THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

Policy Guidelines on Infant and Young Child Feeding

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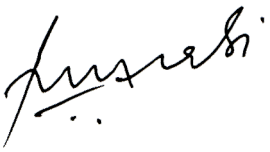
Foreword

The critical value of optimal infant and young child feeding (IYCF) has been recognised for decades, and over the last 25 years tremendous effort has been directed towards the promotion, protection and support of such optimal feeding. Challenges do exist, however, especially since the discovery that breastfeeding is one of the modes of Mother-to-Child Transmission (MTCT) of the Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS).

The Government of Uganda has put in place several policies and programmes in its attempt to promote, protect and support optimal IYCF. In 2001, the government disseminated "Policy Guidelines on the Feeding of Infants and Young Children in the Context of HIV/AIDS". At the global level, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) published "The Global Strategy for IYCF," and "The Framework for Priority Action" in 2002. Since that time, however, additional scientific evidence has become available, suggesting that exclusive breastfeeding for up to six months decreases the risk of HIV transmission compared to non-exclusive breastfeeding. Studies published in the last few years indicate that early cessation of breastfeeding (before six months) is associated with an increased risk of infant morbidity (especially diarrhoea) and mortality in HIV exposed children. A 2006 WHO consensus meeting on IYCF in the context of HIV/AIDS provided further guidance based on these findings. Uganda has taken note of these developments in the current policy guidelines.

These Policy Guidelines on IYCF update and comprehensively address the issues related to feeding of infants and young children. They are intended for use by planners, managers and implementers who are involved in the provision of maternal and child health, reproductive health and HIV/AIDS treatment, care and support.

I therefore call upon all stakeholders in IYCF to take and utilize these policy guidelines to their maximum advantage, to integrate the recommendations into their programs and to fund the necessary interventions listed herein, in order to contribute to a reduction of infant and young child malnutrition, morbidity and mortality. The Ministry of Health will continue to coordinate and monitor the implementation of these policy guidelines and progress made towards achieving optimal IYCF in Uganda.



Dr. Sam Zaramba
Director General of Health Services
Ministry of Health
Government of Uganda

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Acronyms

AFASS	Acceptable, Feasible, Affordable, Sustainable and Safe
ANC	Antenatal Care
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Drugs
ART	Antiretroviral Therapy
BMS	Breast Milk Substitutes
BFHI	Baby Friendly Health facility Initiative
CBO	Community Based Organization
CRC	Convention on the Rights of the Child
EBM	Expressed Breast Milk
ENA	Essential Nutrition Actions
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agricultural Organisation
GMP	Growth Monitoring and Promotion
HBC	Home Based Care
HC IV	Health Centre IV
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
HPAC	Health Policy Advisory Committe
HSSP	Health Sector Strategic Plan
ILO	International Labour Organization
IMAM	Intergrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IBFAN	International Baby Food Action Network
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
IU	International Units
MDG	Millennium Development Goal
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission of HIV infection
MPC	Maternity Protection Convention
MUAC	Mid Upper Arm Circumference
NCHS	National Centre for Health Statistics
NGO	Non Governmental Organization
NuLife	Food and Nutrition Interventions for Uganda
PMTCT	Prevention of Mother-to-Child Transmission of HIV infection
RF	Replacement Feeding

RCQHC	Regional Centre for Quality Health Care
SAM	Severe Acute Malnutrition
TFC	Therapeutic Feeding Centre
UDHS	Uganda Demographic and Health Survey
UHT	Utra Heat Treated
UNAIDS	United Nations AIDS Program
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on Children
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UPHOLD	Uganda Program for Human and Holistic Development
URC	University Research Co. , LLC
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counselling and Testing
WFP	World Food Program
WHA	World Health Assembly
WHO	World Health Organization

Explanation of Terms

AFASS

Acceptable: The mother perceives no significant barrier(s) to choosing a feeding option for cultural or social reasons or for fear of stigma and discrimination.

Feasible: The mother (or other family member) has adequate time, knowledge, skills, and other resources to prepare feeds and to feed the infant as well as the support to cope with family, community, and social pressures.

Affordable: The mother and family, with available community and/or health system support, can pay for the costs of the replacement feeds—including all ingredients, fuel and clean water—without compromising the family's health and nutrition spending.

Sustainable: The mother has access to a continuous and uninterrupted supply of all ingredients and products needed to implement the feeding option safely for as long as the infant needs it.

Safe: Replacement feeds are correctly and hygienically stored, prepared, and fed in nutritionally adequate quantities; infants are fed with clean hands using clean utensils, preferably by cups.

Breast Milk Substitute

Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.

Bottle feeding

Feeding from a bottle, whatever its contents, whether expressed breast milk, water, infant formula or another food or liquid.

Breastfeeding

Is the process of feeding an infant or young child milk directly from the breast.

Breast milk feeding

Feeding a baby expressed breast milk.

Cessation of breastfeeding

Completely stopping breastfeeding (including suckling), and breast milk feeding.

Complementary feeding

Giving a child other foods (solid or semi-solid) in addition to breastfeeding or replacement feeding to meet the babies nutrient requirements from 6 months of age.

Complementary food
Any food, whether manufactured or locally prepared, used as a complement to breast milk or breast milk substitute.

Exceptionally difficult circumstances
Special and difficult situations where families require extra support and attention in order to feed their children optimally.

Exclusive breastfeeding
Feeding a child through only breastfeeding, giving no other liquids or solids, not even water, with the exception of prescribed drops or syrups consisting of vitamins and mineral supplements or medicines, and expressed breast milk.

HIV- exposed children
Refers to children whose mothers were infected with the HIV virus prior to becoming pregnant, while the babies were in the womb or still breastfeeding.

HIV-negative
Refers to people who have taken an HIV test and who know that they tested negative, or to young children who have tested negative and whose parent(s) or guardians know the result.

HIV-positive
Refers to people who have taken an HIV test and who know that they tested positive, or to young children who have tested positive and whose parent(s) or guardians know the result.

HIV status unknown
Refers to people who either have not taken an HIV test or do not know the results of the test they have taken.

Infant
A baby from birth to 12 months of age.

Infant feeding counselling
Counselling on breastfeeding and complementary feeding, including counselling on infant feeding in the context of HIV/AIDS.

Kangaroo care
A method of care for low birth weight babies where the mother/caretaker carries the infant on the chest or abdomen in skin to skin contact. The rest of the baby's body not in contact with the mother/caretaker is covered with warm clothing, binding the mother or caretaker and baby together.

Low birth weight
A birth weight of less than 2500gm, whether pre-term or small for date.

Mixed feeding
Feeding both breast milk and other foods or liquids to a child under 6 months of age.

Normal circumstances
Refers to mothers and children that are not infected with or exposed to HIV or other exceptionally difficult circumstances

Palliative care
Refers to counselling, comforting, treatment and other support offered to terminally ill patients

Physical support
Presence, companionship and sharing responsibilities in a given setting

Pre-lacteal feeding
Giving other fluids or foods to a baby before initiation of breastfeeding.

Re-lactation
Re-establishing breastfeeding after a mother had stopped, whether in the recent or distant past.

Replacement Feeding
The process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients the child needs, until the child is fully fed on family foods. Replacement feeds do not include black coffee/tea, fruit juices, over-diluted milk.

Rooming in/Bedding in
When the mother and her baby stay in the same room/bed.

Young child
A young person from the age of 12 months and above; up to 5 years (60 months).

Executive Summary

These Policy Guidelines on Infant and Young Child Feeding (IYCF) aim to provide the framework for ensuring the survival of, and enhancing the nutrition, health, growth and development of infants and young children, as well as strengthening the care and support services to their parents and caretakers to help them achieve optimal IYCF. The justification for this is outlined below and more extensively in the document.

The feeding of infants and young children is a crucial factor in determining the health, nutrition, survival, growth and development of the individual. Children have the right to health and nutrition as stipulated in the Convention on the Rights of the Child (CRC). Furthermore, caretakers have the right to fully informed decision making on how to feed their children and to ensuring suitable conditions that support their feeding option decisions. Over the past 25 years, Infant and Young Child Feeding (IYCF) has received increasing attention, and several global instruments have guided formulation and implementation of policies and programmes in this area. At the national level, efforts have been directed to the promotion, protection and support of optimal IYCF, spearheaded by the Ministry of Health (MOH) in collaboration with its partners and stakeholders. Much progress has been made in HIV/AIDS prevention in Uganda, including several national policies and guidelines providing information and guidance on IYCF in the context of HIV. Counselling and support on IYCF options are also available in many health facilities.

Despite these impressive efforts,however, IYCF practices are not yet optimal. The Uganda Demographic Health Survey (2006)[1] shows that:

- Timely breastfeeding initiation, within the first one hour after delivery, is only 42%
- 54% of babies receive pre-lacteal feeds
- Exclusive breastfeeding from 0 up to 6 months is only 60%; and by 4 to 5 months it is only 34.8%
- Timely complementary feeding from 6 to 9 months is 80% ; but 72% of children 6 to 23 months receive inadequate complementary feeds (according to the 3 minimum standards of optimal complementary feeding: breastfeeding, plus minimum frequency, plus foods, from atleast 3 food groups)

Partly as a result of these inadequate practices:

- Malnutrition is prevalent with stunting rates at 38%, wasting rates at 6% and the rate of underweight children at 16%
- The infant mortality rate (IMR) stands at 76 deaths per 1000 live births, while the
- Under five mortality rate is currently 137 deaths per 1000 live births.[1]

Challenges exist with feeding of the HIV-exposed, malnourished and low birth weight (LBW) infants and young children, orphaned children, children of adolescent and employed mothers and children in other exceptionally difficult circumstances. None of the previous policies address the issue of IYCF in its totality. Those that touch on the issue give inadequate information and recommendations. It is against this background and in line with the Global Strategy for IYCF[2] that the Ministry of Health and its partners developed these policy guidelines on IYCF. The guidelines provide a framework for enhancing the nutrition, health, growth, and development of infants and young children, as well as strengthening the care and support given to their parents/caretakers in order to achieve optimal IYCF.

This document provides guidance on the feeding of infants and young children as follows:

a. Feeding the Infant/Young Child under "Normal" Circumstances

b. Feeding the Infant/Young Child who is Exposed to HIV

c. Feeding the Infant/Young Child in other Cxceptionally Difficult Circumstances

Implementation of these policy guidelines will be within the context of the Global Strategy for IYCF[2], the draft Uganda Child Survival Strategy, The Food and Nutrition Strategy, and other relevant national policies and guidelines. Several activities will be implemented, including but not limited to: advocacy and social mobilisation; capacity building; Information, Education and Communication (IEC) services; care and support services; counselling; integration; coordination and collaboration; growth monitoring and promotion (GMP); and resource mobilisation. Monitoring and evaluation at all levels will be done to ensure that implementation of the policy and guidelines are proceeding well and that the desired results are being achieved and documented.

Policy Guidelines

a) Feeding the Infant/Young Child under "Normal" Circumstances

Policy Guideline 1

All mothers should be counselled and supported to initiate breastfeeding within an hour of delivery and to exclusively breastfeed their infants for the first 6 months of the infant's life unless medically contra-indicated.

Policy Guideline 2

Parents shall be counselled and supported to introduce adequate, safe and appropriately fed complementary foods at 6 months of the infant's age while they continue breastfeeding for up to 2 years or beyond.

Policy Guideline 3

Pregnant women and lactating mothers should be appropriately cared for and encouraged to consume adequate quantities of nutritious foods.

b) Feeding the Infant/Young Child Who is Exposed to HIV

Policy Guideline 4

4a) Health service providers should establish the HIV status of all pregnant women and lactating mothers.

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

Policy Guideline 5

Exclusive breastfeeding should be recommended for infants of HIV infected women for the first 6 months of the infant's life, irrespective of the infant's HIV status, unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time.

Policy Guideline 6

Infants born to mothers living with HIV should be tested for HIV infection from 6 weeks of age, appropriate IYCF counselling given to the mother, based on her personal situation.

c) Feeding the Infant/Young Child in Other Exceptionally Difficult Circumstances

Policy Guideline 7

Malnourished children should be provided with appropriate medical care, nutritional rehabilitation and follow-up.

Policy Guideline 8

Mothers of infants who are born with low birth weight but can suckle should be encouraged to breastfeed, unless there is a medical contra-indication. Mothers of low birth weight infants who cannot suckle well shall be encouraged and assisted to express breast milk and to give it by cup, spoon or naso-gastric tube.

Policy Guideline 9

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

1 CHAPTER Overview of Infant and Young Child Feeding

1.1 Importance of Optimal Infant and Young Child Feeding

The feeding of infants and young children is crucial in determining the health, nutrition, survival, growth and development of the individual. Nutrition is a key element of the child's right to health as stipulated in the Convention on the Rights of the Child (CRC) [3]. All children have a right to adequate nutrition and access to safe and nutritious food. In addition, caretakers have the right to fully informed decision making on the feeding options for their children and to ensuring optimal conditions that support their feeding decisions. In spite of this recognition, maternal and child under-nutrition is the underlying cause of over a third (3.5 million) of all child deaths, and 35% of the disease burden in children younger than 5 years around the world. [4]

Data from the Uganda Demographic and Health Surveys (UDHS) leaves no doubt that malnutrition is prevalent in Uganda. According to the 2000/2001 UDHS, stunting rates were at 39%, wasting rates were at 4% and the rate of underweight children was at 23% among the under-five year olds included in the survey.[5] The more recent UDHS 2006 offers little consolation: stunting was at 38% wasting was at 6% and underweight at 16% among all children surveyed in the same age bracket. These rates of malnutrition contribute to over half of the high infant mortality rate of 76 deaths per 1000 live births.[1]

The risk of HIV transmission through breastfeeding poses a dilemma for infant feeding, particularly in a developing country like Uganda where the HIV infection prevalence of 6.4% remains a public health concern, and where breastfeeding is the norm and is critical for child survival[6]. Until recently, it was not possible to provide widespread early diagnosis of HIV infection in children or to make specific recommendations on the infant feeding options available. Recent advances in the provision of early diagnostic HIV services for children and the increased availability of antiretroviral therapy (ART) have made it possible to determine the HIV status of children and to provide them with early appropriate care, including counselling on IYCF.

Children exposed to HIV are at high risk of morbidity and mortality due to recurrent and chronic illnesses. Studies suggest that about 66% of infected children die before their third birthday if there is no intervention [7]. However, with early HIV diagnosis, these children will be able to access appropriate care, treatment, and feeding options. HIV exposed children are faced with nutritional challenges, particularly in the first 6 months of life when breast

milk is critical for optimal growth and development, and yet breastfeeding is associated with an up to 20% chance of maternal-to-child-transmission of HIV (MTCT).[8] Therefore, safe infant feeding plays a key role in the Prevention of Mother-to-Child Transmission of HIV infection (PMTCT).

Given the importance of IYCF, the World Health Assembly (WHA) adopted the "Global Strategy for Infant and Young Child Feeding" in the year 2002.[2] The Strategy aims to improve the nutritional status, growth and development, health, and therefore survival, of infants and young children through optimal feeding. It becomes imperative, therefore, that service providers, parents, relatives, and communities are provided with guidance and support to be able to implement optimal infant and young child feeding practices.

1.2 Global Instruments on IYCF

Over the past 25 years, IYCF has received increasing attention and several global instruments have guided the formulation and implementation of policies and programmes in this area. Several international instruments have stressed the need and obligation to support the health and nutrition of children through optimal feeding, to reduce impediments to optimal feeding and to ensure food security for all. [9, 10, 11, 12] They call upon countries to foster opportunities for women to combine child bearing, breastfeeding and child rearing roles, and to empower them to optimally feed their children.

"The International Code of Marketing of Breast-milk Substitutes" adopted by the WHA in 1981, and subsequent WHA Resolutions seek to ensure the provision of safe and adequate nutrition for infants and young children.[11] The Code and the Resolutions protect, promote, and support breastfeeding and ensure that breast-milk substitutes (BMS) are not marketed or distributed in ways that may interfere with breastfeeding. "The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding of 1990" called on all governments to empower women to breastfeed their infants exclusively for the first 4 to 6 months*, and thereafter to continue breastfeeding for 2 years or beyond while providing additional appropriate complementary foods.[12] In 1991, WHO and UNICEF launched the Baby Friendly Hospital Initiative (BFHI) with the objective to create an environment that supports mothers to breastfeed right from pregnancy and delivery, through implementation of the "Ten Steps to Successful Breastfeeding".[13]

In 2001, the "Report of an Expert Consultation on the Optimal Duration of Exclusive Breastfeeding" firmly recommended exclusive breastfeeding for the first 6 months of life for the general population.[14] This provided a foundation for the "Global Strategy for Infant and Young Child Feeding" (2003) which recommends exclusive breastfeeding for the first 6 months of life to the general population, with adequate and safe complementary feeding from the age of 6 months and continued breastfeeding for up to two years or beyond.[2] The Global Strategy also takes children in exceptionally difficult

***Note:** *The recommendation has since been updated to 6 months of exclusive breastfeeding in the Global Strategy for IYCF.*

circumstances into consideration, including those born to HIV-positive women. "The HIV and Infant Feeding: Framework for Priority Action" recommends to governments the key priority actions related to IYCF that cover the special circumstances associated with HIV/AIDS.[15]

The Millennium Summit of 2000 committed participating nations to working towards a world in which sustainable development and elimination of poverty would have the highest priorities. Millennium Development Goal (MDG) No. 4 requires national policies and programmes leading to the reduction of infant mortality by two-thirds by 2015.[16] Ensuring optimal IYCF is one of the key strategies for achieving this goal. At the United Nations General Assembly Special Session on Children (UNGASS) in 2002, 180 nations agreed to "a world fit for children" with a strong future agenda focused on four key priorities, including promoting healthy lives for children.[10] In the drive towards "a world fit for children", Uganda must strive to foster optimal IYCF.

The 2003 publications, "HIV and infant feeding: Guidelines for decision-makers" and "HIV and infant feeding: A guide for health–care managers and supervisors" developed by UNICEF, WHO, the United Nations AIDS Programme (UNAIDS), and the United Nations Fund for Population Activities (UNFPA) provide guidance to decision-makers, health care managers and supervisors on issues that need to be considered in relation to IYCF in the context of HIV/AIDS.[17, 18] These documents "outline the actions to be taken to protect, promote, and support appropriate infant and young child feeding practices for all women in relation to HIV" and "support HIV-positive women in their feeding decisions".

The "Consensus Statement from the WHO HIV and Infant Feeding Technical Consultation" of October 2006 recommends that the appropriate infant feeding option for the HIV-infected mother should depend on the woman's health status and the local situation.[19] Similar statements have also been made by the International Baby Food Action Network (IBFAN), Africa Region. In addition, IBFAN Africa has supported and participated in the development of policies and guidelines on the feeding of infants and young children in Uganda in particular. A study of all these recommendations, policies and guidelines has provided useful background to the development of these comprehensive Uganda "Policy Guidelines on Infant and Young Child Feeding".

1.3 Current National Policies and Guidelines related to IYCF

The child's right to an adequate diet is entrenched in the "Children's Statute of 1996", while the Food Safety Law and the Regulations on Marketing of Infant and Young Child Foods provide the legal framework for protecting the child from artificial undesirable breast milk substitutes.[20, 21] In addition, the maternity protection aspects of the "Employment Act of 2006" seek to safeguard the working mother's necessary role in infant feeding.

The "Uganda Food and Nutrition Policy" and "The Food and Nutrition Strategy" promote the recommended IYCF practices which are also stressed in the "National Health Policy", HSSP II and the "National Policy Guidelines and Service Standards for Reproductive Health Services".[22, 23, 24, 25]

Further guidance on IYCF is given in such Ugandan policies and guidelines as "The Baby Friendly Health Facility Initiative" (BFHI) and "Health Facility Practices Policy" of October 1999, the "Integrated Management of Childhood Illness (IMCI) Feeding Guidelines", the "Vitamin A Supplementation Guidelines" and "A Guide for Health Workers: Facts to know about Breastfeeding and Complementary Feeding",Ministry of Health, 1998. [26, 27, 28, 29]

The recognition of HIV/AIDS in Uganda since the early 1980s has led to formulation of policies to mitigate the impact of the HIV/AIDS epidemic. The revised Ministry of Health (MOH) Policy Guidelines for Prevention of Mother-to-child Transmission of HIV (2006) stresses the indisputable benefits of breastfeeding which result in the greatest protection against infant morbidity and mortality during the first six months of life.[30] The guidelines go on to acknowledge that breastfeeding is associated with transmission of the HIV virus from an infected mother to her baby, as evidenced by the 27.5% MTCT rate in a cohort of breastfeeding women seeking treatment at Mulago Hospital.[30] Given the need to reduce this risk of transmission, the policy stipulates that mothers living with HIV and their partners shall be counselled on infant feeding options to enable them make the most appropriate choices. Where replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), this should be the mother's first recommended option.[30]

As part of the process of scaling up access to services for comprehensive HIV/AIDS care for both adults and children, the Government of Uganda has put in place a programme for early diagnosis of HIV among infants and children less than 18 months old.[31] This provides an opportunity for getting infected children onto HIV care and treatment, including counselling and support to mothers for safe feeding.

In conclusion, much effort has been put into the promotion, protection, and support of optimal IYCF both at international and national levels. Several national policies and guidelines provide information and guidance on IYCF counselling, and support is increasingly available in many health facilities. Despite the efforts made by the Government and other stakeholders in promoting, protecting and supporting optimal IYCF, and the progress that has been made in HIV prevention in Uganda, none of the previous policies addressed IYCF comprehensively.

1.4 Justification

Optimal IYCF is essential for child growth, survival and development. Under normal circumstances, exclusive breastfeeding for the first 6 months is the most economical, safest, most optimal feeding mode critical for the infant's nutrition and survival. The child's requirements above 6 months of age increase beyond what breast milk alone can provide, therefore other foods must be introduced at that time to meet the growing infant's nutritional needs. However, breastfeeding continues to provide a substantial portion of the baby's requirements and should continue for up to 2 years of age or beyond. When the mother is infected with HIV, there exists an up to 20% risk of the infection being transmitted to the child through breastfeeding and this poses a great challenge to parents and health workers alike. [8]

At the national level, efforts have been directed to the promotion, protection and support of optimal IYCF spearheaded by the MOH in collaboration with its partners and stakeholders. Several national policies and guidelines provide information and guidance on IYCF and counselling. Despite these impressive efforts in promoting, protecting, and supporting optimal IYCF, and the progress that has been made in HIV prevention in Uganda, it has been found that:

- Timely breastfeeding initiation, within the first one hour after delivery, is only 42%
- 54% of babies receive pre-lacteal feeds
- Exclusive breastfeeding from 0 up to 6 months is only 60%; and by 4 to 5 months it is only 34.8%
- Timely complementary feeding from 6-9 months is 80% ; but 72% of children 6 to 23 months receive inadequate complementary feeds (according to the 3 minimum standards of optimal complementary feeding: breastfeeding, plus minimum frequency, plus foods from atleast 3 food groups).

Partly as a result of these inadequate practices:

- Malnutrition is prevalent with stunting rates at 38%, wasting rates at 6% and the rate of underweight children at 16%
- Micronutrient deficiencies are high, with rates of vitamin A deficiency among children and women at 20% and 19% and iron deficient aneamia at 75% and 49% respectively[1]
- The infant mortality rate (IMR) and under five mortality rate stand at 76 and 137 deaths per 1000 live births respectively.[1] Malnutrition is an underlying cause of 53% of deaths among children under 5 years of age[32]

Challenges exist with feeding of the HIV-exposed, the malnourished and low birth weight (LBW) infants and young children, orphaned children and children in other exceptionally difficult circumstances. There is still a deficiency in the policy framework on IYCF and support for its implementation. In particular, the provision of IYCF counselling, support, and follow up for HIV positive mothers remains one of the greatest challenges. Therefore, these newly developed comprehensive policy guidelines are designed to cover the entire spectrum of IYCF, and they are meant to provide the framework for enhancing the nutrition, health, growth and development of infants and

young children, as well as strengthening the care and support services to their parents/caretakers in order to achieve optimal IYCF.

1.5 Goal and Objectives

1.5.1 Goal

These "Policy Guidelines on IYCF" aim to provide the framework for ensuring the survival of, and enhancing the nutrition, health, growth and development of infants and young children, as well as strengthening the care and support services to their parents and caretakers to help them achieve optimal IYCF.

1.5.2 Objectives

The specific objectives of the guidelines are as follows:

1. Promote, protect, and support exclusive breastfeeding for the first 6 months of life, with continued breastfeeding up to 2 years and beyond.
2. Ensure nutritionally adequate and safe complementary feeding from 6 months of life while breastfeeding continues.
3. Support PMTCT services while promoting optimal IYCF in HIV-exposed children.
4. Strengthen the care, support, and follow-up services for pregnant women, mothers and caretakers in order to practice optimal IYCF.
5. Enhance optimal IYCF in other exceptionally difficult circumstances.
6. Advocate for appropriate interventions that promote and support the practice of optimal IYCF for all women, including employed mothers.
7. Contribute to the prevention and reduction of childhood and maternal malnutrition, illness and death.

2 CHAPTER IYCF Policy Guidelines

Overview

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

- Feeding the Infant/Young Child under "Normal" Circumstances
- Feeding the Infant/Young Child Exposed to HIV/AIDS
- Feeding the Infant/Young Child in other Exceptionally Difficult Circumstances

2.1 Feeding the Infant/Young Child under "Normal" Circumstances

2.1.1 Introduction

Optimal IYCF is fundamental for the nutrition, health, survival, growth and development of the child. Feeding practices are one of the major determinants of the health and nutritional status of children. Breastfeeding is a traditional practice in Uganda. The majority of mothers maintain breastfeeding for long periods.[33, 34, 35, 36] Breast milk contains all the nutrients required by an infant for the first 6 months of life. In addition, breastfeeding has other benefits including protection from illness for the infant, psychological bonding between the mother and her infant, and economic savings and benefits to mothers, families and communities.[37] Furthermore, breastfeeding improves the health of mothers by decreasing the risk of bleeding after delivery, promoting child spacing, and helping to prevent breast and ovarian cancers.[37] Breastfeeding also offers substantial monetary savings for the nation as well as the individual family with its economic and ecological benefits[37]. Under normal circumstances, an infant should be exclusively breastfed for the first 6 months of life. Thereafter, complementary foods should be introduced while breastfeeding continues for up to 2 years or more.[37] However, mothers and families will need more information and support in order to achieve these optimal IYCF practices.

2.1.2 Aim and Objectives

This section aims at ensuring optimal IYCF under "normal" circumstances. The objectives are to:

- Ensure timely initiation of breastfeeding within the first hour of birth.
- Protect, promote, and support exclusive breastfeeding for the first 6 months and continued breastfeeding up to 2 years and beyond.
- Promote timely introduction of nutritionally adequate complementary foods.

2.1.3 IYCF Issues

Issue 1

a) 58% of mothers do not initiate breastfeeding within the first hour of delivery; and 54% of babies are given pre-lacteal feeds
b) 40% of mothers with infants 0 to 6 months do not exclusively breastfeed.

Justification

Early initiation of breastfeeding helps bonding between the mother and her baby, prevents postpartum haemorrhage and increases breast milk production. However, only 42% of mothers initiate breastfeeding within the recommended one hour after delivery[1]. There is also evidence that rooming/bedding in of mother and baby is important for purposes of practicing breastfeeding on demand, bonding and the baby's temperature control. It was found that in some health facilities in Uganda, babies are still separated from their mothers [26]. Pre-lacteal feeds are not only a source of infection but also interfere with establishing breastfeeding. To maximize the benefits of breastfeeding, it must be exclusive for the first 6 months of the child's life. Data indicates, however, that only 60% of mothers with infants 0 to 6 months were exclusively breastfeeding, although at 4 to 5 months only 34.8% were exclusively breastfeeding.[1]

Policy Guideline 1

All mothers should be counselled and supported to initiate breastfeeding within an hour of delivery and to exclusively breastfeed their infants for the first 6 months of the infant's life unless medically contra-indicated.

Implementation

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

This policy guideline requires that the following recommendations are implemented:

- Ensure that all health facilities offering maternity services implement the Baby Friendly Health facility Initiative (BFHI) and become certified as Baby-Friendly, according to the BFHI Requirements in Chapter 4, 4.1.
- Implement and monitor the Regulations on the Marketing of Infant and Young Child Foods according to the national law.
- Ensure rooming in/bedding in of mothers and newborn infants.
- Support mothers to initiate early contact with their newborn babies for at least one hour, combined with the initiation of breastfeeding within the first hour.
- Encourage mothers to feed their infants colostrums or "first milk" .
- Counsel mothers to breastfeed frequently on demand, both by day and night.
- Strengthen information and communication on the importance of avoiding pre-lacteal feeds such as water, glucose water, teas, and herbal preparations for newborn babies.
- Support mothers to position and attach the baby to the breast correctly, and to completely empty one breast before offering the second, in order to ensure that the infant gets the rich hind milk as well as to avoid breast problems.
- Counsel mothers and support them to continue and even increase the frequency of breastfeeding when the mother or the child is sick. Where the infant is unable to suckle, expressed breast milk should be fed by cup or tube.
- Counsel and educate mothers on how to identify breastfeeding difficulties, including breast conditions, and the need to promptly seek medical care from a Ministry of Health approved provider, preferably in a baby friendly health facility.
- Counsel mothers to maintain a child health card or mother/child health passport to monitor the growth and development of the child, to take their children to health promotion sessions or the nearest health facility, to ensure timely immunisation and to make sure that the child sleeps under an insecticide treated mosquito net (ITN).
- Ensure that employers protect and promote Maternity Rights and Benefits as outlined in Chapter 4, 4.3.
- In emergency situations follow the steps outlined in Chapter 4, 4.7: Practical Steps to Ensure Appropriate Infant and Young Child Feeding In Emergencies.
- Promote key essential nutrition actions (ENA) messages at all relevant contact points .

Issue 2

20% of infants 6 to 9 months do not get timely complementary feeding, and 72% of children 6 to 23 months receive inadequate complementary feeds.

Justification

Breast milk becomes inadequate for the baby's nutritional requirements after 6 months and other foods become necessary.[2, 14] To ensure that infant and children's requirements are met, complementary foods should be timely, nutritionally adequate, safe and appropriately fed. Only 80% of Ugandan infants at 6 to 9 months of age were receiving complementary foods, and 72% of children 6 to 23 months were receiving inadequate complementary feeds according to the 3 minimum standards of optimal complementary feeding (i.e breastfeeding, minimum frequency, and foods from at least 3 food groups).

Infants and young children may not be fed adequately when they or their mothers are sick. When a sick baby stops breastfeeding/ feeding, she or he loses more weight and takes longer to recover. Sick infants and children need to be fed more frequently than usual in order to meet their nutritional requirements. Micronutrient deficiencies are common among Ugandan children as evidenced by a high rate of anaemia of over 73%, and a low serum retinol rate of 20%.[1] This makes consumption of micronutrient supplements and fortified foods essential for all children. [1, 38]

Policy Guideline 2

Parents shall be counselled and supported to introduce adequate, safe and appropriately fed complementary foods at 6 months of the infant's age while they continue breastfeeding for up to 2 years or beyond.

Implementation

The following are key recommendations for implementing this policy:

- Introduce soft, semi-solid complementary foods at 6 months of the child's age and continue breastfeeding until 2 years of age or beyond.
- Promote the use of a variety of nutritious, locally available foods for infants and young children.
- Encourage parents/caretakers and guide them to feed liquid foods using clean cups without spouts and not to use bottles or teats.
- Ensure that the food is of the right consistency (thickness) and nutrient density (especially related to energy and micronutrients).
- Feed complementary food 5 times a day and increase the amount, as the infant grows older.
- Encourage parents to practice active feeding, meaning that they should interact with the infant during feeding times.
- Encourage parents to practice high standards of hygiene when handling the infant's food, and also to maintain sanitation standards and food/water safety.

- Encourage parents to ensure that their infants and children receive vitamin A supplements every 6 months starting at six months of age, and de-worming medicines every 6 months starting at one year of age until the children are 5 years old.
- Counsel and support mothers to space births 2 - 3 years apart in order to achieve the optimal duration of breastfeeding.
- Counsel mothers to continue monitoring the growth of their children through 5 years of age, and maintain the child growth card or mother/child health passport for recording this growth.

Issue 3

Pregnant women and lactating mothers do not have adequete care and intake of nutritious foods.

Justification

Among women of reproductive age, only 71% have a satisfactory Body Mass Index (BMI), 49% are anaemic and 19% exhibit Vitamin A deficiency.[1] Care and support is needed for the optimal reproductive performance of pregnant women and lactating mothers. Yet in many communities in Uganda, pregnant women and lactating mothers do not receive adequate support from their male partners, relatives and the communities.

Policy Guideline 3

Pregnant women and lactating mothers should be appropriately cared for and encouraged to consume adequate quantities of nutritious foods.

Implementation
The following are key recommendations for implementing this policy:

- Encourage all pregnant women and support them to:
  - » Seek ANC services at least 4 times during pregnancy and to carry the Mother and Child Health Passport
  - » Seek other relevant health related services
  - » Eat a variety of foods and have one additional meal every day;
  - » Take de-worming and presumptive malaria treatment according to National Guidelines
- Ensure that all pregnant women and lactating mothers are:
  - » Provided with Iron and Folic Acid tablets according to National Guidelines
  - » Encouraged to sleep under insecticide treated mosquito nets
- Ensure that lactating mothers are:
  - » Provided wth Vitamin A supplements according to National Guidelines

  - » Encouraged to eat a variety of foods and have two additional meals every day
- Encourage communities to find ways to reduce heavy work load, as well as cultural and gender inequities which impair women's reproductive performance.
- Male partners, relatives and communities should be mobilized and guided to provide physical, moral, psychosocial, financial and other material support to pregnant women and lactating mothers
- Provide counselling and support on family planning for women and their partners
- Provide counselling and support on prevention of HIV infection for women and their partners
- For HIV-positive women:
  - » Scale up the establishment of community-based networks offering mother-to-mother support
  - » Be aware of and manage drug-food interactions for those on Anti-retroviral therapy (ART)
- Encourage HIV-positive women to:
  - » Increase their energy intake by 10% (i.e. one additional snack per day) if they are asymptomatic or by 20-30% (which is 2 or 3 snacks a day) if they are symptomatic
  - » Have their weight monitored frequently and seek medical care immediately if their weight reduces significantly (e.g. by 10% or more)
  - » Receive other aspects of HIV palliative care, especially to seek treatment for opportunistic infections as they can interfere with nutrition
  - » Avoid re-infection with HIV

2.2 Feeding the Infant/Young Child who is exposed to HIV

2.2.1 Introduction

HIV/AIDS in Uganda is predominantly caused by the HIV-1 type of virus. MTCT accounts for the vast majority of new infections in children.[39, 40, 41] Infants can acquire HIV from their infected mothers during pregnancy, at the time of delivery, or after birth through breastfeeding.[42, 43, 44, 45, 46, 47] Transmission through breastfeeding accounts for up to 20% of MTCT.[8] It is estimated that more than 20,000 children in Uganda are infected with HIV annually through MTCT if there is no intervention, but with various PMTCT interventions this rate can be reduced by 50-95%.[44, 47, 48] The key strategies in PMTCT include routine HIV counselling and testing during pregnancy; antiretroviral drug (ARV) prophylaxis for HIV-infected pregnant women and their infants; and appropriate infant feeding.

Early diagnosis of HIV in children[31,49, 50, 51] has made it possible to classify HIV- exposed children into three categories, namely:

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

These categories are useful for deciding appropriate care and treatment for HIV-exposed children, including IYCF.

2.2.2 Aim and objectives

This section aims at ensuring optimal feeding for the infant and young child exposed to HIV. The objectives are to:

1. Promote optimal feeding for the HIV-exposed children
2. Reduce HIV transmission through breastfeeding

2.2. 3 Policy issues

Issue 4

Many pregnant and lactating women do not undergo routine HIV counselling and testing.

Justification

Knowing the HIV status of pregnant and lactating women will facilitate identification of HIV-exposed infants and children in order to decide on their most appropriate care and feeding.

Policy Guideline 4

4a) Health service providers should establish the HIV status of all pregnant women and lactating mothers.

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

Implementation

Implementation of this guideline shall be in conjunction with the PMTCT and HCT policy guidelines.

Issue 5

Without intervention one in ten children born to HIV-infected mothers get infected with HIV through breastfeeding.

Justification

When the mother is infected with HIV, there exists an up to 20% risk of the infection being transmitted to the child through breastfeeding and this poses a great challenge to parents and health workers alike. [8]

Current evidence indicates that exclusive breasfeeding and the use of anti -retrovirols greatly reduce MTCT. Replacement feeding (RF), if it is exclusive, eliminates MTCT of HIV through breast milk while offering acceptable nourishment for the child. However, exclusive replacement feeding carries the risk of diarrhoea, pneumonia, and malnutrition if it is not prepared properly, following instructions, and given to the baby in a hygienic way.

Policy Guideline 5

Exclusive breastfeeding should be recommended for infants of HIV-infected women for the first 6 months of the infant's life, irrespective of the infant's HIV status, unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time.

Implementation

Implementation of this policy requires the following actions:

- Counsel HIV-infected pregnant women and lactating mothers on the infant feeding options available to them. There is a need to scale up and strengthen quality infant feeding counselling, support, and follow up services of HIV-infected mothers nationwide.

- Ensure that the counselling:
  - » Is done by IYCF counsellors who have undergone the MOH approved "Integrated Infant and Young Child Feeding Counselling Training Course" (2006)[52]
  - » Makes use of the MOH approved IYCF counselling tools/job aides
- Takes into account the MOH recommended feeding options, which are:
  - » **Exclusive breastfeeding for the first 6 months, OR**
  - » **If AFASS, exclusive replacement feeding for the first 6 months, using infant formula or animal milk**
- Emphasize to HIV positive women that whether they choose breastfeeding or replacement feeding, infant feeding must be exclusive for the first six months with NO mixed feeding

Caution: *Inappropriate use of replacement feeds is associated with high rates of illness and death, especially among infants 0-6 months of age. Until a standardized and nutritionally adequate fresh animal milk product becomes available, parents should be cautioned on the difficulties associated with replacement feeding, including accessing undiluted and undulterated animal milk.*

- Support HIV-infected mothers to initiate their chosen feeding option upon delivery
- For mothers who opt to exclusively breastfeed, stop all breastfeeding at 6 months
  - » **UNLESS** the baby is HIV positive, or
  - » **UNLESS** AFASS criteria are not met and a nutritionally adequate and safe diet cannot be provided without breast milk.

Caution *should be taken to make the transition from exclusive breastfeeding to replacement feeding as short as possible, preferably within 2 weeks.*
Heat treatment of expressed breast milk can be used as a strategy to reduce the risks associated with this transition period.

- If a breastfeeding mother meets AFASS before 6 months, counsel on the transition to exclusive replacement feeding.
- For mothers who opt to **exclusively replacement feed:**
  - » Educate and counsel them to feed their infants using open cups rather than feeding bottles with teats or spouted cups (see Chapter 4, section 4.4)
  - » But no longer meet AFASS criteria before 6 months, counsel and support her to either make it AFASS again or to re-lactate, and avoid mixed feeding after breastfeeding has been re-established
  - » Ensure that the marketing, procurement and distribution of BMS complies with the Regulations on the Marketing of Infant and Young Child Foods

- Where the situation of the mother makes replacement feeding not AFASS, counsel and support the mother to continue breastfeeding after 6 months, with appropriate complementary feeding, for up to 2 years
- Follow up all HIV-exposed infants, whatever the feeding mode, and continue to offer infant feeding counselling and support to caregivers
- If an HIV-exposed child falls sick, regardless of the mode of feeding, counsel the caretaker to feed the child even more frequently than usual in order to meet that child's nutritional requirements*

***Note:** *If the child is HIV-infected she/he needs an additional 10% increase in food if asymptomatic, a 20-30% increase in food if symptomatic, and a 50-100% increase if losing weight.*[53]

- Provide micronutrient supplements to children on animal milk as a replacement feed: give ¼ tablet (50mg) of iron and ¼ tablet (0.5mg) of folic acid daily
- Counsel parents/caretakers on the potential drug-food interactions for children on ART and the management of dietary related symptoms such as diarrhoea, vomiting, mouth sores, and oral thrush

Issue 6

The majority of HIV-exposed infants and young children do not get tested early for HIV.

Justification

Early diagnosis of HIV infection among the exposed infants and young children allows for the opportunity to provide appropriate treatment with follow-up care and support for the affected children, including IYCF counselling. Unfortunately, when mothers who are exclusively breastfeeding learn that their child is HIV-free, they are likely to want to stop the breastfeeding abruptly. Mothers should be counselled to understand the balance of risks associated with not breastfeeding. Counsellors should review a mothers personal situation (AFASS) so that she can make an informed choice wether or not to continue breastfeeding.

Policy Guideline 6

Infants born to mothers living with HIV should be tested for HIV infection from 6 weeks of age, appropriate IYCF counselling given to the mother, based on her personal situation.

Implementation

- Implement this policy guideline in conjunction with the PMTCT and early infant diagnosis of HIV policy guidelines.
- As a general principle, test infants exposed to HIV from 6 weeks of age. During and after the infant HIV testing at that time:
  - » Provide additional counselling support and follow-up for infant feeding to all mothers, reassessing their situation and recommending replacement feeding only if AFASS
  - » Ensure that mothers who have opted to breastfeed, and their infants test negative for HIV-infection, are supported as much as necessary to continue exclusive breastfeeding up to 6 months if Replacement Feeding is not AFASS
- After 6 months, encourage parents to make all efforts to provide a nutritionally adequate and safe diet. Cousellling should address the following:
  - » If the infant tested negative for HIV-infection, stop breastfeeding if the AFASS condition is met, or as soon as the AFASS condition is met
  - » For mothers who opted to breastfeed and their infants tested positive for HIV, counsel them to continue breastfeeding for as long as they can, while introducing complementary foods at 6 months
  - » Breastfeeding protects the infant from other infections, regardless of HIV status

2.3 Feeding the Infant/Young Child Who is in Other Exceptionally Difficult Circumstances

2.3.1 Introduction

In line with the Global Strategy for IYCF, consideration must be given to infants and young children in other exceptionally difficult circumstances, including malnourished children, low birth weight babies, children in emergency situations; street children; children whose mothers are very ill or dead, alcoholic and/or addicted to drugs; and infants/children rejected, abandoned, displaced, in refugee settlements, in foster institutions; and children of imprisoned mothers. Children in these circumstances stand a high risk of malnutrition and therefore require special attention and practical support to ensure optimal IYCF.

Exclusive breastfeeding for the first 6 months is very important for infant nutrition and health in difficult circumstances because it is safe, acceptable, and affordable to many families. However after 6 months there should be timely introduction of nutritionally adequate complemetary foods. If there is no possibility for the infant to be breastfed or fed expressed breast milk by cup and RF becomes necessary, the following critical issues must be addressed:

- Ensure that action is based on an assessment of the factors affecting infant and young feeding practices in the specific situation.
- Create a mechanism for coordinating and monitoring infant feeding activities, with a lead agency nominated to manage infant feeding issues and a framework for action agreed by all parties.
- Eliminate practices that undermine breastfeeding. Donations of infant formula and other breast milk substitutes (BMS) should be systematically refused and any requirements for BMS and replacement feeding should be met by purchasing supplies.
- Recognize the special needs of women feeding infants and support them in every way.
- Minimize the dangers in feeding to infants and their families.
- Increase awareness and knowledge about the benefits of breastfeeding among all stakeholders in emergency situations.

2.3.2 Aim and objectives

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

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

2.3.3 Policy Issues

Issue 7

Malnourished infants and young children do not receive adequate treatment, care and support.

Justification

Whilst promotion of optimal IYCF practices, amongst other interventions, aims to prevent malnutrition from arising, it is important that clear IYCF policies are highlighted if malnutrition manifests. First, it is necessary to identify the risk of malnutrition early in order to prevent further deterioration and provide an opportunity to counsel mothers/caretakers on appropriate practices. Children often become malnourished because their mothers/ caretakers have not been very successful with breastfeeding or they have encountered some difficulties with particular practices. Regular monitoring of growth and documentation on the Child Health Card or mother/child health passport (e.g. monthly) can help to identify a child at risk of malnutrition. Caretakers need information and guidance on appropriate IYCF as part of on-going nutrition support. In addition, results from the therapeutic feeding centres (TFCs) in Uganda indicate that 30-40% of the severely malnourished children are infected with HIV. [54]

Policy Guideline 7

Malnourished children should be provided with appropriate medical care, nutritional rehabilitation and follow up.

Implementation

- Pay extra attention to malnourished children both during the early rehabilitation phase and over the longer term to prevent relapse and promote good health and nutrition.
- Build the capacity of health facility staff to recognise and manage/ refer cases of severe or moderate malnutrition, as recommended in the national guidlines on the "Intergrated Management of Acute Malnutrition in Uganda".

- Counsel and support mothers of malnourished children to continue frequent breastfeeding and, to re-lactate where necessary and appropriate.
- Give nutrition education and support to mothers and caretakers on appropriate breastfeeding and complementary feeding practices using locally available foods , with an emphasis on using the existing community structures to disseminate the messages.
- Assist health and community workers to actively pursue growth monitoring and promotion (GMP) for all children so that malnutrition can be prevented and detected early. Encourage families and communities to take their children for regular growth monitoring and screening for malnutrition by weighing and/or taking their Mid Upper Arm Circumference (MUAC).
- Provide treatment and care of malnourished children in health institutions or in communities as recommended in the national guidelines "Intergrated Management of Acute Malnutrition in uganda".
- Encourage mothers/caretakers and their malnourished children to undergo routine HIV counselling and testing.
- Establish linkages between nutrition rehabilitation units and HIV clinics for more comprehensive care.

Issue 8

Breast milk intake is not adequately promoted for low birth weight (LBW) babies.

Justification

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

Policy Guideline 8

Mothers of infants who are born with low birth weight but can suckle should be encouraged to breastfeed, unless there is a medical contra-indication. Mothers of low birth weight infants who cannot suckle well shall be encouraged and assisted to express breast milk and to give it by cup, spoon or naso-gastric tube.

Implementation

- Care for very small babies, less than 30 weeks gestational age, in the health facility together with their mothers. They usually require feeding through naso-gastric tubes for giving the EBM. Directions on Hand Expression of Breast milk are described in Chapter 4, section 4.5. Slightly larger infants, about 30-32 weeks gestational age, can usually take feeds from a small cup or can be fed with cup and spoon. Infants of about 32 weeks gestational age or more are usually able to start suckling on the breast. They can be cared for in the home using the "Kangaroo" method. Infants from about 34-36 weeks gestational age can take most of what they require directly from the breast.[55]
- Find the details for feeding LBW babies in Chapter 4, Section 4.6 of this document.

Issue 9

Optimal IYCF for children in emergencies and other difficult/special circumstances is not adequately promoted.

Justification

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

The best food for all infants in exceptionally difficult circumstances is their own mother's milk unless medically contraindicated, given the multiple benefits that accrue from breastfeeding. Only when the mother is absent or otherwise unable to breastfeed should replacement feeding be implemented. Such circumstances call for a special and supportive environment for health, community, and emergency workers, as well as families, in order to support appropriate IYCF as required. The special supportive enviroment may also include additional food, water, shelter, and health care services.

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

Policy Guideline 9

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

Implementation

- Emphasize protecting, promoting, and supporting breastfeeding and ensuring timely, nutritionaly adequate, safe, and appropriately fed complementary foods, consistent with the age and nutritional needs of older infants and young children.
- Guide health workers to identify infants who need to be fed with BMS, ensuring that a suitable substitute is provided and fed safely for as long as needed by the infants concerned.
- Ensure that whenever BMS are required for social or medical reasons, for example, for orphans or in the case of HIV positive mothers, they are provided for as long as the infants concerned need them.
- Accept the use of BMS in exceptionally difficult circumstances when the child's mother is not available, but the marketing and distribution of the BMS must be controlled and monitored in accordance with the Uganda law.
- Use donations of BMS and feeding utensils for children in difficult circumstances only if approved and cleared by the MOH before distribution. Feeding bottles and cups with spouts should not be accepted.
- Strengthen education and communication to ensure that children continue to be fed when they or their mothers fall sick. The feeding should be even more frequent during illness and while the child is recovering.
- Avoid separating mothers and their infants to facilitate continued feeding and care.
- Ensure that health workers have accurate and up-to-date information about infant feeding policies, guidelines and practices, and that they have the specific knowledge and skills required to support children and their caregivers in all aspects of IYCF in difficult circumstances.
- Adopt the BFHI, as well as other forms of protection and promotion of breastfeeding, and provide the necessary support to prevent spill-over of artificial feeding for those mothers where breastfeeding is actually the best option.

Additional guidance on optimal IYCF can be found in Chapter 4, Section 4.7: Practical Steps to Ensure Appropriate Infant and Young Child Feeding In Emergencies.

3 CHAPTER Implementation, Monitoring and Evaluation

3.1 Implementation Strategies

The implementation of these policy guidelines will be in line with the Global Strategy for IYCF and the relevant national policies and guidelines cited in this document. The implementation of the section on Feeding of Infants and Young Children exposed to HIV will require wide access to HIV counselling and testing services; strengthening prenatal, delivery, postnatal care, and family planning programmes; as well as strengthening the care provided to both parents and HIV-exposed children. As part of the PMTCT Programme, all pregnant and postnatal clients of unknown status will be offered HIV testing while the Early HIV Diagnosis and Care for Infants Programme undergoes implementation. In addition, children will be identified through well and sick child visits including immunisation, postnatal and paediatric clinics, nutrition rehabilitation units, wards for children with diarrhoeal diseases, and outreach and community-based services.

3.1.1 Advocacy and Social Mobilisation

Advocacy for optimal IYCF will be crucial for the successful implementation of this policy. Advocacy will be done at various levels including the international, national, and district levels. Social partners, including community networks and groups, will be targeted in an effort to encourage support for interventions promoting optimal IYCF.

3.1.2 Capacity Building

Capacity building, in terms of improving the facilities, upgrading the infrastructure, and providing necessary skills for health and community workers will be a key strategy. Recruitment of additional nutritionists at the national, regional and district levels will be required in order to scale up the implementation of this comprehensive IYCF policy.

Training and education (in service and pre-service) of health care providers in the benefits and management of breastfeeding, re-lactation, infant feeding in the context of HIV (AFASS, the use of exclusive breastfeeding and exclusive replacement feeding), "Kangaroo" care, appropriate complementary feeding and all other aspects of optimal IYCF will be stressed. Similarly, community

based workers and networks such as village health teams will need training, follow-up support, and educational/counselling tools on IYCF.
Staff in nutrition rehabilitation centres will require knowledge and skills on management of acute malnutrition. Capacity building to strengthen utilization of data captured for IYCF, including malnutrition and low birth weight data in the Health Management Information System (HMIS), will also be necessary.

Disasters and emergencies can occur anywhere at any time, and usually when least expected. Most often decision makers and community health workers are caught unawares, and they depend on support from development partners and humanitarian agencies that operate under their own guidelines and practices. Health workers shall be trained or sensitized on preparedness and support for IYCF in difficult circumstances. On-going training and sensitization of health workers prior to emergencies makes them more prepared and less likely to be influenced by the outside agencies that respond and help. The need to promote training/sensitization of the relevant workers at national and district levels in preparedness for IYCF in difficult circumstances must be supported.

3.1.3 Information Education and Communication (IEC)

During implementation, an Information, Education and Communication (IEC) strategy will be employed to create awareness on all aspects of optimal IYCF. This will involve the use of print and electronic media as well as interpersonal communication and the community dialogue approach. Community mobilization will be a key intervention in the implementation of these policy guidelines. Creation of awareness at the community level is essential to ensure implementation of optimal infant feeding practices. Community leaders, village health teams, and community resource persons will be sensitized to promote and support optimal IYCF. Communities will be encouraged to initiate and/or strengthen support groups for the promotion of optimal IYCF among other activities. Parents, caretakers, families, and communities will be given information on production, storage, preparation and utilization of food through demonstrations, taking into account different cultures.

3.1.4 Care and Support

Care and support services will be offered to pregnant and lactating women to enhance their reproductive performance. Mothers with poor nutritional status will be offered food supplements where possible in addition to other services. Male partners and other influential relatives are an important source of support for pregnant and lactating women. Besides financial, psychosocial, and physical support, they can help in reducing the women's workload and in removing the cultural and gender imbalances which would otherwise impede a mother's ability to practice optimal IYCF. Efforts will be made to sensitise men and encourage them to participate in the health and nutrition activities that promote optimal IYCF.

Key areas for implementation are promotion of parental love, nutrition services, health care services, and education. Of particular significance is the provision of nutrition support and care during pregnancy and the post-natal period to prevent LBW. Nutritional support for women, which should target especially those of reproductive age, includes provision of information on proper nutrition, iron/folic acid supplements, additional food supplementation and promotion of timely initiation and exclusive breastfeeding. Post-natal follow up and care services for mothers and infants, including those in a PMTCT programme, need to be strengthened.

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

3.1.5 Counselling and Follow-Up

Counselling services will be strengthened to empower parents, caretakers and families to make informed decisions about infant and young child feeding. The parents and families will then be supported to implement their decisions so that optimal IYCF is achieved. Additional counselling and support will be offered to mothers working outside their homes to enable them to practice optimal IYCF. Family caretakers should be counselled to use cup feeding when opting for the IYCF option of replacement feeding or when using EBM. Counselling of parents and sensitization of the communities about the feeding of sick infants and young children will be done. When mothers fall sick they will be encouraged and supported to continue feeding their infants and young children. Efforts will be made to ensure that mothers and infants are not separated under any circumstances.

3.1.6 Integration, Coordination and Collaboration

Strategic linkages will need to be forged with the different Uganda departments, programmes and policies in order to achieve the maximum impacts while implementing these IYCF Policy Guidelines. Coordination and collaboration enhances the effective participation of key stakeholders, maximises the use of resources, provides guidance, and sets standards of achievement. The MOH will be the principal implementer of these policy guidelines. Given the multi-sectoral nature of the interventions required, other important stakeholders will be involved as recommended in the section on roles and responsibilities.

Harmonization of messages and integration of IYCF in initiatives targeting women and children such as BFHI, IMCI, PMTCT, ART, and Home Based Care (HBC) programmes as well as other reproductive health interventions, will be actively pursued. The ENA approach shall be used as a means of ensuring IYCF promotion at the various key contact points (ANC, delivery, post- natal/family planning, immunizations, growth monitoring/well child, and sick child consultations), in addition to promotion at schools and within the community. It will be important to strengthen the use of community

based health workers, peer counsellors, and mother support groups as well as links with agricultural and other extension workers in the promotion of optimal IYCF.

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

3.1.7 Strengthening Growth Monitoring and Promotion (GMP) including Screening and Referral

In order to conduct GMP at the health facility and community levels, it will be necessary to build the capacity of facility and community based health workers, including growth promoters and leaders of mother support groups, on growth monitoring and counselling. The traditional form of growth monitoring (using weight for age) can work alongside the use of MUAC for easier identification of the malnourished. They can then be referred for further care and support. Importantly, GMP that is carried out at the community level shall be used as a contact point for promoting best IYCF practices. Integration of Nutrition into Village Health Team strategy will be required.

3.1.8 Resource Mobilization

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

3.2 Monitoring and Evaluation

Monitoring and evaluation at all levels will be done to ensure that the implementation of the Policy Guidelines is proceeding well and that the desired results are being achieved and documented. Both process and outcome indicators will be assessed routinely as well as periodically.

3.2. 1 Indicators

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

- Percentage of mothers initiating breastfeeding within one hour of delivery
- Percentage of mothers rooming in/bedding in with their newborn babies
- Percentages of HIV negative or unknown status mothers practicing exclusive breastfeeding at 3 and 6 months
- Percentage of babies aged 0-6 months receiving no other food or fluid apart from breast milk
- Percentage of HIV positive mothers practicing mixed feeding at 3 months.
- Percentage of children started on complementary foods at 6 to 10 months
- Percentage of mothers who continue to breastfeed up to 2 years
- Percentage of infants receiving feeds using open cups
- Number of trained IYCF counsellors
- Number of mothers individually counselled on infant and young child feeding
- Percentages of HIV positive mothers practicing exclusive RF at 3 and 6 months
- Percentages of HIV positive mothers practicing exclusive breastfeeding at 3 and 6 months
- Percentage of children under 6 months in difficult circumstances who are being exclusively breastfed
- Percentage of children under 6 months in difficult circumstances who are being fed on breast milk substitutes
- Percentage of children aged 6 to 59 months who received Vitamin A supplements
- Percentage of children aged 6 to 59 months who received
- de-worming medicine
- Number of health workers trained in preparedness and support for IYCF in difficult circumstances at both the national and district levels.
- Number and gravity of violations of the Food Safety (Marketing of Infant and Young Child Foods) Regulations

- Percentages of legible health facilities that are baby friendly
- Propotion of HIV positive mothers practicing mixed feeding at 3 months

3.2. 2 Sources of Information

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

- Health Management Information System (HMIS)
- Nutrition information system
- Support supervision reports
- BHFI assessments
- District nutrition surveys
- Uganda Demographic and Health Surveys (UDHS)
- Monitoring for compliance with and violations of the regulations
- Community-based management information systems, where established
- Other surveys and researches

3.3 Roles and responsibilities

3.3.1 Cabinet, Parliament and Judiciary:

- Accept and position IYCF as a priority on the national agenda
- Provide support for laws, regulations, policies, strategies and programs dealing with IYCF, including maternity protection regulations.
- Ensure compliance with the existing laws and regulations on IYCF.

3.3.2 MOH:

- Act as the principal implementer and coordinator of all the interventions aimed at achieving the goal and objectives of these Policy Guidelines and ensure that other health and other related policies and strategies are in harmony with these guidelines.
- Liaise with and coordinate the IYCF activities of the line ministries assigned responsibility in this document.
- Strengthen the Nutrition Unit by providing it with adequate human, material and financial resources to spearhead implementation and coordination of this policy and strengthen the capability of other divisions to implement the policy guidelines. .
- Facilitate the training of health professionals and health workers and all others who work with women and caregivers on IYCF, in recognizing malnutrition and LBW, following the BFHI, and preparedness for IYCF in difficult circumstances, in order to ensure competence in these areas.
- Disseminate and monitor the Regulations on Marketing of Infant and Young Child Foods.
- Conduct a needs assessment to identify children in difficult circumstances.
- Undertake training/sensitization of health workers on monitoring and evaluating the impact of using various replacement feeds for infants exposed to HIV.
- Facilitate access to replacement feeds where appropriate.
- Support expansion of GMP.
- Develop and/or update and disseminate national guidelines and materials on the management of malnutrition and LBW.
- Recruit, empower and employ Regional Nutritionists and hospital dieticians to strengthen management of severe malnutrition nationwide.
- Develop promotional materials to support implementation of the policy guidelines, including tools for IYCF counselling, job aides and information materials for mothers.
- Harmonize nutrition related materials on IYCF and develop appropriate IYCF communication strategy.
- Harmonize and integrate existing nutrition intervention packages and guidance on PMTCT.

- Review and/or revise malnutrition indicators in HMIS in addition to strengthening HMIS data reporting and utilization.
- Monitor progress of implementation and keep stakeholders updated.

3.3.3 Health Care Providers:

- Whether in public or private practise, be informed of the latest guidelines and tools which help in recognizing malnutrition and LBW, implementing and following the BFHI, and preparedness for IYCF in difficult circumstances, in order to ensure competence in these areas.
- Disseminate and monitor the Regulations on Marketing of Infant and Young Child Foods.
- Create awareness on voluntary confidential and routine counselling and testing and provide these services.
- Encourage the use and strengthening of ANC services and strengthen them to provide information about prevention of HIV infection, offer and/or refer for routine HIV counselling and testing, and support other interventions to reduce MTCT. These services should be provided in addition to the basic package for obstetric care.
- Provide IEC and counselling on infant feeding for all pregnant women and mothers. This includes both support and counselling on breastfeeding for mothers who are HIV negative or of unknown status and counselling about RF options for women who are HIV positive and choose not to breastfeed.
- Support HIV positive women in their choice of feeding method, whether they choose breastfeeding or RF. This should include advice on how to access replacement feeds where appropriate.
- Prevent any "spill-over" effect of RF which may undermine breastfeeding among HIV negative women and those of unknown status. In this regard, there should be no group counselling and education on RF in any setting providing heath, nutrition or HIV care, at any level.
- Integrate all interventions for PMTCT of HIV into reproductive, nutrition and child health services.
- Conduct sensitisation and mobilisation of communities to support activities related to optimal IYCF.

3.3.4 Hospital Level:

- Manage malnourished children and provide nutritional supplements, where possible.
- Provide IYCF counselling for all mothers. In addition, provide special support to mothers of malnourished and LBW infants, and others in special circumstances (employed, adolescent, caretakers who are not biological mothers, etc).
- Support outreaches and community mother support groups to conduct growth monitoring including screening, referral and IYCF promotion and education.

- Facilitate follow-up of children and mothers/caretakers.
- Include promotion, protection, and support of IYCF in hospital policies, guidelines, programmes and practices and ensure the hospital is certified as Baby Friendly.

3.3.5 Lower Level Health Facilities:

- Conduct GMP both at health facility level and during community outreaches in order to be able to promote adequate growth, identify the malnourished, and appropriately counsel mothers/caretakers of young children.
- Support and strengthen links with community health workers to promote IYCF and growth monitoring, including screening and referral of the malnourished.
- Manage LBW babies appropriately and provide mothers with the necessary support.
- Provide IYCF counselling for all mothers in addition to special support to mothers of malnourished children and LBW babies.
- Support outreaches and community mother support groups to conduct growth monitoring, including screening, referral, and IYCF promotion and education.
- Include promotion, protection, and support of IYCF in health facility policies, guidelines, programmes and practices.

3.3.6 Ministry of Education and Sports:

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

3.3.7 Universities and Tertiary Health Training Institutions:

- Ensure that training on IYCF includes sufficient hands-on experience empowering graduates to promote, protect, and support optimal IYCF.
- Promote research in priority topics related to IYCF.
- Integrate management of malnutrition into the training curricula
- Support mothers in their institutions to practice optimal IYCF.

3.3.8 Ministry of Labour, Gender and Social Development:

- Ensure that the International Labour Organization (ILO) Convention 183 is ratified and enacted into Uganda law.
- Advocate for enactment of any other laws and regulations that enhance maternity protection.
- Advocate with employers to support mothers practice optimal IYCF.

3.3.9 Ministry of Agriculture, Animal industry and Fisheries:

- Empower its extension workers to support families and communities to produce and consume locally available crops and to rear animals of improved nutritional quality.
- Ensure household food security.

3.3.10 Ministry of Trade and Industry:

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

3.3.11 Uganda National Bureau of Standards:

- Ensure that imported foods and equipment for infants and young children maintain the standards specified by the Uganda National Bureau of Standards, the Regulations on Marketing of Infant and Young Child Foods and the Codex.
- Monitor the implementation of the Regulations on Marketing of Infant and Young Child Foods and report findings to the MOH and the Ministry of Justice and Constitutional Affairs

3.3.12 Local Governments at District Level:

- Support orientation of health workers and other relevant officers on issues relevant to optimal Infant and Young Child Feeding.
- Strengthen the structures, services, and interventions needed for the implementation of these policy guidelines.
- Establish a health facility and a community-based monitoring/feedback system for IYCF practices and the quality of care given to women and children.
- Empower communities with the knowledge and skills necessary to implement this policy.

- Train health facility and community health workers on IYCF, BFHI, GMP, and the management of severe malnutrition.
- Support supervision and on the job performance training.
- Strengthen HMIS reporting on LBW babies and malnourished children in hospitals and health centre IV facilities (HC IVs). Encourage feedback discussions of the HMIS results.
- Strengthen the capacity of hospitals to manage severe malnutrition and LBW.
- Support routine GMP and referral of malnourished children to treatment centres.
- Strengthen referral between Nutrition Rehabilitation Units and routine HIV/AIDS counselling and testing sites.
- Identify children in difficult circumstances.
- Develop comprehensive policy implementation strategies.
- Identify and involve partners in implementation.
- Monitor implementation of this policy.
- Disseminate the Regulations on Marketing of Infant and Young Child Foods at all levels.
- Carry out intensive social mobilization of all stakeholders in the district to promote and protect optimal IYCF.

3.3.13 Non-Governmental, Community Based and Religious Organizations (NGOs and CBOs):

In collaboration with the relevant Central and Local Government officials:

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

3.3.14 Political Leaders:

- Advocate for and support budgetary allocations for the implementation of these guidelines and any other related IYCF laws and policies.

3.3.15 Mothers:

- Breastfeed exclusively for the first six months of a child's life.
- Take responsibility to learn what is required in preparing foods and feeding infants and young children; and pay particular attention to hygiene, correct mixing and feeding methods.

- Prepare safe foods by following these basic principles:
  - » Wash hands with soap and flowing water before preparing and cooking food and before feeding
  - » Boil water for preparing safe food and drinks.
  - » Avoid storing prepared feeds/foods. If this is not possible, store them in a refrigerator (or in a cool place) and reheat thoroughly before feeding
  - » Avoid contact between raw and cooked foods.
  - » Wash fruits and vegetables with water that has been boiled. Peel if possible or cook before feeding infants and young children
  - » Avoid feeding with a bottle or spoutted cup; always use an open cup
  - » Give any food left over by the baby to an older child rather than keeping it for the next feeding
  - » Wash the cup, bowl or mixing utensils for the infant's food thoroughly with soap and water. Boil them if possible, or dry them in the sun. Bacteria breed in food that sticks to utensils
  - » Store food and water in covered containers to protect from rodents and insects
  - » Keep food preparation surfaces clean
- If using replacement feeding, ensure that you have some means for accurate measurement of both water and the powdered or liquid milk so that these ingredients can be mixed accurately and correctly.
- Form and/or participate in Mother Support Groups and alert the nearest health facility or stakeholders in the community for more support.

3.3.16 Fathers:

- Develop an interest in promoting, supporting and protecting IYCF.
- Participate in decision making on IYCF in the family.
- Provide physical, psychological and financial support during pregnancy, delivery and lactation for optimal IYCF.
- Participate in the care of infants and young children.

3.3.17 Community:

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

3.3.18 The Private Sector and all Employers:

- Adhere to the Regulation on Marketing of Infant and Young Child Foods.
- Provide maternity and paternity entitlement to employees in accordance with the Employment Act of 2006.
- Create a working environment that promotes optimal IYCF.
- Provide facilities and time for breastfeeding, expression of breast milk and/or preparation of replacement feeds.

3.3.19 Media:

In collaboration with relevant Central and Local Government officials, the print, electronic and theatre media shall:

- Inform the public on all IYCF issues.
- Abide by the Marketing of Infant and Young Child Foods Regulations especially with regard to advertisements.

3.3.21 United Nations Agencies (UNICEF, WHO, UNFPA, UNDP, UNAIDS, WFP, and the Food and Agriculture Organization (FAO) as well as Other Bilateral Agencies and Development Partners:

- Enhance advocacy for IYCF.
- Contribute to the mobilization of resources.
- Provide funds for the implementation of this policy.
- Provide technical support, especially on staff training, development of appropriate IYCF tools, the management of malnutrition and LBW manuals, tools and job aides in an integrated manner.
- Support the MOH at National and District levels to implement their roles and responsibilities.

CHAPTER 4

Suppotive Information

4.1 BFHI Requirements

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding, mother to child transmission (MTCT) of HIV, benefits of routine counselling and testing for HIV, and infant feeding options for HIV positive women (*ensure that infant feeding options are not discussed in groups*).
4. Help mothers initiate breastfeeding within the first hour of birth; establish a feeding option with an HIV positive mother, and encourage HIV positive women who opt to breastfeed to do so exclusively for the first 6 months.
5. Show mothers how to breastfeed and maintain lactation even if they are separated from their infants. Counsel about AFASS condition , and show HIV positive mothers who can meet AFASS criteria and have decided not to breastfeed how to prepare appropriate replacement feed of their choice.
6. Give newborn infants no foods or drinks other than breast milk, unless *medically* indicated, for example infants born to HIV positive mothers who opt not to breastfeed.
7. Practice rooming-in (allow mothers and infants to remain together) 24 hours a day. HIV positive mothers who decide not to breastfeed should be allowed to room in/bed in without breastfeeding.
8. Encourage breastfeeding on demand.

9. Do not give artificial teats or pacifiers (also called dummies or soothers) to infants and young children.
10. Ensure that all new born babies delivered in health facilities or clinics receive BCG and Polio "0" vaccine before discharge.
11. Ensure that all mothers who deliver in health facilities or clinics receive 200,000 IU of Vitamin A before discharge. Non-breastfed infants should receive 50,000 IU of Vitamin A before discharge.
12. Issue a correctly filled in Child Health Card for each newborn, and the "Woman's Passport" where available, to the mother before discharge from the maternity ward.
13. Foster the establishment of Community Based Support Groups for optimal Infant and Young Child Feeding (IYCF) and refer mothers to them on discharge from the health facility.
14. Support infant feeding in the context of HIV.
15. Comply with the Regulations on Marketing of Infant and Young child Foods.
16. Offer mother-friendly care

4.2 Summary of the Main Provisions of the Regulations on Marketing of Infant and Young Child Foods.

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

4.3 Maternity Protection rights and Benefits

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

Importance of Maternity Protection:

- More and more women are spending their child bearing years in active employment.
- Many working women are the sole bread winners for their families and they cannot afford to lose income when they give birth.

- It is the only way that women can be sure to take time off from work to give birth and care for their infants.
- It is therefore important to have adequate national legislation that ensures employers are giving women the necessary paid leave and job security.

Elements of Maternity Protection:

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

Current Conventions related to Maternity Protection

- The ILO adopted the revised Maternity Protection Convention (MPC) 183 and Recommendation 191 in June 2000.
- Whereas an ILO Convention is an international standard which is binding upon all member States once ratified, a Recommendation provides guidelines for national legislation which is enforceable at the country level.

Key elements of Maternity Protection Convention 183 of 2000

The new Convention and Recommendations provide several improvements on the previous instruments including provisions for:

- All women to be covered without any discrimination.
- An increase in the minimum length of maternity leave from 12 to 14 weeks.
- Six weeks compulsory leave after birth, or according to national law and practice.
- Protection of pregnant and lactating women against hazardous occupations.
- The right to one or more daily paid breaks for breastfeeding or a daily reduction of working hours.
- The right to return to the same job or equivalent after leave has expired.
- Non-discrimination on the basis of maternity.
- Non-liability of the individual employer to solely bear the costs.

Recommendation 191 of MPC 183 of 2000 Advocates

- An increase in the length of maternity leave from 14 to 18 weeks.
- Facilities for breastfeeding at or near the workplace.
- Adoptive parents have the right to maternity leave.
- Adoptive parents have a right to maternity benefits.

4.4: Cup Feeding

Why cup feeding is safer than bottle feeding:

- Cups are easy to clean with soap and water, even when boiling is not possible. Cups with no spouts have no hidden areas where bacteria can multiply and make the cleaning difficult. Cups are also less likely than bottles to be carried around for a long time, which gives bacteria time to breed.
- A cup cannot be left beside a baby, for the baby to feed himself. The person who feeds a baby by cup has to hold the baby and look at him, and give him some of the contact that he needs.
- A cup does not interfere with suckling at the breast.
- A cup enables a baby to control his own intake.

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

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

Practical steps to feed a baby by cup:

- Hold the baby sitting upright or semi upright on your lap.
- Hold the small cup of milk to the baby's lips.
- Tip the cup so that the milk just reaches the baby's lips.
- The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- The baby becomes alert, and opens his mouth and eyes.

- A LBW baby starts to take the milk into his mouth with his tongue.
- A full term or older baby sucks the milk, spilling some of it.
- DO NOT POUR the milk into the baby's mouth. Just hold the cup to his lips and let him take it himself.
- When the baby has had enough, s/he closes her/his mouth and will not take any more. If s/he has not taken the calculated amount, s/he may take more next time, or you may need to feed her/him more often.
- Measure her/his intake over 24 hours – not just at each feed.

4.5 Hand Expression of Breast milk

Why Hand expression is recommended:

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

How to prepare a container for the expressed breast milk:

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

How to express breast milk by hand:

- Teach a mother to do this herself. Do not express her milk for her. Touch her only to show her what to do, and be gentle. Teach her to:
- Wash her hands thoroughly.
- Sit or stand comfortably, and hold the container near her breast.
- Put her thumb on her breast ABOVE the nipple and areola, and her first finger on the breast BELOW the nipple and areola, opposite the thumb. She supports the breast with her other fingers (see accompanying Figure)

- Press her thumb and first finger slightly inwards towards the chest wall. She should avoid pressing too far or she may block the milk ducts.
- Press her breast behind the nipple and areola between her finger and thumb. She must press on the lactiferous sinuses beneath the areola.
- Sometimes in a lactating breast it is possible to feel the sinuses. They are like pads, or peanuts. If she can feel them, she can press on them.
- Press and release. Then repeat as often as necessary. This should not hurt - if it hurts, the technique is wrong. At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active. Press the areola in the same way from the sides, to make sure that milk is expressed from all segments of the breast.
- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
- Avoid squeezing the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple.
- Express one breast for at least 3 - 5 minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast, or change when they tire.
- Explain that to express breast milk adequately takes 20 - 30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.

About the volume of breast milk

If a mother is expressing more than her baby needs, let her express the second half of the milk from each breast into a different container. Let her offer the second half of the EBM first. Her baby gets more hind milk that way, which helps him to get the extra energy that he needs.

If a mother can only express very small volumes at first, give whatever she can produce to her baby. Even very small amounts help to prevent infection. Help the mother to feel that this small amount is valuable. This helps her confidence, and will help her to produce more milk.

Remember the supply and demand rule!
The more you breastfeed or express breastmilk the more milk you make.

4.6 Feeding Low Birth Weight Babies

Babies less than 30 weeks gestational age usually need to be fed by naso-gastric tube

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

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

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

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

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

- Across her body, holding him with the arm on the opposite side to the breast.
- The underarm position.
- In both of these positions, she supports her baby's body on her arm and supports and controls his head with her hand. This is important with LBW babies, but not with larger babies.

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

- All LBW babies should be followed up and weighed regularly to make sure that they are getting all the breast milk that they need for adequate growth.
- All LBW babies should be provided with ¼ tablet of iron (50mg) daily since they are at higher risk of iron deficiency and iron deficiency anaemia. Iron supplements should begin at 2 months and continue until the infant is on complementary feeding. This should be in conjunction with measures to prevent and control malaria.
- It is recommended not to give folic acid supplements.

4.7 Practical Steps to Ensure Appropriate Infant and Young Child Feeding In Emergencies

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

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

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

- A lead agency should be nominated to manage infant feeding issues. A framework for action should be agreed upon.
- Representatives of national and international agencies involved in food aid, social services and health/nutrition should meet regularly in a specific forum to address infant feeding issues.
- Monitoring of interventions includes:
  - » Mortality/morbidity of infants;
  - » Provision of infant feeding support;
  - » Procurement, distribution and use of breast milk substitutes or complementary foods; and
  - » Quality of infant foods supplied and/ or used by the affected population.
- Include infant feeding issues in initial screening for new arrivals. Information collection on number of infants and unaccompanied infants and infant feeding practices.

3. Eliminate practices that undermine breastfeeding.

- Donations of infant formula and other breast milk substitutes (BMS) should be systematically refused (i.e. any requirements for BMS should be met by purchasing of supplies).
- Dried milk powder should NEVER be distributed as part of a general ration programme because of the risk that it will be used as a BMS. Rather, it should be mixed with other foods (such as blended foods) or provided under strictly supervised wet feeding conditions.
- Bottles and teats should never be accepted or distributed; cups without spouts should be used instead.
- Where Ultra Heat Treated (Long-life Milk) is distributed, it should be clearly labeled with an appropriate health message.

4. Recognize the special needs of women feeding infants.

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

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

Ensure that certain criteria are met where BMS is provided:

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

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

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

- National expertise should be available as a resource for all emergency agency staff to gain a better understanding of good practices in infant and young child feeding and to assist agencies in developing strategies to develop good practices.
- Ensure that expertise at national and district level is available to train health workers and community-based staff in breastfeeding and infant feeding issues in order to ensure that consistent and well informed advice is given.
- Ensure breastfeeding promotion via health workers, multiple channels for example, radio, print media etc.
- Ensure that an infant's nutritional needs will be met during the first six months of life with an average daily ration of approximately 110g (or 3.3 kg) per month, of replacement feeds, if necessary and appropriate.

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Annexes

Annex 1: List of Contributors

MOH	Dr. D.K.W.Lwamafa, Dr. E. Madraa, Dr.J. Nsungwa, Dr.J.Twa-twa,Dr. Onyango Saul, Dr Jacinta Sabiiti Ursula Wangwe, Samalie Namukose Bananuka, Orone-Kanya C,Christine. R. Mubiru Dr. Justine Nankinga, and Babughirana Geoffrey, Bakyayita Tabley
A-Z Project	Dr. Henry Wamani
UNICEF	Dr. Richard Oketch, Eric Alain Ategbo, Brenda Kaijuka Muwaga,
WHO	Dr. Geoffrey Bisoborwa, Dr. Olive Sentaabwe
WFP	Barbara Nalubanga Tembo,
EGPAF	Dr. Mary Namubiru, Dr. Kobusingye Agnes
FANTA/AED	Dr. Robert Mwadime,
CDC	Dr. Florence Naluyinda K, Margaret Achom Dr . Jaco Homsy.
GAIN	Loiuse Sserunjogi
IBFAN Uganda	Dr. Mukasa Gelasius(Lead Consultant/ IYCF Policy Guidelines development process) John Musisi, Mary Nabisere
PREFA	Dr. Goeffery Waiswa
Nsambya Hospital	Dr. Praxedes N. Kituuka
Makerere University	Dr. Charles Karamagi, Dr. Philipa Musoke
Mulago Hospital	Dr. Hanifa Bachou, Dr. Jolly Nankunda Dr. Elizabeth Kiboneka
RCQHC	Dr. Hana Neka Tebeb, Dr Wamuyu Maina
URC-NuLife	Peggy Koniz-Booher, Margaret Kyenkya, Martha Anyango-Oringo, Joseph Mugisha, Jill Nogi, Victor Nolasco, Kurt Muholand
USAID	Rachel Cintron, Dr.Justine Mirembe

Annex 2: List of participants at the Meeting to reach consensus on the use of cow milk for infants less than six months of age

Chairperson: Dr. DKW Lwamafa, CHS / National Disease Control

Venue: WHO Office Kampala

Date: 20, March 2008

Name	Title	Organization
Dr. Hanifa Bachou	Senior nutritionist	Mwanamugimu N.U
Dr. Elizabeth Kiboneka	Consultant Pediatritian	Mulago hospital
Loiuse Sserunjogi	Nutrition Advisor	GAIN
Rita Nalwadda	NPO-HIV	WHO
Dr. Charles Karamagi	Senior Lecturer	MUK
Dr. M. Sendyona	SMO-MOH/IMCI	MOH
Brenda Kaijuka Muwaga	PO-Nutrition	UNICEF
Barbara Nalubanga.T.	PO- Nutrition	WFP
Dr. Gelasius Mukasa	Pediatrician	IBFAN Uganda
Dr. Jolly Nankunda	Pediatrician	Mulago Hospital
Samalie.N. Bananuka	Nutritionist	STD/ACP
Dr. Saul Onyango	SMO	STD/ACP
Ursula Wangwe	Principal Nutritionist	CHD-MOH
Orone-Kanya C.	PNO/PHN	MOH
Margaret Kyenkya	Dep.Chief of Party	URC/Nulife
Jaco Homsu	Technical Advisor	CDC
Dr. Julius N. Kalamya	Prog.Specialist PMTCT	CDC
Dr. Paul Tumbu	Pediatrician	PIDC
Dr. Sarah Naikoba	PM-Saving Newborn lives	Save the Children
Dr. Sarah Kiguli	Head Pead&child health	MUK
Dorothy N. Bushara	SPA, Nutrition	WFP
Dr. Florence Naluyinda	TA PMTCT/OVC	CDC
Rebecca Mirembe	Nutritionist	MOH
Peggy Koniz-Booher	Chief of Party	URC/Nulife