IYCF.

3.3.7 Ministry of Labor Gender and Social Development:

- Ensure that the International Labor Organization convention 183 is ratified and enacted into Uganda law
- Advocate for enactment of any other laws and regulations that enhance maternity protection.

3.3.8 Ministry of Agriculture, Animal industry and Fisheries:

- Empower its extension workers to support families and communities to grow/rear and utilize locally available crops and animals that will help to improve the nutritional quality of foods and animals.
- Ensure household food security.

3.3.9 Ministry of Trade and Industry:

- Promote local initiatives to fortify foods
- Engage customs and excise, police and port authorities in implementing the relevant laws and regulations
- Sensitize at all levels on the importance of food standards.

3.3.10 Uganda National Bureau of Standards

- Ensure that imported foods and equipment for infants and young children maintain the standards specified by the Uganda National Bureau of Standards, The Food Safety (Marketing of Infant and Young Child Foods) Regulations, 2005 and the Codex
- Monitoring the implementation of the code on Marketing.

3.3.11 Local governments at District level:

- Strengthen structures, services and interventions which are needed for the implementation of this policy
- Establish health facility and community based monitoring and feedback system for infant and young child feeding practices and the care of women and children
- Empower the communities with knowledge and skills necessary to implement this policy
- Train health workers and community health workers on IYCF, BFHI, growth monitoring and promotion, management of severe malnutrition
- Support supervision and on the job performance training
- Strengthen HMIS reporting on low birth weights and malnourished children in Hospitals and HC IV
- Strengthen the capacity of hospitals to manage severe malnutrition and or low birth weights
- Support routine growth monitoring and promotion and referral of malnourished children to treatment centres
- Strengthen referral between Nutrition Rehabilitation units and routine HIV/AIDS counselling and testing sites
- Identify children in difficult circumstances
- Develop comprehensive policy implementation strategies
- Identify and involve partners in implementation
- Monitor implementation of this policy
- Disseminate The Food safety (Marketing of Infant and Young Child Foods) Regulations 2005
- Carry out intensive social mobilization to all stakeholders in the district.

3.3.12 Universities and tertiary health training institutions:

- Ensure that training on IYCF includes sufficient hands-on experience empowering their graduates to promote protect and support optimal IYCF
- Promote research in priority topics in IYCF.

3.3.13 Non-Governmental, Community Based and Religious Organizations:

- Mainstream IYCF into their agendas
- Advocate for the child's rights to food and nutrition
- Provide technical support to districts, sub-counties and communities to promote IYCF, growth monitoring and promotion and to implement other roles and responsibilities
- Where possible provide direct support to mothers, families, communities or congregations.

3.3.14 Political leaders:

- Advocate for and support the implementation of this and any other related laws and policies.

3.3.15 Mothers:

- Breastfeed exclusively meaning that absolutely nothing but breast milk should be given to the infant for the first 6 months.
- The mothers should know what is required in preparing and giving feeds to infants, and that particular attention needs to be paid to hygiene, correct mixing and feeding method
- Preparation of safe feeds for the infant requires the mother to follow these basic principles:
    - Wash the hands with soap and flowing water before preparing and cooking the infant's food and before feeding the infant
    - Boil water for preparing the infant's food and drinks
    - Avoid storing prepared feeds. If this is not feasible, store in a refrigerator or in a cool place and reheat thoroughly before feeding the infant
    - Avoid contact between raw and cooked feeds
    - Wash fruits and vegetables with water that has been boiled. Peel them if possible or cook before giving them to the infant
    - Avoid feeding infants with a bottle; use an open cup
    - Give unfinished formula feed to an older child rather than keeping it for the next feed

- Wash the cup, bowl or mixing utensils for the infant's food thoroughly with soap and water. Boil them if possible. Bacteria breed in food that sticks to feeding utensils
- Store food and water in covered containers to protect from rodents, and insects
- Keep food preparation surfaces clean.

- The mother should ensure that she has some means for accurate measurement of both water and the powdered or liquid milk so that these ingredients can be mixed accurately and correctly.

3.3.16 Fathers:

- Develop interest in promoting, supporting and protecting IYCF
- Participate in decision making on IYCF in the family
- Provide physical, psychological and financial support for pregnant women and lactating mothers for optimal IYCF.

3.3.17 Community:

- Community leaders should participate in the sensitisation and mobilisation of their members for these activities
- Organise a social support network at that level for affected families and take steps to minimise stigmatisation and discrimination
- Foster love and attention to children in difficult circumstances
- Protect and promote appropriate IYCF in difficult circumstances.

3.3.18 The Private Sector:

- Adherence to The Food Safety (Marketing of Infant and Young Child Foods) Regulations
- Provide maternity entitlement to their female employees
- Create a working environment that promotes optimal infant and young child feeding
- Provide facilities for breastfeeding, expression of breastmilk and/or preparation of commercial formula.

3.3.19 Media:

The print, electronic and theatre media shall:

- Inform the public on all IYCF issues
- Abide by the Regulations, especially with regard to advertisements.

3.3.20 The United Nations agencies (UNICEF, WHO, UNFPA, UNDP, FAO, UNAIDS, WFP) and Other Bilateral Agencies:

- Enhance advocacy for IYCF
- Contribute to the mobilization of resources
- Provide technical support for implementation of the policy, especially to support training and development of appropriate IYCF, management of malnutrition, low birth weights etc. manuals, tools and job aides in an integrated manner
- Otherwise support MOH at National and district levels to implement their roles and responsibilities.

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ANNEXES

Annex 1: Cup Feeding

Why cup feeding is safer than bottle feeding:

- Cups are easy to clean with soap and water, if boiling is not possible. Cups are less likely than bottles to be carried around for a long time, giving bacteria time to breed.
- A cup cannot be left beside a baby, for the baby to feed himself. The person who feeds a baby by cup has to hold the baby and look at him, and give him some of the contact that he needs.
- A cup does not interfere with suckling at the breast.
- A cup enables a baby to control his own intake.

Why cup feeding is usually better than feeding with a spoon and cup:

- Spoon feeding takes longer than cup feeding.
- You need three hands to spoon feed: to hold the baby, the cup of milk and the spoon. Mothers often find it difficult, especially at night.
- Some mothers give up spoon feeding before the baby has had enough. Some spoon fed babies do not gain weight well.
- Mothers are more likely to continue with cup feeding.
- However, spoon feeding is safe if a mother prefers it, and if she gives the baby enough. Also, if a baby is very ill, for example with difficult breathing, it is sometimes easier to feed him with a spoon for a short time.

About the volume of breast milk:

- If a mother is expressing more than her baby needs:

  Let her express the second half of the milk from each breast into a different container. Let her offer the second half of the EBM first. Her baby gets more hind milk, which helps him to get the extra energy that he needs. This helps a baby to grow better.

- If a mother can only express very small volumes at first:

Give whatever she can produce to her baby. Even very small amounts help to prevent infection. Help the mother to feel that this small amount is valuable. This helps her confidence, and will help her to produce more milk.

Practical steps to feed a baby by cup

- Hold the baby sitting upright or semi upright on your lap
- Hold the small cup of milk to the baby's lips
- Tip the cup so that the milk just reaches the baby's lips
- The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip
- The baby becomes alert, and opens his mouth and eyes
    - A LBW baby starts to take the milk into his mouth with his tongue
    - A full term or older baby sucks the milk, spilling some of it
- DO NOT POUR the milk into the baby's mouth. Just hold the cup to his lips and let him take it himself
- When the baby has had enough, s/he closes her/his mouth and will not take any more. If s/he has not taken the calculated amount, s/he may take more next time, or you may need to feed her/him more often
- Measure her/his intake over 24hours – not just at each feed.

Feeding a baby by cup

Annex 2: Hand Expression of Breastmilk

Why Hand expression is recommended

- Hand expression is the most useful way to express milk. It needs no appliance, so a woman can do it anywhere, at any time
- It is easy to hand express when the breasts are soft. It is more difficult when the breasts are engorged and tender. So teach a mother how to express her milk in the first or second day after delivery. Do not wait until the third day, when her breasts are full
- **Key point:** *A woman should express her own breast milk.* The breasts are easily hurt if another person tries. If you are showing a woman how to express, show her on your own body as much as possible, while she copies you. If you need to touch her to show her exactly where to press her breast, be very gentle.

How to prepare a container for the expressed breast milk

- Choose a cup, glass, jug or jar with a wide mouth
- Wash the cup in soap and water (She can do this the day before)
- Pour boiling water into the cup, and leave it for a few minutes. Boiling water will kill most of the germs
- When ready to express milk, pour the water out of the cup.

How to express breast milk by hand

Teach a mother to do this herself. Do not express her milk for her. Touch her only to show her what to do, and be gentle. Teach her to:

- Wash her hands thoroughly
- Sit or stand comfortably, and hold the container near her breast
- Put her thumb on her breast ABOVE the nipple and areola, and her first finger on the breast BELOW the nipple and areola, opposite the thumb. She supports the breast with her other fingers (see Figure below)
- Press her thumb and first finger slightly inwards towards the chest wall. She should avoid pressing too far or she may block the milk ducts
- Press her breast behind the nipple and areola between her finger and thumb. She must press on the lactiferous sinuses beneath the areola

  Sometimes in a lactating breast it is possible to feel the sinuses. They are like pads, or peanuts. If she can feel them, she can press on them

- Press and release, press and release

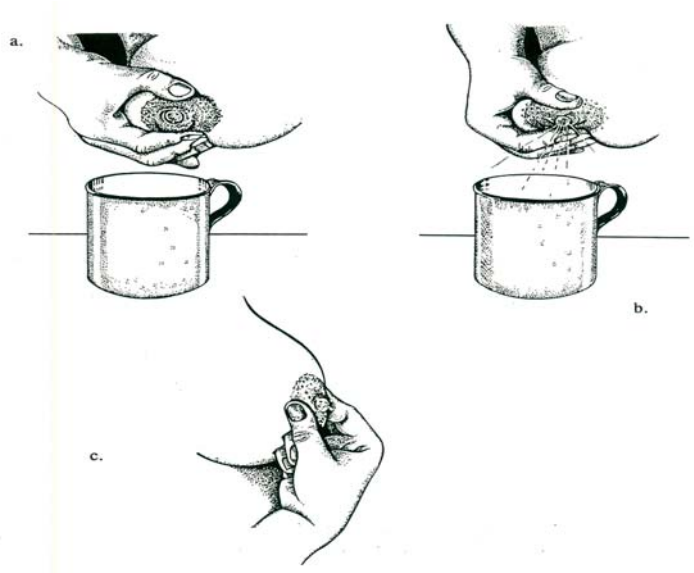
  This should not hurt - if it hurts, the technique is wrong

  At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active

  Press the areola in the same way from the SIDES, to make sure that milk is expressed from all segments of the breast
- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling
- Avoid squeezing the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple
- Express one breast for at least 3 - 5 minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast, or change when they tire
- Explain that to express breastmilk adequately takes 20 - 30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.

How to express breastmilk (Figure)

a. Place finger and thumb each side of the areola and press inwards towards the chest wall
b. Press behind the nipple and areola between your finger and thumb
c. Press from the sides to empty all segments.



Annex 3: BFHI Requirements

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding; Mother to Child Transmission of HIV; Benefits of HIV Voluntary Counselling and Testing; Infant Feeding options for HIV positive women (*ensure that infant feeding options are not discussed in groups*).
4. Help mothers initiate breastfeeding within a half-hour of birth; establish a feeding option chosen by an HIV positive mother and encourage HIV positive women who opt to breastfeed to do so exclusively for the first 3 – 6 months
5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants; for HIV positive mothers who have decided not to breastfeed show them how to prepare appropriate replacement feed of their choice.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated for example infants born to HIV positive mothers who opt not to breastfeed
7. Practice rooming-in – allow mothers and infants to remain together – 24 hours a day. HIV positive mothers who decide not to breastfeed be allowed to room in/bed in without breastfeeding
8. Encourage breastfeeding on demand
9. Do not give artificial teats or pacifiers (also called dummies or soothers) to infants and young children.
10. Ensure that all new born babies delivered in Health Facilities or clinics receive BCG and Polio "O" vaccine before discharge
11. Ensure that all mothers who deliver in Health Facilities or clinics receive 200,000 IU of Vitamin A Capsule before discharge. Non-breastfed infants should receive 50,000IU of Vitamin A before discharge
12. Issue a correctly filled in Child Health Card for each new born to the mother before discharge from the maternity ward
13. Foster the establishment of Community Based Support Groups for optimal Infant and Young Child Feeding and refer mothers to them on discharge from the Health Facility.
14. Support Infant Feeding in the context of HIV
15. Comply with The Food Safety (Marketing of Infant and Young child Foods) Regulations 2005

Annex 4: Summary of the Regulations

SUMMARY OF THE MAIN PROVISIONS OF THE FOOD SAFETY (MARKETING OF INFANT AND YOUNG CHILD FOODS) REGULATIONS 2005

- No advertising of breast milk substitutes and other products to the public.
- No free samples to mothers.
- No promotion in the health service.
- No company personnel to advise mothers.
- No gifts or personal samples to health workers.
- No pictures of infants or other pictures idealizing artificial feeding, on the labels of the products.
- Information to health workers should be scientific and factual.
- Information on artificial feeding, including that on labels, should explain the benefits of breastfeeding and the costs and dangers associated with artificial feeding.
- Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

Annex 5: Maternity Protection Convention

Rights of Working Women to Maternity Protection (MP)

- There is an increasing trend of women's entrance into the formal labour force;
- Women are concentrated in a relatively narrow range of female occupations. Examples are: clerical, manufacturing, service industries and self employment. These jobs command low wages and few rewards

- This increase is due to:
  - Worsening economic situations
  - Changes in Government Policies e.g. restructuring and retrenchment
  - National and international political situation e.g. wars which take away men from families
  - Restructuring of private companies
- The Labour laws have not been fully updated to accommodate the increased women participation and their changing situation. These laws were enacted at the time when women were not very active participants in the labour markets because of culture and low level of education.
- Most Labour laws and Codes are not gender sensitive for example:
  - Women are discriminated against at recruitment or promotion.
  - No equality of opportunity within the workplaces
- Labour laws are supposed to create an enabling environment for working women

Maternity Protection:

- Maternity Protection means protecting the jobs and welfare of working pregnant women, working mothers and their babies, irrespective of their work places.
- Maternity Protection provides the support which women need to help them to harmonize their productive and reproductive lives in a satisfactory way

Importance of Maternity Protection:

- More and more women are spending their child bearing years in active employment
- Many of them are sole bread winners for their families and they cannot afford to lose income when they give birth
- It is the only way that women can be sure that they take time off their work to give birth and care for their infants

- It is therefore important to have adequate National Legislation to ensure that employers give women the necessary paid leave and job security

Elements of Maternity Protection:

- Right to maternity leave
- Right to cash and medical benefits
- Right to social security
- Right to non discrimination
- Right to job security during prescribed periods

Current Conventions related to Maternity Protection

- The International Labour Organization (ILO) adopted the revised MPC 183 and Recommendation 191 in June 2000
- Whereas an ILO Convention is an International Standard which is binding upon all member States once it is ratified, a Recommendation provides guidelines for National Legislation which is enforceable at country level.

Key elements of Convention 183 for women:

- The new Conventions and Recommendations provides several improvements on the previous instruments which include:
- All women are included without any discrimination
- An increase in the minimum length of maternity leave from 12 to 14 weeks
- Six weeks compulsory leave after birth, or according to National law and practice
- Protection of pregnant and lactating women against hazardous occupations
- A woman has the right to one or more daily paid breaks for breastfeeding or a daily reduction of working hours
- The right to return to the same job or equivalent after leave has expired
- Non discrimination on the basis of maternity
- Non-liability of the individual employer to solely bear the costs
- Recommendation 191 advocates:
    - An increase in the length of maternity leave from 14 to 18 weeks;
    - Facilities for breastfeeding at or near the workplace
    - Adoptive parents have the right to maternity leave

Annex 6: Practical Steps to Ensure Appropriate Infant and Young Child Feeding In Emergencies

1. Ensure that action is based on an adequate understanding of the factors affecting infant feeding practices in the specific situation.

- A rapid assessment should be carried out immediately at the onset of the emergency, including information on pre-crisis infant feeding practices and the impact of prevailing conditions on infant and on the ability of mothers to breastfeed and care for children. Where possible, information should be accessed on demographics and numbers of infants, orphans, etc.
- A second stage emergency assessment should be carried out in conjunction with implementation of early relief activities. It should include mobilization of the affected population to participate in problem identification, solution and support; assess resource requirements; and identify mechanisms to actively involve local international partners. The prevalence of malnutrition among infants younger than 6 months should be assessed by their inclusion in nutrition surveys.

2. Create a mechanism for coordinating and monitoring infant feeding activities.

- A lead agency should be nominated to manage infant feeding issues. A framework for action should be agreed upon.
- Representatives of national and international agencies involved in food aid, social services and health/nutrition should meet regularly in a specific forum to address infant feeding issues.
- Monitoring of interventions includes: (1) mortality/morbidity of infants; (2) provision of infant feeding support; (3) procurement, distribution and use of breastmilk substitutes or complementary foods; and (4) quality of infant foods supplied and/ or used by the affected population.
- Include infant feeding issues in initial screening for new arrivals. Information collection on number of infants and unaccompanied infants and infant feeding practices.

3. Eliminate practices that undermine breastfeeding.

- Donations of infant formula and other breastmilk substitutes (BMS) should be systematically refused (i.e. any requirements for BMS should be met by purchasing of supplies).
- Dried milk powder should NEVER be distributed as part of a general ration programme because of the risk that it will be used as a BMS. Rather, it should be mixed with other food (such as blended foods) or provided under strictly supervised wet feeding conditions.
- Bottles and teats should never be accepted or distributed; cups should be used instead.
- Where UHT (Long-life Milk) is distributed, it should be clearly labeled with an appropriate health message.

4. Recognize the special needs of women feeding infants.

- Effective referral systems (e.g. registration, health/nutrition services) should be established at the outset.
- Where appropriate, provide secluded shelter areas for breastfeeding, including rest areas in transit centres.
- Where appropriate, facilitate and prioritize access to food aid, water, etc., for women with infants and young children.
- Provide additional fortified food supplement for pregnant and lactating women and young children.
- Integrate support services for breastfeeding and infant feeding issues into health services, growth monitoring services, unaccompanied children centres and nutrition rehabilitation centres (supplementary and therapeutic).

5. Minimize the dangers in feeding to infants and their families

Certain criteria are met where BMS is provided:

- Infant is assessed by a qualified nutrition or health worker to verify need.
- BMS is distributed and targeted only to infants who have an established requirement.
- The supply is continued as long as the child needs it*.
- The labels must be in a language that the mother understands and must adhere to specific labeling requirements of the International Code of Marketing of Breastmilk Substitutes. This can be achieved by re-labeling brand products or purchasing generically labeled products that display no company logos or advertisements.

- The delivery of BMS to the mother is accompanied by practical information on how to safely prepare the milk (e.g. how to cup feed, how to sterilize).
- There is no display of brand name products.
- BMS are prepared in accordance with the relevant Codex Alimentarius standards.
- Any facility supporting mothers who are unable to breast-feed should provide separate facilities for mothers who are breastfeeding and those who are using BMS.
- Procurement of small amounts of generic BMS (by designated agency) should be made available for specific cases in need.

6. Increase awareness and knowledge about the benefits of breastfeeding among all stakeholders in the emergency situation.

- Expertise should be available as resource for emergency agency staff to gain a better understanding of good practices in infant feeding and to assist agencies in developing strategies to develop good practice.
- Ensure that expertise (preferably national) is available to train health workers and community-based staff in breastfeeding and infant feeding issues to ensure that consistent and well informed advise is given.
- Breastfeeding promotion via health workers and via radio and other media.
- An infant's nutritional needs will be met during the first six months of life with an average daily ration of approximately 110g or 3.3 kg per month, of bona fide infant formula.

Annex 7: The Technical Working Group

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