



COMPENDIUM OF SKILLED BREASTFEEDING COUNSELLING CASE STUDIES

GLOBAL BREASTFEEDING
COLLECTIVE

unicef 

 World Health
Organization

ACKNOWLEDGEMENTS

The compilation of these case studies was coordinated by the Global Breastfeeding Collective task team, listed in alphabetical order: Mona Alsumaie, Jeniece Alvey, Heidy Guzman, Alyssa Klein, Altrena Mukuria, Lesley Oot, Linda Smith and Zion Tankard. The task team received guidance and oversight from The Global Breastfeeding Collective Coordination Committee and Fatmata Fatima Sesay of UNICEF. Editorial support was provided by Julia D'Aloisio and layout was completed by Nona Reuter.

The Global Breastfeeding Collective task team would like to thank the authors of each case study (listed in order of appearance) for responding to the request to share their experiences and programmes to increase access to skilled breastfeeding counselling: Michelle Buckner, Sandra Hoy, Ginette Lafrenière, Mona A. Alsumaie, Fatma Bujarwa, Hector Menendez, Miguel Marroquin, Julia Godinez, Dora Lopez, Nisha Sharma, Mackenzie Green, Atul Upadhyay, Babita Adhikari, Dale Davis, Kimberly Mansen, Kiersten Israel-Ballard, Binh Ta, Duong Vu, Linh Phan, Lesley Oot, Maurice Gerald Zafimanjaka, Manisha Tharaney, Nathalie Likhite and Maria Teresa Hernández-Aguilar.

The case study authors would like to acknowledge the following individuals, representatives, organizations, and institutions for their support in the successful implementation of the programmes described in the case studies: Burkina Faso – the teams from the Ministry of Health (Central Directorates, Health Regions and Districts), UNICEF, Alive & Thrive, and the World Bank; Canada – Kathleen Slofstra, Jennifer Quin, Jacqui Alac and Heidi Blom; Guatemala – Ministry of Health of Guatemala, Da Vinci University and Maggie Fischer; Kenya – Kenya Ministry of Health, Nairobi County, Department of Health, UNICEF Kenya, WHO Kenya Country Office, and Mary Waiyego of Pumwani Maternity Hospital; Kuwait – Nawal Alhamad, Niran Alnaqeeb, Rima Alsawan, Eisa Ahmad and Nawal Alkazemi; Nepal – Maryanne Stone-Jiménez, Sabina Hora, Indu Adhikary, Giriraj Subedi, Krishna Poudel, Ame Stormer, Gary Mundy, Alissa Pries, Elizabeth Zehner and Ellen Piwoz; Spain – Jesús Martín-Calama Valero, Carmen R. Pallás-Alonso, and Juan-Jose Lasarte-Velillas; Viet Nam – Department of Maternal and Child Health, Viet Nam Ministry of Health, Da Nang Hospital for Women and Children, Kalusugan ng Mag-Ina, Inc., Philippines.

CONTENTS

Introduction	5
Acronyms	6
Case study 1a: Peer support: Canada’s Breastfeeding Buddies Programme in Waterloo, Ontario	7
Case study 1b: Counselling in the continuum of care: Skilled breastfeeding counselling in Kuwait	12
Case study 2: Preservice education: Guatemala’s University Technical Midwifery Programme	17
Case study 3: Training in competencies: Lactation management training among nurses in Nepal	21
Case study 4: Skilled care for vulnerable babies and mothers: Kenya’s Mother-Baby Friendly Initiative Plus	26
Case study 5: Baby-friendly Hospital Initiative: Viet Nam’s Centers of Excellence for Breastfeeding	32
Case study 6: Policies and funding: Burkina Faso’s ‘Stronger with Breastmilk Only’ campaign	39
Case study 7: Funding for training: Spain’s national breastfeeding counselling training programme implemented by IHAN	45
Further resources for skilled breastfeeding counselling	50
Endnotes	51

ACRONYMS

A&T – Alive & Thrive

BFB – Breastfeeding Buddies (Waterloo Region, Canada)

BFHI – Baby-friendly Hospital Initiative

COE – Centers of Excellence (Viet Nam)

DHM – Donor human milk

EENC – Early essential newborn care

GDP – Gross domestic product

HMB – Human milk bank

IBCLC – International Board-Certified Lactation Consultants

IHAN – Initiative for a more human birth and lactation care (Spain)

LMICs – Low- and middle-income countries

MBFI+ – Mother-Baby Friendly Initiative Plus

MIYCN – Maternal, Infant and Young Child Nutrition

SSNB – small and sick newborn

TUP – The Midwifery University Technician Programme (Guatemala)

UNICEF – United Nations Children’s Fund

USAID – United States Agency for International Development

WHO – World Health Organization

INTRODUCTION

Breastfeeding is vital to ensuring children around the world have the best start to life. Breastmilk is the ideal food for infants, offering protection against infections and helping to stimulate brain development, while also protecting women’s health. Increasing breastfeeding worldwide to recommended levels would prevent 820,000 child deaths each year.¹ Policies that protect, promote and support breastfeeding not only save lives but can improve health and cognitive development for infants and young children, leading to better learning, educational attainment and productivity, increased household wages and stronger economies.² Despite these benefits, globally, only 49 per cent of infants initiate breastfeeding within the first hour of life³ and only 44 per cent of infants under 6 months of age are exclusively breastfed.⁴

BOX 1

The World Health Organization and UNICEF recommend that infants begin breastfeeding within the first hour of life, breastfeed exclusively for the first six months and continue breastfeeding up to two years or beyond.

The provision of skilled, quality breastfeeding counselling is critical to improving breastfeeding rates. The provision of antenatal and postnatal breastfeeding counselling to mothers and other family members by community health workers, peer-to-peer counsellors, nurses, midwives, lactation counsellors, or other health providers, can increase exclusive breastfeeding by 48 per cent.⁵ Mothers need support, time and space to breastfeed, and the provision of quality breastfeeding counselling throughout pregnancy and the postpartum period are critical to ensuring mothers have the knowledge, skills and confidence to breastfeed.

The Global Breastfeeding Collective has developed an advocacy brief outlining **seven actions** that stakeholders, donors, and governments can take to improve access to skilled breastfeeding counselling. This document is a companion to that brief, providing a compendium of current examples of how individual countries, programmes and initiatives have successfully answered these calls to action and offering practical guidance and recommendations on how others can replicate their success. Eight case studies were selected because they explicitly address a call to action, while also providing a geographically diverse and robust set of examples with learnings that are applicable for audiences around the globe. The table below provides a list of each call to action and the associated case study.

Table 1. Breastfeeding counselling call to action and associated case studies

SKILLED BREASTFEEDING COUNSELLING CALL TO ACTION:	CASE STUDY
<p>1. Provide skilled breastfeeding counselling on a scheduled basis six or more times to all mothers as part of routine health coverage, without extra costs. The counselling should be provided antenatally and throughout at least the first two years of the child’s life. Counselling should be delivered primarily face-to-face, using telephone and other technologies as needed.</p>	<p>Peer support: Canada’s Breastfeeding Buddies Programme in Waterloo Region, Ontario</p> <p>Counselling in the continuum of care: Skilled breastfeeding counselling in Kuwait</p>
<p>2. Include basic breastfeeding education as a regular part of all basic curricula in the training of physicians, midwives, nurses, nutritionists and dietitians. Enhanced education is needed to ensure that all health care providers who are interacting with breastfeeding families are appropriately trained.</p>	<p>Preservice education: Guatemala’s University Technical Midwifery Programme</p>

<p>3. Ensure that training for skilled breastfeeding counselling gives trainees the competencies to anticipate and address important breastfeeding challenges in varying contexts.</p>	<p>Training in competencies: Lactation management training among nurses in Nepal</p>
<p>4. Ensure that at-risk mothers and infants, such as premature and sick newborns, those in under-represented communities, and those in emergency situations, receive equitable provision of skilled breastfeeding counselling and specialized care to adequately address their special needs.</p>	<p>Skilled care for vulnerable babies and mothers: Kenya’s Mother-Baby Friendly Initiative Plus</p>
<p>5. Support implementation of the Baby-friendly Hospital Initiative’s ‘Ten Steps to Successful Breastfeeding’ in all maternity facilities as an important first step in supporting the initiation of breastfeeding.</p>	<p>Baby-friendly Hospital Initiative: Viet Nam’s Centers of Excellence for Breastfeeding</p>
<p>6. Policies must be implemented and funding must be provided to give mothers access to skilled breastfeeding counselling (antenatally and through the first two years of a child’s life) in all situations and among all populations, at no additional cost to families.</p>	<p>Policies and funding: Burkina Faso’s ‘Stronger with Breastmilk Only’ campaign</p>
<p>7. Funding must be provided to support training in breastfeeding counselling for health care professionals, including physicians, nurses, midwives, dietitians, lactation consultants and community-based peer and lay counsellors.</p>	<p>Funding for training: Spain’s national breastfeeding counselling training programme implemented by IHAN</p>

Action 1. Provide skilled breastfeeding counselling on a scheduled basis six or more times to all mothers as part of routine health coverage, without extra costs. The counselling should be provided antenatally and throughout at least the first two years of the child’s life. Counselling should be delivered primarily face-to-face, using telephone and other technologies as needed.

CASE STUDY 1A.

Peer support: Canada’s Breastfeeding Buddies Programme in Waterloo Region, Ontario



INTRODUCTION AND BACKGROUND

Breastfeeding Buddies of Waterloo Region is a community-based peer support breastfeeding programme that has been active in the Waterloo Region of Ontario since 2001. Breastfeeding Buddies (BFB) aims to assist families to meet their breastfeeding goals through feeling connected and supported in their community.

Canada is a high-income country with a large geographic area that is home to about 38 million people.⁶

Waterloo Region, in southwestern Ontario, has a population of about 617,000;⁷ it includes three fast-growing urban cities and is surrounded by rural communities. About one in five residents identify as a ‘visible minority’, including many people of Asian heritage.

Canada has a decentralized, universal, publicly-funded health system. The BFB programme is located within one of the 101 community health centres in the Province of Ontario. These centres are non-profit organizations that deliver primary care services, with a multidisciplinary approach to illness prevention and health promotion, and an emphasis on service integration.

In Ontario, 91.3 per cent of mothers initiate breastfeeding in hospital. At discharge, 56.5 per cent of infants are exclusively breastfeeding, while 28 per cent receive a supplement of infant formula that is not medically indicated.⁸ Waterloo Region has one of the highest rates of breastfeeding initiation in Ontario, at 93 per cent.^{9, 10} However, the most recent data available on longer-term breastfeeding practices for Waterloo Region show that only 33 per cent of babies receive breastmilk exclusively at 6 months of age and that 68 per cent receive any breastmilk.¹¹

Hospital practices, non-medically indicated supplementation, and social determinants of health are common barriers to establishing and maintaining the breastfeeding relationship. In Canada, babies born to white, middle class, educated mothers are most likely to receive breastmilk.¹² This ‘breastmilk inequity’ is a social injustice that has potentially lifelong effects. As such, one of the goals of the BFB programme is to address breastfeeding-related disparities.

OVERVIEW OF THE BFB PROGRAMME

Programme mission and values

BFB is a community-based peer breastfeeding support programme that was initiated by breastfeeding mothers in 2001. It aims to increase the number of families achieving their breastfeeding goals by helping them feel more connected and supported. The programme is guided by a community development approach to breastfeeding support and promotion that is non-judgmental and aims to boost personal self-efficacy and address systemic barriers faced by participants.

The community model: education, support, advocacy and partnerships

BFB is one of the largest peer breastfeeding support initiatives in Canada, with 147 volunteers. Volunteers ('Buddies') are well-trained peers with lived experiences who offer prenatal and postnatal support to women and their families. Buddies facilitate a two-hour prenatal course and families can be matched pre- or post-delivery with a Buddy who has similar experience (e.g., low milk supply, postpartum maternal depression, young motherhood, feeding multiples) for follow-up help. Buddies facilitate free community drop-in breastfeeding cafés. Further, a community breast pump-loaning programme was developed in partnership with a local hospital to allow hospital social workers to refer families facing financial barriers to the BFB programme.

Community education efforts include breastfeeding training sessions for health care partners and non-medical providers, as well as pre-conception university guest lectures and community workshops for families. Advocacy with individual families and within the larger community is built into the BFB educational model, programmes, and roles of staff and volunteers. Staff and volunteers serve as advocates to help families nurse their children while facing challenges in maintaining a breastfeeding relationship. As community leaders in normalizing public breastfeeding, the BFB programme works within community systems to foster change. For example, when a Buddy volunteer was asked to breastfeed in a changeroom at a city swimming pool, the BFB programme advocated for municipal workers to be educated on the right to breastfeed in public. The result was a new municipal breastfeeding policy and training for all municipal employees.

The BFB community model relies on community partnerships to connect with families facing barriers to health, such as organizations serving young families, newcomer and refugee families, and mothers using substances. In 2019, BFB began a pilot programme in partnership with a local hospital, where peers offer non-judgmental bedside breastfeeding support and follow-up support after hospital discharge.

To become a Buddy, a mother must have given her baby human milk for at least 6 months and be passionate about breastfeeding. New Buddies attend a three-day, 18-hour WHO-based peer training and are trained in a person-centred, strengths-based, informed decision-making model. Hospitality and community building is embedded in the model of care, including volunteer training and support that emphasize leadership development and a sense of a team, through monthly meetings, self-care events, and social media connections.

Programme sustainability and growth

BFB began with a series of time limited seed grants. Since 2005, the programme has been supported by a small yearly budget from Region of Waterloo Public Health, which funds a part-time staff coordinator and programme supplies.

In partnership with local university partners, evaluation activities have led to programme improvements and plans for further scale-up. In 2018, BFB secured four years of additional funding from a local private foundation, the Lyle S. Hallman Foundation. With support from the foundation, there are now 2.5 positions, [an interactive website](#) and an in-hospital bedside peer support service, while programme efforts have been scaled up to reach families facing barriers to health care.

RESULTS AND ACHIEVEMENTS

Programme evaluation and research activities are an important component of the BFB programme. An ongoing partnership with universities has been an integral part of programme quality improvement and growth.

Results from a Breastfeeding Buddy perspective

Research partners of BFB conducted interviews with 25 Buddies, many of whom are former participants, who described the value of the BFB programme.

Listening and offering emotional support. By normalizing breastfeeding and encouraging mothers to trust themselves, their bodies and their instincts, Buddies report that mothers have increased confidence and the feeling of being a capable parent. Buddies describe the BFB community as non-judgmental and supportive. As one Buddy explained:

“... these women are in tears...crying on the phone to you and they need to hear something like, ‘hey, you nursed your baby this morning.... you got on the phone with me... you are seeking help. You’re trying.’ As a Buddy, you can give them positive feedback.”

Sharing lived experience: Buddies believe that sharing lived experiences is key for parents to feel comfortable reaching out for help and normalizes their breastfeeding journey. Volunteers spoke about how some participants might feel that their concerns are too small to bother medical professionals but are issues important for self-efficacy.

Fostering knowledge transfer: Buddies remarked about the importance of trusted, evidence-based BFB training and the commitment to current evidence-informed practice that the programme offers its volunteers.

Providing meaningful service: Buddies described the satisfaction they felt in contributing to their community, but also a deeper sense of personal fulfilment and well-being from their service; some volunteers have been involved for more than 10 years. They report that BFB staff are highly invested in volunteer engagement and support.

Building individual and community capacities and connections: Buddies who were former programme participants themselves reported receiving effective help to meet their breastfeeding goals, which in turn motivated them to volunteer. Buddies reported that these connections during the COVID-19 pandemic were invaluable:

“In all honesty, half of the reason that I have stayed sane during COVID-19 is Breastfeeding Buddies meetings. Some of my only actual human connections during all of this COVID have been thanks to Breastfeeding Buddies.”

Building a wide network of community influence: The reach and impact of the programme goes beyond the formal participants; many Buddies are ambassadors for the programme by extending their knowledge and support to the greater community. Volunteers shared that they are known within their own communities as a person who is knowledgeable about breastfeeding; their family, friends, neighbours and co-workers turn to them for breastfeeding support.

Results from participant perspectives

Participant feedback was collected through pre- and post-workshop surveys and from interviews conducted with a group of 20 programme participants in 2015.

Interviews with former participants six weeks after giving birth revealed that participants appreciated that the BFB workshops were free and offered them useful knowledge to build their confidence and capacity. Women struggling with new motherhood and breastfeeding challenges did not always reach out for help. Therefore, the programme shifted to a more assertive approach that actively ‘reached in’ by performing wellness calls to mothers to facilitate the postnatal breastfeeding support pathway.

An analysis of 136 pre- and post-participant surveys from prenatal breastfeeding workshops found significant improvements in the pre- and post-workshop breastfeeding confidence and comfort ratings. After completing the peer-led workshop, participant self-ratings of confidence in their breastfeeding knowledge increased by an average of 65 per cent, self-ratings of their confidence in their future ability to breastfeed increased by 43 per cent, self-ratings of confidence in their ability to solve future breastfeeding problems increased by 60 per cent, self-ratings of comfort feeding their baby increased by 13 per cent, and self-ratings of comfort in breastfeeding in public increased by 20 per cent. Further, 132 out of 136 participants indicated that they were now knowledgeable about where to seek breastfeeding support in the community – a 116 per cent increase after participating in the workshop.

CHALLENGES

The BFB programme has faced four key challenges:

- **Unstable funding and a culture of austerity.** The main programme funding has remained unchanged since its establishment and is vulnerable during a time of continued austerity in public services. Moreover, local health care organizations have let their Baby-friendly Hospital Initiative¹³ (BFHI) accreditation lapse in an effort to cut costs, making the work of BFB more challenging. In general, the Canadian health care system focuses most of its resources on responding to health problems, rather than investing in preventative health efforts.
- **Evidence-based peer breastfeeding support work in a bottle-feeding culture.** Canada does not enforce the WHO Code of Marketing of Breast-milk Substitutes and only a few hospitals have accreditation from the BFHI. Health care providers receive minimal or no training in evidence-based breastfeeding support. For example, many health care providers recommend scheduled feeding to mothers, whereas the BFB programme emphasizes cue-based feeding and responsiveness, which reinforces mothers' confidence and ability to produce enough milk.
- **A community development approach makes waves.** Community development work that emphasizes the lived experiences of mothers often challenges existing power structures and the status quo. For example, helping marginalized mothers, such as refugees, young mothers and those with mental health challenges to meet their breastfeeding goals requires time to build relationships. This work often involves advocating for the importance of the breastfeeding relationship within mainstream systems, such as the child protection system.
- **Pandemic realities and technology:** Programmes shifted online quickly during the COVID-19 pandemic; however, it was challenging for BFB staff to continue providing meaningful breastfeeding support virtually. At the same time, it is anticipated that some BFB services will remain virtual, even as the pandemic subsides, in order to keep them accessible and maintain online presence.

LESSONS LEARNED

There is power in investing in a community of volunteers with lived experiences. A breastfeeding community does not just happen; it takes time, recognition, nurturing and support, but it can be remarkably self-sustaining.

An evidence-informed approach to peer breastfeeding support is essential and increases credibility with partners.

Leadership matters. BFB is led by a staff leader that is committed to transformative, egalitarian servant leadership. A servant leader works to empower and shift influence from herself to those she leads. The BFB programme is currently led by a social worker with experience in community development.

Community partnerships are worth nurturing for collaboration and connecting with a diversity of families and service providers.

Leveraging university partnerships facilitates programme growth and improvement through evaluation, knowledge mobilization and grant writing.

Success cannot be replicated within a bureaucratic, risk averse environment. A community development approach requires responsiveness, flexibility and innovation.

Technologies and adaptations leveraged during the pandemic provided opportunities for growth; for example, the virtual services provided resulted in unforeseen national and international attention and opportunities to collaborate.

Articulating a vision for the future and anticipating new developments are important. BFB has been driven by a vision wherein breastfeeding is supported by the community and the breastfeeding relationship is viewed holistically. BFB's community connections facilitate its ability to anticipate and respond nimbly to relevant new developments. Within this vision, peer support is understood as a key component of developing a breastfeeding relationship using a safe, non-judgmental, and non-medicalized approach that is responsive and relevant to the breastfeeding family. In the words of Penny Van Esterik: *breastfeeding should not be viewed as simply a feeding system that is focused on a product, but a process that requires nurturing and centring.*¹⁴

CONCLUSIONS

To grow and sustain a volunteer programme such as BFB, it is important to:

- Devise mother-friendly volunteer opportunities through flexibility in roles, and including funding for childcare, food and transportation.
- Build and nurture a culture of mutuality, where peers feel they offer meaningful service, receive evidence-based training, and gain a sense of support and fulfilment.
- Employ a model where peers are viewed as capable, recognizing that they offer a unique form of essential support for families that is not a mere add-on to professional support.
- Aim to build capacity, skills and leadership in the community.

A community development approach to peer breastfeeding support emphasizes the importance of relationships, dignity and shared humanity. Community breastfeeding support is not simply health care service provision, but rather a form of community capacity building that involves engaging in efforts to inform, support and advocate for establishing healthy human connections. This form of service can be an act of love that aims to transform a community, one connection at a time.

ADDITIONAL INFORMATION

Authors: Sandra Hoy, Laurentian University; Michelle Buckner, Breastfeeding Buddies of Waterloo Region; Ginette Lafrenière, Wilfrid Laurier University

Programme website: <https://www.breastfeedingbuddies.com/>

Documentary – Weaving Our Common Threads: <https://www.breastfeedingbuddies.com/weaving-our-common-threads/>

Action 1. Provide skilled breastfeeding counselling on a scheduled basis six or more times to all mothers as part of routine health coverage, without extra costs. The counselling should be provided antenatally and throughout at least the first two years of the child’s life. Counselling should be delivered primarily face-to-face, using telephone and other technologies as needed.

CASE STUDY 1B

Counselling in the continuum of care: Skilled breastfeeding counselling in Kuwait

INTRODUCTION AND BACKGROUND

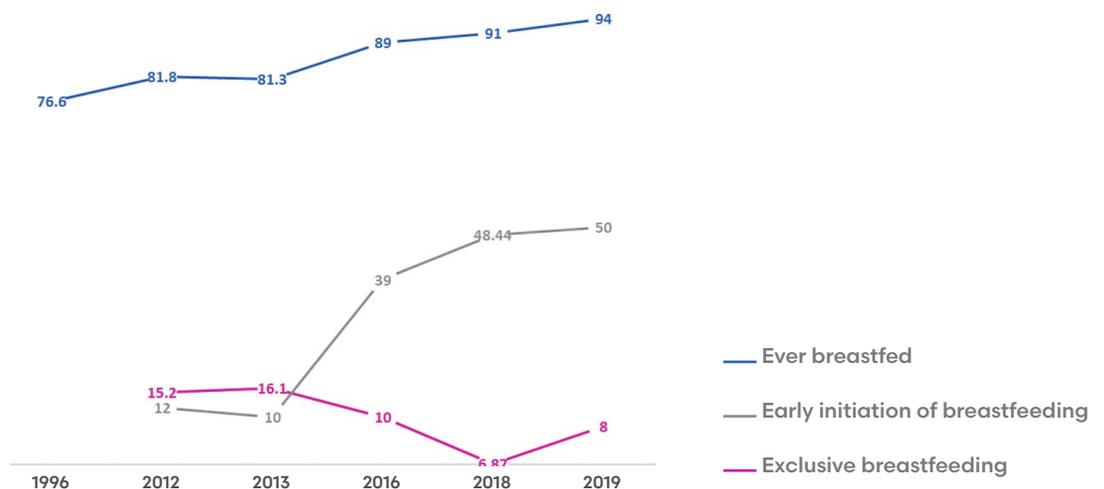
This case study presents Kuwait’s experience in implementing skilled breastfeeding counselling support by well-trained counsellors during the antenatal and postnatal periods. According to 2019 estimates, Kuwait’s total population is 4.2 million.¹⁵ Citizens enjoy a high standard of living that includes free education and medical care. The country’s gross domestic product (GDP) per capita is US\$32,032 (2019). The under-five mortality rate per 1,000 live births is 8 and the life expectancy at birth is 75 years.¹⁶

In 2019, there were 53,565 live births in Kuwait. All deliveries took place at hospitals with the support of skilled attendants. There are four public sector health facilities with maternity services: Maternity Hospital, Farwaniya Hospital, Adan Hospital and Jahra Hospital, with 10,565; 5,846; 5,749 and 3,859 live births respectively. The number of private sector hospitals with maternity services is also growing quickly. To date, 11 private hospitals have maternity services, and in 2019, the majority of births – 36,054 live births – took place in these facilities.^{17, 18}

OVERVIEW OF THE KUWAIT MATERNAL, INFANT AND YOUNG CHILD NUTRITION PROMOTION PROGRAMME

In Kuwait, a breastfeeding promotion programme has been implemented since 1998, with guidance from WHO. A national breastfeeding coordinator was appointed, and a multisectoral Ministry of Health committee was established, including members of different health sectors, to provide information, support and assessment for health facilities working to implement best practices in relation to breastfeeding.

Graph 1:
Trends of Ever breastfed rates, Early initiation of breastfeeding rates and Exclusive breastfeeding rates



The Government of Kuwait developed and launched a **Maternal, Infant and Young Child Nutrition (MIYCN) Strategy** in December 2019, which calls for increasing access to information, guidance and counselling for mothers and caregivers. The MIYCN builds on existing structures and is integrated within the health system, involving partnerships with various sectors and groups. It also leverages existing achievements and provides a framework for action, including measures to prevent the unethical marketing of breastmilk substitutes, to fully implement baby- and mother-friendly practices at health facilities and protect the breastfeeding rights of employed women. As part of the MIYCN Strategy, skilled counselling on infant and young child feeding is delivered by health service providers who are equipped with the knowledge and skills to effectively support mothers. Special emphasis is placed on the protection, promotion and support of infant and young child nutrition when difficult circumstances arise (e.g., premature birth) and during emergency situations (e.g., natural disasters, pandemics, etc.).

Description of the skilled breastfeeding counselling services in Kuwait

The provision of at least six breastfeeding counselling contacts of sufficient quality – beginning in the antenatal period through to the introduction of complementary feeding and beyond – allows for a full range of support to breastfeeding mothers.

The six contacts may occur at the following time points: before birth (antenatal period); during and immediately after birth (perinatal period up to the first 2–3 days after birth); at 1–2 weeks after birth (neonatal period); in the first 3–4 months (early infancy); at 6 months (at the start of complementary feeding); and after 6 months (late infancy and early childhood), with additional contacts as necessary (e.g., when the mother returns to school or work, or anytime that breastfeeding concerns or challenges arise) or when opportunities for breastfeeding counselling occur (such as during child immunization visits).¹⁹

In Kuwait all related contact point services are using consistent messages and materials to support infant and young child feeding, including the use of uniform guidelines, training materials, education sheets and job aids.

The antenatal breastfeeding counselling programme was established and implemented at all public antenatal clinics of the Ministry of Health to raise awareness and educate pregnant women about breastfeeding management. Staff use a tool – the Breastfeeding Education Sheet – to educate pregnant mothers during their routine visits to the clinics. The tool is installed within the electronic file system and includes a monitoring process for evaluating its implementation. In addition, clinic staff receive capacity building sessions about breastfeeding counselling and mother-friendly practices to improve programme implementation.

Postnatal hospital-based counselling services include breastfeeding support clinics and hospital lactation units.

- **Postnatal breastfeeding support clinics** are established and run by International Board-Certified Lactation Consultants (IBCLCs) and/or breastfeeding counsellors at all public hospitals providing maternity services. Post-hospital discharge breastfeeding support services, with skilled follow-up for breastfeeding mothers and their infants, is a critical part of preventing kernicterus, avoiding premature weaning and improving exclusive breastfeeding. As most mothers are sent home from the hospital well before the onset of copious milk production, every mother is assigned a follow-up visit to the postnatal breastfeeding support clinic within the first week postpartum to reinforce previous education and assess milk production. During this visit, mothers are assisted with latching and positioning, educated about milk production and given referrals to community resources, if required.

BOX 2

Skilled breastfeeding counselling services in Kuwait include:

- Ante-natal care clinics at Primary Health Care and at secondary health care facilities,
- Hospital based and Primary Health Care based Breastfeeding Clinics,
- Well Baby Clinics (0-5y) at Primary Health Care,
- Nutrition Clinics at Primary Health Care and hospitals,
- BirthKuwait Community Peer Support Breastfeeding Programme,
- Public Authority for Food and Nutrition Breastfeeding Promotion Team,
- Lactation Consultants Society and Peer Breastfeeding Counselors

Hospital lactation units are available in almost all public hospitals. Lactation units are responsible for:

- *Programme development and administration* – including ensuring that the principles of the BFHI are implemented throughout hospital premises by reviewing and monitoring policies, procedures, documentation, patient information, statistics and quality assurance; and developing a strong, effective relationship with community health care services.
- *Clinical services* – including offering inpatient and outpatient consultations and remote consultations via daily telephone calls, alongside skilled breastfeeding counselling support to mothers during their hospital stay and at discharge. Routine check-ups of baby’s weight and general health, and observation of breastfeeding also occur during scheduled follow-up visits.
- *Education services* – including building the capacities of IBCLCs, nursing and medical students and community health care providers to maintain high standards of care.

Skilled community-based infant and young child feeding counselling services are available to support women as part of primary health care.

- **Breastfeeding support clinics** are walk-in clinics available to mothers in the community established and run by IBCLCs and/or breastfeeding counsellors at six community level primary health care clinics. Professional support is critical in the first few weeks after delivery when lactation is being established.
- **Well-baby clinics** for children aged 0–5 years are run by well-trained family medicine physicians at 45 primary health care centres (about half of all such centres in Kuwait). Physicians provide routine check-ups of children’s health and growth, with particular emphasis on nutrition and health education.
- **Nutrition and dietetics clinics** are available at 30 per cent of the primary health care centres and are run by well-trained dietitians and nutritionists who receive referrals from physicians at primary health care centres. They provide nutrition assessments, dietary plans, behaviour change counselling and regular follow-up for all age groups.

BIRTHKUWAIT BREASTFEEDING SUPPORT HOTLINE

WWW.BIRTHKUWAIT.COM | +965 55241221 | @BIRTHKUWAIT | @BIRTHKUWAITACADEMY

- 1 **Whatsapp:** send us a text describing your concerns .
- 2 Our operator will receive your message and ask you a few questions.
- 3 Your information will be forwarded to one of our Breastfeeding Counselors
- 4 The counselor will contact you from her number within 24 hours .
- 5 You can always contact your assigned counselor for more breastfeeding support

WE WISH YOU A HAPPY BREASTFEEDING EXPERIENCE

BirthKuwait Breastfeeding Support Helpline



Dr. Azar Tolbe, Lactation Unit of Adan Hospital, Kuwait



Ms Noor Zarea, Breastfeeding Support Program of BirthKuwait

Community peer support groups

- BirthKuwait group is a local non-profit community health network mother-to-mother support group, including a breastfeeding support programme established in 2014. The group comprises experienced mothers and passionate health professionals that form a widespread network of trained peer counsellors to work with mothers in the community. The group runs a breastfeeding support hotline, which offers mothers remote support via voice and text message services, home visits, and in-person consultations. They also offer expectant families antenatal and postnatal education via workshops. Through their telehealth-based approach, services are available to all mothers in Kuwait, as well as mothers from outside the country who can access them through an online support service.
- *BirthKuwait* is a recognized breastfeeding support counsellor organization. They meet the criteria established by the International Board of Lactation Consultant Examiners, which states they must provide a structured training programme for counsellors, a Code of Ethics or a Code of Professional Conduct, and structured supervision of their counsellors through a continuing education programme.²⁰

Capacity building and continuing education Nine WHO/UNICEF 40-hour breastfeeding counselling courses have been conducted over six years in English and Arabic. Through these courses, 141 breastfeeding counsellors have been trained (103 based in Kuwait and 38 from Bahrain, Qatar, Oman and Saudi Arabia).

Of those trained, 41 counsellors are active on the breastfeeding support line. They speak six different languages and are located in six countries around the world. To receive support from a counsellor, mothers send a WhatsApp message to the support line's number; an operator will reply and send her a list of intake questions to answer. Once the mother responds to the questions, she is assigned a counsellor who will receive her responses from the operator and contact her to discuss them. Face-to-face counselling may also be offered via home visit or an appointment at BirthKuwait's Centre.

Newly trained counsellors are asked to participate in a mentoring programme arranged by *BirthKuwait*, which enables them to be granted more opportunities to work with *BirthKuwait's* breastfeeding support programme. *BirthKuwait* has conducted 25 free continuing education lectures on relevant topics by local experts. This capacity building process is constantly evolving, aiming to maintain the standard of services and the quality of information provided by the counsellors.

Support for breastfeeding was critical during the COVID-19 pandemic. During the early period of the pandemic, mothers struggled to access support and were more likely to stop breastfeeding. Professional support at health facilities was limited or even cancelled.

However, lactation units managed to re-establish services to maintain breastfeeding support during the pandemic. According to regular audit and continuous monitoring data collection from hospitals, the number of mothers who visited and directly breastfed their babies at the neonatal intensive care unit during the COVID-19 pandemic increased steadily after the significant drop-in visits at the start of pandemic.

Taking full COVID-19 precautions, the lactation team makes daily rounds to assess all breastfeeding mothers during their hospital stay and before discharge. A follow-up appointment is offered within a week, and high-risk mothers who do not attend are called back. Mothers at the COVID-postnatal wards are supported to express their breastmilk regularly, store it, and send it to their babies at the neonatal intensive care unit. Lactation unit staff also provide support to mothers at lactation clinics and by phone.

RESULTS AND ACHIEVEMENTS

The range of skilled counselling services provided to mothers and babies in Kuwait – from pregnancy through to the child's first years of life – provide a critical foundation for starting and maintaining the breastfeeding relationship. Investments in building the capacities of health staff have been critical to providing women with the skilled support they need.

Over the past two decades, breastfeeding rates have increased among Kuwaiti mothers. The rate of children ever breastfed increased from 76.6 per cent in 1996 to 94 per cent in 2019. Similarly, the rate of breastfeeding initiation within one hour of birth increased from 10 per cent in 2013 to almost 50 per cent in 2019. However, rates of exclusive breastfeeding remain low at 7.83 per cent, based on the 2019 report, presenting a significant challenge.²¹

CHALLENGES

The budget allocated to the breastfeeding promotion programme is often limited and unclear. The Ministry of Health usually directs its budget to the management of diseases, rather than to investments in health promotion and prevention programmes. This has contributed to a slow implementation process and insufficient capacity building.

Lack of human resources, staff reluctance and insufficient support from leadership within the Ministry of Health were major challenges that led to some delays in programme implementation. Yet these challenges were largely overcome through effective local ownership at hospital and community levels, and the passion and enthusiasm of staff.

LESSONS LEARNED

The integration of skilled behaviour change counselling and support to mothers at all points of contact during pregnancy and through the first two years of life is key to improving breastfeeding practices and increasing breastfeeding rates.

Consistent messages and materials must be used at all points of contact, including antenatal care clinics, delivery care, postnatal care, breastfeeding clinics, nutrition support clinics and well-baby clinics to support mothers, infants and young children.

Hospitals that develop a strong effective lactation programme, including a lactation-specific counselling component, will contribute to the long-term impact on breastfeeding promotion and support in the country, leading to improved health for mothers, infants, and children.

Peer support groups represent a culturally competent way to promote and support breastfeeding for women of varying backgrounds, especially where professional breastfeeding support is not widely available.

CONCLUSIONS

- Appropriate feeding practices to protect infants from both undernutrition and overnutrition, depend on accurate information and skilled support from the health care system and the community.
- Breastfeeding counselling should be provided at least six times, and additionally as needed, through face-to-face counselling and telephone or other remote modes of counselling.
- Skilled infant feeding counselling should be provided as part of the continuum of care and delivered by trained health care providers and community peer support breastfeeding counsellors, with a mechanism to monitor and supervise support activities at all levels.
- The capacity building process at health care services and community peer support levels should be constantly evolving and updated to maintain the standards and quality of services provided.
- Indicators for monitoring and evaluating trends should be incorporated into existing health information systems for every contact point to ensure high standards of care, with outcome and impact indicators included in national surveys.

ADDITIONAL INFORMATION

Authors: Mona A. Alsumaia, Public Authority for Food and Nutrition; and Fatma Bujarwa, Kuwait University

Action 2: Include basic breastfeeding education as a regular part of all basic curricula in the training of physicians, midwives, nurses, nutritionists and dietitians. Enhanced education is needed to ensure that all health care providers who are interacting with breastfeeding families are appropriately trained.

CASE STUDY 2.

Preservice education: Guatemala's University Technical Midwifery Programme

INTRODUCTION AND BACKGROUND

Skilled attendance during pregnancy, childbirth and the postpartum period is key for mothers and their babies. The role of skilled attendants in reducing risks during pregnancy has been recognized jointly by WHO, the International Confederation of Midwives and the International Federation of Gynaecology and Obstetrics.²²

Based on the need to increase the numbers of skilled health personnel in Guatemala, United States Agency for International Development (USAID) supported the Ministry of Health to design and implement the Midwifery University Technician Programme (TUP, in Spanish) to support increased demand for health care services.²³ The TUP programme was implemented in 2018 in Huehuetenango Department by the private 'Universidad Da Vinci'²⁴ and took a comprehensive approach to sexual and reproductive care, counselling, research, education and human rights. Academic training and professional duties include essential newborn care and breastfeeding as a high-impact nutrition-specific intervention for preventing malnutrition.

Maternal mortality and stunting are the main public health issues in Guatemala, a country with one of the highest maternal mortality ratios in the Latin America and Caribbean. Only 65 per cent of deliveries are attended in health facilities and there are significant inequities between regions. In rural areas, where most indigenous women live, only 50 per cent of women have deliveries supported by a skilled attendant in health facilities, while the other 50 per cent receive care at home by traditional birth attendants.²⁵

Although Guatemala ranks as a middle-income country, 59 per cent of people live in poverty. Huehuetenango has approximately 1.17 million people, 74 per cent of whom live in poverty.²⁶ Of these, 69 per cent are part of the Mayan indigenous population. The maternal mortality ratio of Huehuetenango is 221 per 100,000 live births, the highest in the country.²⁷ In Guatemala, 63 per cent of newborns begin breastfeeding during the first hour of life, 53 per cent are exclusively breastfed and 57 per cent continue breastfeeding until 24 months of age.²⁸

The epidemiological surveillance on health and nutrition conducted in Huehuetenango in 2018 shows that 52 per cent of newborns initiate breastfeeding during the first hour of life, 39 per cent are exclusively breastfed, 76 per cent of children aged 12–15 months continue breastfeeding. Huehuetenango has a 69 per cent stunting prevalence in children under 5 years of age.²⁹

The protection, promotion and support of early, exclusive, and continued breastfeeding is fundamental to preventing malnutrition – and health professionals, including midwives, have an important role to play.

OVERVIEW OF THE TUP PROGRAMME

In response to the need for more skilled health personnel in the country, and given the scarcity of human resources for health in rural areas, USAID Guatemala has been supporting the Ministry of Health to design and implement the TUP programme. Young indigenous women are invited to participate through a selection process. Students speak local languages and know the sociocultural context where they will eventually be working; they receive a scholarship from the Ministry of Health to pay the university costs and the Ministry commits to hiring them after graduation to work in the health system.

One of the TUP programme's specific objectives is to develop knowledge, skills and attitudes to improve care and education for women related to pregnancy and delivery, newborn care, and services for the family and the community. During the three-year programme, students receive theoretical and clinical practice support and develop skills on the social, epidemiological, and cultural context of maternal and newborn care.

Programme competencies related to breastfeeding and nutrition knowledge and skills include:

- Knowledge, skills and attitudes related to counselling and health education.
- Pre-conception period: Nutrition for women of reproductive age and adolescents.
- Antenatal period: Maternal and child nutrition; fetal growth monitoring; counselling on exclusive breastfeeding, continued breastfeeding and complementary feeding.
- Labour and delivery: Hydration and nutrition; umbilical cord care; early attachment of the newborn; and early initiation of breastfeeding.
- Postpartum period: Lactation physiology; importance of early, exclusive, and continued breastfeeding for mother and the child and common challenges; expressing and storing breastmilk; management of complications including mastitis and anaemia; and maternal nutrition, rest, and physical activity.
- Newborn nutrition: Characteristics of low birthweight and preterm newborns and their special nutritional needs; normal growth, development; nutritional requirements from birth to age 2 years; options for feeding; and importance of early skin-to-skin contact.

This curriculum was developed with technical assistance from expert midwives and teachers from the Peruvian San Martin de Porres University, given the sociocultural and multi-ethnic similarities that exist between Guatemala and Peru, the expertise gained by this university for more than 100 years, and the existing evidence regarding the recommendations for breastfeeding and newborn care. As of August 2021, 33 students have graduated from the TUP programme, and 161 students are currently participating in the programme with support from the Ministry of Health.

RESULTS AND ACHIEVEMENTS

A survey was conducted using open questions to assess student experiences in the TUP programme. Questions addressing theoretical learning and clinical practice on skilled counselling for breastfeeding promotion were sent to eight recently graduated midwives and 81 students from the TUP programme.

These questions addressed:

- Results achieved in learning about breastfeeding counselling, including what worked well and the reasons for achieving success;
- Opportunities and how they could be leveraged in implementing breastfeeding counselling;
- Barriers to breastfeeding counselling and how they could be solved;
- Lessons learned during their learning process on breastfeeding counselling;
- Recommendations for improving breastfeeding counselling.

When interviewed about the most important theoretical topics they had put into action during their clinical practice, 40 per cent said they could explain the benefits of breastfeeding to mothers in simple words, in their maternal language. A similar percentage said that the most important topic was the knowledge gained by mothers on the benefits of breastfeeding, including those related to child health and nutrition and economic savings. More than one fourth said that the most relevant topics of their learning included applying appropriate positions for a greater latch and suction of the babies. One fifth said that they received the most comprehensive learning when they combined theory with practice.

Students identified the following as the most important topics to discuss for a successful counselling session: the benefits of exclusive breastfeeding, the nutritional value of breastmilk and colostrum, the importance of early breastfeeding, and the early attachment of the newborn with his/her mother. Nearly 20 per cent of students reported that they were satisfied when they observed mothers putting their new knowledge into practice (especially first-time mothers) and when they could clarify some doubts from mothers on the breastfeeding process.

Students reported different opportunities they use to deliver breastfeeding counselling: 30 per cent said they provide counselling during home visits and antenatal visits; 38 per cent provide counselling during the childbirth event and the immediate postpartum period, emphasizing latching technique and appropriate positions for successful breastfeeding. About 10 per cent of students reported that they provide counselling when mothers take their children for vaccination, while others said that they talk to their pregnant relatives or neighbours about the importance of breastfeeding.

CHALLENGES

The survey revealed several challenges:

- **The language spoken by the patient.** Language was a frequent barrier, reported by almost one third of students. Five different languages are spoken in Huehuetenango and although students are requested to speak at least one local language (plus Spanish), they must sometimes deliver counselling to women who speak a different language. One fifth of students noted difficulty in translating messages because of the mother's low level of education.
- **Myths about breastfeeding.** The survey revealed: misperceptions about the lack of nutritional value of colostrum; beliefs that formula was more nutritious than breastmilk; and the belief that multiparous mothers cannot produce milk of good quality and quantity.
- **Lack of time and support.** Further barriers leading to unsuccessful breastfeeding included lack of time for working mothers, especially for those living in urban areas; lack of knowledge on proper positions for breastfeeding; lack of family support; lack of knowledge about how to manage cracked nipples; and the COVID-19 pandemic (e.g., service disruptions, fear of infection, curfews, job losses and mobility restrictions). One fifth of students recognized that mothers lack knowledge on the importance of breastfeeding, and that skilled counselling is necessary.

LESSONS LEARNED

Breastfeeding messages delivered via counselling must emphasize: the importance of breastfeeding for mother and child; early initiation of breastfeeding and attachment; exclusive breastfeeding; complementary feeding beginning at 6 months of age; the adoption of appropriate positions; avoidance of breastmilk substitutes or other liquids; breastfeeding on-demand; and the uptake of nutritious and balanced food and good hydration by the mother, even during labour.

Illustrative teaching materials, including videos produced by TUP students, should be disseminated in public spaces and display promotional posters in pharmacies.

Counselling must be delivered in the patient's mother-tongue in a simple, clear and respectful way to generate confidence and empathy between the counsellor and the user.

Counselling must engage families, especially husbands, whose emotional support is important. Communities can also be engaged to help address myths and misperceptions.

Students must constantly update and deepen their knowledge to deliver better counselling. Social and media communication networks are useful tools for promoting breastfeeding through advertising campaigns.

The curriculum theory and clinical components of breastfeeding counselling in the TUP programme must continuously be strengthened. This requires improving teaching processes at community and family level to tackle myths and misperceptions within the population.

Traditional birth attendants should also be trained to support breastfeeding, particularly given the high proportion of home deliveries. In addition, staff in health facilities need to be trained to support the practice of the early attachment and breastfeeding within the first hour of life.

The dissemination of teaching messages to the general population is necessary to increase awareness of breastfeeding benefits.

CONCLUSIONS

The perceptions of the TUP programme's students in Huehuetenango demonstrate that skilled breastfeeding counselling requires consideration of the social and cultural contexts in which such counselling is delivered. Drawing from the successes, barriers, challenges and lessons learned by participating students, the theoretical and the clinical practice content of the programme should be further strengthened. This includes implementing culturally adapted illustrative teaching materials, communicating with users in their maternal language, engaging families in counselling, updating training for traditional birth attendants and health facility personnel and diffusing teaching messages to the general population.

ADDITIONAL INFORMATION

Authors: Hector Menendez (USAID Guatemala); Miguel Marroquin (Jhpiego); Julia Godinez (Universidad Da Vinci); and Dora Lopez (Jhpiego)

Website: <https://udv.edu.gt/carrera/tecnico-en-parteria/>

Action 3. Ensure that training for skilled breastfeeding counselling gives trainees the competencies to anticipate and address important breastfeeding challenges in varying contexts.

CASE STUDY 3.

Training in competencies: Lactation management training among nurses in Nepal

INTRODUCTION AND BACKGROUND

This case study describes the development and roll-out of an evidence-based training package for health facility staff in Nepal, including achievements in improving the breastfeeding counselling and support provided by nurses.

Nepal is a landlocked country in South Asia. With an annual growth rate of 1.8 per cent, the total population of the country in 2019 was 28.6 million. Nepal is ranked 147 out of 189 countries in the Human Development Index. Economic growth, as measured by GDP, is 7.1 per cent per year.¹ Child health and nutrition status is fragile in Nepal. Although child mortality has decreased over time, 1 in every 24 children in Nepal does not survive to his or her first birthday and 1 in every 23 children does not celebrate his or her fifth birthday.² Half of all deaths in children under age 5 in the country can be attributed to malnutrition.²

Breastfeeding is a culturally common practice in the country and almost all infants (98 per cent) are breastfed at some point.² However, exclusive breastfeeding is decreasing. The Nepal Demographic and Health Survey data showed a 12 per cent decline in exclusive breastfeeding, from 75 per cent in 1996 to 66 per cent in 2016.² Data also showed that 45 per cent of newborns were not breastfed within an hour of birth. A population-based study revealed that 26.5 per cent of newborns received prelacteal feeds and milk other than breastmilk in Nepal; infant formula was the most common prelacteal fed to the newborns.³

While counselling and support provided by health workers to mothers play an important role in influencing breastfeeding practices, these services are missed by many mothers due to inadequate antenatal care visits and lack of institutional delivery. The 2016 Nepal Demographic and Health Survey revealed that 31 per cent of mothers did not have the recommended number of antenatal care visits (at least four) and only 57 per cent of mothers had an institutional delivery. Province 3, including Kathmandu Valley, had institutional delivery rates higher than the national average, at 71 per cent.

OVERVIEW OF THE LACTATION MANAGEMENT TRAINING PROGRAMME

An effort to improve health worker training on breastfeeding

The lactation management training programme was developed in response to research conducted on the breastfeeding support provided in health facilities. Helen Keller International's 'Assessment and Research on Child Feeding' (ARCH) project partnered with the Child Health Division of the Ministry of Health and Population in Nepal in 2013 to conduct a study⁴ in Kathmandu Valley hospital. Key findings are presented in Table 2.

The study reported that mothers were 16.7 times more likely to use infant formula if they received a recommendation from health workers. Furthermore, the study reported high rates of caesarean delivery (29.3 per cent), and mothers who had caesarean delivery were almost nine times more likely to give their newborns prelacteals compared to mothers who had a vaginal delivery.

Table 2. Breastfeeding practices among mothers delivered in Kathmandu Valley hospitals⁴

Immediate skin-to-skin contact with newborns after birth	9 per cent
Early initiation of breastfeeding	41 per cent
Provided newborn infant formula within three days of birth	56 per cent
Mothers recommended by health workers to use infant formula	48 per cent

In 2015, service delivery practices were assessed in maternity and neonatal wards to understand why delayed initiation of breastfeeding and prelacteal use of infant formula were high in these hospitals. Findings showed that doctors and nurses lacked the knowledge and skills to help mothers initiate breastfeeding, particularly for caesarean births. They were unaware that early initiation of breastfeeding after caesarean birth was feasible and lacked the skills needed to help with positioning and attachment after these deliveries. Furthermore, mothers and newborns were separated after caesarean sections for up to 24 hours and newborns were supplemented with infant formula.

The assessment also uncovered misperceptions among nurses, which led them to recommend infant formula. Nurses often believed that mothers had no or low milk production in the first few days after birth and that the amount of milk (colostrum) produced was insufficient for the newborn. Subsequently, they advised the use of infant formula to reduce the risk of hypoglycaemia and dehydration. They reported advising mothers to use infant formula when newborns cried, believing that newborns cry from hunger. The assessment found that both doctors and nurses recommended infant formula without justifying their advice on acceptable medical conditions for formula use. This was a violation of the Government’s Mother’s Milk Substitute (Control of Sale and Distribution) Act,³⁰ which adopted the International Code of Marketing of Breast-milk Substitutes into national policy; however, doctors and nurses had no awareness of the Act.

In response to these findings, the Child Health Division of the Ministry of Health and Population suggested that Helen Keller International develop and introduce a lactation management training package³¹ in the 10 Kathmandu Valley hospitals to equip nurses with up-to-date knowledge and skills to improve breastfeeding support among mothers in maternity and neonatal wards. These hospitals included public and private facilities and covered more than 90 per cent of facility-based births in the Valley. Maternity and neonatal nurses were targeted as the key front-line service providers with the most interaction with mothers; indeed, the 2013 Kathmandu Valley study showed that 81 per cent of the recommendations for infant formula originated with these nurses.³²



A training participant practices counselling new mothers during hospital practicum.

Designing the lactation management training programme

In coordination with the Child Health Division, a training curriculum for nurses was designed using the WHO and UNICEF Infant and Young Child Feeding training package,³³ and contextualized based on the 2013 and 2015 assessments. The gaps identified in the knowledge and skills of nurses helped reflect practical problems they faced in their day-to-day work. Local experts were consulted – including paediatricians, obstetricians/gynaecologists, nurses and public health professionals – to review and adapt the package for the Nepalese context.

A three-day training curriculum was developed, focusing on the mother-newborn dyad in an early postpartum hospital setting. The curriculum addressed the common misperceptions found among health workers, with sessions on the amount of milk sufficient for the baby, cues to identify a hungry baby, and signs to determine whether milk is sufficient for the baby. Diagrams illustrated optimal breastfeeding positions for caesarean births and a session was included to equip nurses with skills and knowledge to enable early initiation of breastfeeding for mothers who had caesarean births. A mnemonic approach, GALIDRAA³⁴ (greet, ask, listen, identify, recommend, agree and appoint), was included to equip health workers with skills on counselling and negotiating with mothers. The curriculum included a session on the Mother's Milk Substitute Act to educate staff on the national legislation. The training package was designed to be participatory and employed a variety of training methods, including oral and visual presentations, demonstrations, case studies and role plays. A hospital-based practice session was included to enhance nurses' confidence in their ability to perform the targeted skills while practising in a real-life work setting.

The Child Health Division finalized and endorsed the curriculum and 47 master trainers were trained to conduct the sessions for nurses. Master trainers included senior health workers from the participating hospitals. Trainers were oriented on the curriculum and equipped with skills in effective training methodologies and counselling.

The plan was to train all nurses working in maternity and neonatal wards of the 10 hospitals. Over a two-month period in 2015, master trainers rolled out 24 batches of training covering the 10 Kathmandu Valley hospitals and training 575 nurses altogether. Pre- and post-tests were administered at the beginning and end of each training batch, enabling master trainers to clarify any confusion or gaps in meeting teaching objectives.



A woman demonstrates the recommended breastfeeding positioning for caesarean birth. The illustration is intended to address the misconception among health workers that early breastfeeding is not possible for caesarean births.

RESULTS AND ACHIEVEMENTS

In January 2016, three months after the completion of the training, Helen Keller International conducted follow-up visits to each participating hospital and interviewed doctors and nurses from maternity and neonatal wards on current breastfeeding support and use of prelacteal feeds. The interview methods used provided a lower cost means of evaluating changes in the training of health workers (in terms of funds, staff time and study duration) than interviews with mothers. Interviews relied on self-reported information from hospital staff.

Throughout the interviews, nurses shared how they were doing things differently. They described improvements in their counselling and support to mothers on good positioning, attachment and encouraging frequent suckling to increase milk secretion. Nurses reported corrections to their own misperceptions since the training; for example, many now avoided recommending infant formula after learning about the amount of milk sufficient for the newborn in the first few days after birth. They also shared their understanding that crying was not always related to hunger or insufficient milk, and that they were now more careful to assess the underlying reasons for crying and advise mothers accordingly. Doctors confirmed that the training motivated nurses to encourage breastfeeding and avoid infant formula.

The management of caesarean births also improved. Nurses reported that the training helped them understand that it is feasible for a mother to give her newborn her own milk as a first feed after a caesarean birth and many were taking steps to support early initiation with these mothers. A doctor shared that nurses were being sought to provide support for initiating breastfeeding inside operation theatres. One of the participating hospitals had even created a separate, small, post-operative ward for caesarean births to allow mother-newborn dyads to remain together, facilitating breastfeeding during recovery.

All participants reported being aware of the Mother's Milk Substitute Act because of the training, and frequently noted being mindful of the consequences of violating the Act. Doctors and nurses shared that they were limiting their recommendations for the use of infant formula to only medically needed cases; nurses reported they were no longer recommending infant formula on their own.

CHALLENGES

After completion of the master training in March 2015, an earthquake struck the country in April 2015, causing thousands of casualties and massive infrastructure destruction. Training was postponed after the earthquake, as master trainers prioritized clinical services and were unable to commit time to training. Helen Keller International continued to coordinate with health facilities and assured them that a safe place would be arranged to hold the training. A second round of master training was conducted in June 2015 and rolled out in August 2015.

LESSONS LEARNED

Acceptability of the training was achieved by tailoring the curriculum to address the practical knowledge and skill gaps among health workers that were identified in the health facility assessment. Country-specific evidence helped convince health facility leaders who were initially hesitant about the need for additional training, believing that the benefits of breastfeeding and how to support breastfeeding were already widely known among their staff.

Accountability is achieved by involving health facilities from planning to execution of the training. Engaging hospital leaders in the planning and scheduling of the training built accountability for the improvements and helped allocate the needed time and resources. This ensured the full participation of nurses and cultivated a willingness to embrace new content and service delivery practices. Some hospitals were motivated to go even further, making structural changes to the management of caesarean deliveries to support early breastfeeding. Additionally, government ownership and endorsement of the curriculum helped to improve accountability.

Smooth execution of such a large-scale training programme with full participation was possible through frequent communication and follow-up with the health facilities.

Sustainability of the training, often a concern for one-time trainings, can be achieved by working with master trainers from the facility. This allows master trainers to plan and facilitate future training in their hospitals and support nurses with optimal breastfeeding recommendations.

CONCLUSION

The evidence-based lactation management training package has great potential for educating and motivating nurses to improve their performance in supporting optimal breastfeeding in hospitals. Lactation management training has the potential to improve optimal breastfeeding practices in hospitals elsewhere, with a training package adapted to the geographic and cultural context.

Gathering evidence on the local context is effective in convincing government and health facilities to adopt training and to contextualize the curriculum, which in turn increases the acceptability of the training by participants. Further, partnering with the government in designing and developing the training package increases its acceptability among national stakeholders.

Health facilities should be engaged from the start to facilitate a smooth implementation of the programme and foster ownership. It is also important to plan for sustainability early on, including by training health facility staff as a master trainers to allow the programme to be housed within the facility. Future lactation management training programmes would benefit from using a short survey to assess changes in participants' skills and knowledge during training and post-training. A more independent evaluation using surveys of mothers' experiences would be useful to document the impact of the training on hospital practices.

CONTACT INFORMATION

Authors: Nisha Sharma, Helen Keller International, Nepal; Mackenzie Green, Helen Keller International, Cambodia; Atul Upadhyay, Helen Keller International, Nepal; Babita Adhikari, Helen Keller International, Nepal; and Dale Davis, Helen Keller International, Nepal.

Website: <https://archnutrition.org/>

Lactation management training resources: <https://archnutrition.org/?s=Lactation+Management+Training>

Action 4. Ensure that at-risk mothers and infants, such as premature and sick newborns, those in under-represented communities, and those in emergency situations, receive equitable provision of skilled breastfeeding counselling and specialized care to adequately address their special needs.

CASE STUDY 4.

Skilled care for vulnerable babies and mothers: Kenya's Mother-Baby Friendly Initiative Plus

INTRODUCTION AND BACKGROUND

Each year, approximately 2.5 million newborns around the world die during the first 28 days of life.³⁵ More than 98 per cent of these deaths occur in low- and middle-income countries (LMICs).^{36,37} Those at greatest risk of death are small and sick newborns (SSNBs), defined as infants born preterm (<37 weeks gestation), small for gestational age, low birthweight (<2,500g), suffering an illness from a birth complication and requiring hospitalization.³⁸

Global efforts are under way to establish context-specific data and evidence to guide the scale-up of high-quality care for SSNBs, including the 2019 'Survive and Thrive: Transforming Care for Every Small and Sick Newborn', and the 2020 'Standards for Improving the Quality of Care for Small and Sick Newborns in Health Facilities', which calls for improved care for SSNBs in LMICs.^{39,40} Although support for breastfeeding and the use of human milk are noted as the best practice in these guidelines, detailed operationalization guidance is lacking on how to ensure optimal human milk diets for SSNBs through the provision of skilled breastfeeding counselling for mothers.

SSNBs face unique challenges in accessing human milk. Despite evidence supporting the role of breastfeeding in newborn survival, significant and unique challenges can impact the provision of human milk for feeding SSNBs.⁴¹ Unlike healthy term infants, who can typically be put directly to the breast to feed within the first hour post-birth, a SSNB may have difficulty at the breast due to immature or delayed neurocognitive capabilities.^{42,43} Challenges for the mother can also arise that impact lactation, such as birth complications, maternal stress or restrictive neonatal intensive care unit visitation policies. Routine breastfeeding promotion and lactation support designed for mothers of healthy, term infants are insufficient; targeted, skilled lactation support and interventions that are specific to mothers and their SSNBs are essential for optimal newborn nutrition and health.



County Innovation Challenge Fund,
adapted from Evidence Brief:
Helping Babies Thrive: Establishing
the first Integrated Human Milk
Bank in Kenya, 2020

A key component of providing skilled lactation support for mothers of SSNBs is making appropriate alternatives available to be used as a bridge when the mother's own milk is not available, or when her milk supply is increasing during the first few days of her child's life. An estimated 40 per cent of vulnerable infants in neonatal intensive care unit settings lack sufficient milk from their mothers for either a limited period during the first hours or days after birth, or longer-term.⁴⁴ WHO guidelines on optimal feeding of low birthweight infants prioritize the mother's own milk as optimal and also state that when mother's milk is not possible, provision of safe donor human milk (DHM) from a human milk bank (HMB) is the preferred alternative to preterm or standard infant formula.⁴⁵

A HMB is a service established to recruit breastmilk donors, collect donated milk, and pasteurize, screen, store and distribute safe DHM to meet infants' specific needs and achieve optimal health.⁴⁶ Most SSNBs, who have the greatest need for DHM, reside in LMICs.⁴⁷ Yet paradoxically, the estimated 800,000 infants who receive DHM each year (from more than 750 HMBs in 66 countries), are in high-income settings.⁴⁸ Equitable access is lacking, in part, due to the lack of comprehensive global standards for guiding safety, quality and ethical use of DHM, as well as the paucity of LMIC-appropriate models linking DHM with breastfeeding promotion.⁴⁹

OVERVIEW OF THE MOTHER-BABY FRIENDLY INITIATIVE PLUS

This case study highlights the experience of implementing Mother-Baby Friendly Initiative Plus (MBFI+), a programme for providing improved lactation support for vulnerable mother-infant dyads on the newborn unit, including using DHM from a HMB as a breastfeeding promotion effort. The *plus* in the acronym indicates the inclusion of a HMB.

Kenya was an optimal site for the introduction of the MBFI+ model, given the level of ownership demonstrated by the Ministry of Health in seeking to expand its newborn nutrition services and ongoing Baby-friendly Hospital and Community Initiatives. In response to slow declines in the neonatal mortality rate in the country,⁵⁰ the Government of Kenya had also prioritized breastfeeding as a core intervention to address neonatal and infant morbidity and mortality.

With this commitment from the Government, exclusive breastfeeding rates in Kenya have seen dramatic increases over the last two decades. In 2014, the rate of exclusive breastfeeding reached 61 per cent in infants under 6 months of age, from only 32 per cent in 2008.^{51, 52} Early initiation of breastfeeding remains low, with only 62 per cent of infants being put to the breast within the first hour of life.⁵³ For the most vulnerable of infants, skilled lactation support for ensuring early initiation and provision of human milk is essential for optimal newborn health, a primary aspect of the MBFI+ programme.



Celebration for the launch of the first Human Milk Bank in Kenya. Photo: © PATH.

The MBFI+ approach

This MBFI+ approach is in line with the Global Breastfeeding Collective's call to action to ensure that at-risk mothers and infants, such as premature and sick newborns, those in under-represented communities, and those in emergency situations, receive equitable provision of skilled breastfeeding counselling and specialized care to adequately address their special needs. The MBFI+ model focuses on provision of enhanced lactation support for all mothers with inpatient infants, especially premature babies and SSNBs.

A unique aspect of the MBFI+ is the integration of a HMB service directly within the newborn unit to provide DHM as a bridge while the mother's own milk is increasing; this helps ensure an exclusively human milk diet for the most vulnerable infants. Like Brazil, where the world's largest network of nationalized, integrated HMBs exist (locally referred to as 'Houses of Lactation', since their focus is on lactation support),⁵⁴ the MBFI+ HMBs serve as a pivotal hub for lactation support and care, which are often lacking in newborn critical care units. This platform offers enhanced lactation support in a separate nearby space to the newborn unit; coaching on best practices in milk expression, hygiene and breastmilk storage; access to breast pumps when needed; and services for mothers with excess milk to donate their surplus for infants in need.

Data show that the cycle of donation and use of DHM, combined with enhanced lactation care, effectively protects, promotes and supports breastfeeding by allowing all infants to receive human milk. It also creates an in-hospital environment that values human milk, increasing exclusive breastfeeding.⁵⁵ In addition to being encouraged to express breastmilk for their infants, mothers are supported in achieving direct breastfeeding at the breast by the time of their infant's discharge. Trained staff, including nurses, provide individualized lactation care to identify and respond to challenges.

MBFI+ implementation in Kenya

The MBFI+ model was piloted from 2016–2019 at Pumwani Maternity Hospital, an obstetric and referral hospital in Nairobi, through a purpose-driven partnership between the National Ministry of Health and Nairobi County Department of Health. The hospital serves around 80 deliveries per day, and 400 neonates per month, with upwards of 30 per cent of them born preterm. Building on a long-time trusted partnership with the Kenya Ministry of Health, a County Innovation Challenge Fund award through a UKAid support mechanism (from January 2016–March 2019) helped to carry this pilot to fruition, establishing the first HMB in the region as part of an MBFI+ approach.

Following the PATH implementation model for sustainability, a phased approach was employed, as shown in Figure 3. The first phase fostered local ownership through formative research to determine public perceptions of the use of DHM.⁵⁶ This formative research, which was conducted prior to MBFI+ implementation, revealed positive attitudes towards donating and using DHM, and identified concerns related to health, safety, and cultural and social factors in its use. Furthermore, a needs assessment conducted at four health facilities, including a nearby hospital, Kenyatta National Hospital, showed that 45 per cent of infants were separated from their mother for the first hour to 6 hours of birth, resulting in 36 per cent of infants not being fed during that time, and 22 per cent receiving formula.⁵⁷ These data, aside from confirming the need to implement the MBFI+ approach, helped to further shape and inform how the MBFI+ model was implemented in Kenya.

Learning exchanges and technical trainings also took place in South Africa and Scotland in 2016 and 2018 to allow policy, clinical and programme staff to learn from these countries' experiences in HMB operation and connection with lactation support. Phase II operationalized the model by involving multidisciplinary experts, including those in nursing and clinical leadership, microbiology, policy, infection control and nutrition, in the creation and review of

BOX 3

Partners critical to the establishment and launch of the MBFI+ programme in Kenya:

- National Ministry of Health; Nutrition and Child Health
- Nairobi County
- Pumwani Maternity Hospital
- PATH
- Africa Population Health research Centre
- United Kingdom Department for International Development
- Country Innovation Challenge Fund – KPMG and Options Consultancy Services
- World Health Organization
- UNICEF

the Kenya Human Milk Banking Guidelines and facility-based standard operating procedures to ensure safety and quality, through the Hazard Analysis and Critical Control Point (HACCP), a food-systems based quality assurance method.

In-depth MBFI+ training was held prior to the launch of the milk bank to train clinical staff to provide breastfeeding promotion and lactation support across maternity and newborn units, to prepare multidisciplinary staff for participation in the HMB, and to prevent the overuse of DHM through a decision-tree model emphasizing processes to protect the use of mother's own milk.⁵⁸ This training included adaptation of the PATH 'Resource Toolkit for Establishing and Integrating Human Milk Bank Programs'.^{59, 60} In addition, a mentorship and training visit was also provided by staff from the Glasgow Human Milk Bank as part of the learning exchange. These phases were essential for safety, quality and achieving the long-term goal of exclusive human milk use in the ward.

Figure 3. Phases and key steps to establishing the MBFI+ model in Kenya⁶¹



The MBFI+ model was officially launched in March 2019. Since then, key activities for maintaining this integrated system have included an endline evaluation and routine audits as a quality improvement approach.

Enhanced focus for providing specialized lactation support

Strengthening systems to provide specialized lactation support as part of routine neonatal care was paramount to MBFI+. Establishing and operationalizing critical linkages between child health, newborn care and nutrition was necessary, bringing together teams from the Ministry of Health, hospital, WHO and UNICEF. Importantly, the multidisciplinary technical working group that oversaw and advised this project included dieticians and experts in lactation counselling. As a centralized hub in the neonatal unit for lactation support, the HMB provided a setting for training on and access to breast pumps for mothers who were dependent on milk expression to establish and maintain lactation. Additionally, in the neonatal unit, group counselling on optimal breastfeeding and lactation practices helped mothers address breastfeeding difficulties and provided training on how to establish an effective breastmilk supply. Individual counselling was provided by neonatal nurses and HMB staff where specialized attention was needed, including demonstrating milk expression techniques, assisting with positioning and latch, and ensuring optimal milk supply through frequent and thorough breast expression. As a part of overall quality assurance, a standard operating procedure was developed to guide and monitor hygienic milk expression and support.

RESULTS AND ACHIEVEMENTS

Between April 2019 and March 2020, the MBFI+ programme realized important achievements: 8,912 mothers were provided with breastfeeding counselling in the neonatal ward; 1,402 were supported to express milk; 605 milk donors were screened; 491 milk donors provided milk to the HMB (at least once); 224.2 litres of milk were donated; 145 litres of milk were distributed (57 litres were discarded due to initial challenges with microbiology assays); and 138 vulnerable infants received DHM. Additionally, 113 hospital staff participated in training sessions.

Mixed methods baseline and endline studies were conducted in October 2018 and September 2019 respectively (around the launch of the HMB, in March of 2019), to document the impact on feeding practices, and the acceptability and feasibility of the HMB implementation. Postnatal ward surveys included 531 and 560 mother-newborn pairs at baseline and endline, respectively. Newborn unit surveys included 123 and 116 newborns at baseline and endline, respectively. Qualitative data were collected through 19 key informant interviews, 11 in-depth interviews, and 5 focus group discussions with health care workers and mother/caregivers. Key findings include significant improvement in the proportion of infants fed human milk as the first feed and that maintaining operational safety of the HMB was feasible. Data suggest that an integrated model with lactation support positively impacts breastfeeding when implemented comprehensively. Importantly, provision of DHM displaced formula; it did not displace mothers' own milk. These data are being prepared for publication.

CHALLENGES

Several challenges arose throughout the initial implementation:

- **Leadership changes across the health system.** During the pilot programme timeline, changes occurred within the hospital administration, county health leadership and at the Ministry of Health. While this caused slight delays and varying degrees of leadership buy-in, continued overarching support remained for moving the programme forward due to early investments in building trust and local ownership.
- **Implementation challenges.** The microbiology lab lacked adequate resources and equipment to perform donor serological and DHM screening assays in a timely manner. However, infrastructure and equipment upgrades were eventually acquired, resulting in overall improvements to microbiology systems that benefited the entire hospital. Finally, HMB equipment, such as the DHM pasteurizer, was not immediately available in the region, requiring international procurement and importing. Complications with customs caused unforeseen delays with procurement and operations. Future exploration of best practices in supply chain and procurement will be important for new settings seeking to open HMBs.
- **Mentorship, quality improvement and evaluation.** While these had been planned by PATH, the COVID-19 pandemic impacted funder priorities and programme support ended unexpectedly in March 2020. Since that time, the hospital and county have taken full ownership of the HMB. Throughout the COVID-19 pandemic, HMB services have continued despite the staffing limitations and competing priorities that have challenged existing services.

LESSONS LEARNED

Kenya's pilot of the MBFI+ model, with integration of a HMB, may serve as a centre of excellence and training model for other hospitals who serve SSNBs in Kenya or in other countries of East Africa and beyond. In the absence of global implementation guidance for integrating HMB services, exemplar programmes such as the Kenya MBFI+ programme serve as a model for improving newborn nutrition in other LMIC settings.

A phased approach ensures a solid foundation for the establishment of HMBs by fostering ownership, building capacity, evaluating impact and integrating HMBs into nutrition and newborn care systems.

An integrated model ensures that breastfeeding promotion and skilled lactation support go hand-in-hand with provision of DHM to those without access or with insufficient access to their own breastmilk.

Continuous quality improvement and mentorship are essential in ensuring provision of specialized lactation support and safe quality DHM.

Provision of DHM is feasible in LMIC settings when systems are established that are context-specific, with local ownership and a solid foundation built on formative assessments to determine readiness and acceptability.

CONCLUSIONS

There remains a vital gap in operationalizing systems for achieving exclusive human milk diets for vulnerable newborns in LMIC settings. Rigorous newborn nutrition models of care, which ensure lactation is supported through skilled, trained staff, are needed to effectively address the complex and unique needs of mothers with SSNBs.

With the recent launch of the WHO 'Standards for Improving the Quality of Care for Small and Sick Newborns in Health Facilities', it is essential that nutrition and lactation play a central role in implementation models. However, further implementation science is needed to identify and document best practices for LMIC contexts. While the HMB serves as an essential bridge while a mother's own milk supply is being established, it is not the sole solution for optimal nutrition. Rather, integrated programmes that optimize support for maternal lactation and optimal newborn feeding, while providing appropriate and life-saving alternatives to meet the needs of SSNBs, are essential to further reduce the burden of neonatal mortality and morbidity.

ADDITIONAL INFORMATION

Authors: Kimberly Mansen, PATH; Kiersten Israel-Ballard, PATH.

Programme web page: <https://www.path.org/programs/maternal-newborn-child-health-and-nutrition/increasing-access-and-intake-human-milk/>

Resource Toolkit for Establishing and Integrating Human Milk Banks: <https://www.path.org/programs/maternal-newborn-child-health-and-nutrition/strengthening-human-milk-banking-resource-toolkit/>

Evidence brief on MBFI+ in Kenya: https://options.co.uk/sites/default/files/helping_babies_thrive_hmb.pdf

Action 5. Support implementation of the Baby-friendly Hospital Initiative’s ‘Ten Steps to Successful Breastfeeding’ in all maternity facilities as an important first step in supporting the initiation of breastfeeding.

CASE STUDY 5.

Baby-friendly Hospital Initiative: Viet Nam’s Centers of Excellence for Breastfeeding

INTRODUCTION AND BACKGROUND

Viet Nam, a lower-middle-income country of around 95 million people, has made significant economic progress over the past 30 years.⁶² The country has heavily invested in its health infrastructure, resulting in improved utilization of health services and improved health and nutrition outcomes. As of 2014, 94 per cent of women reported giving birth in a health facility⁶³ and currently more than 87 per cent of the population has access to universal health coverage.⁶⁴ In addition, Viet Nam has made commitments to improving maternal, infant, and young child nutrition over the past decade, enacting legislation that is supportive of breastfeeding (see Box 4). Despite significant improvements over the past decade, breastfeeding practices remain below optimal levels; around 45 per cent of infants under 6 months of age are exclusively breastfed and only about 26 per cent of infants continue breastfeeding until 2 years of age and beyond.⁶⁵ While most women give birth in health facilities, only 0.4 per cent of births occur in baby-friendly⁶⁶ hospitals or maternities that promote the Ten Steps to Successful Breastfeeding.⁶⁷

OVERVIEW OF THE PROGRAMME AND INITIATIVE

Since 2014, Viet Nam has been implementing early essential newborn care (EENC) services in maternity hospitals⁶⁸ to improve childbirth and newborn care, but the coverage and quality of services provided have been inadequate.⁶⁹ In 2018, WHO and UNICEF provided updated BFHI global guidance and guidelines, asking countries to integrate the BFHI into their existing national health care systems to improve access and coverage. However, individual countries are encouraged to develop their own approaches to operationalizing this recommendation.

In 2018, the Alive & Thrive (A&T) initiative⁷⁰ began working with the Government of Viet Nam to revise the national BFHI implementation strategy and design and implement a new approach that would integrate BFHI into the existing national system and improve EENC and BFHI services across the country. The strategy would call for the creation of Centers of Excellence for Breastfeeding (COE) across Viet Nam. The COE initiative does not replace the existing BFHI system within Viet Nam, but rather builds off the existing BFHI structure, providing both current BFHI and non-BFHI hospitals the chance to enroll in the initiative and incorporate a performance-based model to guide implementation of BFHI services. The COE model supports implementation of the Ten Steps to Successful Breastfeeding by providing hospitals with additional guidance, tools and

BOX 4

Supportive breastfeeding policy environment:

Government Decree No. 100 (2014).

Regulates the trade and use of breastmilk substitutes, feeding bottles and artificial pacifiers for young children.

Ministry of Health’s Decision No. 4673 (2014) and 6734 (2016).

Approves the guidelines for maternal and early essential newborn care during and after birth (for vaginal and caesarean deliveries).

Ministry of Health’s Decision No. 6858 (2016).

Issues the National Hospital Standards and Accreditation that institutionalizes the Baby-friendly Hospital Initiative’s 10 Steps to Successful Breastfeeding.

Ministry of Health’s Circular No. 38 (2016).

Promotes breastfeeding in health facilities and designates baby-friendly hospitals.

assessments to support improved programme implementation and sustained change (see Table 3). The COE initiative was officially launched in January 2019 with 28 private and public hospitals across eight provinces enrolled.⁷¹

Table 3. Comparing Centers of Excellence for Breastfeeding and the BFHI

AREAS OF COMPARISON	BFHI	COE
Use of EENC clinical observation checklists	No	Yes
Use of exit interviews with mothers	Yes	Yes
Use of phone surveys with mothers after hospital discharge	No	Yes
Requirement to achieve Grade 4 in Criteria E1.3 of Viet Nam’s National Hospital Quality Standards ⁷²	Yes	Yes
Reassessment after designation	n/a	Yes
Number of assessments for designation	1	2–3 times

BOX 5

COE evaluation and accreditation criteria

Hospitals are designated as COE if they meet the following criteria:

- Criterion 1: Achieve a Grade 4 or higher in the Criterion E1.3 (on breastfeeding), as stipulated in the National Hospital Standards and Accreditation.**
- Criteria 2: Pass the eight checklists⁷³ for breastfeeding support and EENC though an external assessment conducted by the Ministry or Department of Health and independent assessor.**
- Criterion 3: Receive positive feedback from quarterly mother’s experience surveys⁷⁴ that are conducted via mobile phone with mothers after hospital discharge.**



A&T took the following steps to help the Government implement COEs in Viet Nam:

Step 1. Developed and obtained Government agreement on the COE designation criteria and evaluation and accreditation process – Building upon the legal framework described in Box 4, A&T worked with the Ministry of Health to develop the process for evaluating COEs across the country, based on the country’s national hospital quality and accreditation standards (see Box 5). After eight months of implementation, in August 2019, the Ministry of Health approved the guidelines for COE designation criteria and accreditation process, providing the legal foundation to implement COEs nationwide (termed Decision 3451/QD-BYT). Once a hospital meets the accreditation requirements, it can then be designated a COE. Central hospitals are accredited by the Ministry of Health, and provincial and district hospitals are accredited by the provincial Department of Health.

Step 2. Developed tools and materials– A&T created a full package of resources to help hospitals reach the COE designation, including tools to assess and monitor progress adapted from the WHO’s EENC tools (see step 1), communication products (e.g., posters, education and promotional videos⁷⁵) and coaching materials.

Step 3. Asked hospitals to join the COE initiative – A&T created a strategy to generate demand for the COE initiative and worked with the Ministry of Health and Department of Health to identify champion hospitals that would be interested in enrolling in the COE initiative. Next, A&T reached out to at least two to three hospitals in each of the provinces where it works, asking them to enroll in the COE initiative to generate healthy competition among hospitals. The goal is to ensure equitable access to COEs across Viet Nam, engaging with at least one provincial hospital and one district hospital per province. To encourage enrollment, A&T promoted the following benefits to hospitals joining the initiative:

- **Technical assistance to improve breastfeeding support practices.** A&T helped to establish the Da Nang L&R Centre for Newborn Care and Human Milk and train master trainers to provide sustainable technical assistance to hospitals. Each hospital forms a group of 10–15 master trainers who are head doctors, head midwives and head nurses from the delivery ward, operation room, postpartum ward, neonatal department, quality control department and nursing department. Coaching is conducted at the delivery ward and is simulation-based. Hospitals typically complete three courses: 1) early essential newborn care for breathing and non-breathing babies; 2) breastfeeding counselling; and 3) family-friendly childbirth room, restricted episiotomy and caesarean sections policy.



- **Public recognition and wide dissemination of COE status.** Following COE designation, hospitals receive a recognizable signboard with a logo for public display. Their accreditation is published in the media and on breastfeeding community social media platforms.
- **Timely feedback from mothers and families to facilitate performance improvement.** A key to ensuring high-quality services and hospital adherence to COE criteria is the use of a quarterly feedback survey (the mothers' experience survey), that is provided to mothers once they are discharged from the hospital.⁷⁶ The survey provides hospitals with disaggregated data by vaginal and caesarean sections, term versus full-term birth, and childbirth versus postpartum ward. This means that hospital managers can locate where EENC guidelines were not followed and where violations of the International Code of Marketing of Breast-milk Substitutes were most present. Hospitals are not only provided with data on their own performance over time, but also comparison data with peer hospitals in the same province. This helps to stimulate healthy competition between hospitals and improve breastfeeding support for mothers.

Step 4. Helped hospitals achieve COE status – After enrollment in the COE initiative, A&T helped hospitals adjust their service delivery to achieve the established COE criteria. Support included expert observations, coaching and supportive supervision to achieve improved performance on key performance- and output-based indicators (see Box 6). Interactive and practical on-the-job coaching is a key part of the COE initiative that helps hospital staff identify gaps in practices and make improvements. Hospitals that do not reach these benchmarks receive additional coaching and support from A&T and the Da Nang L&R Centre for Newborn Care and Human Milk to create a performance improvement plan that addresses gaps and barriers to optimal performance.

Step 5. Created a continuous monitoring process to ensure compliance and adherence to COE criterion – Lastly, A&T and the Ministry of Health created a long-term monitoring plan to ensure hospitals continue to meet the high-quality standards expected of a COE. Hospitals are required to do an annual internal assessment, and external evaluations will continue quarterly through the mothers' experience surveys as well as every five years through an assessment conducted by the Ministry of Health or Department of Health⁷⁷. Hospitals must continue to meet COE criteria or their designation can be revoked.

BOX 6

COE Performance Indicators::

- At least 80 per cent of mothers receive comprehensive breastfeeding counselling.
- At least 90 per cent of mothers report exclusively breastfeeding during their hospital stay.
- At least 80 per cent of mothers with vaginal births and 50 per cent of mothers with caesarean births receive prolonged skin-to-skin contact for at least 90 minutes and practice early initiation of breastfeeding.
- At least 95 per cent of mothers who had vaginal births report being able to room-in with their newborns.
- Adherence to national legislation on the International Code of Marketing of Breast-Milk Substitutes – meaning no Code violations.

RESULTS AND ACHIEVEMENTS

The COE approach is being successfully replicated across the country: As of March 2021, 56 hospitals across 12 provinces were enrolled in the COE initiative, up from 28 hospitals in 8 provinces 18 months previously. A total of 21 hospitals are considered COE and 35 are working towards accreditation.

The Government of Viet Nam is committed to continuing the COE initiative: Three out of the eight provinces involved in the COE initiative have committed local government funding to continue the initiative. Furthermore, the monitoring plan of the Prime Minister's National Nutrition Programme for first 1,000 days of life sets the target of having 50 per cent of health facilities designated as COE by 2025 and 70 per cent by 2030.⁷⁸

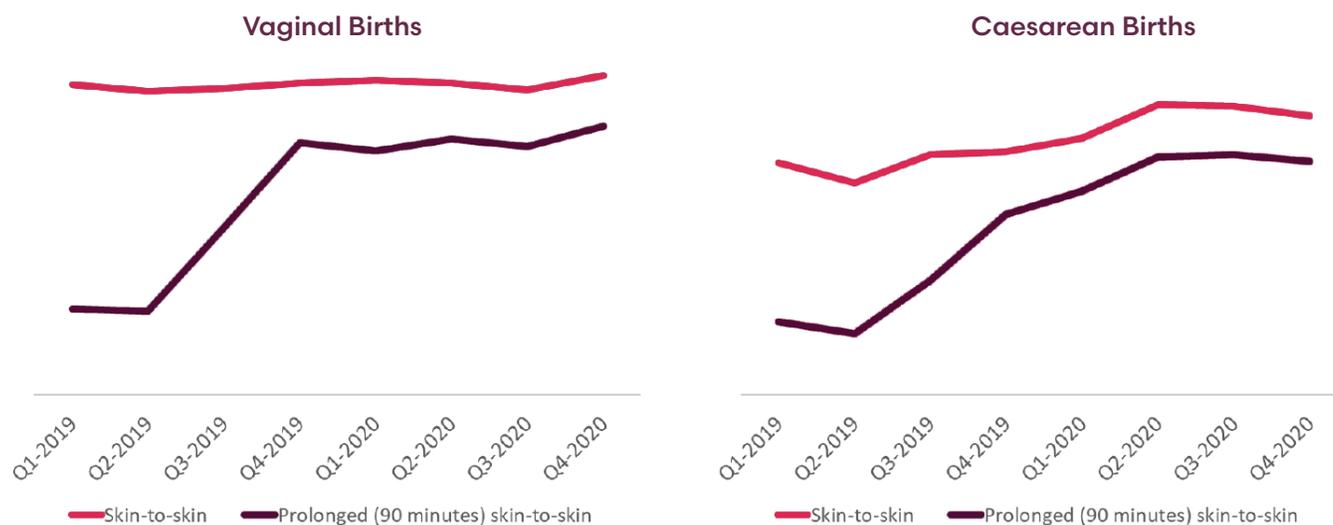
The initiative has a sustainable monitoring system: The system developed for the mothers' experience survey and used in more than 1,200 hospitals nationwide has been transferred to the Ministry of Health to maintain.

The initiative has resulted in a cadre of COE experts: More than 600 master trainers (doctors, nurses and midwives) have been

coached on how to provide quality breastfeeding counselling services, newborn care, and family-friendly birth services.

The performance of key breastfeeding indicators improved: Data from the mothers’ experience survey between the first quarter (Q1) of 2019 (the start of the initiative) and the fourth quarter (Q4) of 2020 show improvements in prolonged skin-to-skin contact. As shown in Figure 4, prolonged skin-to-skin contact increased from 41 per cent to 86 per cent among vaginal births and from 38 per cent to 78 per cent among caesarean births.

Figure 4. Prolonged skin-to-skin (vaginal and caesarean births)



The mothers’ experience survey also shows increases in key COE indicators over 24 months of implementation from Q1 of 2019 through Q4 of 2020, including early initiation of breastfeeding, exclusive breastfeeding, the provision of breastfeeding counselling, and mothers rooming-in with their newborn infants (Table 4).

Table 4. Progress among key COE indicators

INDICATOR	VAGINAL BIRTH		CAESAREAN BIRTH	
	2019 Q1	2020 Q4	2019 Q1	2020 Q4
Early initiation of breastfeeding	81%	94%	71%	90%
Exclusive breastfeeding during hospital stay	66%	87%	60%	80%
Breastfeeding counselling	87%	97%	87%	98%
Rooming-in	97%	99%	83%	89%

Lastly, violations of the International Code of Marketing of Breast-milk Substitutes were monitored through the mothers’ experience survey. The advice to use infant formula declined substantially, from 13 per cent in Q1 2019 to 1 per cent by Q2 of 2020. There was a slight increase in Q3 2020 to 4 per cent, which may have been related to the COVID-19 pandemic, but the prevalence dropped down to 0.3 per cent in Q4 2020. The survey found that other Code violations also declined, from 9 per cent in Q1 2019 to 0.6 per cent in Q4 2020.

Overall, a study on the first 28 hospitals enrolled in the COE initiative found that enrollment was associated with a 6 percentage-point increase in the level of early initiation of breastfeeding, which continued to increase in the post-enrollment period, and a 5 percentage-point increase in the level of exclusive breastfeeding during hospital stay.⁷⁹

CHALLENGES

- **Lack of resources and buy-in from key hospital officials can impede reaching COE status.** Some hospitals face barriers to reaching COE status, citing staff turnover, lack of human and other resources, and insufficient staff buy-in and support to reach COE status. To counter these barriers, A&T offered learning visits from other hospitals, coaching, and improved training and supportive supervision. Resistance to the COE approach by some hospital leaders and other staff illustrates the importance of generating political will and leveraging COE champions within each hospital.
- **The COE monitoring checklists, while robust, are unable to monitor the provision of continuous breastfeeding support following discharge from hospital.** While the COE approach ensures hospitals provide initial breastfeeding support, there is no additional monitoring after discharge. Links to breastfeeding support following hospital discharge are key to facilitate continued breastfeeding. To address this gap, A&T has also been working with the Little Sun Franchise⁸⁰ (a social franchise model for delivering counselling services on infant and young child feeding in Viet Nam) to ensure mothers receive breastfeeding support during pregnancy, postpartum, and well-child visits.

LESSONS LEARNED

Engagement with the Ministry of Health and Department of Health throughout the process fostered government buy-in and was critical to ensuring the integration of the COE into the existing health system. Ministry of Health engagement in the design, implementation, assessment and funding of the COE approach was critical. A&T facilitated this relationship by hosting quarterly meetings and sharing annual and biannual evaluation reports to update the progress of COE implementation, share lessons learned, and illustrate the impact of COE on breastfeeding and key neonatal health outcomes.

Engagement with the breastfeeding community builds trust. A&T engaged breastfeeding mothers throughout the COE conceptualization and implementation process by consulting with the administrators of Betibuti, a public breastfeeding community on Facebook with more than 260,000 members. This helped to create trust in the COE designation process, and the group felt comfortable promoting COE hospitals to families. This type of support, in turn, encouraged hospitals to continue evaluating and improving their service provision.

Demand creation is essential to successful uptake. A&T created demand for the COE 'brand' by associating the COE title with high-quality care and improved outcomes for babies and mothers. Effective coaching and supervision helped to improve service provision and the mothers' experience survey provided hospitals with cost-effective data for improving the hospital's services and increasing demand for services. A&T's recognition and broadcasting of a hospital's COE status in both traditional and social media further helped to create demand for the COE brand. A&T utilized these demand generation activities and the competitive health care marketplace to attract more hospitals to the initiative.



Continued internal and external monitoring are critical for establishing and maintaining COE status. The mothers' experience survey provided hospitals with a real-time monitoring system to both empower mothers and allow hospitals to monitor the services they are providing. Surveys allow hospitals to see improvement in health outcomes for mothers and newborns, further incentivizing hospitals to continue their new practices. In addition, the external assessment that occurs every five years helps to keep hospitals accountable and ensure they maintain the high COE standards. These two additions, the mothers' experience survey and continued external monitoring, differentiate the COE model from the original national BFHI model and promote accountability, self-improvement and sustainability.

In the context of COVID-19 travel restrictions, when traditional on-site monitoring could not be conducted, the mothers' experience survey, conducted by phone, allowed COEs to measure performance in real-time. Despite the Viet Nam Ministry of Health's interim COVID-19 guidelines (which stipulate immediate separation, no skin-to-skin contact, and no direct breastfeeding for suspected or confirmed COVID-19 cases⁸¹), a phone survey of mothers who sought care at 28 hospitals enrolled in the COE initiative showed that hospitals have maintained good practices of EENC and breastfeeding support. As shown in Figure 4, the rate of prolonged skin-to-skin contact still improved dramatically during the peak months of the COVID-19 epidemic.

Hospitals need sustainable sources of technical assistance. A&T helped establish the Da Nang L&R Centre, a unit based in the Da Nang Hospital for Women and Children that provides hospitals enrolled in the COE initiative with technical support, including the COE assessments and learning exchange visits for hospitals. The Da Nang L&R Centre and master trainers within Viet Nam provide a sustainable source of technical assistance to hospitals enrolled in the COE that will continue to provide support after A&T's departure.

A&T used lessons learned from implementing the COE approach in Viet Nam to begin replicating the model within three additional countries in the region: Cambodia, Lao People's Democratic Republic and Myanmar, as well as in several countries in West Africa. Although the process for creating COEs may differ according to the country context, the core principles – engagement with the government, establishing clear designation criteria, and developing a robust user-centered monitoring system – remain constant.

CONCLUSIONS

A&T offered the following reflections for those considering establishing a similar programme:

- Engage with the government throughout the process to ensure buy-in and support.
- Integrate the initiative within the national health system and ensure alignment with national hospital quality standards.
- Develop clear strategies and tools to assess and monitor service provision and COE status.
- Document and share successes to create recognition and demand for high-quality services.
- Ensure sustainable sources of technical assistance and funding for the initiative.

ADDITIONAL INFORMATION

Authors: Binh Ta, A&T; Duong Vu, A&T; Linh Phan, A&T; and Lesley Oot, A&T.

Viet Nam Centers of Excellence for Breastfeeding website: <https://www.aliveandthrive.org/how-we-work/centers-of-excellence-for-breastfeeding/>

COE overview: [CoE-BF-Brief_ENG_19.8.2019.pdf \(aliveandthrive.org\)](#)

COE FAQ: [coe-faq_final.pdf \(aliveandthrive.org\)](#)

Action 6. Policies must be implemented and funding must be provided to give mothers access to skilled breastfeeding counselling (antenatally and through the first two years of a child’s life) in all situations and among all populations, at no additional cost to families.

CASE STUDY 6.

Policies and funding: Burkina Faso’s ‘Stronger with Breastmilk Only’ campaign

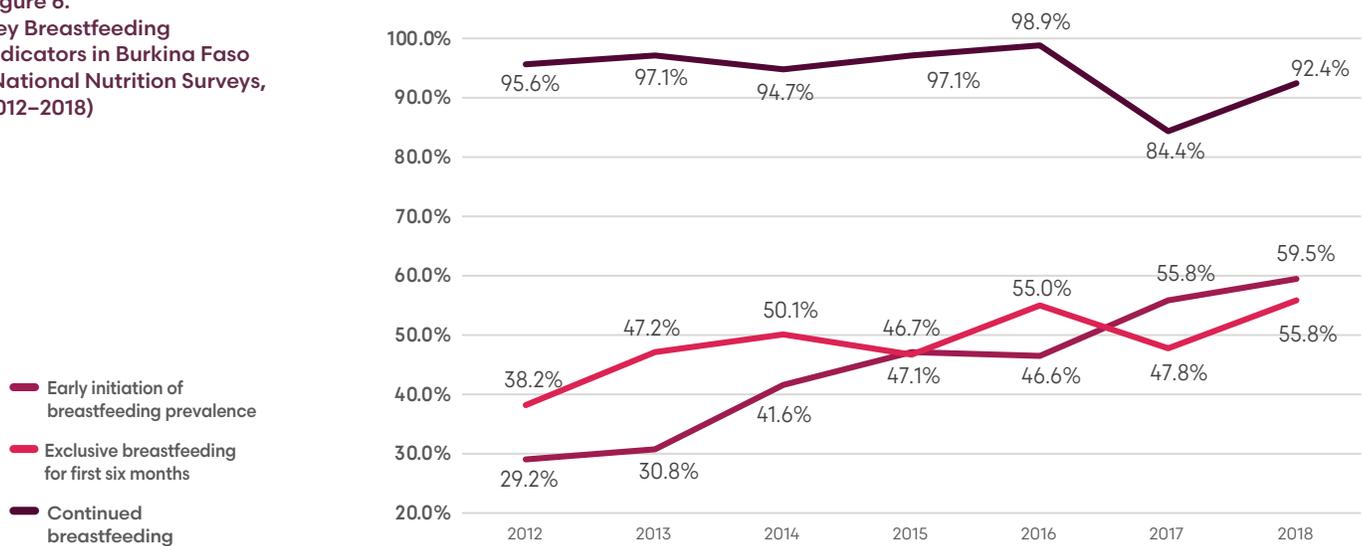
INTRODUCTION AND BACKGROUND

Burkina Faso is a hot, dry, landlocked West African country bordering the Sahel desert. Almost half of its rapidly growing and diverse population of 21.5 million people is under 15 years of age.⁸² Burkina Faso is classified as a low-income country, where poverty is prevalent. Over one third of the population is estimated to live on less than US\$1.90 a day. Nearly three quarters of the population live in rural areas and are reliant on subsistence farming.⁸³

In 2013, the Ministry of Health introduced a National Infant and Young Child Feeding Scaling Up Plan (2013–2025) to promote at scale interventions for improving infant and young child feeding practices, including breastfeeding. The plan’s goal is to achieve an exclusive breastfeeding rate of 80 per cent by 2025.

Breastfeeding is near universal in Burkina Faso. Most women breastfeed longer than one year; in fact, 64 per cent continue for up to 24 months.⁸⁴ Early initiation rates (60 per cent) and exclusive breastfeeding rates (50 per cent) have improved steadily over the past 10 years (Figure 6) but fall below the 2025 target.⁸⁵ Some harmful feeding practices also persist in early life that can put infants’ lives in danger. In 2018, 14 per cent of newborns were given prelacteal feeds within the three days after birth, 3 per cent of whom received infant formula.⁸⁶ Uptake of infant formula is increasing, particularly during the first three months of an infant’s life. The main obstacle to exclusive breastfeeding is the practice of giving water to infants at birth and during the first six months of life.^{87, 88}

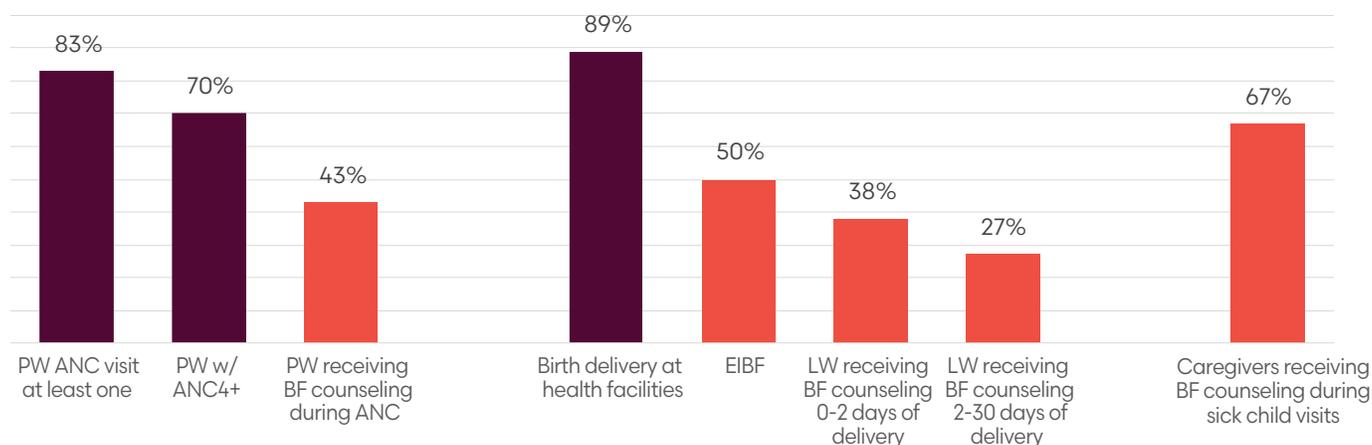
Figure 6.
Key Breastfeeding
Indicators in Burkina Faso
(National Nutrition Surveys,
2012–2018)



While the uptake of maternal and child health services is high in Burkina Faso, data reveal important gaps in accessing breastfeeding counselling. Although 70 per cent of women attended at least four antenatal care visits, only 43 per cent reported receiving breastfeeding counselling during those visits. Further, 89 per cent of women gave birth at health facilities, but only 50 per cent initiated breastfeeding within one hour after birth. These findings highlight missed opportunities to discuss and support breastfeeding practices with mothers and their families.⁸⁹

Figure 7. Maternal, Newborn, and Child Health Services and Breastfeeding Counselling Indicators

*Data are from the 2020 Performance Monitoring for Action Report (2018 data)



OVERVIEW OF THE 'STRONGER WITH BREASTMILK ONLY' CAMPAIGN

As part of efforts to improve adoption of the recommended breastfeeding practices in Burkina Faso, Alive & Thrive⁹⁰ (A&T) and UNICEF worked with the Burkina Faso Ministry of Health to launch the 'Stronger with Breastmilk Only' national campaign. The campaign supports and promotes exclusive breastfeeding, emphasizing that no water, other liquids or foods should be provided to babies during the first six months of life. The campaign includes an evidence-informed national social and behavioural change strategy, which guides the adoption and implementation of policies and interventions to standardize skilled breastfeeding counselling at critical times in the maternal, newborn and child health continuum of care across Burkina Faso, at no additional cost to mothers and families.

The 'Stronger With Breastmilk Only' campaign is part of a regional initiative by the same name, which aims to improve exclusive breastfeeding rates in West and Central Africa by ending the practice of giving water to babies in the first six months of life – the main obstacle to exclusive breastfeeding in the region. In Burkina Faso, the campaign builds on the results of A&T's exclusive breastfeeding interventions in the Boucle de Mouhoun region.

The socioecological model was used to analyse the situation and identify strategic areas of intervention at all levels of influence. Approaches to be scaled up nationally include policy advocacy for implementation of the International Code of Marketing of Breast-milk Substitutes and the BFHI, as well as integration of 'Stronger With Breastmilk Only' indicators and activities into the national nutrition programme. Suggested activities include: social mobilization of religious and traditional leaders, professional associations, and journalists and other media professionals, mass communication to align public perceptions regarding the benefits of exclusive breastfeeding, the composition of breastmilk and risks of giving water in the first six months of life, and the strengthening of interpersonal communication to support exclusive breastfeeding, without giving infants water, throughout the existing health system. A&T and UNICEF worked with the Government throughout the design and implementation of the campaign to increase national ownership, commitment, and leadership.

Framing the story

In 2019, A&T and UNICEF built on well-established relationships with the Nutrition Directorate of the Ministry of Health by approaching them with a clear, evidence-informed, and meaningful message: to improve exclusive breastfeeding rates in the country, the national programme should focus on ending the practice of giving water to babies during the first six months of life.

A&T and UNICEF used 2010 national data and subnational data from a recent concept test conducted in the Boucle de Mouhoun region to demonstrate that the practice of giving water to babies was the main obstacle to exclusive breastfeeding. They also shared evidence on the effectiveness of increasing exclusive breastfeeding practices through multiple platforms, including by embedding skilled breastfeeding counselling at critical times (as part of antenatal care, delivery, postnatal care, and well-child visits). This included standardizing breastfeeding counselling messages and strengthening health workers' interpersonal communication skills, in health centres and communities, to provide high-quality breastfeeding counselling. The message resonated with the Ministry of Health, and a partnership comprising the three institutions was established. A budgeted road map was created to mobilize funds to design and implement the national 'Stronger With Breastmilk Only' campaign.

Generating evidence to design effective strategies for social and behavioural change

In designing the campaign, the partnership sought to better understand exclusive breastfeeding patterns and determinants, the prevalence and practices related to giving water, other liquids and foods, and opportunities for promoting exclusive breastfeeding.

- Results from a secondary analysis of National Nutrition Survey 2018 data confirmed that the practice of giving water to children aged of 0–5 months was the main barrier to exclusive breastfeeding.
- A desk review of available literature on the practice of giving water in Burkina Faso helped document the known facilitators and barriers to exclusive breastfeeding and the underlying motivations for giving water. Two common practices emerged as obstacles to initiating and maintaining exclusive breastfeeding: the tradition of welcoming the newborn with water at birth (l'eau de bienvenue) and the social norm of giving water to quench a baby's thirst given the hot and dry climate.
- An internal review of 2020 Performance Monitoring for Action data⁹¹ conducted by A&T highlighted missed opportunities for counselling on exclusive breastfeeding in health facilities at critical times, including during antenatal care, delivery, postnatal care and well- and sick-child visits.

RESULTS AND ACHIEVEMENTS

Mobilizing partners through national and regional launch events

As of June 2021, numerous events were organized to mobilize programme partners – including national champions, media professionals, professional associations and traditional leaders – and the general public around 'Stronger With Breastmilk Only' at national level and in the 13 regions of Burkina Faso.

- The Ministry of Health held the national launch ceremony for the campaign in June 2020. While the event was limited to 50 stakeholders due to COVID-19 restrictions, it was also broadcast on social media by U-Reporters,⁹² resulting in more than 3,500 additional stakeholders attending the event via Facebook and Zoom.
- All 13 regions of Burkina Faso have developed their own campaign action plans and organized official ceremonies to launch them.
- Awareness-raising activities were organized alongside launch ceremonies to mobilize journalists and other media professionals, national and regional champions, professional associations and traditional leaders around the campaign.



A regional launch ceremony is attended by the Governor, the Regional Champion, all traditional Chiefs, journalists and members of professional associations, in September 2020. Credit: R. Kindo, Regional Health Directorate

Securing World Bank Power of Nutrition funding for national implementation

Additional funding for the full initiative was needed after A&T and UNICEF financed the design and launch of the campaign. As early as 2018, A&T began supporting the Nutrition Directorate to develop an investment case for implementing the Infant and Young Child Feeding Scaling Up Plan (2013–2025) through the Global Financing Facility.⁹³ The Ministry of Health, via the World Bank-funded governmental project (the Health Services Strengthening Project) allocated funding for a ‘Stronger With Breastmilk Only’ mass media campaign and health-sector capacity building. Simultaneously, A&T and UNICEF assisted by developing scopes of work and budgets, while coaching the Nutrition Directorate during advocacy meetings with the national project management unit of the Ministry of Health and the World Bank.

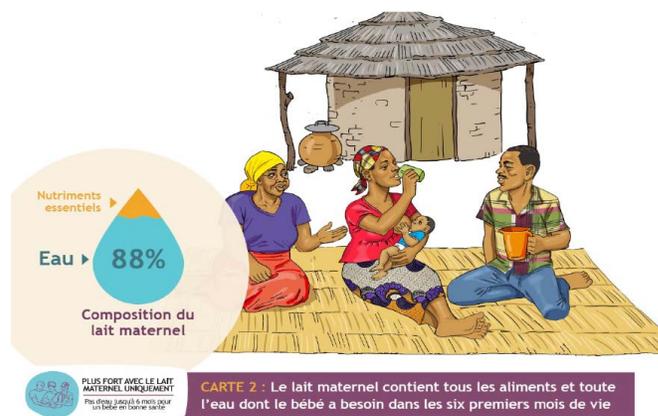
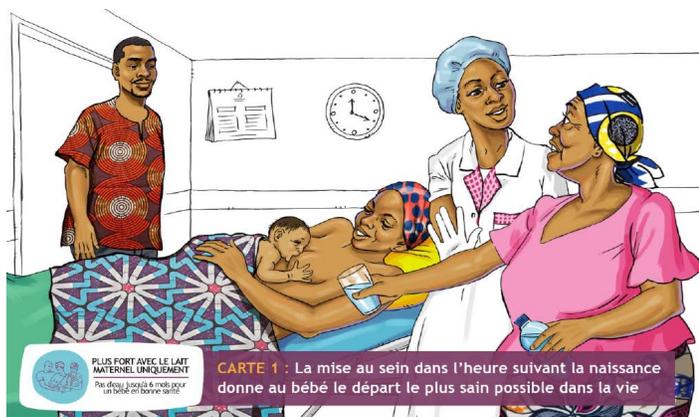
In 2020, more than US\$1 million in funding was granted by the Ministry of Health (via World Bank funding) for national health system strengthening for exclusive breastfeeding. This funding provided capacity building in interpersonal communication for 15,584 health workers and 18,000 community health workers in the 1,948 health centres across the country. The capacity building would help front-line workers anticipate and address breastfeeding challenges, especially the practice of giving water during the first six months of life. To initiate the capacity building efforts, several two-day training-of-trainers sessions were held in March 2021, which resulted in 75 master trainers being trained. The master trainers are key staff and focal points from each regional health directorate and district hospital of each health district. The training curriculum was developed by A&T and shared with the Nutrition Directorate and UNICEF for prior validation, and later with a group of nutrition partners for final validation. The training covered 10 modules (see Box 7).

During a soon-to-be implemented pilot phase, health workers in the health centres and communities of 13 districts will be trained in interpersonal communications and receive coaching and supportive supervision. An assessment will be conducted after three months of implementation to inform scale-up of the approach nationwide.

BOX 7

Content of training modules for front-line staff

- Module 1:** Context of exclusive breastfeeding and objectives of the ‘Strong With Breastmilk Only’ campaign in Burkina Faso
- Module 2:** Exclusive breastfeeding from the first hour of life until 6 months of age: evidence, current practices, barriers for optimal practice adoption
- Module 3:** Exclusive breastfeeding without giving water (motivators for giving water, associated risks of giving water and other liquids), key messages, and interpersonal communication tools for the campaign
- Module 4:** Interpersonal communication: Six listening and learning skills
- Module 5:** Individual and group interpersonal communication
- Module 6:** Field practicing
- Module 7:** International Code of Marketing of Breast-milk Substitutes
- Module 8:** Increasing quality and coverage of exclusive breastfeeding counselling (in health facilities and communities): seven contacts and four key moments for communicating
- Module 9:** Breastmilk expression techniques
- Module 10:** Monitoring and evaluation



'Stronger With Breastmilk Only' counselling cards convey messages supporting giving breastmilk only in the first six months of life for a healthier baby. These were pre-tested with the four main ethnic groups of Burkina Faso. Illustrations were tailored to each group based on pre-test results.

CHALLENGES

- **Leadership transition in the Ministry of Health National Nutrition Unit caused delays.** The absence of a Director for the national Nutrition Unit for several months in 2019 delayed the start of the campaign.
- **Capacity building of Ministry of Health National Nutrition Unit took time.** This may have been the first time that Ministry of Health nutrition partners were so intimately engaged in the design and implementation of a national social and behavioural change campaign in Burkina Faso. It was also the first time that funds were leveraged from an internal World Bank-funded mechanism. A&T and UNICEF helped build the Ministry of Health's capacity by using a learning-by-doing approach, providing hands-on experience on how to design, implement, and monitor a social and behavioural change campaign.
- **Mobilizing partners in government and among its technical and financial partners.** Intra-ministerial and multiple-partner coordination is challenging for such a large national campaign. A&T and UNICEF are working with the Ministry of Health to implement coordinating bodies at central and subnational levels where a matrix (describing who is doing what, where and when) will be regularly updated and discussed during quarterly meetings to help ensure smooth implementation.

LESSONS LEARNED

Frame the issue around a clear, meaningful message set the stage for success. Advocacy requires clear, consistent, evidence-based and targeted messages to inspire action and change. Strategic use of available data provided the evidence and helped identify the message. A&T and UNICEF utilized these concepts to convince the Government of the importance of implementing and funding the 'Stronger With Breastmilk Only' campaign.

Form partnerships around a common initiative that actively builds on each organization's assets. UNICEF and A&T combined their distinctive competencies and resources to support the Ministry of Health during the design and implementation of the campaign. All activities were passed through the group of partners before implementation, ensuring coordinated and timely actions were taken. All nutrition-related working groups and coordinating bodies were informed of and invited to participate in campaign activities, ensuring buy-in and support from key partners.

Invest in time and resources to build the capacities of government. The best way to build the capacity of the government and health system is working with them, rather than substituting for them. A participatory and engaging approach increases ownership, leadership and the competencies of key managers of the health system.

Conduct anticipatory and active advocacy to mobilize funding for well-designed initiatives. Stakeholders need to encourage nutrition leaders to assess funding opportunities and actively seize them, rather than waiting for funding to become available.

CONCLUSIONS

There are important opportunities to further strengthening the breastfeeding agenda in Burkina Faso. The Government issued a decree updating its regulations on the marketing of breastmilk substitutes in March 2021. The objective was to strengthen the existing International Code of Marketing of Breast-milk Substitutes legislation, which had not been updated since 1993. This new decree provides improved implementation and enforcement of the Code and facilitates implementation of the BFHI 10 Steps to Successful Breastfeeding. The momentum from this important policy adoption will be leveraged to support implementation of the ‘Stronger With Breastmilk Only’ campaign.

A circular for the adoption of the 10 Steps to Successful Breastfeeding is expected to be signed by the Minister of Health in 2021, requiring all health system actors and health facility managers to implement them. This policy will help to establish a supportive enabling environment for breastfeeding, improve the provision of breastfeeding services, and support the messages and actions promoted by the campaign.

The campaign and the circular will work hand-in-hand to improve breastfeeding services across the country and provide an umbrella under which to consolidate advocacy and messaging for the adoption of pro-breastfeeding policies.

To undertake a similar initiative, it is important to:

- Frame nutrition issues around meaningful, evidence-based and targeted messages to mobilize partners around a common ask or initiative.
- Build partnerships between the government and its technical and financial partners to mobilize funding and support sustainable programmes.
- Build the leadership of the Ministry of Health at each level of the health system, from national to subnational levels, to increase ownership and facilitate continuous implementation.
- Work with professional associations to introduce and maintain new norms and standards in providing skilled breastfeeding counselling at health facilities.
- Mobilize national champions, media professionals and traditional leaders to spread the message and help shift social norms in favour of exclusive breastfeeding.

ADDITIONAL INFORMATION

Authors: Maurice Gerald Zafimanjaka, A&T, Burkina Faso; Manisha Tharaney, A&T; Nathalie Likhite, A&T, West Africa; Mediatrice Kiburente, UNICEF Burkina Faso; Estelle Bambara, Ministry of Health, Burkina Faso.

Website: <https://www.aliveandthrive.org/en/where-we-work#burkina-faso>

Action 7. Funding must be provided to support training in breastfeeding counselling for health care professionals, including physicians, nurses, midwives, dietitians, lactation consultants and community-based peer and lay counsellors.

CASE STUDY 7.

Funding for training: Spain's national breastfeeding counselling training programme implemented by IHAN

INTRODUCTION AND BACKGROUND

Spain, located in southern Europe, has more than 49 million inhabitants and 400,000 births per year. The country is divided into 13 regions, and regional governments are autonomous in health policy matters. Every citizen in Spain is entitled to free access to health care and public health services.

The exclusive breastfeeding rate in Spain is 73.9 per cent at 6 weeks of age, 63.9 per cent at 3 months of age and 39 per cent at 6 months of age.⁹⁴ Health care professionals in both primary and specialized care are responsible for breastfeeding clinical care and support. More than 90 per cent of births take place in hospital maternity wards attended by midwives, obstetricians and paediatricians. Both prenatally and after discharge, the care of mother-infant dyads falls under the responsibility of the primary health care team composed of family medicine doctors, paediatricians, midwives and nurses.⁹⁵

There is no national breastfeeding strategy in Spain and no national breastfeeding authority. Further, breastfeeding care is not included in the service portfolio of the national health care system.⁹⁶ Lactation specialists and IBCLCs are not officially recognized and training in breastfeeding counselling is not required for health care professionals working in maternity or paediatric wards, or in primary health care centres. Early initiation of breastfeeding rates are not officially monitored in Spain. In 1997, the results of a national survey showed an 84.2 per cent early initiation of breastfeeding rate and 24.8 per cent rate of any breastfeeding at the age of 6 months.⁹⁷ Several studies showed a lack of knowledge and skills in breastfeeding counselling among Spanish health professionals.⁹⁸ The study also noted that although paediatricians have no training in breastfeeding counselling, they play an important role in influencing the care and monitoring of child feeding. Moreover, most of the scientific, training and/or research activities of Spanish paediatricians were financed by the baby food industry - creating conflicts of interest.

OVERVIEW OF BREASTFEEDING COUNSELLING TRAINING PROGRAMME

In 1995, UNICEF Spain convened a working group with different stakeholders to support BFHI implementation in the country and appointed a BFHI national coordinator. In 2001, the group incorporated as an NGO under the name of IHAN (the Spanish acronym for BFHI). The board included representatives of several Spanish perinatal professional associations and mothers' support groups. The national coordinator advocated for the publication of protective breastfeeding laws, disseminated breastfeeding knowledge at scientific conferences, organized two 80-hour 'train-the-trainer' breastfeeding counselling courses and several 20-hour breastfeeding counselling courses, and assessed hospitals promoting changes towards the BFHI. Despite initial efforts, progress was slow and met with professional and institutional resistance. Health care authorities showed no interest in the initiative and did not support it. Moreover, non-compliance with the

International Code of Marketing of Breast-milk Substitutes in Spain (the Code) was widespread.

Dr. Jesús Martín-Calama, who had founded the Breastfeeding Committee inside the Spanish Association of Paediatrics in 1997, represented the Spanish Paediatric Association in the IHAN board. He identified the need for improvement in the interest, skills and knowledge on breastfeeding counselling among Spanish health care professionals.

Following his suggestions, IHAN decided on an initial plan with three main activities: hosting a biennial multidisciplinary breastfeeding congress that would generate interest on the topic, publishing a breastfeeding manual for health care professionals and implementing a breastfeeding counselling training strategy. In 2007, Dr Martín-Calama was appointed national coordinator of IHAN. The new board prompted a change in the IHAN bylaws and structure. Training health care professionals on breastfeeding counselling was included as a main objective of IHAN.



The new IHAN devised a new plan to achieve its objectives. The following activities were planned and implemented:

Activities for in-service breastfeeding counselling training, directed to different health care professionals already working in perinatal or paediatric care. The following were included:

- Participation in scientific meetings with breastfeeding seminars and lectures to paediatricians, obstetricians, midwives and nurses.
- Promoting interest in breastfeeding research by awarding the best research projects at each breastfeeding national congress.

- Publishing two breastfeeding management textbooks directed to professionals, with a special focus on counselling.
- Offering breastfeeding counselling train-the-trainer courses directed to health care professionals. These 60-hour courses are carried out as three modules, which include personalized training in small groups, advice for preparing training activities and the opportunity to teach the 20-hour course in groups of three tutored by an IHAN teacher. Each of these courses can train between 9 and 12 new trainers, while providing a cascade training for 60–90 professionals. Since 2000, IHAN offers two or three of these courses each year.
- Renewing the IHAN web page. Since 2007, www.ihan.es, gets permanently updated and includes selections of scientific breastfeeding literature and announcements of breastfeeding events. The site also offers information and resources for BFHI accreditation of health care institutions and a complete breastfeeding counselling programme.⁹⁹ In 2019, the web page had 640,000 visits: 79 per cent of visitors were from Spain and 21 per cent were from Latin America, the United States and Europe. Since 2019, the website has included an online offer of breastfeeding counselling training directed to health care professionals and breastfeeding counsellors, with credits from the national continuing education system and Continuing Education Recognition Points for IBCLCs. The contents of the website are linked to IHAN's presence on social media networks, such as Twitter, Facebook, Instagram and YouTube.

Activities for breastfeeding counselling preservice training, aimed to reach doctors and nurses during their specialty training (i.e., during residency). These included:

- Annual courses targeted to paediatric residents on breastfeeding counselling, humanizing birth-care and the Code. These were launched in 2008 and sparked a paradigm shift, with many more residents expressing interest in participating the following year. As such, the course was reorganized in 2010, more trainers were hired to reach 90 trainees per session and opportunities to participate were extended to other specialists in training (e.g., obstetricians and family medicine doctors). Following the request of some nurse and midwife associations, additional courses were added in 2012 for residents of midwifery and paediatric and family nursing.
- Training on breastfeeding counselling online was offered to paediatric residents for several years, starting 2009. Through an online breastfeeding-help forum held by members of IHAN and the Breastfeeding Committee of the association of paediatrics, the forum was used as a practical tool for training paediatric residents on breastfeeding counselling.¹⁰⁰

Mobilizing funds

Funding for breastfeeding support and protection efforts was requested from the beginning from National Health Authorities without response. UNICEF, however, initially allocated funds to IHAN to support the implementation of the BFHI in Spain for 10 years. This funding helped initiate IHAN's first activities. It also financed the activities of the national coordinator, some courses to train BFHI assessors and a first train-the-trainer breastfeeding counselling course. The breastfeeding congress financed itself with fees from attendees and was free from Code violations. Profits from the sale of the two breastfeeding manuals written by some members helped increase the funds. Further, advocacy from IHAN with regional public health authorities also resulted in some additional funding to finance courses for hospitals.

The Spanish Paediatrics Association agreed to partly finance annual breastfeeding counselling courses for paediatric residents starting in 2007.

In 2008, IHAN won a call for health care quality improvement projects in which breastfeeding counselling training was included. A new opportunity appeared when *The National Strategy for Reproductive Health* was launched in 2009. IHAN wrote project proposals in a way that positioned breastfeeding counselling as an essential part of reproductive health and it was possible to secure partnerships with the national government and regional governments to train health professionals. Breastfeeding counselling training was included in the dissemination activities of that strategy. Advocacy efforts with some regional public health authorities that were interested in disseminating the BFHI strategy resulted in some extra funding for breastfeeding counselling training. In 2012, IHAN started collaborations with the Spanish Ministry

of Health to support breastfeeding by aligning its objectives with the national five-year health care plans. Although the Spanish Ministry of Health did not consider publishing a national breastfeeding strategy or nominating a national breastfeeding authority, funds were allocated, responding to IHAN requests for collaboration to partially fund the *train-the-trainer* courses, *breastfeeding counselling training* courses and most of the preservice breastfeeding counselling training activities. Some activities were partly paid by the participants who were asked to contribute with small fees, which not only permitted lowering the final cost but also ensured attendees' commitment.

RESULTS AND ACHIEVEMENTS

Forty-five *train-the-trainer* courses have taken place resulting in 410 new trainers. Nearly 120 breastfeeding counselling training courses have been offered to health care professionals and lay assessors throughout all regions in Spain. With an average attendance of 21 people, around 2,500 professionals have been trained with these courses since 2005. Nearly 600 professionals completed a basic online breastfeeding course in 2019. The average satisfaction rating of this training is good (above 4 out of 5). Nearly 900 medical residents and more than 500 nursing residents have received breastfeeding counselling training over a period of 12 years.

CHALLENGES

- **Lack of secure funding.** While the programme has effectively employed various strategies to increase resources, funding is still insecure. On three occasions, the programme suffered annual suspensions of budgeted government funds due to unexpected changes of government or national budget freezes. This forced the programme to reduce the number of breastfeeding counselling courses offered and even suspend some courses for residents and awards for research projects. To overcome this barrier, diverse fund collecting strategies have been employed, which proved effective including aligning objectives with the strategic lines of the national and regional health care plans when applying for funds. However, having a national breastfeeding authority and strategy would be the best way to ensure optimal support and protection for breastfeeding families. It would also offer sustainability to breastfeeding counselling training efforts.
- **Resistance of health care providers and health care facilities.** In Spain, the baby food industry finances most of the training for health care professionals and provides funding for some public and private health care activities. Paediatric professional associations receive funding from industries that violate the Code, but do not understand the need to avoid conflicts of interest and to break these ties. There are regulations in place for the pharmaceutical industry, but infant formula is not covered by drug regulation. The Code is only partially covered in Spanish legislation, and non-compliance is not monitored or punished. In 2013, when members of the Breastfeeding Committee and IHAN asked the Spanish Paediatric Association to comply with the Code, the Spanish Paediatric Association disassociated itself from the breastfeeding counselling project and suspended its support to the Breastfeeding Committee. This led to members resigning and the Spanish Paediatric Association integrating the Breastfeeding Committee into the Nutrition Committee. IHAN's conflict-of-interest-free teaching offerings, dissemination of Code knowledge and resident training are intended to overcome this barrier.
- **The COVID pandemic.** In 2020, the pandemic altered training activities for professionals. It prevented face-to-face and hands-on training and suspended central funding as resources were diverted to address COVID-19. In response, IHAN reduced expenses by improving online training offerings (including offering advanced courses in breastfeeding counselling online), analysing pandemic-related changes in breastfeeding protection, and collaborating with health authorities on recommendations to protect breastfeeding.

LESSONS LEARNED

Funds are needed to support training in breastfeeding counselling, which is essential for the provision of quality birth-care and adequate support for breastfeeding.

Funding can be secured by aligning objectives with health care plans and by advocating for the importance of breastfeeding to prevent chronic disease, but only a national breastfeeding strategy can foster sustainability in breastfeeding counselling training efforts.

Improving breastfeeding counselling skills among health care professionals is an effective way to increase breastfeeding indicators and to adequately support optimal infant feeding practices.

'Train-the-trainer' sessions are a cost-efficient way of increasing the number of trainers by training professionals using a cascade effect.

Planning ahead for possible unexpected crises is important to ensure the sustainability of this type of programme, particularly when secure funding is not available.

CONCLUSIONS

The financing of breastfeeding training needs stable funding from health authorities and must be included in the national budget. Nominating a breastfeeding national authority and publishing a national breastfeeding strategy can help ensure proper breastfeeding support and respect for the Code. In the absence of government commitment and ownership, NGOs may provide leadership, aligning the need for breastfeeding training with national health plans and the Sustainable Development Goals to mobilize funding.

ADDITIONAL INFORMATION

Author: Teresa Hernández Aguilar, IHAN-Spain delegate for international affairs, BFHI Network coordinator.

Programme website: www.ihan.es

Further resources for skilled breastfeeding counselling

BFHI

- Protecting, promoting and supporting Breastfeeding in facilities providing maternity and newborn services: the revised BABY-FRIENDLY HOSPITAL INITIATIVE: <https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf>
- Protecting, promoting and supporting breastfeeding: The Baby-friendly Hospital Initiative for small, sick and preterm newborns: <https://www.who.int/publications/i/item/9789240005648>
- Competency verification toolkit: Ensuring competency of direct care providers to implement the Baby-friendly Hospital Initiative: <https://www.who.int/publications/i/item/9789240008854>
- Baby-friendly Hospital Initiative training course for maternity staff: <https://www.who.int/publications/i/item/9789240008915>

EDUCATION AND TRAINING (OTHER THAN BFHI)

- American Academy of Pediatrics – Physician education and training on breastfeeding: <https://services.aap.org/en/patient-care/breastfeeding/physician-education-and-training-on-breastfeeding/>
- International Lactation Consultant Association: <https://ilca.org/>
- La Leche League International: <https://www.llli.org/>
- International Board of Lactation Consultant Examiners: <https://iblce.org/>
- Community based infant and young child feeding: <https://www.enonline.net/iycfcommunityinterventions>
- WHO/UNICEF IYCF training course Infant and young child feeding counselling: an integrated course | Global Breastfeeding Collective

POLICIES AND FUNDING

- Implementation Guidance on Counselling Women to Improve Breastfeeding Practices
- Global Breastfeeding Collective – Breastfeeding Advocacy Toolkit: [Breastfeeding Advocacy Toolkit | Global Breastfeeding Collective](#)
- World Breastfeeding Costing Initiative (WBCi): <https://www.worldbreastfeedingtrends.org/resources/wbci-tool>
- The Cost of Not Breastfeeding Tool: <https://www.aliveandthrive.org/en/the-cost-of-not-breastfeeding>

THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

- The International Code of Marketing of Breast-milk Substitutes: Frequently asked questions on the roles and responsibilities of health workers: <https://www.who.int/publications/i/item/9789240005990>
- Online Code training course: <https://www.unitar.org/event/full-catalog/international-code-marketing-breast-milk-substitutes-open-access>
- Marketing of Breast-milk Substitutes: National implementation of the international Code, status report 2020: <https://www.who.int/publications/i/item/9789240006010>

Endnotes

- 1 Victora, C.G., et al., 'Breastfeeding in the 21st Century: Epidemiology, Mechanisms, and Lifelong Effect', *Lancet*, 30 January 2016, vol. 387, no. 10017, pp. 475–490.
- 2 United Nations Children's Fund, et al., *Nurturing the Health and Wealth of Nations: The Investment Case for Breastfeeding*, Breastfeeding Collective, 2017.
- 3 Rollins, N.C., et al., 'Why Invest, and What it Will Take to Improve Breastfeeding Practices?', *Lancet*, 30 January 2016, vol. 387, no. 10017, pp. 491–504.
- 4 United Nations Children's Fund, 'Infant and Young Child Feeding', <<https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding>>, accessed 2 July 2020.
- 5 McFadden, A., et al., 'Counselling Interventions to Enable Women to Initiate and Continue Breastfeeding: A Systematic Review and Meta-Analysis', *International Breastfeeding Journal*, 21 October 2019, vol. 14, no. 42, pp. 14–42.
- 6 Statistics Canada, 'Canada's Population Clock (Real-Time Model)', <www150.statcan.gc.ca/n1/pub/71-607-x/71-607-x2018005-eng.htm>, accessed 22 April 2021.
- 7 Region of Waterloo, 'Planning Information Bulletin - 2019 Year-End Population and Household Estimates for Waterloo Region', <www.regionofwaterloo.ca/en/regional-government/resources/Census/DOCS_ADMIN-3290126-v1-Year_end_2019_Population_and_household_Bulletin.pdf>.
- 8 Baby-Friendly Initiative Ontario, 'Ontario's Baby Friendly Initiative Report, 2019', <https://breastfeedingresourcesontario.ca/sites/default/files/pdf/BFI_OntarioReportCard_201904_FINAL.pdf>, accessed 2 April 2021.
- 9 Ibid.
- 10 Born Ontario, *One in a Million - Born Ontario Biennial Report: 2016-2018*, Born Ontario, Ottawa, 2018.
- 11 Region of Waterloo Public Health, 'The 2011-2013 Infant Feeding Study', <www.regionofwaterloo.ca/en/regional-government/resources/Reports-Plans--Data/Public-Health-and-Emergency-Services/2014_INFANT_FEEDING_STUDY.pdf>, accessed 1 April 2021.
- 12 Best Start Resource Center, *Populations with lower rates of breastfeeding: A summary of findings*, Toronto, Ontario, Canada, 2015, <<https://resources.beststart.org/wp-content/uploads/2018/12/B09-E.pdf>>.
- 13 The Baby-Friendly Hospital Initiative is a global initiative of UNICEF and WHO that aims to give every baby the best start in life by creating a health care environment that supports breastfeeding as the norm. See <www.unicef.org/documents/baby-friendly-hospital-initiative>.
- 14 Van Esterik, P., R.A. O'Connor, *The Dance of Nurture - Negotiating Infant Feeding*, Berghahn Books, 1 June 2017.
- 15 World Bank, 'Population, total - Kuwait',
- 16 World Bank, 'World Bank Open Data', <<https://data.worldbank.org>>.
- 17 Kuwait Ministry of Health, Annual Bulletin for Vital Statistics 2019, (unpublished).
- 18 Al-Razouki, M. M., Kuwait 2020 Health Report, <<https://mussaad.medium.com/kuwait-2020-health-report-5d62412ad05a>>.
- 19 World Health Organization, Guideline: Counselling of women to improve breastfeeding practices, Geneva: World Health Organization, 2018, <<https://www.who.int/publications/item/9789241550468>>.
- 20 International Board of Lactation Consultant Examiners, 'Recognised Breastfeeding Support Counsellor Organisations', <https://iblce.org/wp-content/uploads/2019/10/2019_September_recognised-breastfeeding-support-counsellor-organisations.pdf>.
- 21 Kuwait Ministry of Health, *Kuwait Nutrition Surveillance System 2019 Report*, 2019, <www.moh.gov.kw/FoodNutrition/KNSS%20Report%202019_Final.pdf>.
- 22 World Health Organization, *Making Pregnancy Safer: The Critical Role of the Skilled Attendant. A joint statement by WHO, ICF and FIGO*, Geneva: WHO, 2004.
- 23 Ministerio de Salud Pública y Asistencia Social (MSPAS), Comisión Técnica de Partería del MSPAS, *Programa Oficial para la formación de técnicas universitarias en partería (TUP)*, Guatemala City: MSPAS, 2016.
- 24 The private "Universidad Da Vinci" signed an institutional agreement with the Ministry of Health for the development of the Programme. The Ministry finances scholarships for the students to cover fees and their maintenance.
- 25 Ministerio de Salud Pública y Asistencia Social (MSPAS), Instituto Nacional de Estadística (INE), ICF International, *Encuesta Nacional de Salud Materno Infantil 2014-2015: Informe Final*, Guatemala: MSPAS/INE/ICF, 2017.
- 26 Instituto Nacional de Estadística Guatemala, *Encuesta Nacional de Condiciones de Vida*, INE, 2015.
- 27 Ministerio de Salud Pública y Asistencia Social, *Informe de País: Situación de la Mortalidad Materna - Años 2016-2017-2018*, MSPAS, Guatemala, 2020.
- 28 Ministerio de Salud Pública y Asistencia Social (MSPAS), Instituto Nacional de Estadística (INE), ICF International, *Encuesta Nacional de Salud Materno Infantil 2014-2015: Informe Final*, Guatemala: MSPAS/INE/ICF, 2017.
- 29 United States Agency for International Development, Institute of Nutrition of Central America and Panama and Centers for Disease Control and Prevention, *Sistema de Vigilancia Epidemiológica en Salud y Nutrición - Informe final 2018*, USAID/MCSP, Guatemala, 2019.
- 30 An Act published by the Government of Nepal (the then HMG) made to control the sale and distribution of breastmilk substitute. Act No. 39 of 2049 (1992 A.D.), Kathmandu, 1992.
- 31 Helen Keller International, *Lactation Management in Early Postpartum 3-Day Training Manual*, Helen Keller International, Kathmandu, Nepal, 2015.
- 32 Pries, A.M., et al., 'Promotion and Pre-lacteal Feeding of Breastmilk Substitutes Among Mothers in Kathmandu Valley, Nepal', *Maternal & Child Nutrition*, April 2016, vol. 12, no. 2, pp. 8–21.

- 33 World Health Organization, *Infant and Young Child Feeding Counselling: An Integrated Course, 2006*, < <https://www.globalbreastfeedingcollective.org/infant-and-young-child-feeding-counselling-integrated-course> >, accessed 23 August 2018.
- 34 Guyon, A., V. Quinn, J. Nielsen and M. Stone-Jimenez, *Essential Nutrition Actions and Essential Hygiene Actions Training Guide: Health Workers and Nutrition Managers*, USAID, 2015.
- 35 United Nations Children’s Fund, World Health Organization, World Bank, and United Nations, *Levels and Trends in Child Mortality Report 2018 - Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation*, UNICEF, 2019.
- 36 Blencowe, H., et al., ‘Born Too Soon: The Global Epidemiology of 15 million Preterm Births’, *Reproductive Health*, 15 November 2013, vol. 10, no. S2. 2.
- 37 United Nations Children’s Fund and World Health Organization, *Survive and Thrive - Transforming Care for Every Small and Sick Newborn*, WHO, 2019.
- 38 World Health Organization, *Standards for Improving the Quality of Care for Small and Sick Newborns in Health Facilities*, WHO, 2020.
- 39 United Nations Children’s Fund and World Health Organization, *Survive and Thrive - Transforming Care for Every Small and Sick Newborn*, WHO, 2019.
- 40 World Health Organization, *Standards for Improving the Quality of Care for Small and Sick Newborns in Health Facilities*, WHO, 2020.
- 41 Lawn, J. E., et al., ‘Born Too Soon: Care for the Preterm Baby’, *Reproductive Health*, 2013, vol. 10, no. S5.
- 42 Bhutta, Z. A., et al., ‘Can Available Interventions End Preventable Deaths in Mothers, Newborn Babies, and Stillbirths, and At What Cost?’, *Lancet*, 2014, vol. 384, no. 9940, pps. 347–370.
- 43 Briere, C.-E., et al., ‘State of the Science: A Contemporary Review of Feeding Readiness in the Preterm Infant’, *Journal of Perinatal & Neonatal Nursing*, 2014, vol. 28, no. 1, pp. 51–58; quiz E3–4. 1.
- 44 Israel-Ballard, K., ‘Strengthening Systems to Ensure All Infants Receive Human Milk: Integrating Human Milk Banking into Newborn Care and Nutrition Programming’, *Breastfeeding Medicine*, 2018, vol. 13, no. 8, pp. 524–526.
- 45 World Health Organization, *Guidelines on Optimal Feeding of Low Birth Weight Infants in Low- and Middle-income Countries*, WHO, 2011.
- 46 PATH, *Strengthening Human Milk Banking: A Resource Toolkit for Establishing & Integrating Human Milk Bank Programs - A Global Implementation Framework, Version 2.0*, PATH, 2019.
- 47 Chawanpaiboon, S., et al., ‘Global, Regional, and National Estimates of Levels of Preterm Birth in 2014: A Systematic Review and Modelling Analysis’, *Lancet Global Health*, 2019, vol. 7, no. 1, pp. e37–e46.
- 48 Shenker, N., ‘Maintaining Safety and Service Provision in Human Milk Banking: A Call to Action in Response to the COVID-19 Pandemic’, *Lancet Child & Adolescent Health*, 2020, vol. 4, no. 7, pp. 484–485.
- 49 Israel-Ballard, K., et al., ‘Call to Action for Equitable Access to Human Milk for Vulnerable Infants’, *Lancet Global Health*, 2019, vol. 7, no. 11, e1484–e1486.
- 50 Mansen, K., et al., ‘Strengthening Newborn Nutrition Through Establishment of the First Human Milk Bank in Vietnam’, *Journal of Human Lactation*, 890334420948448.
- 51 Kenya National Bureau of Statistics and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, KNBS and ICF Macro, 2010.
- 52 Kenya National Bureau of Statistics, et al., *Kenya Demographic and Health Survey 2014*, KNBS, 2015.
- 53 United Nations Children’s Fund, ‘Infant and Young Child Feeding’, <<https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding>>.
- 54 Meneses, T. M. X. de, M. I. C. de Oliveira and C. S. Boccolini, ‘Prevalence and Factors Associated with Breast Milk Donation in Banks that Receive Human Milk in Primary Health Care Units’, *Jornal de Pediatria*, 2017, vol. 93, no. 4, pp. 382–388.
- 55 Arslanoglu, S., et al., ‘Presence of Human Milk Bank is Associated with Elevated Rate of Exclusive Breastfeeding in VLBW Infants’, *Journal of Perinatal Medicine*, 2021, vol. 41, no. 2, pp. 129–131.
- 56 Kimani-Murage, E. W., et al., ‘Perceptions on Donated Human Milk and Human Milk Banking in Nairobi, Kenya’, *Maternal & Child Nutrition*, 2019, vol. 15, no. 4, e12842.
- 57 Kibore, M. *The Mother Baby Friendly Initiative Plus – An Integrated Model for Strengthening Access to Human Milk in Kenya*. Presented at the 5th International Congress of the European Milk Banking Association. Turin, Italy; Oct 11, 2019
- 58 Brandstetter, S., et al., ‘A Decision Tree for Donor Human Milk: An Example Tool to Protect, Promote, and Support Breastfeeding’, *Frontiers in Pediatrics*, 2018, vol. 6, no. 324.
- 59 County Innovation Challenge Fund and PATH, *Evidence Brief: Helping Babies Thrive: Establishing the First Integrated Human Milk Bank System in Kenya*, May 2019.
- 60 PATH, *Strengthening Human Milk Banking: A Resources Toolkit for Establishing and Integrating Human Milk Bank Programs--A Training Curriculum Template for Hospital and Human Milk Bank Staff*, Seattle, Washington, USA: PATH, 2019.
- 61 World Bank, ‘The World Bank in Vietnam: Overview’, <www.worldbank.org/en/country/vietnam/overview>, accessed 23 March 2021.
- 62 General Statistics Office and United Nations Children’s Fund, *Viet Nam Multiple Indicator Cluster Survey 2014*, GSO, Viet Nam, 2015.
- 63 World Bank, ‘The World Bank in Vietnam: Overview’, <www.worldbank.org/en/country/vietnam/overview>, accessed 23 March 2021.
- 64 World Bank. 2020. *The World Bank in Viet Nam: Overview*. Accessed on March 23, 2021. <https://www.worldbank.org/en/country/vietnam/overview>
- 65 National Institute of Nutrition, *General Nutrition Survey 2020*.
- 66 The BFHI is a global initiative of the World Health Organization and UNICEF that aims to give every baby the best start in life by creating a health care environment that supports breastfeeding as the norm.
- 67 World Health Organization, *National Implementation of the Baby-friendly Hospital Initiative*, Geneva: World Health Organization, 2017.
- 68 In 2016, EENC began to be implemented in caesarean section births.

- 69 Morseth, M.S., et al. 'Health staff experiences with the implementation of early essential newborn care guidelines in Da Nang municipality and Quang Nam province in Viet Nam', *BMC Health Serv Res*, vol. 20, no. 585, 2020, <<https://doi.org/10.1186/s12913-020-05449-2>>.
- 70 For more information, see <<https://www.aliveandthrive.org/en/where-we-work/southeast-asia>>. Since 2014, A&T has provided strategic technical assistance to seven countries in Southeast Asia (Cambodia, Indonesia, the Lao People's Democratic Republic, Myanmar, the Philippines, Thailand, and Viet Nam).
- 71 Joyce, C. M., et al., 'The Association between a Novel Baby-Friendly Hospital Program and Equitable Support for Breastfeeding in Vietnam', *International Journal of Environmental Research and Public Health*, 2021, vol. 18, no. 13, p. 6706.
- 72 Criterion E1.3 on breastfeeding of the National Hospital Standards and Accreditation system includes Baby-friendly Hospital Initiative and EENC norms. Grade 4 (out 5) or higher of Criterion 1.3 is one of the criteria for COE designation and requires adherence to local legislation on breastfeeding promotion and the Code, as well as provision of high-quality breastfeeding support services. Grading is based on hospital self-assessment and annual review by the Department of Health/Ministry of Health. Main criteria of Grade 4 are equivalent to COE performance indicators (see Box 6).
- 73 See <www.aliveandthrive.org/sites/default/files/2021-04/CoE_Evaluation-checklists-EN-Updated-Sep-18.pdf>.
- 74 See <www.aliveandthrive.org/sites/default/files/2021-04/CoE_Mother-survey-questionnaire-EN-Updated_Sep-18.pdf>.
- 75 See for example <www.youtube.com/watch?v=0ngLI5Ut1eY&t=105s>
- 76 The sample size for the mothers' experience surveys is between 50-100 mothers each quarter and the response rate is over 82 per cent.
- 77 The tools used to determine initial COE designation (see Box 2) are also used by hospital and Ministry of Health staff to routinely monitor and assess COE status.
- 78 Prime Minister Decision 1896/QĐ-TTg, available at: <<https://thuvienphapluat.vn/van-ban/The-thao-Y-te/Quyết-dinh-1896-QĐ-TTg-2019-Cham-soc-dinh-duong-phong-chong-suy-dinh-duong-ba-me-tre-em-432172.aspx>>
- 79 Joyce, C. M., et al., 'The Association between a Novel Baby-Friendly Hospital Program and Equitable Support for Breastfeeding in Vietnam', *International Journal of Environmental Research and Public Health*, 2021, vol. 18, no. 13, p. 6706.
- 80 See <www.aliveandthrive.org/en/resources/overview-of-the-social-franchise-model-for-delivering-counseling-services-on-infant-and-young-child>.
- 81 In August 2021 the Government of Vietnam updated its COVID 19 guidelines to allow mothers to room-in with their babies, provide skin-to-skin contact, and breastfeed even if the mother is infected or suspected of COVID-19.
- 82 Institut National de la Statistique et de la Démographie, <www.insd.bf>, accessed 14 May 2021.
- 83 The World Bank, 'Burkina Faso', <<https://data.worldbank.org/country/BF>>, accessed 14 May 2021.
- 84 PMA2020, Performance Monitoring for Action 2020, <Available at: <https://www.pmadata.org/countries/burkina-faso>>.
- 85 Ministère de la Santé, Enquêtes nationales nutritionnelles, 2012-2020.
- 86 Institut Supérieur des Sciences de la Population du Burkina Faso, Performance Monitoring for Action 2020, August 2018.
- 87 Institut National de la Statistique et de la Démographie, Enquête Démographique et de Santé et à Indicateurs Multiples (EDSBF-MICS IV), 2010.
- 88 Institut Supérieur des Sciences de la Population du Burkina Faso, Performance Monitoring for Action 2020, August 2018.
- 89 Institut Supérieur des Sciences de la Population du Burkina Faso, Performance Monitoring for Action 2020, August 2018.
- 90 Alive & Thrive is a global nutrition initiative, managed by FHI Solutions and funded by the Bill & Melinda Gates Foundation, Irish Aid, and other donors that has been working to protect, promote, and support breastfeeding in Viet Nam since 2009.
- 91 PMA2020, Performance Monitoring for Action 2020, <Available at: <https://www.pmadata.org/countries/burkina-faso>>.
- 92 U-Reporters are young people who have joined U-Report. U-Report is a social messaging platform created by UNICEF available via SMS, Facebook and Twitter where young people express their opinions and can be a positive agent of change in their communities. See <www.unicef.org/innovation/U-Report>. There were 82,360 U-Reporters in Burkina Faso on 11 May 2021, <<https://burkinafaso.ureport.in>>.
- 93 The Global Financing Facility for Women, Children and Adolescents (GFF) is a multi-stakeholder global partnership housed at the World Bank that is committed to ensuring all women, children and adolescents can survive and thrive. Launched in July 2015, the GFF supports 36 low and lower-middle income countries with catalytic financing and technical assistance to develop and implement prioritized national health plans to scale up access to affordable, quality care for women, children and adolescents.
- 94 Webpage of the Spanish National Statistics Institute (Instituto Nacional de Estadística de España), <www.ine.es>, accessed 16 June 2021.
- 95 Hernández-Aguilar, M.T., et al., 'The Baby-Friendly Initiative in Spain: A challenging Pathway', *Journal of Human Lactation*, 2014, vol. 30, no. 3, pp. 276-282.
- 96 Spanish Ministry of Health, National Healthcare Portfolio (Ministerio de Sanidad. Cartera de Servicios comunes del Sistema Nacional de Salud), <www.msbs.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/home.htm>, accessed 16 June 2021.
- 97 García-Vera, C. and J. Martín Calama, 'Lactancia Materna en España - Resultado de una Encuesta de Ambito Estatal', *Revista Pediatría de Atención Primaria*, 2000, vol. 7, pp. 373-387.
- 98 Gómez Fernández-Vegue, M. and M. Menéndez Orega, 'National Survey on Breastfeeding Knowledge Amongst Residents in Pediatrics in Spain', *Revista Espanola de Salud Pública*, 2019, vol. 2, no. 93, e201908060.
- 99 The IHAN website is: <www.ihan.es>.
- 100 Lasarte Velillas, JJ., et al., 'A Breastfeeding e-Learning Project Based on a Web Forum', *Breastfeeding Medicine*, vol. 2, no. 4, 2007, pps. 219-228, <<https://www.liebertpub.com/doi/abs/10.1089/bfm.2007.0008>>.

FOR MORE INFORMATION AND TO JOIN THE COLLECTIVE
breastfeeding@unicef.org | unicef.org/breastfeeding

Global Breastfeeding Collective Partners: 1000 Days | Academy of Breastfeeding Medicine | Action Against Hunger | Alive and Thrive | Bill and Melinda Gates Foundation | Carolina Global Breastfeeding Institute | Centers for Disease Control and Prevention | Concern Worldwide | Helen Keller International | International Baby Food Action Network | International Lactation Consultant Association | La Leche League International | New Partnership for Africa's Development | Nutrition International | PATH | Save the Children | UNICEF | United States Agency for International Development | WHO | World Alliance for Breastfeeding Action | World Bank | World Vision International

World Health Organization (WHO)
Avenue Appia 20
1202 Geneva, Switzerland
www.who.int/en

**United Nations Children's Fund
(UNICEF) 3 United Nations Plaza**
New York, NY 10017, USA
www.unicef.org

unicef.org/breastfeeding