National Guidelines on Baby-Friendly Initiatives in Nigeria

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FEDERAL MINISTRY OF
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Foreword

The National Guidelines for Baby Friendly Initiative (BFI) is a guide for all hospitals providing maternity and new born services and for communities and workplaces to support optimal infants breastfeeding practices. Breast milk is the only food that contains all the necessary nutrients a child need to grow healthy in the first 6 month of life. It also provides significant nutrients for the children up the first 2 years of life. The practice of breasfeeding is therefore recognized as a natural human phenomenon for child survival, growth and development.

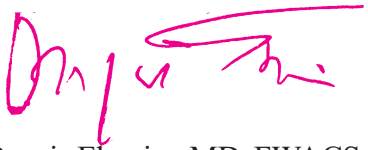
This document will be implemented as part of the strategiues contributing to the reduction of malnutrition, which is one of the underlying causes of early childhood morbidity and mortality. Malnutrition also contributes to the staggering cause of hospitalization , intergenerational poverty and a significant cause of Non-communicable diseases (NCDS) burden in Nigeria.

The development of the National BFI Guidelines is in response to the resolution of the seventy-first (71st) World Health Assembly of m May 2018 for revamping the baby friendly Hospital Initiative by integrating the **'Revised Ten Steps to Successful Breastfeeding'** into all programmes in the Health system for improve quality care of the mother, newborn and Child. This is further reinforced by the resolution at the 61st National Counsel on Health (NCH) in June, 2018 on implementation of culturally friendly policies that promote optimal breastfeeding in Nigeria.

The development of this document involved the building of consensus through National consultative meetings with relevant stakeholders for country specific needs; the assessment of the existing Baby-Friendly activities as well as adoption and adaptation of 2018 WHO BFHI guidance into a holistic Nigeria BFI guidelines. It it therefore designed to facilitate the linkage of Health facility ; community and workplace of Baby-Firendly practices to improve early initiation of breastfeeding ; exclusive breastfeeding for six months and continuation of breastfeeding to two years and beyond achieve universal breastfeeding coverage in Nigeria.

The Nigeria BFI guidelines is therefore a standard protocol for implementing the three components of Baby-Friendly Initiative: Baby-Friendly Hospital Initiative; Baby-Friendly community Initiative and; Baby-Friendly workplace Initiative toward creating a supportive environment for optimal breastfeeding practices.

I recommend this guidelines for use by all stakeholders including Healthworkers, Social workers and development partners towards achieving improved breastfeeding practices in Nigeria.



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Honourable Minister of Health
July, 2021

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The contribution of the following Organizations is of immense recognition and therefore fit for mentioning in this document: They include various departments of the federal Ministry of Health, National Primary Health Care Development Agency (NPHCDA), National Agency for Food and Drugs Administration and Control (NAFDAC), State Ministry of Health, State Hospital Management Boards (SHMB), Secondary and Tertiary Health Facilities. The professional Associations and their Regulatory Board-Nutrition Society of Nigeria (SNS), Dietitian Association of Nigeria (DAN), Paediatric Association of Nigeria (PAN), Society of Gynaecologist and Obstetrician (SOGON) and National Paediatric Nurse Association of Nigeria (NPNAN), Nigeria Nurses and Midwives Association and State Nutrition Officers from the State including the Federal Capital Territory.

The Development Partners and their implementing Agencies including Donors were not exempted from the technical expertise and contribution that enriched the production of National Guidelines Baby-Friendly Initiatives. They are USAID, Spring Project , UNICEF, Action Against Hunger, FHI 360, Alive and Thrive, Hellen Keller International, Save the Children International, Civil Society Scaling Up Nutrition in Nigeria, Well Being Foundation to mention just and WHO.

Finally, the leadership of Dr. Chris Isokpunwu, the immediate past head of the Nutrition Division and Dr. Binyerem Ukaire, the Current head of the Division who saw the guideline development to a successful conclusion as well as the commitment of staff of the Nutrition Division, Family Health department is commended for ensuring effective technical coordination and facilitation in the successful development of the National Guideline for Baby Friendly Initiatives.

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Acronyms

ANC	Antenatal Care
BFCI	Baby-friendly Community Initiative
BFCI-CSG	Baby-friendly Community Initiative - Community Support Group
BFHI	Baby-friendly Hospital Initiative
BFI	Baby-friendly Initiative
BFWI	Baby-friendly Workplace Initiative
BMS	Breast Milk Substitute
CBO	Community Based Organization
CHC	Comprehensive Health Center
CHEW	Community Health Extension Worker
CHIPS	Community Health Influencers, Promoters and Services
CHMT	Community Health Management Team
CHVs	Community Health Volunteers
CIYCF	Community Infant and Young Child Feeding
CORPS	Community Oriented Resource Persons
CSG	Community Support Group
CVs	Community Volunteers
DAN	Dietetic Association of Nigeria
DHIS2.0	District Health Information System 2.0
DHS	Demographic and Health Survey
EBF	Exclusive Breastfeeding
EBM	Expressed Breastmilk
ECCDC	Early Child Care Development Centre
EIB	Early Initiation of Breastfeeding
FMOH	Federal Ministry of Health
FGN	Federal Government of Nigeria
HIV	Human Immunodeficiency Virus
IHI	Institute of Healthcare Improvement
IYCF	Infant Young Child Feeding
JCHEW	Junior Community Health Extension Worker
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministry Department and Agencies
MICS	Multiple Indicator Cluster Survey
MIYCN	Maternal Infant and Young Child Nutrition
MOH	Ministry of Health
NAFDAC	National Agency for Food and Drug Administration and Control
NDHS	Nigerian Demographic and Health Survey
NFP	Nutrition Focal Person
NHMIS	National Health Management Information System
NNHS	National Nutrition and Health Survey

NPHCDA	National Primary health Care Development agency
NSN	Nutrition Society of Nigeria
NTWG	Nutrition Technical Working Group
OTP	Outpatient Therapeutic Programme
PAN	Pediatric Association of Nigeria
PDSA	Plan Do Study Act
PHC	Primary Health Care
PNC	Postnatal care
QI	Quality Improvement
RMNCAH+N	Reproduction Maternal Newborn Child Adolescent Health + Nutrition
SBCC	Social and Behaviour Change Communication
SCFN	State Committee on Food and Nutrition
SMOH	State Ministry of Health
SNO	State Nutrition Officer
SOGON	Society of Obstetrician and Gynecologist of Nigeria
SPRING	Strengthening Partnerships, Results, Innovations, in Nutrition
TBA	Traditional Birth Attendant
Ten Steps	Ten Steps to Successful Breastfeeding
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WDC	Ward Development Committee
WFP	Ward Focal Persons
WHA	World Health Assembly
WHO	World Health Organization

Definition of Terms

Breastfeeding

The process of feeding an infant or young child breastmilk directly from the breast.

Bottle-feeding

Feeding from a bottle, whatever its content, which may be expressed breastmilk, water, infant formula, or another food or liquid.

Breastfeeding Counselling

Breastfeeding counselling is the effective public health intervention to increase rates of any and exclusive breastfeeding. Breastfeeding counselling is provided face-to-face, and in addition, may be provided by telephone, both antenatally and postnatally, to all pregnant women and mothers with young children.

Breastmilk feeding

The child receives breastmilk that has been expressed.

Breast Milk Substitute

Any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for the purpose.

Caesarean Section

A surgical operation for delivering a child by cutting through the wall of the mother's abdomen.

Colostrum

The first yellowish milk produced from the breasts after birth, rich in protein and antibodies.

Community

A group of people living in the same place or having a particular characteristic in common.

Complementary feeding

The process of feeding a child other foods and liquids along with breastmilk or a breastmilk substitute and solid (or semi-solid) food.

Complementary food

Any food, other than breastmilk or infant formula (liquids, semisolids, and solids) introduced to an infant to provide nutrients.

Continued breastfeeding

The provision of breastmilk beyond the first 6 months of life.

Cup-feeding

Feeding the child from or drinking from an open cup, irrespective of its content.

Early initiation of breastfeeding

Provision of mother's breastmilk to infants within one hour of birth immediately after cutting the cord.

Exclusive breastfeeding

Feeding a child with only breastmilk for the first six months of life, 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 breastmilk.

HIV-positive

Refers to people who have tested positive for the Human Immunodeficiency Virus (HIV) and who know they tested positive, or to young children who have tested positive and whose parent(s) or guardians know the result.

International Code of Marketing of Breast-milk Substitutes (BMS), WHO Code

The International Code of Marketing of Breast-milk Substitutes (the Code) is an international health policy framework for breastfeeding promotion adopted by the World Health Assembly (WHA) of the World Health Organization (WHO) in 1981, after consultation with stakeholders, including governments an infant food manufacturers. The Code was developed as a global public health strategy and recommends restrictions on the marketing of breastmilk substitutes, such as infant formula, to ensure that mothers are not discouraged from breastfeeding and that substitutes are used safely if needed. The Code also covers ethical considerations and regulations for the marketing of feeding bottles and teats. A number of subsequent WHA resolutions have further clarified or extended certain provisions of the Code.

Mixed feeding

Feeding both breastmilk and other foods or liquids.

Responsive feeding

Responsive breastfeeding involves a mother responding to her baby's cues, as well as her own desire to feed her baby. ... For example, when a mother breastfeeds her baby responsively, she may offer her breast when her baby shows signs of hunger or when her baby is distressed, fractious, or appears lonely.

Sentinel indicator

A sentinel indicator Is a type of proxy indicator used not to measure a result, but rather as a bellwether for indicating that greater. changes are occurring within a complex system.

Scheduled feeding

Scheduled feeding is feeding a baby or infant according to a fixed schedule (e.g., every 4 hours or on a schedule time or day).

Workplace

A workplace is a location where someone works for their employer, a place of employment. Such a place can range from a home office to a large office building or factory.

Chapter 1: Introduction

1.1 Overview of the Baby-friendly Initiative

Optimum breastfeeding is vital to achieving national goals on nutrition, health and survival, economic growth, and environmental sustainability. Breastfeeding initiation within the first hour after birth, exclusive breastfeeding for the first 6 months of life, and continued breastfeeding up to 2 years and beyond with the introduction of appropriate, safe, and adequate complementary foods at 6 months or beyond are recommended both globally and nationally. Globally, less than half of infants are put to the breast within the first hour after birth, 44% are exclusively breastfed for 6 months and 44% of children are still breastfeeding by 2 years (UNICEF, 2020).

WHO and United Nations Children's Fund (UNICEF) published the Ten Steps to Successful Breastfeeding (Ten Steps) in 1989, with a package of policies and procedures that facilities providing maternity and newborn services should implement to support breastfeeding. The 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding also called on all governments to ensure that every facility providing maternity and newborn services fully practice the adopted Ten Steps. In 1991, WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI) to help motivate facilities providing maternity and newborn services worldwide to implement the Ten Steps. Facilities that documented their full adherence to the Ten Steps, as well as their compliance with the WHO International Code of Marketing of Breast-milk Substitutes and relevant WHA resolutions on the Code, were designated as "baby-friendly."

Several global health initiatives have emphasized the importance of the Ten Steps. The WHA resolutions in 1994 and 1996 called for specific actions related to the BFHI. Similarly, the 2002 Global Strategy for Infant and Young Child Feeding also required all facilities providing maternity and newborn services worldwide to implement the Ten Steps. At the 15th anniversary of the Innocenti Declaration in 2005, partners issued a call to action, which included a call to revitalize the BFHI, maintaining the global criteria as the minimum requirement for all facilities. The initiative's application was expanded to include neonatal, child health services, community-based support for lactating women, and caregivers of young children and the workplace baby-friendly initiative.

In 2012, the WHA endorsed six targets for maternal, infant and young child nutrition (MIYCN), including increasing the global rate of exclusive breastfeeding in the first 6 months of life to at least 50%.[14] Thereafter, the Second International Conference on Nutrition (ICN2) of 2014 proposed a Framework for Action[13] that forms the bedrock of the United Nations Decade for Action on Nutrition that called for policies, programs, and action to ensure that health services protect, promote and support breastfeeding, including the BFHI. The global monitoring framework for MICYN, endorsed by the WHA in 2015,[15,16] included an indicator on the percentage of births occurring in facilities that have been designated as "baby-friendly." As of 2017, WHO estimated that only about 10% of babies in the world were born in facilities designated as "baby-friendly."[18]

In 2015, WHO and UNICEF coordinated a process to review the scientific evidence behind the Ten Steps to Successful Breastfeeding, and to strengthen implementation of the initiative. These included systematic literature reviews along with a thorough examination of the success factors and challenges to implementation of the BFHI. In 2016, the BFHI Congress was convened, bringing together 130 countries to discuss the new direction needed to reach universal coverage and sustainability of the BFHI.

1.2 The Baby-friendly Initiative in Nigeria

Immediate and uninterrupted skin-to-skin contact and initiation of breastfeeding within the first hour after birth are important for the establishment of breastfeeding, and for neonatal and child survival and development in Nigeria. According to the 2018 Nigeria Demographic and Health Survey (NDHS), 42% of newborns received breastmilk within one hour after birth, 29% of infants under 6 months of age were exclusively breastfed, and 28% of children are breastfed up to 2 years of age. About half of the infants in Nigeria were introduced to pre-lacteal feeds and four out of 10 infants less than six months received plain water along with breastfeeding, a practice that undermines exclusive breastfeeding and can put infants at risk. The median duration of any breastfeeding in Nigeria was 20 months among children in rural areas and 16.3 months among children in urban areas. The proportion of children who were **not breastfeeding** increased with age, from about 2% among those aged 0-1 month to 62% among those aged 18-23 months.

Almost all countries in the world have implemented the BFHI at some point in time including Nigeria. In 1991, Nigeria launched the BFHI in response to the 1990 Innocenti Declaration for the protection, promotion, and support of breastfeeding to combat malnutrition and other related childhood illnesses. Between 1991 and 2006, over 1000 of the 25,000 Nigerian hospitals operating during that time were designated "baby-friendly."

The adoption of key policy initiatives in Nigeria like the Global Strategy for Infant and Young Child Feeding and the International Code on the Marketing of Breast-milk Substitutes (the Code) called for a review of the BFHI in Nigeria. In 2009, the National Council on Health (NCH) made a resolution that BFHI should be expanded in scope to further accommodate and strengthen the community component of the BFHI calling for a Nigeria Baby-friendly Initiative (BFI). This resolution led to establishing community-infant and young child feeding (CIYCF) support groups with links to primary health care (PHC) facilities across the country as part of the Nigeria BFI. Later, flexible maternity entitlement policies in workplaces were incorporated as part of the BFI. Both additional elements aimed to increase the protection, promotion, and support for optimal Infant and Young Child Feeding (IYCF) practices, including breastfeeding.

Working parents are a major force in Nigeria's economy, and balancing work and family is an important priority. The International Labour Organization (ILO) Convention C183 – Maternity Protection Convention, 2000 (No. 183) and Labour Act 2004 provides the framework for maternity protection in Nigeria. The 2004 Nigerian Labour Act gives female public sector employees 16 weeks of maternity leave with full pay, and two hours off-duty every day to enable them to breastfeed or feed their babies expressed breastmilk once a woman is back at work. While the public service rules have been revised to include the 16-week maternity leave for public sector employees, the law itself has not been revised to accommodate these changes and new international recommendations since 2004.

At the launch of the 2016 International Lancet Breastfeeding Series in Nigeria, enacting a policy for maternity protection and workplace interventions to support breastfeeding was a key recommendation. This recommendation also aligned with the Abuja Declaration of 2016. A national maternity entitlement assessment study conducted in 2016 by the Federal Ministry of Health (FMOH), Alive & Thrive, and UNICEF increased the understanding on how workplace policies and practices were affecting working parents and the potential for extending maternity leave to six months in line with global recommendations. Although some progress has been made—for example, states including Lagos, Kaduna, Ekiti and Oyo have enacted policies for six months paid maternity leave—efforts are on-going by the Nigerian Governors forum to encourage more states to increase paid maternity leave entitlements to six months.

1.3 Strengths and Limitations of the BFHI in Nigeria

Following the global review of the BFHI in 2018, Nigeria commenced a review process of its own. A readiness assessment study of BFHI implementation was conducted in Bauchi, Kebbi, and Sokoto states with support from the United States Agency for International Development (USAID) Strengthening Partnerships, Results, Innovations, in Nutrition (SPRING) project. An evaluation of the BFHI was carried out in four tertiary facilities in Kwara, Lagos, Edo, and Imo states by the FMOH with support from Action Against Hunger. The findings from these reviews of the BFHI, identified its strengths and gaps as well as opportunities from improvements in its implementation.

Substantial evidence showed that the BFHI significantly contributed to improved breastfeeding practices during the period of its active implementation in Nigeria. National surveys revealed an increase in exclusive breastfeeding rates from 2% in 1990 to about 14% when the comprehensive package on IYCF was introduced in 2011, and a steady increase after that to the current rate of 29%.[19]

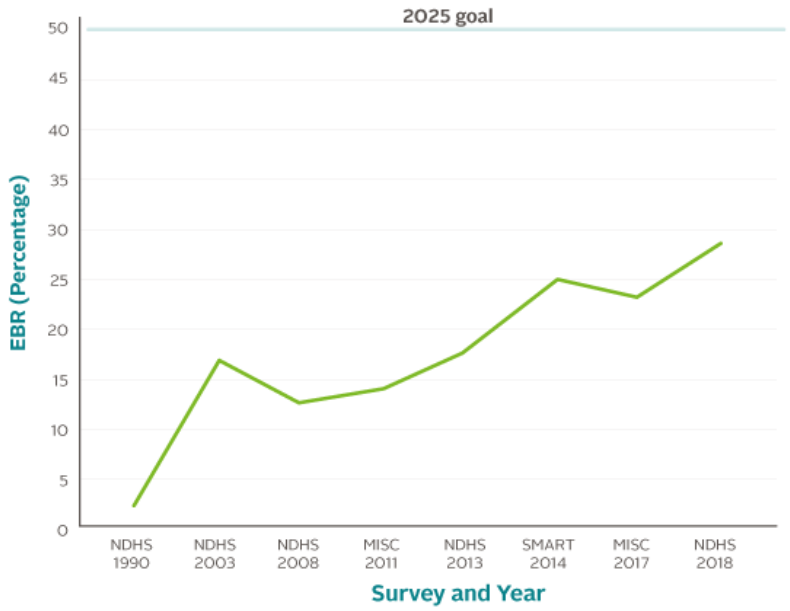

Figure 1. Trend in Exclusive Breastfeeding Rate (EBR) in Nigeria

Despite the increasing positive trend in breastfeeding, the BFHI evaluation found that the initiative was identified many gaps in implementation, including:

- A lack of integration of breastfeeding support skills and knowledge into pre-service education in relevant training institutions such as medical and nursing schools.
- Low coverage of the initiative as individual facilities focused on their individual policies and standards rather than national quality of care standards.
- A lack of sustainability in facilities that attained the "baby-friendly" designation; inadequate monitoring in place to ascertain the continued adherence of the facilities to BFHI guidelines and protocols.
- Insufficient building and sustaining staff capacity in designated facilities that are dependent on in-service training; breastfeeding training was not well integrated into the health care system.
- Weak links between facilities and community structures made it challenging to implement the tenth step of the original Ten Steps, i.e., "the establishment of breastfeeding support groups especially in the community."
- Inadequate monitoring of compliance with the provisions of the National Regulations on the Marketing of Infant and Young Children Foods & other Designated Products (registration, sales, etc.) by stakeholders.
- A lack of comprehensive reporting tools for BFHI as well as an inadequacy of job aids to promote and support mothers on breastfeeding practices.

Based on international guidance and the lessons from the review of the BFHI in Nigeria, the revised Baby-friendly Initiative implementation in Nigeria calls for:

- Identifying health facilities that offer maternity and newborn services including skilled birth delivery; assessing them based on the Ten Steps using the WHO/UNICEF BFHI Assessment Tool; and following the guidelines to address findings from the assessment.
- Establishing community-IYCF support groups linked to PHC facilities, and;
- Creating and putting in place maternity entitlement policies for workplaces to ensure the goal of protection, promotion, and support for optimal IYCF practices.

1.4 Updated Ten Steps to Successful Breastfeeding in Nigeria

The updated Ten Steps are presented in two categories: Critical Management Procedures and Key Clinical Practices. The Critical Management Procedures address steps 1 and 2 ensuring that care is delivered consistently and ethically, while the Key Clinical Practices address the other eight steps, spelling out standards for clinical care of mothers and infants.

Critical Management Procedures

Step 1 (this step includes three sub-steps):

a. Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions and the National Regulations of the Marketing of Infant and Young Children Foods & other Designated Products (Registration, sale, etc.).
b. Have a written infant feeding policy that is routinely communicated to staff and clients
c. Establish ongoing monitoring and data-management systems.

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

Key Clinical Practices

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

Step 4: Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding immediately after clamping of the cord (within an hour of birth)

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

Step 6: Do not provide breastfed newborns any food or fluids other than breastmilk, unless medically indicated

Step 7: Enable mothers and their infants to remain together and to practice rooming-in and bedding -in 24 hours a day

Step 8: Support mothers to recognize and respond to their infants' cues for feeding and ensure the baby is fed on demand

Step 9: Give no artificial teats or pacifiers (also called dummies or soothers) and feeding bottles to infants and young children

Step 10: Coordinate discharge so that parents and their infants have timely access to facility and community support and care

Chapter 2: Vision, Goal, Targets, and Guiding Principles

Considering the ongoing contribution of the Ten Steps over the past thirty years, Nigeria has recommitted to the Tens Steps and to an improved and comprehensive BFI to implement them.

2.1 Vision

A country where all infants and children are optimally breastfed and grow up to be healthy adults that are able to contribute to national development.

2.2 Goal

To promote, protect and support optimum breastfeeding practices in health facilities, communities and workplaces thereby contributing to the nutritional well-being, growth and development of infants and young children in Nigeria.

2.3 Targets for 2025

- Increase by at least 50% pregnant and lactating mothers who receive nutrition counselling in ANC and Post Natal Care (PNC).
- Increase by 50% infants who were put to breast within one hour after delivery in all maternities.
- Increase from 29% in 2018 to 50% in 2025, infants below 6 months who are exclusively breastfed.
- 50% of health facilities and workplaces implement, monitor, and enforce the Code (registration, sales, etc.).
- At least 50% of the states in Nigeria—from 4 states in 2021 to 18 states— review maternity protection laws and regulations to allow for 6 months maternity leave.
- At least 50% of workplaces operationalize baby-friendly interventions such as lactation and breastfeeding corners/rooms that enable mothers to continue breastfeeding or express breastmilk in a supportive, safe, and clean environment.

2.4 Guiding Principles

The principles for implementation of these guidelines shall include the following:

1. Aligning with all the relevant national policies and strategies on maternal, infant, and young child nutrition
2. Allowing for community ownership and participation
3. Caring for mother and child with respect
4. Establishing a partnership for optimal breastfeeding
5. Utilizing a rights-based approach to breastfeeding at all levels, from facilities where women deliver infants, to the community and the workplace
6. Recognizing the multi-sectoral and cross-cutting nature of breastfeeding

Chapter 3: BFI Establishment and Sustainability

3.1 Establishment of BFI

The following should be undertaken in the revitalization of the BFHI:

- Constitute the Nutrition Technical Working Group (NTWG) at the federal level.
- Utilize external assessment systems to regularly evaluate adherence to the Ten Steps.
- Develop via the NTWG, standardized incentives for compliance and/or sanctions for non-compliance with the Ten Steps.
- Implement via the State Committee on Food and Nutrition (SCFN), standardized incentives for compliance and/or sanctions for non-compliance with the Ten Steps at the state level.
- Provide technical assistance to those facilities that are making required efforts and changes to adopt the Ten Steps, through the TWG and the SCFN.
- Monitor implementation of the BFI annually at the national level, quarterly at the state level, and monthly at the Local Government Area (LGA) levels respectively.
- Advocate for BFI to relevant audiences and stakeholders in the community and at workplaces.
- Ensure sufficient budgetary allocation and timely approval and release of resources to implement the initiative.

3.2 Policies and Professional Standards of Care

Integrate the Ten Steps into relevant national policy documents, professional standards of care, and planning documents. Some of these policy and other government documents include:

- National Policy for Food and Nutrition and its Action Plans
- Maternal, Newborn, and Child Health Action Plans
- Hospital accreditations to enhance protection, promotion, and support for breastfeeding in all facilities (public and private) providing maternity and newborn care services.
- Reproductive Maternal Newborn, Child, and Adolescent Health plus Nutrition services (RMNCAH+ N)
- National Policy on Maternal, Infant and Young Child Nutrition
- National Social and Behaviour Change Communication (SBCC) Strategy for Infant and Young Child Feeding
- Ministry Department and Agencies (MDAs)

The Federal Government of Nigeria (FGN) through the FMOH will ensure that Baby-friendly standards are mainstreamed into the care of mother–infant pairs for the dyad to benefit from timely evidence-based care and services appropriate to their needs. To ensure that BFI is mainstreamed into the care of the mother–child pair government should:

- Ensure legislation, regulation, accreditation and/or certification of the BFI
- Ensure health-care facilities adhere to the BFI guidelines.
- Facilitate the development of Infant Feeding Policy and ensure that they are displayed in strategic locations in all health facilities.
- Ensure steering and implementation committees are set up at facility level to monitor the enforcement of the infant feeding policy and the Ten Steps
- Sanction non-compliant staff to the Infant Feeding Policy and the Ten Steps
- Facilitate periodic formal and informal (on the job) training of all facility staff.

- Ensure conducive environment for lactating mothers and staff to encourage breastfeeding at the facilities, homes, and workplaces.
- Ensure recognition and provision of incentives to facilities that adhere to the Ten Steps.
- Ensure that key clinical practices and national standards of the revised Ten Steps are integrated into the standards of care for professional bodies as basic quality of care for all newborns for nursing, midwifery, family medicine, obstetrics, paediatrics, neonatology, nutrition and dietetics, and anaesthesiology.
- Observe and enforce the national protocols for the feeding of infants of mothers who are living with HIV, as well as protocols for the use of donated human milk.
- Ensure the maintenance of policies and standards of care for the protection, promotion, and support of breastfeeding in facilities providing maternity and newborn care services
- Strengthen humanitarian settings to prevent violation of the National Regulations on the Marketing of Infant and Young Child Foods, and other Designated Products and respect for the right of infants and young children.

3.3 Health Professional Competency Building

Health Professionals and managers at all levels of the healthcare system should have adequate knowledge, competency, and skills to implement national recommended practices and procedures for the protection, promotion, and support of breastfeeding in facilities providing maternity and newborn care services. Each facility (private or public) has the responsibility to assess competencies and ensure that those who work in the facility have the appropriate knowledge and skills to support recommended breastfeeding practices.

Competency-building using national documents and curricula that cover necessary clinical practices and the provisions of the WHO code and the National Regulations on the Marketing of Infant and Young Children Foods and other Designated Products (Registration, Sale, etc.) should be included in pre-service and in-service training and as well as in continuing education. Designated teaching and training staff with appropriate qualifications and experience should facilitate this capacity-building. The teaching staff in all relevant schools and universities, including trainers engaged in the in-service training and continuing education should be trained based on the BFI guidelines.

Pre-service Training

Curricula for pre-service training should allocate adequate time and attention to breastfeeding, including practical demonstration of the Ten Steps, clinical and administrative practices related to the protection, promotion, and support of breastfeeding, as well as professionals' responsibilities on the National Regulation of the Marketing and Promotion of BMS and other Designated Products.

In-Service Training

While pre-service training is a critical component of long-term change in maternity practices, the in-service training is a short-term solution for capacity-development. All health professionals working with pregnant women, mothers, and infants already in practice should also have regular refresher training on timely and appropriate care.

Continuing Professional Development

Continuing Professional Development and on-the-job refresher training sessions are needed regularly and should be done in a flexible manner to forestall interference with the provision of services. Training needs

are to be competency-based, with a focus on practical skills rather than theoretical knowledge. Training of Trainers (TOT) approach should be used to create a large pool of BFI experts across the country for the dissemination of in-depth information on the Ten Steps.

Online Courses

Online courses are an efficient and cost-effective means of educating health professionals at their own pace. Health professionals should be encouraged to take advantage of online courses on BFHI for capacity development. However, some skills require face-to-face interaction and group learning to help resolve personal experiences on breastfeeding difficulties or situations. Group learning and competency-based assessment through supportive monitoring and supervision should be ensured.

Managerial Level

Facility managers such as medical directors and senior administrative personnel should have an adequate understanding of breastfeeding and the BFI, so that they can guide and oversee BFI implementation at all levels. Their role is crucial in the formulation of infant feeding policy, support for performance-based incentives with targets for increased breastfeeding rates, and accountability on BFI implementation in the health facilities. A combination of pre-service and in-service training should be used to achieve this purpose. Existing managers without adequate skill and knowledge should get refresher training and new ones should be trained through pre-service training. Job descriptions of facility managers should include pre-service training and regular in-service training on BFI.

3.4 External Assessment

It is important to utilize an external assessment system to regularly evaluate adherence to the Ten Steps. Although facilities should routinely appraise their practices, external assessment is also critical for quality assurance. Monitors from outside the facility (Federal, State, LGA, or others) should validate the results and identify gaps in care and noncompliance with standards of BFI within the facility. All facilities providing maternity and newborn care services aligned with the BFI and national evidence-based quality standards are responsible for timely and appropriate documentation of care for mothers and newborns.

External assessment includes validation of the facility's data on monitoring via interviews with staff, pregnant women, and mothers. The external assessors should review documentation on all indicators of the key clinical practice using recommended tools/checklist. The assessment provides guidelines and tools to use initially to assess whether hospitals meet the global criteria and fully comply with the Ten Steps, and subsequently to reassess, on a regular basis, whether they continue to maintain the required standards.

Revised reassessment materials include an updated set of global criteria, revised hospital self-appraisal and monitoring tools, and revised assessment and reassessment tools. The tool for external assessment or reassessment is for the use of assessment teams external to facilities, and only available to the national BFI coordinating authority through the WHO / UNICEF technical team responsible for BFI. Facilities will be scored "pass" or "fail" based on the threshold for each indicator as defined by the assessment team (e.g., the 80% target).

The external assessors should report back to the FMOH, the State Ministry of Health (SMOH), as well as the management of the facility. In addition, the FMOH/SMOH should provide formal feedback to the facilities. State and LGA levels of assessment should be an ongoing process (including assessments and re-assessments) to ensure adherence to the Ten Steps and provide feedback to each facility on areas for improvement. The Federal and State Ministries of Health are expected to maintain a database of reports

from all facilities. However, the FMOH should collaborate with the SMOH to decentralize the data storage process at the relevant levels for planning and quality improvement purposes.

External assessments should be conducted once every 3-5 years for re-certification. The depth and frequency of the external assessments depends on the quality and frequency of internal monitoring, and information being reported to higher levels. The external assessment process should be integrated with other quality-assurance processes such as facility certification/ accreditation, or assessments for health insurance schemes to guarantee compliance with breastfeeding standards.

The health facility management team/committee is expected to conduct an appraisal of the facility twice a year to ensure and maintain quality care services in accordance with the Critical Management Procedures and Key Clinical Practices of the BFI. Data on MIYCN with an emphasis on the Ten Steps should be integrated into routine data collection in the facilities. Data collected from routine services and those generated during the biennial facility appraisal should be sent to the SCFN to assess adherence the BFI.

The indicators to assess the adherence to the Ten Steps at the facility level and their means of verification are presented in section 9 of this document.

3.5 Incentives and Sanctions

Incentivizing compliance with the BFI guidelines is critical to sustaining the initiative. It is therefore essential to develop and implement incentives for compliance and/or sanctions for non-compliance with the Ten Steps. Appropriate incentives such as the award of certificates, letters of commendation, appreciation visits, support of facility-level training, and provision of technical and other forms of assistance are recommended for facilities that provide satisfactory and adequate services aligned with these guidelines for mothers and their children. Other forms of incentivizing compliance with the standards such as performance-based financing to support facilities that comply with funds to protect, promote, and support breastfeeding are encouraged.

Certification could also serve as an incentive for public recognition. The list of BFI certified hospitals should be updated and published annually by the press and on the FMOH website. Its benefits might include:

- Acknowledgement of staff efforts through formal commendation
- Motivation for staff through promotion and special recognition
- Improved image of the facility
- Increase in the number of clients and revenue

Failure to implement or sustain the implementation of the Ten Steps should result in some, or all of the following sanctions:

- Decertification of an already certified health facility
- Deregistration or suspension of the facility from the provision of care for mothers and children until remediation action has been taken and certified. Consequently, such a facility cannot access all funds attached to maternal, newborn and child health activities including those provided by the National Health Insurance Scheme
- Payment of fines equivalent to costs to train health workers for private facilities
- Executive inquiry into the leadership of the facility

3.6 Technical Assistance to Facilities

Providing technical assistance to all facilities that offer maternity and newborn services is key to the adoption of the Ten Steps. It is essential to have a pool of experts to facilitate technical support. All facilities offering maternity and newborn services require external assistance to adopt the Ten Steps as a standard of care, from experts who manage the change process in other facilities. Each facility, whether public or private, providing the Ten Steps should:

- Constitute and inaugurate a team within the facility comprised of a relevant cadre of trained professionals to provide technical assistance to facilities working through the change process.
- Work with groups of facilities to support one another in the change process.

The SMOH should put a process in place for quality improvement to ensure compliance of public and private facilities as well as within the informal sectors such as faith homes and traditional birth attendants (TBAs):

- Identify one facility in each LGA with a history of quality-improvement success or previously designated as "baby-friendly" to serve as a model for implementing the recommended policies and practices.
- Identify a large facility that can serve as a reference for smaller facilities for the implementation of BFI and scaling up.
- Include an orientation on BFI for all newly employed health workers and plan for more comprehensive training for them at the earliest possible time.

Chapter 4: The Role of Health Facilities

The core purpose of BFI in Nigeria is to ensure that mothers and newborns receive timely and appropriate quality care before, during and after staying in facilities providing maternity and newborn services while ensuring breastfeeding is protected, promoted, and supported. Families need quality and unbiased information about infant feeding while health facilities, communities and workplaces provide support to mothers for optimal feeding of newborns and infants. Health facility actions identified as mother-and baby-friendly care practices:

- Mother-friendly practices should ensure that breastfeeding women are not subjected to harmful practices during labour, childbirth, and early post-natal period.
- Women should be encouraged to adopt the best labour position for a comfortable delivery
- Pregnant women should be allowed to have a companion of choice during labour
- Mothers and newborns must be treated with respect, not subjected to mistreatment, allowed to make informed decisions, and have their privacy respected.

4.1 Critical Management Procedures to Support Breastfeeding

Facilities providing maternity and newborn services need to adopt and maintain four critical management procedures (covering the first two of the Ten Steps) to ensure universal and sustained application of the key clinical practices.

A. Implement the provisions of the Code of Marketing of Breastmilk Substitutes and relevant resolutions of the WHA and the National Regulations for Marketing of Infant and Young Children Food and other Designated Products (registration, sales, etc.)
B. Have a written infant feeding policy
C. Maintain regular monitoring and functional data-management systems.
D. Ensure adequate and regular capacity-building of all facility staff.

Implement Provisions of the Code

Comply fully with the National Regulation for Marketing of Infant and Young Children Food and other Designated Products and relevant World Health Assembly resolutions.

The National Regulation for Marketing of Infant and Young Children Food and other Designated Products (registration, sales, etc.) and the provisions of the International Code of Marketing of Breastmilk Substitutes and the subsequent relevant WHA resolutions, lay out clear responsibilities of health-care systems:

- Not to promote infant formula, feeding bottles or teats and by manufacturers and distributors of such products.
- The National Regulation for Marketing of Infant and Young Children Food and other Designated Products (registration, sales, etc.) completely prohibit the use of feeding bottles and teats.
- Breastmilk substitutes should be acquired in line with the National Regulation through normal procurement channels and not received free or from subsidized supplies.
- Health care workers and health care facilities should not engage in any form of promotion or permit the display of any type of advertisement of breastmilk substitutes
- Heath care workers and health care should not display, distribute any equipment, materials bearing the brand of manufacturers of breastmilk substitutes and discount coupons
- Samples of infant formula and designated products should not be given to mothers in the facility or as take home.
- Health workers and health systems should prohibit activities of companies that produce or market BMS for infants and young children.

- Healthcare professional meetings should never be sponsored by manufacturers of designated products or their distributors and should not participate in parenting education in line with the National Regulations and the provisions of the WHO Code.

Infant Feeding Policy

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

The clinical practices articulated in the Ten Steps should be incorporated into facility policies to guarantee that appropriate care is equitably provided to all mothers and babies. Facilities providing maternity and newborn services should:

- Have a written breastfeeding policy visible to staff, pregnant women, mothers, and their family members
- Communicate the breastfeeding policy routinely to staff and clients

Regular Monitoring and Functional Data-Management Systems

Establish regular monitoring and functional data-management systems.

Facilities providing maternity and newborn services should:

- Provide capacity building to health workers in facilities on the use of health management information system tools for the integration of the clinical practices related to breastfeeding into their quality-improvement/monitoring systems.
- Routinely track early initiation of breastfeeding and exclusive breastfeeding indicators for each mother–infant pair.
- Incorporate and record information on sentinel indicators* into medical charts and collate into relevant registers.
- Ensure that all facilities/ ward development committees coordinate BFI-related activities within a facility/community to review progress at least every 6 months.
- Hold a facility/community monthly review of tracked indicators to evaluate the targets within each, and, if not, plan and implement corrective actions.
- Conduct a maternal discharge survey through exit interviews with mothers by social workers, via short paper questionnaires, or upon discharge via SMS for confidential completion.

The global standards call for a minimum of 80% compliance for all process and outcome indicators, including early initiation of breastfeeding and exclusive breastfeeding. Each facility should attempt to regularly achieve at least 80% adherence on this indicator, and facilities that do not meet this target should focus on increasing the percentage over time.

Staff Competency

Ensure that all staff have adequate knowledge, competence, and skills to support breastfeeding.

Training of health staff enables them to develop effective skills, give consistent messages, and implement policy standards. All health-facility staff who provide infant feeding services, including breastfeeding support, should have sufficient knowledge, competence, and skills to support women to breastfeed.

All staff who help mothers with infant feeding should:

- Use listening and learning skills to build the confidence of pregnant women and lactating mothers on exclusive breastfeeding

- Help mothers to initiate breastfeeding within 1 hour of delivery and facilitate proper positioning and attachment
- Help mothers to maintain lactation even in difficult situations (i.e., low birth weight, mastitis, inverted nipple, etc.)
- Implement the WHO Code and the National Regulations for Marketing of Infant and Young Children Food and other Designated Products (registration, sales, etc.)

The Quality-Improvement (QI) Process

Quality improvement is a management approach that health professionals can use to reorganize care to ensure that patients receive good-quality health care.30 A QI process is designed to monitor, analyze, and improve the quality of processes in order to improve the healthcare outcomes in an organization.

Quality-improvement processes are cyclical and comprise the following steps: (i) planning a change in the quality of care; (ii) implementing the changes; (iii) measuring the changes in care practices and/or outcomes; and (iv) analyzing the changed situation and taking other action to either further improve or maintain the practices. In the institute of Healthcare Improvement (IHI) model, these steps are called: Plan, Do, Study and Act (PDSA) and are visualized in the figure above.

In the context of the BFI, a PDSA cycle can be used to improve implementation of each of the Ten Steps. The BFI-related aspects can be combined with other quality-improvement initiatives that are already in RMNCH+N services at the facility. The quality-improvement approach is very relevant for the BFI as it improves outcomes for patients, improves the efficiency of staff and reduces the wasting of time.

Regardless of what model of quality improvement is used, some key principles of quality improvement are central to the triad of planning, improvement, and control. So, implementing team needs guidance on how to move through these steps:

- Constitute a Quality Improvement (QI) team in every facility with active participation of the main service providers or front-line implementers.
- Engagement of leadership and facility management
- Measurement and analysis of progress over time
- External evaluation or assessment i.e., quality-assurance systems implemented by national, state, and local authorities are relevant to validate the results and the maintenance of agreed standards.

Figure 2. Plan, Do, Study, Act cycle

4.2 Key Clinical Practices to Support Breastfeeding

Eight key clinical practices based on the WHO Guidelines on the protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services[1] are the continuation of the critical management policies (the first two of the Ten Steps) indicated earlier covering the remaining steps in the Ten Steps.

Antenatal Information to ALL Pregnant Women and Attendees

Discuss the importance and management of breastfeeding with pregnant women and their families especially during Antenatal care.

Conversations on breastfeeding should begin at the first antenatal visit, so that there is time to discuss any challenges. Additionally, women who deliver prematurely may not have adequate opportunities to discuss breastfeeding if the conversations are delayed until late in pregnancy. The facility should provide breastfeeding education to caregivers through counseling and practical demonstrations.

Counselling. Antenatal breastfeeding counseling must be tailored to the individual needs of the woman and her family, addressing any concerns and questions they have. Counselling needs to be delivered with sensitivity and consideration for the social and cultural context of each family. Pregnant women need practical information about breastfeeding to make informed decisions. Invite pregnant women and key family members for breastfeeding counselling on benefits and management of breastfeeding and what to expect when they deliver at the facility. Service providers should use short breastfeeding video clips, printed materials or flip chart for effective counselling and ensure relevant topics are covered. Interpersonal counselling in one-on-one interaction enables women to discuss their feelings, doubts and ask questions about infant feeding.

Women at increased risk for preterm delivery or birth of a sick infant (e.g., pregnant adolescents, high-risk pregnancies, known congenital anomalies) must begin discussions with knowledgeable providers as soon as feasible concerning the special circumstances of feeding a premature, low-birthweight, or sick baby.

Families and mothers should be given information on the importance of breastfeeding and risks associated with giving formula or other BMS. They should be presented with up- to-date information on best practices in the facilities regarding skin-to-skin contact, early initiation of breastfeeding, exclusive breastfeeding, on-demand feeding, appropriate complementary feeding, rooming-in and bedding-in. They should be informed about possible breastfeeding difficulties and discuss how to address them with their provider. s

Practical demonstrations**.** Practical demonstrations are a necessary component of antenatal counseling/education. Practical skills on positioning and attachment, recognizing feeding cues and painful colic should be provided. Effective breastfeeding practical sessions during antenatal or postnatal visits require the provision of a demonstration kit such breast model, mannequins etc.

A national standard protocol for antenatal breastfeeding discussions must include the following:

- Adequate maternal nutrition
- Essential family and community support for safe motherhood and successful breastfeeding and its importance
- Active spouse participation at booking, delivery, care of the home and other children
- The importance of early initiation of breastfeeding and immediate and sustained skin- to-skin contact
- The importance of rooming-in /bedding in, the basics of good positioning and attachment
- Recognition of feeding cues and painful colic recognition and possible solution to breastfeeding difficulties (e.g., breast engorgement, inverted nipples, cracked nipples, fear of insufficient milk production to satisfy the baby – "insufficient milk syndrome").
- National recommendations on exclusive breastfeeding for the first 6 months, the risks of giving formula or other breastmilk substitutes
- Continued breastfeeding well into the second year.
- Introduction of appropriate complementary feeding from 6 months or beyond

Immediate postnatal care

Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding immediately after cutting the cord (within one hour of birth).

Immediate postnatal care entails:

- Support mother to help the baby to the breast to get the first milk (colostrum).
- Ensure immediate and uninterrupted skin-to-skin contact for at least 60 minutes and support mothers to initiate breastfeeding immediately after cutting the cord (within one hour of birth).
- Document time of birth; and time of initiation of breastfeeding must be recorded in the case file (case notes) of the mother and on the register

Initiation of breastfeeding is typically a direct consequence of uninterrupted skin-to-skin contact, as it is a natural behaviour for most babies to slowly squirm or crawl toward the breast. Mothers should be supported

Skin-to-Skin and Early Initiation of Breastfeeding

Immediate skin-to-skin contact and early initiation of breastfeeding are two closely linked interventions that need to take place in tandem for optimal benefit. Immediate and uninterrupted skin- to-skin contact facilitates the newborn's natural rooting reflex that helps to imprint the behaviour of looking for the breast and suckling at the breast. Additionally, immediate skin-to-skin contact helps populate the newborn's microbiome and prevents hypothermia. Early suckling at the breast will trigger the production of breastmilk and accelerate lactogenesis. Many mothers stop breastfeeding early or believe they cannot breastfeed because of insufficient milk, so establishment of a milk supply is critically important for success with breastfeeding. In addition, early initiation of breastfeeding has been proven to reduce the risk of infant mortality. The amount of colostrum a newborn will receive in the first few feedings is very small. Early suckling is important for stimulating milk production and establishing the maternal milk supply. During immediate skin-to-skin contact, and for at least the first 2 hours after delivery, sensible vigilance and safety precautions should be taken so that health professionals can observe for, assess, and manage any signs of distress and any other anomalies. Mothers who are sleepy or under the influence of anesthesia or drugs will require closer observation by health workers.

to help the baby to the breast to get the first milk (colostrum). Colostrum is highly nutritious and contains important antibodies and immune-active substances.

Caesarean Section. Immediate skin-to-skin care and initiation of breastfeeding is feasible following a caesarean section with local anesthesia. After a caesarean section with general anesthesia, skin-to-skin contact and initiation of breastfeeding can begin when the mother is sufficiently alert to hold the infant. Mothers or infants who are medically unstable following delivery may need to delay the initiation of breastfeeding. However, even if mothers are not able to initiate breastfeeding during the first hour after birth, they should still be supported to provide skin-to-skin contact and to breastfeed as soon as they are able.

Preterm and low-birth weight infant. Kangaroo mother care (skin-to-skin contact) should be used as the main mode of care for preterm and low-birth-weight infants as soon as the baby is stable owing to

Support with Breastfeeding
Support mothers to initiate and maintain breastfeeding and manage common difficulties.

demonstrated benefits in terms of survival, thermal protection, and initiation of breastfeeding. Early initiation of effective breastfeeding may be difficult for these infants if the suckling reflex is not yet established and/or the mother has not yet begun plentiful milk secretion. Early and frequent milk expression is critical to stimulating milk production and secretion for preterm infants who are not yet able to suckle. A top-up feed (Expressed Breast Milk-EBM) should be given to this category of babies. Transition to direct and exclusive breastfeeding should be the aim whenever possible and is facilitated by prolonged skin-to-skin contact.

Breastfeeding is a natural human behaviour however most mothers need practical help in maintaining successful lactation. Direct observation of a feed is necessary to ensure that the infant can attach to and suckle at the breast.

In the facility, mothers:

- Should receive **practical support** to enable them initiate and maintain breastfeeding and manage common breastfeeding difficulties. Practical support includes providing emotional and motivational support, imparting information, and teaching concrete skills to enable mothers to breastfeed successfully.
- Should stay in the facility provide a unique opportunity to discuss and assist the mother with questions or problems related to breastfeeding and to **build confidence** in her ability to breastfeed.
- Should receive **individualized attention**, but first-time mothers and mothers who have not breastfed before will require extra support. However, even mothers who have had another child might have had a negative breastfeeding experience and need support to avoid previous problems.
- Who deliver by Caesarean Section (CS) and obese mothers should be given **additional help with positioning and attachment.**
- Who deliver preterm infants and are in a critical health situation may require **extra support for milk expression.**
- Need to **be educated** on the management of engorged breasts, ways to ensure a good milk supply, prevention of cracked and sore nipples, and evaluation of milk intake by the infants. They should be coached on how to express breastmilk as a means of maintaining lactation in the event of temporal separation from their infants. Mothers also need to be supported for collection and storage of expressed milk.

- Of multiple births also need extra support, especially for positioning and attachment. It is essential to **demonstrate good positioning** and attachment at the breast, which are crucial for stimulating the production of breastmilk and ensuring that the infant receives enough milk.

In conditions such as maternal death, higher-order multiple births (triplets and above), severe maternal illness etc., breastmilk should be provided by a donor/wet nurse following adequate screening (for HIV, Hepatitis B and C, etc.) An informed consent of both the wet nurse and parent/caregiver of the recipient infant should also be obtained. Where the above is not available, adequate breastmilk substitute should be prescribed and provided. Prescription should be and supervised by well-trained service provider backed with proper preparation, feeding and storage methods.

No Supplementation

Do not provide breastfed newborns any food or fluids other than breastmilk, unless medically indicated.

Giving newborns any foods or fluids other than breastmilk in the first few days after birth interferes with the establishment of breastmilk production. Newborns' stomachs are very small and easily filled. Newborns who are fed other foods or fluids will suckle less vigorously at the breast and thus inefficiently stimulate milk production, creating a cycle of insufficient milk and supplementation that leads to breastfeeding failure. Babies who are supplemented prior to facility discharge have been found to be twice as likely to stop breastfeeding altogether in the first 6 weeks of life. In addition, foods and liquids may contain harmful bacteria and carry a risk of disease. Supplementation with artificial milk significantly alters the intestinal microflora.

- Mothers should be discouraged from giving any food or fluids other than breastmilk, unless medically indicated.
- Infants should be assessed for signs of inadequate breastmilk intake and the situation addressed.
- Lack of resources or staff time or knowledge is not justification for the use of early additional foods or fluids.
- When replacement feeding is medically indicated, the mothers must be informed of the risks and costs of its use and taught about its safe preparation and storage and how to respond adequately to their child's feeding cues.
- Infants who cannot be fed by their mother's own milk, or who need to be supplemented, especially low birth weight infants and other vulnerable infants, should be fed donor human milk or surrogate mother's milk. If donor/surrogate milk is unavailable or culturally unacceptable, breastmilk substitutes may be required but under close supervision by trained service provider.
- In most cases, supplementation is temporary, until the newborn is capable of breastfeeding and/or the mother is available to breastfeed. Mothers must also be supported and encouraged to express their milk to continue stimulating production of breastmilk, and to prioritize use of their own milk.

Rooming-in and Bedding-in

Enable mothers and their infants to remain together and to practice rooming-in and bedding-in 24 hours a day.

Rooming-in involves keeping mothers and infants together in the same room, immediately after vaginal birth or caesarean section, or from the time when the mother is able to respond to the infant, until discharge. Rooming-in is necessary to enable mothers to practice responsive feeding, as mothers learn how to establish breastfeeding. Bedding-in is an extension to skin-to-skin contact where the newborn and the mother are

placed side-by-side not just in the same room but also on the same bed. Bedding-in is a means of facilitating initiation of breastfeeding, responsive feeding and establishing mother-child bond.

Post-natal wards need to be designed such that there is enough space for mothers and their newborns to be together:

- Hospital management should ensure mothers have large beds adequate for rooming- in and bedding-in.
- Facilities should enable mothers and their infants to remain together and to practice rooming-in and bedding-in throughout the day and night.
- Facility staff need to visit the ward regularly to ensure the babies are safe and mothers are able to feed their newborns. Babies should only be separated from their mothers for justifiable medical and safety reasons.

Responsive Feeding

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

Mothers should be supported to practice responsive feeding, recognize, and respond to their infants' cues for feeding, closeness, and comfort during their stay at the facility to increases mother's confidence in breastfeeding

When the mother and baby are not in the same room for medical reasons (post-caesarean section, preterm or sick infant) the facility staff need to support the mother to visit the infant as often as possible, so that she can recognize feeding cues. When staff notice feeding cues, they should bring the mother and baby together.

Discourage the Use of Feeding Bottles, Teats and Pacifiers

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

- Give no artificial teats or pacifiers (also called dummies or soothers) and feeding bottles to infants and young children. The use of these items can lead to a reduction of maternal milk production and may interfere with the mother's ability to recognize feeding cues.
- When expressed breastmilk or other feeds are medically indicated for preterm infants, cups should be used (no spoons).
- Preterm infants who are unable to breastfeed directly and oral stimulation may be beneficial until breastfeeding is established. Oral stimulation involves the use of a gloved finger or a breast that is not yet producing milk.
- There should be no promotion of feeding bottles or teats in any health facility or by any of the staff as these products fall within the scope of the National Regulation on marketing of the Infant and Young Children Food and other Designated Products (registration, sales, etc.) and the WHO Code.
- It is important that the facility staff ensure appropriate hygiene in the cleaning of utensils since they can be a breeding ground for bacteria.
- Facility staff should also inform mothers and family members of the hygiene risks related to inadequate cleaning of feeding utensils, the expression of breastmilk and its storage and preparation and storage of feeds.

Care at Discharge from Facility

Coordinate discharge so that parents and their infants have timely access to support and care at the facility and within the community.

Mothers need sustained support to continue breastfeeding and it is possible for some mothers that milk supply has not been fully established until after discharge. Breastfeeding support is especially critical in the succeeding days after discharge, so it is important to:

- Identify and address early breastfeeding challenges that occur before discharge
- Plan and coordinate discharge, so that the mother and baby have access to ongoing support and receive appropriate care
- Link mother to lactation-support groups in the community upon discharge
- Provide appropriate referrals to ensure that mothers and babies are followed-up by health worker and Community Volunteers to assess the feeding situation.

Tertiary and secondary facilities should engage with the surrounding community to leverage existing community resources, including primary health-care centers, community health workers, community volunteers, peer counsellors, mother-to-mother support groups, or phone lines ("hot lines"). The facilities should maintain contact with the groups and individuals providing the support as much as possible and invite them to the facility where feasible.

Chapter 5: Baby-friendly Community Initiative

A baby-friendly community protects, promotes, and supports breastfeeding, adequate and appropriate complementary feeding as well as maternal nutrition through existing community health structure (such as community support groups), in conjunction with the health facilities. Baby-friendly Community Initiative (BFCI) is a component of BFI that ensures that the maternity and childcare support is continued upon discharge of the mother from the hospital. BFCI is aimed at providing the framework for promoting, protecting, and supporting breastfeeding at the community level. Its implementation shall provide proper guidance on how to ensure and sustain a baby-friendly supportive environment in the community. The BFCI also strengthens care and support for feeding of sick children, early childhood stimulation, and facilitates referral from the community.

5.1 Actions to Establishment a BFCI

Health officers at all levels (federal, state, local government, and community) work closely with relevant partners and stakeholders to ensure successful and sustainable implementation of BFCI. The Ward Development Committee (WDC) shall be the main entry point for BFCI implementation. The SMOH and LGAs facilitate the implementation of BFCI through the existing community structures, PHC and Community Support Groups. The following are the actions needed to establish baby-friendly communities:

Orientation of State and Local Government Health Management Teams together with key stakeholders

State and Local Government Health Management Teams, and key stakeholders shall receive appropriate orientation on the BFCI component of BFI package on the need to support the implementation of the initiative from the SCFN. Key stakeholders to be oriented and sensitized shall include staff of line ministries, Local Government Committee on Food and Nutrition, development and implementing partners, opinion leaders, key decision makers in the community, and any other stakeholder identified by the state and local government as integral to BFCI implementation.

Training of Trainers on BFCI

A BFCI trainer should be an individual who has received prior training on the MIYCN package for health workers. BFCI TOT shall be for five (5) days in duration conducted for the National, State and Local Government Area health workers who will cascade the training to other levels. The TOT will incorporate the Community Health Extension Workers (CHEW) and nutritionists, who will be the primary personnel in BFCI implementation at the community level. Key persons at line ministries and Partners may be co-opted for the TOT.

Training of Health Care Workers

Training of all relevant health care workers including CHEWS, Junior Community Health Extension Workers (JCHEWS), members of Community Support Group (CSG), and other stakeholders in the community on BFCI shall be ensured. This training shall not be less than 5 days and should be practically-oriented as much as possible, to allow for the required skills, and competences as well as knowledge. The State and LGA Nutrition Focal Persons should ensure the development of a work plan for the establishment of workable Community Support Groups.

Orientation of Ward Development Committee, and other community leaders on BFCI

The State and LGA Food and Nutrition Committees shall in partnership with the trained primary health care workers conduct a one-day orientation for the WDC, Community Health Committee (CHC), Primary

Health Care Facility Management Committee (PHFMC), local opinion leaders and key decision makers. The participation of community and religious leaders and other local authority leaders, such as LGA Chairman and Supervisory Councilor for Health and the Chairman, State Assembly Committee on Health, and other line ministries in the state is very important to the success of BFI at the community level. Opinion leaders are key in mobilizing resources and enhancing ownership of BFCI.

Mapping of Households

This will involve:

- Selection and training of Community Health Volunteers/Ward Focal Persons for mapping: Community Health Volunteers (CHVs)/ Community Health Influencers, Promoters and Services (CHIPS)/ Ward Focal Persons (WFP) shall be selected through the existing Ward Development Committee in the Community. Where there are no community units, volunteers who can read and write, who are permanent residents of the community, and have been vetted and accepted by the community shall be selected by the community leaders. After selection, an orientation on Households' mapping shall be conducted.
- Mapping and enlisting of households: Household mapping is an important exercise that identifies the number and place where the primary target audience can be found and will be done at the beginning of the program and subsequently updated biannually. Household registration is intended to provide information for planning BFCI activities through identifying households with pregnant and lactating mothers and with children below two years of age as the primary target for BFCI. The CHV/CHIPS/WFP with relevant LGA health team and national population officer will develop a household register for each community with the number of households. In addition, the WFP will review community resources, assets, manpower, and networks, including the provision of summary of community health situation and the causes of the current health situation in the community profile, based on information in the household register. This includes population structure, pregnant and lactating women, children under two years, environment, immunization, place of delivery, insecticide treated bed nets, use of family planning, diseases (including malnourished children and women), births and deaths by age and sex, education, food, and income.

Establishing Community Support Groups

A Community Support Group (CSG) is a group of community members that oversee plans and execute community baby-friendly meetings by mobilizing all the community members to participate in BFCI activities. This could be the existing MIYCN Support Groups or newly established groups. BFI-CSG members should be selected from the community, by community leaders, WDC, and with the support of health workers (CHEW and ward nutrition focal person)

The CSG should include the CHEW, nutrition focal person, representatives from CHCs and CHVs/CHIPS, local administrators, and the lead mother. This group could also include fathers of children under 2 years, religious and traditional leaders, opinion leaders (influential men and women), TBAs, birth companions, and young mothers. The mothers are recruited by the CHVs with the lead mother facilitating home visitations, antenatal care, Maternal and Child Health (MCH), and any other community groups. The membership of 9 to 15 participants is formed and can be split into two groups when larger than 15 members. The groups meet at least once per month at any convenient place agreed by the group members. For a CSG to be functional, it should have:

- Regular meetings with clear documentation
- Active participation of all members

- Monthly report by the Community Health Volunteers (CHVs)/CHIPS with assistance of the lead mother
- Schedule of the planned activities

Training of CHVs and Community Support Group/ MIYCN facilitator/ Supervisor/Lead Mother on BFCI

The CHVs and CSG facilitator/ Lead mother shall be trained on a 3- day training module focusing on enhanced MIYCN and how to establish CSG. It is recommended that the trainings be conducted within the community. The CSG will go through a 3-day enhanced MIYCN training to build their capacity on BFI implementation.

5.2 Community BFCI Interventions/Activities

The following are recommended BFCI interventions and/or activities to implement where appropriate:

- Enhanced MIYCN training at various levels: TOT, Community Volunteers (CVs) and CSG
- Targeted home visits by the WFP and CHC with the aid of the established community register produced by them
- Baby-friendly community meetings/community dialogue/commemorative days
- Celebrations for mothers who practice 6 months EBF in the community
- Education sessions for mothers at ANC, postnatal care (PNC), Outpatient Therapeutic Programme (OTP), Nutrition Clinics, Monthly CSG meetings, etc.
- Bi-monthly CHVs meetings
- Monthly CSG meetings which can be adjusted to meet the needs of the community to ensure cohesion and effectiveness
- Mentorship and supervision of CVs
- Monitoring, evaluation, and reporting of BFCI activities by the WFP and WDC in collaboration with the Nutrition Focal Person (NFP) at the LGA level
- Periodic BFCI assessments, including self-assessments and external assessments

Successful implementation of BFCI shall be dependent on the collaborative efforts and synergies of all stakeholders through effective partnerships. Key actors at different levels should play their roles to effectively plan, coordinate, implement, monitor, and evaluate BFCI activities. In return, the community will be able to attain the “baby friendly” status.

Chapter 6: Baby-friendly Workplace Initiative

One of the key barriers to exclusive breastfeeding is mothers returning to work before the baby is six months old. Rather than breastfeeding exclusively, mothers who resume work during the critical first months of life typically end-up feeding and supplementing the baby with BMS and other liquids and foods. Comprehensive maternity protection will help Nigerian mothers provide their infants with the very best start in life and will benefit the wellbeing and economy of the whole country. With women constituting nearly half of the labor force in Nigeria, improving maternity benefits including paid maternity leave and workplace support for breastfeeding is of necessity.

6.1 Establishment of a Baby-friendly Workplace

A Baby-friendly Workplace is a workplace with appropriate facilities and family-friendly policies to accommodate the needs of breastfeeding employees and their families. The two components of the Baby-friendly Workplace Initiative (BFWI) are: appropriate policies in the workplace and the enabling work environment.

The key elements of maternity protections ensure that women's work does not pose risks to the health of the woman and her child and that women's reproductive roles do not compromise their economic and employment security. These elements include the right to:

- maternity leave
- paid leave to ensure the mother can support herself and her child during leave
- medical care
- protection of the health of pregnant and breastfeeding women and their children from workplace risks
- protection from dismissal and discrimination; and
- enabling environment for mothers to continue breastfeeding on return to work.

6.2 Workplace Policy on Maternity Protections

Employers in the public and private sector need to develop and articulate an appropriate policy that stipulates the rights and privileges of nursing mothers including paid maternity leave and the opportunity to continue to breastfeed their babies without hindrance on resumption of work after maternity leave. The organization's policy must align with the Nigeria Labour Act and related national and state policies as a minimum standard for maternity protections. These should be contained in the civil service rules for the public sector and the organizational policy that contains benefits and privileges for the private sector. The policy will also include the provision of a supportive environment to enable breastfeeding employees to express breastmilk during work hours and protection from discrimination because of pregnancy. The organization/workplace policy shall be communicated to all employees and included in any new employee orientation training.

The policy shall clearly state the employer's responsibilities which shall include:

- **Paid maternity leave**: The policy shall stipulate the number of weeks approved for maternity leave.
- **Allowable time to breastfeed**: Breastfeeding employees who choose to continue providing breastmilk for infants after returning to work shall receive 'time to breastfeed, a time when breastfeeding employees shall be allowed to breastfeed or express milk during work hours using normal breaks and mealtimes. For time that may be needed beyond the usual break times, negotiated time can be provided.

- **Appropriate space for lactation room/on-site creche**: The employer shall provide a place for breastfeeding mothers to breastfeed their babies. The designated breastfeeding space shall be within the workplace and/or within 5 minutes walking distance from the workstation. A private room (not a toilet, stall, or restroom) shall be available for employees to breastfeed or express breastmilk. The room shall be private and sanitary, located near a sink with running water for washing hands and rinsing out breast pump, and have an electrical outlet. Expressed milk can be stored in designated refrigerators provided in the lactation room, another nearby location, or in employee's personal cooler.
- **Breastfeeding Education**: The employer shall also provide prenatal and postpartum breastfeeding classes and informational materials for all mothers and fathers, as well as partners as may be available.
- **Required support to mothers**: Employers shall provide required support to all breastfeeding employees. Supervisors shall be responsible for alerting pregnant and breastfeeding employees about the employer's workplace lactation support policy, and for negotiating policies and practices that will help facilitate each employee's infant feeding goals. It is expected that all employers assist in providing a positive atmosphere of support for breastfeeding.

6.3 Establishing a Workplace Lactation/Breastfeeding Space

Establishing a workplace lactation/breastfeeding space is achieved through the following steps in the workplace.

Initiate discussions with the organization's leadership and workers union

It is recommended that a memorandum of understanding (MOU) between employer and representatives of the workers union on the rules and modalities for running the site be signed. An MOU should ensure that the operation of the site is in compliance with the provision of the National Regulations on the Marketing of Infant and Young Children Food and other Designated Products Regulations.

Identify appropriate spaces in the workplace

Suitable spaces such as old and unused spaces can be conveniently converted for this purpose. Spaces should be adequate to accommodate simple equipment/furniture such as comfortable chairs, table, fridge, colourful baby mats and baby cots. Agreements should be made with the employer and representatives of workers union to commit resources for equipment, operation, and maintenance of the lactation rooms. Equipment can also be donated by staff members.

Provide orientation and communication materials

Contact the State Ministry of Health or the State Committee on Food and Nutrition for resource persons to provide orientation to interested staff to improve staff knowledge and awareness on the benefits of exclusive breastfeeding, the maternity rights highlighted in the national and state labor policies, and the significance of a workplace lactation space/room. Distribute breastfeeding Information, Education, and Communication (IEC) materials to all employees.

Activate the workplace breastfeeding/lactation space

If many breastfeeding employees will use the room, employers shall consider scheduling usage of the room or use more than one room where space is available. The lactation room shall be locked between uses to safeguard equipment, supplies, and breastmilk stored in the refrigerator. A key can be issued to each breastfeeding mother who is enrolled to use the space. Keys may also be retained by the health staff, or any other designated individual. This space shall be made available and accessible for mothers who desire to

express breastmilk. Mothers shall be encouraged to bring their own breast pumps to workplace. The breastfeeding space shall always be kept clean. Waste baskets should be emptied daily. If a cleaning team is not available, consider a schedule that assigns users to conduct routine inspection and cleaning of the room.

6.4 Roles and Responsibilities of Key Actors in Implementation of BFWI

The roles and responsibilities of the key stakeholders in implementation of the BFWI are outlined in Table 1.

Table 1 Roles and Responsibilities of Key stakeholders in BFWI implementation

Stakeholders	Roles and Responsibilities
Employees (Public and Private)	• Prevent abuse and comply with the maternal protection policy of the organisation in a professional and responsible manner • Provide support and encouragement to breastfeeding colleagues • Ensure compliance with the National Regulations on the Marketing of Infant and Young Children Foods and other designated Products
Federal Ministry of Labour and Employment	• Inspect workplaces regularly to ensure compliance to the maternity protection of labour laws • Sanction violators of maternal protection of the Nigeria Labour Act • Ensure that the rights, dignity and respect of pregnant and breastfeeding mothers and their children are respected and protected at workplace
Federal/State Ministries of Health	• Provide list of guidelines/protocols on how the crèches should operate • Participate in monitoring and supportive supervision and monitoring checklists to the Crèches • Collaborate with other actors and non-actors to advocate and mobilize for more resources for Baby-friendly Workplaces
Federal/States Ministry of Women Affairs	• Ensure that the rights, dignity and respect of pregnant and breastfeeding mothers and their children are protected at workplace • Advocate for maternal protection policy at workplace • Advocate and promote the establishment of creches/designated breastfeeding spaces at workplace • Collaborate with partners and related MDAs to promote breastfeeding at workplace
Federal/States Ministry of Finance, Budget and National Planning	• Coordinate stakeholders in the implementation of the BFI guideline • Provide platform for and awareness creation on breastfeeding at the workplace
Federal/States Ministry of Information, National Orientation Agency, Media	• Create awareness on the establishment of Baby-friendly workplace across all media outlets
Development Partners	• Provide appropriate support and partnership needed for the development and effective implementation of workplace maternal protection and breastfeeding policy
NAFDAC	• Sensitize, advocate, implement, and enforce the provisions of the WHO Code and ensure compliance with the WHO Code and the National Regulations for Marketing of Infants and Young Children and Designated Products (registration, sales, etc.) at the workplace
National Employers Consultative Association (NECA)	• Advocate to the private sector on maternity protection policy at workplace and Baby-friendly workplace • Provide advice to member organisations on the establishment of baby friendly workplace

Civil Society Organisations	• Advocate and mobilize resources to support the development and implementation of workplace maternal protection and breastfeeding policy across government and private organizations
Organised Labour Unions (NLC and TUC)	• Ensure that working pregnant mothers and breastfeeding mothers are fairly treated in the workplaces as well as their rights to the best care and work environment consistent with their physiological status are provided.
National Human Rights Commission	• Provide redress to aggrieved breastfeeding employees

Chapter 7: Leadership and Coordination

7.1 National Coordination

The National Nutritional Technical Working Group is the recommended body established for the protection, promotion and support of BFI in Nigeria. The working group shall provide strategic leadership and coordination of the multi stakeholder partnership for effective implementation of the guidelines. Nutrition stakeholders at national and subnational levels shall adopt and use the coordination structures as proposed coordination structure in *figure 3 below.*

7.2 Facility-level Coordination

Health facility management committee at all levels shall integrate the Ten Steps into existing services for the coordination, protection, promotion, and support of the initiative.

7.3 Community-level Coordination and Structure

Community level coordination and implementation of the BFI shall be led by the WDC to strengthen its implementation and coordination.

7.4 Workplace-level Coordination and Structure

The human resources unit shall put in place structure comprising the management and workers union to coordinate the protection, promotion and support of breastfeeding while achieving the workplace objectives without distractions to other employees. An organization may set up a committee to coordinate and sustain BFI at the workplace.

7.5 Coordination and Oversight Functions for BFI Implementation

The tables below highlight the coordination and oversight functions for BFI implementation by administrative level.

FEDERAL LEVEL	STATE LEVEL
Policy and tools development, dissemination, and compliance	Domestication and dissemination of policies
Advocacy including promotion of performance - based support	Advocacy including promotion of performance - based support
Planning and Budget for BFI	Planning and Budget for BFI
Coordination and oversight of National program	Coordination and oversight of BFI implementation at state
Coordinate partners in the implementation of BFI	Monitoring and Evaluation
Monitoring and Evaluation	Capacity Building
Relevant Surveys	Supportive Supervision
Capacity Building	External Assessment
Supportive Supervision	
External Assessment and Designation	

LOCAL GOVERNMENT LEVEL	WARD LEVEL
Advocacy including promotion of performance - based support Planning and Budget for BFI Coordination and oversight of LGA program Monitoring and Evaluation Capacity Building Supportive Supervision Mobilization and sensitization Implementation	Monitoring and Evaluation Planning and Resource mobilization for BFI Community mobilisation and sensitization Implementation

FMOH CO-ORDINATION STRUCTURE FOR NUTRITION

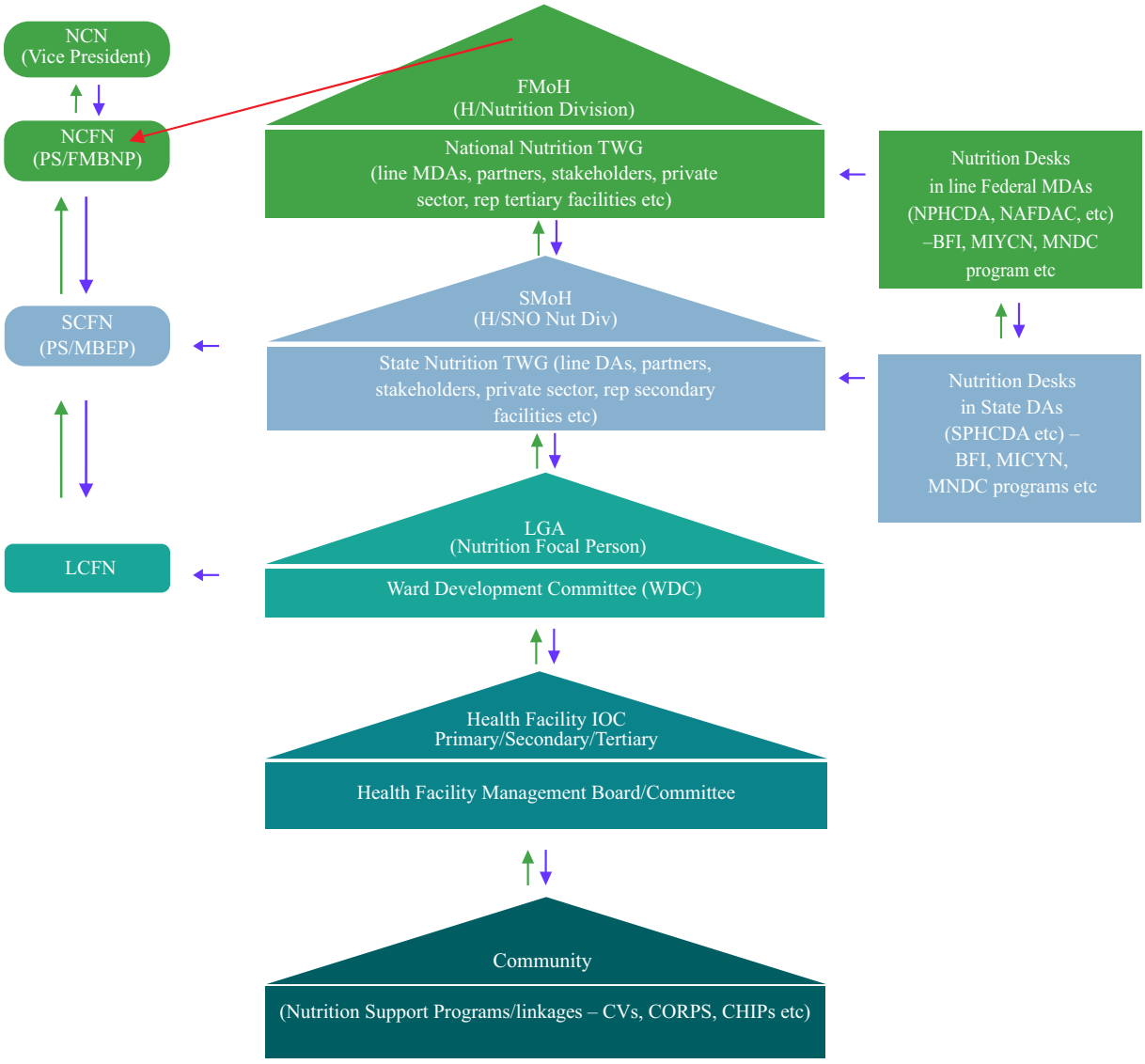

Figure 3 FMOH Co-ordination Structure For Nutrition

Chapter 8: Advocacy and Communication for BFI

Advocacy for BFI involves the process of educating and motivating influential audiences for support and buy-in for the implementation of the BFI at health facilities, workplaces, and in communities in Nigeria. The objective of advocacy and communication is to sensitize and galvanize resources for the BFI towards ensuring sustained implementation at all levels. The communication plan for the BFI should be in line with the Reproduction Maternal Newborn Child Adolescent Health + Nutrition (RMNCAH+N) advocacy and the SBCC Strategy of the Federal Ministry of Health. The target audiences and key stakeholders for both BFI advocacy and communication are within the health and other relevant sectors as identified in the SBCC strategy. The national NTWG shall undertake communications and advocacy efforts to ensure sustained implementation of BFI.

It is important to understand what the target audiences already understand about breastfeeding and the BFI before developing communication interventions. Audience (formative) research as already identified in the National SBCC strategy shall be considered in the identification of key opportunities, where actions are required to be taken, as well as challenging areas where perceptions need to be altered and information gaps need to be filled.

8.1 Identification of Key Audiences

The audiences targeted in the BFI are categorized as:

Primary audience: This is composed of pregnant and nursing mothers whose behavior/decision regarding breastfeeding practices is to be informed.

Secondary audience is comprised of people who will be used as intermediaries to get the message across to the target population. They include the following: families (key household influencers like husband, in-laws, grandparents) and other community members including women's groups and TBAs. Professional associations of nutritionists, dietitians, nurses, midwives, pediatricians, obstetricians, public health physicians and other health-related associations are also means to spread messages and promote positive norms about the BFI.

Tertiary, or influencing audience is made up of people who can facilitate the communication process and behaviour change for improved breastfeeding practices. They are comprised of:

- Facility management (both governmental, non-governmental and private sector), such as hospital directors and departmental heads including obstetrics, paediatrics, midwifery, nursing, and nutrition among others who are critical decision-makers in implementing the Ten Steps at both the facility and community levels.
- Traditional and religious leaders, the private sector (markets and service providers), media organizations (national and local)
- Legislators at all levels (Federal, state, and local government councils) as well as parliamentary committees

8.2 Development and Adaptation of Key Messages

The messages for each audience segment are informed by the audience's knowledge and attitudes, as well as their expected role in supporting the BFI. The National SBCC strategy contains typical sets of messages on the importance of breastfeeding and can be adapted as may be required to cover the:

- Importance of breastfeeding to newborn, mother and public.
- The Ten Steps in simple language for all audiences.

- The importance of implementing the Ten Steps.
- Need to adhere to the National regulation for Marketing of Infant and Young Child Food and other Designated Products for achieving optimal health.
- The importance of ensuring that all health facilities, workplaces, and communities providing maternity and newborn care comply with the BFI guideline.

8.3 Identification of Key Communication Channels

Each audience segment needs to be reached through the channel(s) they mostly rely on.

- Public: For communication to the public, the use of mass media communications, and social media may be relevant, to complement interpersonal communication channels.
- Legislators: Involvement of consumers' and women's groups / organizations, where these exist, and/or work with community leaders, could be important channels for advocating to legislators.
- Professionals: Regular presentations at professional association meetings and conferences are needed to maintain the ongoing support of health professionals.
- Facility Leaders: Targeted communication messages to facility leaders through direct mailings or at planned meetings can be useful.

Other recommended communication channels that are applicable are listed in the National IYCF/SBCC Strategy.

Chapter 9: Monitoring and Evaluation of BFI

BFI monitoring and evaluation will address issues of adherence to standards in the implementation of activities in protecting, promoting, and supporting optimal breastfeeding. The monitoring and evaluation in BFI therefore will monitor and report on both intervention activities (e.g., policy changes, promotional activities) and the intended outcomes (e.g., breastfeeding behavior). National and state monitoring shall focus on the clinical practices of the facilities, BFI programmatic activities, and breastfeeding outcomes while each facility shall monitor its own activities in protecting, promoting, and supporting breastfeeding, as well as the breastfeeding behaviour of mothers.

Facilities providing maternity and newborn services shall report their BFI data to the Health Management Information Systems (HMIS). The data collected at the facility level should be reported and collated at the LGA level by the Monitoring and Evaluation officer of the LGA. The national NTWG shall ensure that HMIS is updated and validated to capture BFI-related data. Hospital management and staff as well as all nutrition managers at various levels should use the results to identify areas needing improvement and then develop plans of action to make needed changes for improvements as may be required. The national and state authority responsible for monitoring BFI implementation (NTWG and SCFN) shall obtain the monitoring report from the HMIS and use it as guide for planning of action as may be applicable and appropriate.

9.1 Levels of Monitoring

Monitoring shall be at national, state, LGA, community and facility levels. Assessment shall be both internal and external. All facilities providing maternity and newborn services shall be responsible for the provision of timely and appropriate care for mothers and newborns, in line with the baby-friendly guidelines and standards. Although facilities must routinely appraise their practices, external assessment is also critical for quality assurance. In addition to the monitoring by the NTWG and SCFN, state ministries of health may also monitor BFI activities and breastfeeding outcomes at the state, LGA, facility, and community levels.

Three of the indicators for monitoring BFI are:

- Prevalence of exclusive breastfeeding in infants aged 6 months or less;
- Percentage of births in Baby-friendly facilities (extract from DHIS); and
- Percentage of facilities that implement the provisions of the WHO Code and the National Regulations for Marketing of Infants and Young Children Food (registration, sales, etc.).

Other key indicators of breastfeeding outcomes, clinical practices, and BFI activities for monitoring across all levels are presented in Tables 2-4.

The data sources for the assessment to adherence to the Ten Steps as well as effective monitoring and evaluation include:

- Household surveys, nationally (such as DHS, Multiple Indicator Cluster Survey (MICS), National Nutrition and Health Survey (NNHS), etc.) and others are useful sources to estimate the percentage of mothers whose maternity experiences adhere to recommended standards.
- The NFPs at the LGA shall routinely conduct client satisfaction surveys and/or exit interviews using the requisite form as part of their job responsibility. With adequate coordination, data from this level could be useful in providing national data on selected aspects of maternity care.
- Periodic monitoring in the states and annual monitoring nationally of the compliance of the provisions of the WHO Code and the National Regulations for Marketing of Infant and Young Children Food (registration, sales, etc.)

9.2 Strategies for Monitoring

Strategies for monitoring include the following:

Maintaining Standards at Health Facilities

Reports shall be requested on an annual basis by the coordinating authority from the committee responsible for BFI at each facility and community, specifying degree of implementation of all the Ten Steps to Successful Breastfeeding. The committee that coordinates BFI-related activities within a facility needs to maintain monthly review along with other interventions. The purpose of the review is to continually track the values of these indicators, to determine whether targets are being met, and, if not, plan and implement corrective actions. In addition, if the facility has an ongoing system of maternal discharge surveys for other quality-improvement/quality assurance assessments, additional questions could be added for one of the three indicators for additional verification purposes or periodic checks.

Internal Monitoring Approaches

Self-Appraisal**.** Consistent use of the *Hospital Self-Appraisal Tool* shall be integrated into any periodic review of care practices and provide early notice of any deterioration in practice.

Daily review of mother and child**.** This reveals any tendency to slip back to inferior patterns of care, such as limited skin-to-skin contact, separation of mother and newborn, or use of pacifiers and bottles. The review shall also cover women who are not breastfeeding to ensure that a double standard of care has not evolved. Mothers who are not breastfeeding nevertheless need continuous skin-to-skin contact with their newborns, rooming-in, and protection from commercial influences.

Review of mother and baby cards. It is feasible to have key information regarding immediate skin-to-skin contact, the first breastfeed, and whether the baby receives any other liquids or foods before discharge included in the mother or baby card. If included, this would help emphasize the fundamental importance of these practices and comprise a standard record from which data on these indicators could be collected.

Review of staff skills and competency: In many settings staff turnover is quite common and the knowledge and skills of the in-service health workers tends to deteriorate over time. Thus, it is essential for health facilities to have an on-going system for training new staff and providing needed refresher courses for those still on the job. A good monitoring system should review both the current training curricula and recent staff training records to ensure that the knowledge and skills needed are maintained.

Review of receipts and invoices: By reviewing records of use, purchase, and full payment of BMS and other designated products**,** administrators can ensure that no free or low-cost supplies of infant feeding products, including BMS, bottles and teats, are found in the hospitals

Learning from mothers' experiences. Feedback from a random sample of mothers may also be used to evaluate the current practices. Such feedback could be:

- *Verbal discharge questions for mothers.* Selected questions may be addressed to mothers when they are being discharged by someone who did not provide care for the mothers and is not associated in the mothers' minds with the maternity services. This is so as not to influence the mother's answer as well as to provide more objectivity on the part of the interviewer. The interviewer could be either from outside the facility or from a department or unit other than the maternity services.
- *MCH Clinic questions for individual mothers*. At any MCH clinic in the community being served by the facility, a few randomly selected mothers can be surveyed monthly and asked about their

experience in the maternity facility. Their first postpartum visit to the clinic would be perhaps the best time. Written answers can also be collected in clinics, where appropriate, and modified based on education level.

- *MCH Clinic focus groups*. One member of the hospital maternity staff, or a person not connected with the maternity facility might go to the MCH clinic and talk with groups of mothers of newborns to learn about any difficulties or doubts regarding breastfeeding. Such feedback could be used to improve the quality of care being provided before discharge and the system of referral to community support.

9.3 Monitoring and Supervision of Baby-friendly Community Initiative

The BFI guidelines are designed to help Nigeria improve breastfeeding practices through implementation of activities at the community level. This includes protection, promotion and support of early initiation and exclusive breastfeeding for the first six months of life, adherence to the provisions of the WHO Code and the National Regulation on the Marketing of Infant and Young Children Food (registration, sales, etc.), and care, support, and follow up for pregnant and lactating women. It also clearly defines the roles and responsibilities of stakeholders in promoting appropriate MIYCN practices and providing guidance on how to sustain a baby-friendly supportive environment at the community level.

Routine monitoring will assist Community Oriented Resource Persons (CORPS) to conduct day-to-day monitoring of BFCI practices at community level in places such as patient medicine shops, creches, day care centers, religious institutions, Early Child Care Development Centres (ECCCDs), markets, workplaces, etc. CORPS shall randomly select at least 10 mothers with children 0-6 months old every month per community and administer a questionnaire to gather data and submit to the catchment facility and WDC for analysis and action.

Table 2. Recommended indicators for facility-based assessment of critical management procedures for the protection, promotion, and support of breastfeeding

Recommendation	Indicators	Target	Means of verification	Responsible person	Frequency of measurement
Step 1a: Comply fully with the National Regulations for the Marketing of Infant and Young Children Food (Registration, Sale, etc.) and the provisions of the WHO Code and the relevant Subsequent World Health Assembly Resolutions (WHA)	Number of infant formula not procured with the prescription	0%	Evidence of prescription	External monitor: NAFDAC, FMOH, SMOH, SPHCDA.	LGA: Monthly State: Quarterly National: Biannually
	Number of products Displayed in contravention to the National regulation	0%	Observation of products	External monitor: NAFDAC, FMOH, SMOH, SPHCDA,	LGA: Monthly State: Quarterly National: Biannually
	Number of health professionals who provide antenatal / delivery service who can explain at least two elements of the National regulation	80% Denominator Total Number of health professionals sampled.	Interviews with Health Care Providers	External monitor NAFDAC, FMOH, SMOH, SPHCDA,	LGA: Monthly State: Quarterly National: Biannually
	Number of health facilities that implement the provisions of the WHO Code and the National Regulations	80% Denominator Total Number of health facilities sampled.	Appraisal of the policy	External monitor	LGA : Monthly State: Quarterly National: Biannually
Step 1b: Have a written infant feeding policy that is routinely communicated to staff and parents	Number of Facilities with written policy displayed openly and visible to all staff and clients	80% of facilities with written breastfeeding policy displayed 80% Facilities display summary of the infant feeding policy	Sighting of the facility written policy on breastfeeding at strategic locations in the Facility	External monitor: NAFDAC, FMOH, SMOH SPHCDA,	LGA: Monthly State: Quarterly National: Bi-annually
	Number of Health Care Providers who provide antenatal/delivery services who can explain at least the meaning and importance of early initiation and EBF	80%	Interviews with Health Care Providers	External monitor: FMOH, SMOH SPHCDA	LGA: Monthly State: Quarterly National: Bi-annually

Step 1c: Establish / strengthen ongoing monitoring and data-management systems.	Number of Facilities reporting to National Health Management Information System (NHMIS)	80%	NHMIS registers and other documentation in the facility	External monitor: FMOH, SMOH SPHCDA	LGA: Monthly State: Quarterly National: Bi-annual
	Number of Healthcare providers trained on NHMIS Tools	80%	Availability of training manual and NHMIS Tools	External monitor: FMOH, SMOH SPHCDA	LGA: Monthly State: Quarterly National: Bi-annual
Step 2: Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.	Number of Health Care Providers that are able to correctly answer three out of four questions on breastfeeding knowledge and skills to support breastfeeding	80%	Interviews with Healthcare providers	External monitor: FMOH, SMOH SPHCDA	LGA: Monthly State: Quarterly National: Bi-annually

Table 3. Recommended indicators for facility-based monitoring of the key clinical practices for the protection, promotion, and support of breastfeeding

Key clinical practice	Indicator definition	Target	Primary source	Additional sources	Responsible Persons	Frequency of measurement
Step 3: Discuss the importance and management of breastfeeding with pregnant women and their families.	Number of pregnant women that received counseling from the facility.	80%	Interviews with pregnant women	Clinical records (HMIS Register)	External monitor: FMOH, SMOH SPHCDA	Monthly
Step 4: Facilitate immediate and uninterrupted skin-to skin contact and support mothers to initiate breastfeeding as soon as possible after birth	Numbers of mothers whose babies had skin-to-skin contact with them immediately or within 5 minutes after birth	80%	Interviews of mothers of with babies	Clinical records (HMIS Register)	External monitor: FMOH, SMOH SPHCDA	Monthly
	Number of Newborn that were put to the breast within 1 hour after birth	≥80%	Interviews of mothers of term infants	Clinical records (HMIS Register)	HMIS officer	Monthly
Step 5: Support mothers to initiate and maintain breastfeeding and manage common difficulties.	Number of mothers who received support for Early Initiation, continue breastfeeding and management of common difficulties	≥80%	Observation Interviews	Monitoring report	External monitor: FMOH, SMOH SPHCDA	Monthly
	Percentage of breastfeeding Mothers that can give at least 2 benefits of early breastfeeding	≥80%	Interviews with breastfeeding mothers	Monitoring Report	- OIC - FMOH, SMOH, SCFN LGA Team	Monthly/Quarterly /Biannually
	Number of breastfeeding mothers that can correctly demonstrate or describe how to express breastmilk	≥80%	Interviews with Breastfeeding mothers	observation	Monitors: F / SMOH, SCFN LGA Teams -	Monthly/ Quarterly / Biannual
Step 6: Do not provide breastfed newborns any food or fluids other than breastmilk, unless medically indicated.	Number of Newborn that received breastmilk substitute without prescription	>80%	Interviews with mothers of Newborns (Preterm & Term babies)	Treatment sheet and the prescription sheet, Health workers	Monitors: FMOH, SMOH, SCFN LGA Teams -	Monthly
Step 7: Enable mothers and their infants to remain together and to practice rooming-in /bedding-in 24 hours a day.	Number of mothers practicing rooming-in / bedding-in.	≥80%	Sighting of mothers on the same bed / room with their babies	Observation.	Monitors: FMOH, SMOH, SCFN LGA Teams	Monthly
Step 8: Support mothers to recognize and respond	Number of breastfeeding Mothers that can describe at least two feeding cues	≥80%	Interviews With mothers of newborns	Observation	Monitors: FMOH, SMOH, SCFN	Monthly/ Quarterly / Biannual

to their infants' cues for feeding						
Step 9: Counsel mothers on the risk and use of feeding bottles, teats, and pacifiers.	Number of mothers Counsel led on the use and risk of feeding bottles, teat and pacified.	≥80%	Interviews with mothers of preterm and term infants	Register Monitoring Report	Monitors: F/SMOH, SCFN LGA Teams	Monthly/ Quarterly and Biannual
Step 10: Coordinate discharge so that parents and their infants have timely access to ongoing support and care.	Number of mothers of newborn discharged and linked to support group through PHCs / CHEW / CHVs, / CHIPS.	80%	Interviews with mothers of newborn	List of existing functional support groups	FMOH, SMOH, SCFN LGA Teams	Monthly, Quarterly and Biannual

Table 4. Outcome indicators for national and state monitoring of BFI facilities providing maternity and newborn services (national annually, state quarterly, and LGA monthly)

Indicator	Definition	Baseline/ Target by 2025	Primary Source	Possible additional sources	Responsible persons	Frequency of measurement
Global Nutrition Monitoring Framework Indicators						
Exclusive breastfeeding in infants aged under 6months	The percentage of infants aged 0–5 months who received only breastmilk during the previous day	B= 29% (NDHS 2018) T ≥50%	Household surveys (NNHS, MICS, NDHS, etc.)	Routine data e.g., DHIS, HMIS	National	Annually / as applicable
Births in Baby-friendly facilities ("BFHI coverage")	The percentage of births occurring in facilities that have been designated/ certified as "Baby-friendly" within the past 5years	B= 0% T ≥30%	Reports on programme implementation ; national database where present	Routine data e.g., DHIS, NDHIS	National	Annually / as applicable
Clinical practice indicators						
Antenatal counselling	Number of mothers who received breastfeeding counselling in antenatal clinics	B= TBD T ≥90%	Household surveys (MICS, DHS, etc.)	NHMIS, exit interviews, facility survey	National	Annually / as applicable
Early skin-to-skin contact	The percentage of mothers who had skin-to-skin contact with their babies immediately or within 5 minutes after birth	B= TBD T ≥90 %	Household surveys (MICS, DHS, etc.)	NHMIS, exit interviews, facility survey	National	Annually / as applicable
Early initiation of breastfeeding	The percentage of mothers that put their infants to the breast within 1 hour after birth	B= 42% T ≥ 90 %	Household surveys (MICS, DHS, etc.)	NHMIS, exit interviews, facility survey	National	Annually / as applicable
Support with breastfeeding	The percentage of mothers who received support with initiation to breastfeed after delivery	B= TBD T ≥ 90 %	Household surveys (MICS, DHS, etc.)	NHMIS, exit interviews, facility survey	National	Annually / as applicable
Exclusive breastfeeding during facility stay	The percentage of mothers reporting that their infants received only breastmilk throughout their stay at a health facility	B= TBD T ≥ 90%	Household surveys (MICS, DHS, etc.)	NHMIS, exit interviews, facility survey	National	Annually / as applicable
Rooming-in	The percentage of mothers whose babies stayed with them since birth in same room / bed without separation	B= TBD T 90%	Facility and Household surveys (MICS, DHS, etc.)	NHMIS, exit interviews, facility survey	National	Annually / as applicable
Referral to community support	The percentage of mothers who reported that they were informed on how to access breastfeeding support in their community	B= TBD T ≥90 %	Household surveys (MICS, DHS, etc.)	NHMIS, exit interviews, facility survey	National	Annually / as applicable
BFHI programmatic output indicators						
Pre-service training on the BFHI standards	The number of newly graduated health professionals who received training on the updated BFHI standards	B= 0 T= TBD	Reports from training institutions	Curriculum of schools training health professional	National	Annually

In-service training on the BFHI standards	The number of practicing health care providers who received in-service training on the BFHI standards	B= TBD T= 80%	Reports from States based on trainings conducted	Training Agenda and list of participants	National	Annually
Ongoing external assessment process	The number of facilities providing maternity and newborn services that have completed an external assessment of BFHI in the past 3–5years	B= 0 T= 20% of Health Facilities	Reports of BFHI assessments		National	Annually

Chapter 10: Data Management at the Implementation Level

Data Collection

Clients seen at the different service delivery points /point of contact shall have their data entered directly into the register by the service providers. Program officers from the implementing partners and BFI desk officer/ State Nutrition Officer (SNO)/NFP are responsible for ensuring documentation of services are done routinely.

Data Flow and Reporting Channels

Data are collated, submitted, and entered in DHIS 2.0 monthly from health facilities including community sites by the LGA Monitoring and Evaluation Officer/Nutrition FPs before the 7th of a new month. On or before the 14th of the month, the SNO/ HMIS/ PHCB SMOH should have access to data entered on the DHIS 2.0 as well as copies of the Monthly Summary Forms (MSFs) from facilities.

Facility Level

At the health facility level (public and private health facilities), individual client cards, tally sheets and registers need to be completed by health service providers and aggregated at the end of the month in the HMIS monthly summary form by the LGA Monitoring and Evaluation (M&E) officer or NFP. The LGA M&E and/or NFP officer collects all monthly reports from both public and private health facilities and enter into appropriate registers at the LGA and have it aggregated on a monthly summary form at the LGA for onward submission to the SNO who then reviews the LGA-specific data along with the State HMIS Officer and shares the summary with the SCFN for program planning and decision making. This process also applies to the community sites with strong community linkages to the facility. Data from both community and health facility levels gets aggregated at the LGA level to achieve comprehensive data reporting.

Facility/Community-level Data Reporting Timelines

Data are aggregated at the points of service and a report is generated at the end of each month. Data can be aggregated and summarized by the service provider in the respective community. The summary shall be made available to the designated health facility for entry into the HMIS monthly summary reporting form. This shall be done by the last day of the month through to the seventh day of the new month. In other instances, all the registers in the different service communities can also be taken by the WFP and aggregated into the Monthly Summary Form (MSF) at the end of the month. The NFP is responsible for collecting the summarized data from all the WFPs. The NFP along with the LGA M&E officer shall provide the first level review of the report before the report leaves the facility for onward transmission to the state.

The Table below gives the description of key timelines for monthly data transmission and reporting.

Table 5. Overview of timelines and responsibilities

Task	Dates	Deadline	Responsible	Reviewer
Data collection from facilities/ communities	1-7th	7th	Facility FP/ LGA M&E Officer/LGA Nutrition FP	State HMIS/PHCB
NHMIS, District Health Information System 2.0 (DHIS2.0) Data Entry from all LGAs	7-14th	15th	LGA M&E Officer/ Nutrition FP	State HMIS/PHCB
Data review, verification, validation, and analysis	15-20th	20th	LGA M&E/ Nutrition Officer/IPs	State Nutrition Officer/ HMIS/ PHCB, M&E

Data Entry into the NHMIS, DHIS2.0 Database

Prior to data entry from the MSFs, the designated officer for data entry at the health facility and M&E officer at the LGA shall:

- Check that the minimum dataset is completed
- Check that boxes are properly checked
- Check that values and comments are eligible and clear
- Check that numbers--date, age, contacts, and other values are valid
- Investigate all unclear data with relevant staff before data entry
- Correct all errors prior to data entry

Data Errors

Errors can occur at both the data collection and data entry phase. Some types of data collection errors are as follows:

- Routing errors – i.e., when a person filling out a form places the number in the wrong part or wrong order
- Consistency errors – i.e., when two or more responses on the same form are contradictory. For example, when the birth date and age are inconsistent
- Transposition – i.e., "39" is entered instead as "93" This is typically a typing error.
- Range errors – When a number lies outside the range of probable or possible values

Types of data entry errors are as follows:

- Copying errors – i.e., "1" is entered as "7"
- Coding errors – Inserting the wrong code
- Misinterpretation errors – misreading or misunderstanding what is written, and then entering what is the presumed response

Data Analysis and Results

Data analysis on results from the data verification will allow us to determine the accuracy of reports; a 5% error margin is allowed, meaning:

- If reported data / verified data are the same, or less than 5% in error then reported data from site is accepted.
- If error margin is above 5% then reported data should be corrected based on laid down procedures

Feedback/Data Dissemination and Use

Feedback should be provided to the facilities as recommendations and an action plan on how to address challenges identified with timelines provided. There should be regular follow-up to ensure the plans are followed through.

A critical component of any routine program monitoring system is providing feedback on the information collected to key stakeholders (Facility Officer in Charge, LGA Nutrition Officer, State Nutrition Officer, etc.).

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