EASTERN REGIONAL HEALTH AUTHORITY

Policy ID no

BABY FRIENDLY POLICY

This policy is applicable to: all ERHA employees.

DOCUMENT CONTROL

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Contents

REVISION RECORD

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2002	1.0	
27.08.2019	2.0	
24.08.2023	3.0	Amendment from Breastfeeding to Baby Friendly Policy (include a breakdown of the 10 Steps, HIV and Infant Feeding and Mother Friendly Care)

SIGNATORIES

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2. DEFINITIONS AND ABBREVIATIONS

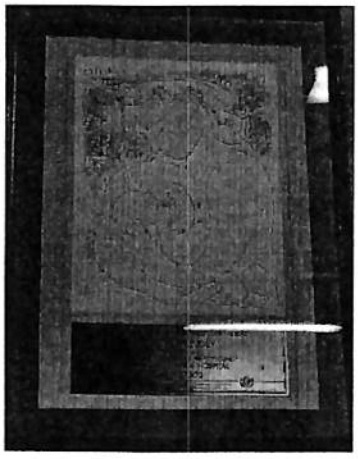
Term	Meaning
ANC	Antenatal Clinic
BFHI	Baby Friendly Hospital Initiative
CBO	Community Based Organisations
CLU	Community Liaison Unit
ERHA	Eastern Regional Health Authority
MOH	Ministry Of Health
NGO	Neonatal Intensive Care Unit
NICU	Non-Governmental Organisation
OT	Operating Theatre
PAHO	Pan American Health Organization
RHA	Regional Health Authority
UNICEF	United Nations Children Emergency Fund
WHO	World Health Organization
ADDITIONAL DEFINITIONS	
Exclusive Breastfeeding	The feeding of an infant with only breast-milk. No other food (solid or liquid or water) is given.
Support Group	A community group that provides Support for mothers. The main function of such a group is to counsel and educate pregnant and lactating mothers and family members on matters related to breastfeeding.
Prelacteal Feeds	Feeds given before the initiation of breastfeeding.

3. BACKGROUND

The World Health Organisation (WHO) has recommended that breastfeeding for children be initiated within the first hour of birth and that they be exclusively breastfed for the first six (6) months of life – meaning no other foods are provided, inclusive of water. Breastfeeding has been found to be one of the most effective ways to ensure child health and survival. However, contrary to WHO recommendations, fewer than half of infants under 6 months old are exclusively breastfed.

In keeping with the WHO guidelines, the aim of the Ministry of Health is to promote the practice of breastfeeding throughout all healthcare facilities operated by the Regional Health Authorities (RHAs). A major component in achieving this purpose is to make all public health hospitals "Baby-Friendly". Data from 2017 and 2018 from the Directorate of Women's Health, reveals that over 90% of women delivered at a public health facility, and it is estimated that over 95% utilize a public health-antenatal service at primary or secondary care, making the national policy objectives highly achievable. Therefore, in an effort to achieve the desired breastfeeding rate of 95% exclusive breastfeeding on discharge from hospitals, all Maternity Units must be designated as baby-friendly.

It must be noted that the Sangre Grande Hospital was the only hospital in Trinidad and Tobago to achieve "Baby-Friendly" status in April, 2002 as defined by WHO under a UNICEF sponsored program developed in 1992. The requirement for re-certification involves re-assessment every three (3) years. Unfortunately, this was not conducted which led to the status not being maintained. However, the ERHA in conjunction with the Ministry of Health, in 2019 embarked on the journey to regain its certification.



In 2011, the population of the Eastern Region, according to the Central Statistical Office's (CSO) Census Report was 111,546, of which 57,415 were male and 53,965 were females[1]. Utilizing the same annual growth rate of 1.5% for Sangre Grande and 0.6% for Mayaro/ Rio Claro, as provided in the report, it is projected that the region's population should have grown to approximately 124,912 in 2018, with around 60,620 females and 64,292 males. A further disaggregation of the female population by age shows that 48% of the total female population fell within the more active childbearing age group of 15 – 44 years, whilst 23% were in the age group 1 – 14 years.

At the national level the crude birth rate has declined from a high of 37.3 per 1,000 people in 1960 to 13.3 per 1,000 in 2017, a 65% drop over the last 57 years [2](worldbank.org). Figures for the Eastern Region between the period 2008 to 2018 (Counties Nariva/Mayaro and St. Andrews/St. David) shows a decline from 18 per 1,000 in 2008 to 14 per 1,000 in 2018. In spite of this gradual decline in the birth rate in recent years data from the Central Statistical Office revealed that the second highest rate of births per 1000 women was found in the county of St. Andrew/St. David.

It is universally accepted that breastfeeding is an unequalled way of providing ideal nourishment for the healthy growth and development of infants and has a unique biological and emotional influence on the health of both mother and child. Research has shown that exclusive breastfeeding for the first 6 months of life is the most optimal way of feeding an infant. The Eastern Region's Community Services Reports for 2018 show an exclusive breastfeeding rate of 19% at 3 months for that year, which represents a 6% drop from the rate in 2009.

Table 1: Exclusive Breastfeeding Rates in the Eastern Region, 2015-2018

	2015	2016	2017	2018
Total Infants	1574	1937	1616	1628
Solely breast fed for one (1) month	581	574	493	455
Solely breast fed for two (2) months	381	399	443	380
Solely breast fed for three (3) months	283	333	338	308

Source: Community Health Services Report (CHS)

A survey on Infant and Young Child Feeding Practices in Trinidad conducted by the Ministry of Health in collaboration with the Caribbean Public Health Agency (CARPHA) in 2014 revealed that 95.5 % of women-initiated breastfeeding from the moment their baby was born

[1] 2011 Census Data. (2023). Central Statistical Office. 2011 Census Data - Central Statistical Office (cso.gov.tt)
[2] Recent data up to 2021 from The World Bank shows a further increase in the % decrease in the Crude Birth Rate from 65% to 72%.

but only 24.1% of mothers were exclusively breastfeeding at 3 months. At 6 months, only about 5.4% of the mothers were still exclusively breastfeeding.

Other findings of the Infant Feeding Survey:

- 16% of population stopped breastfeeding at 1-3 months
- 88% of infants were bottle fed
- 35% of infants were first given infant formula at 1 month
- 52% continued to breastfeed after first introducing other food or drinks

Overall, 88% of mothers indicated a history of bottle-feeding. Formula and water were liquids introduced at high rates in the first month of an infant's life. Breast Milk (BM) and other non-milk liquids (e.g. arrowroot and coconut water) were also given to infants. Of those who bottle-fed, 40.5% began bottle-feeding in the 1st month, by the end of the 3rd and 6th month 67.2% and 90.1% were bottle-fed respectively. As the statistics and research finding show, this pattern is quite similar for the counties within the Eastern Region where it has been noted that the practice of breastfeeding has declined among the mothers who attended the clinics at the Health Centres in the Region. This is still clearly unsatisfactory.

For this reason, the health care personnel at the Sangre Grande Hospital embarked upon a Baby-Friendly Hospital Initiative in order to protect, promote and support breastfeeding and to provide expectant mothers consistent advice in this regard.

A critical component to the success of achieving this, is the establishment of an effective monitoring system that can collect and analyse the relevant data associated with this initiative.

4. TITLE

Eastern Regional Health Authority Baby Friendly Policy.

5. POLICY VISION

The Eastern Regional Health Authority is committed to creating an environment that supports respectful maternal care and promotes breastfeeding in order to improve health, nutritional status and development of all infants.

6. PURPOSE

The primary objective of this policy is to provide a structured and standardized approach as it relates to promoting and encouraging breastfeeding amongst women within the region and the country at large. The resultant effect will be an increase in the compliance rates for exclusive breastfeeding, the reduction of infant and child morbidity and mortality as well as the improvement of short and long term maternal and child wellbeing. This policy is also a

key deliverable in the attainment and maintenance of the "Baby Friendly" status at the Sangre Grande Hospital (SGH).

This policy was guided by the Trinidad & Tobago, Ministry of Health's National Breastfeeding Policy 2019[3], the joint WHO/UNICEF Statement on Protecting, Promoting and Supporting Breastfeeding and the Neo-BFHI: The Baby-friendly Hospital Initiative for Neonatal Wards, 2015 Edition.

7. SCOPE

The ERHA's Baby-Friendly Policy is applicable to all stakeholders involved in the care and feeding of infants 0-2 years old, including but not limited to:

- All departments of the Sangre Grande Hospital
- All Primary Health Care Facilities across the ERHA
- Parents/ Clients
- Ministry of Health
- Early Childhood Development Agencies
- Educational Institutions
- Public and Private Employers
- Non-Governmental Organisations (NGOs)
- Community Based Organisations (CBOs)
- Religious groups
- Manufacturers and distributors of Breast Milk Substitutes
- Health Professional Associations
- Central Statistical Office

8. POLICY OBJECTIVES

Expected outcomes include, but are not limited to:

1. Full staff compliance with the International Code of Marketing of breast-milk substitutes and relevant World Health Assembly (WHA) Resolutions.
2. Increase the percentage of babies who are exclusively breastfed for the first six (6) months of life to 95%.
3. Maintain a minimum of 98% initiation of Breastfeeding in the Hospital.
4. Protect, promote and support breastfeeding and infant nutrition at both Primary and Secondary Health care facilities within the Eastern Region.

[3] National Breastfeeding Policy 2020. (2020) Ministry of Health, Trinidad and Tobago.

5. Collaborate with and provide support to all major Governmental Agencies, Schools, CBO's, NGO's and Private Institutions in developing an environment that promote and encourage better breastfeeding practices.
6. Achieve and maintain re-certification at the Sangre Grande Hospital as a Baby Friendly Hospital.
7. Build capacity among all relevant staff for the promotion, protection and support of breastfeeding and infant feeding.
8. Foster a supportive and sustainable environment which will motivate, educate, encourage and support parents/caregivers to adopt recommended feeding practices for infants, inclusive of safe and adequate complementary foods post breastfeeding.
9. Monitor and evaluate relevant programs and interventions ensuring that the deliverables are in keeping with optimal breastfeeding and infant feeding practices.
10. Implement the ten steps to successful breastfeeding, mother friendly care and the enforcement of regulations concerning the International Code of Marketing of Breast milk Substitutes in all health care facilities.
11. Provide counselling to Human Immunodeficiency Virus (HIV) positive mothers including advantages and disadvantages of feeding options and specific guidance on the options suitable for their situations.
12. Establish and maintain a research and surveillance system for accurate, timely and comprehensive data collection and dissemination.

9. POLICY DETAILS

9.1 Policy Statement

The policy identifies the best evidence-based practice that should be taken by all relevant stakeholders, directly and indirectly involved in protecting, promoting and supporting optimal feeding of infants 0-2 years.

Figure 1: Official WHO/ UNICEF poster highlighting the 10 steps to Successful Breastfeeding

10. THE TEN STEPS TO SUCCESSFUL BREASTFEEDING

Step 1a: HOSPITAL POLICIES

All stakeholders within the ERHA must comply fully with the International Code of Marketing of Breastfeeding substitutes and the World Health Assembly Resolutions.

Goals

i. Encourage early initiation of breastfeeding
ii. All staff must encourage, support and promote exclusive breastfeeding for the first 6 months of a baby's life

iii. All staff must adhere to the Code of Marketing of breast milk substitutes and maternity protection legislation for workers

iv. All staff must support the initiative of the Baby-Friendly Hospital Unit

v. All Manufacturing and distributing companies of breast-milk substitutes will not be permitted to communicate with staff or clients under the ERHA with the exception of Dietitians/Nutritionist.

vi. All staff under the ERHA shall promote appropriate feeding for infants in exceptionally difficult circumstances

- Low Birth weight (LBW) Babies
- Hospitalized infants and mothers
- Severely malnourished infants
- Infants of HIV-positive mothers
- Infant Feeding in Emergencies

vii. All staff within the ERHA must refuse donations/free gifts, product samples, nonscientific information including advertorial information, materials or equipment inducements, money or support for in-service education, meetings, updates or events from manufacturers or distributers of products within the scope of the Code.

viii. Failure to comply with the ERHA's Baby Friendly Policy especially as it relates to Code of Marketing of breast milk substitutes will result in disciplinary action being initiated by the Authority.

Step 1b.

Develop and implement a written Baby Friendly policy that is routinely updated and communicated to staff and parents.

Goals-

i. The ERHA's Baby Friendly Policy must be available, visible and routinely communicated to all staff providing maternal and new-born care.

ii. The policy should be available in the primary and secondary language of the region.

iii. The Baby-Friendly Coordinator shall ensure the ERHA policy is continuously updated in keeping with international standards for maintaining the Ten Steps to Successful Breastfeeding, mother-friendly care, HIV and Infant feeding and Code compliance.

Step 1c.

Establish ongoing monitoring and data-management systems.

Goals-

i. All clients' medical records shall contain the Ministry of Health's SIPS and data capture Forms A, B and C for completion by the relevant staff.
ii. The system shall be reviewed by the BFHI Committee and end users at scheduled meetings every three (3) months.
iii. The Baby-Friendly Coordinator shall collaborate with the relevant stakeholders to ensure that a data and monitoring system for clinical practices within the ERHA is established

Step 2: STAFF COMPETENCY

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

Goals-

i. The Organisational and Employee Development Department shall collaborate with the BFHI Unit to ensure that all clinical staff receive twenty-one (21) hours of training and all non-clinical staff receive three (3) hours of training with an emphasis on the Ten Steps required for BFHI, the Ministry of Health's (MOH) and the ERHA's Breastfeeding Policies, HIV and Infant feeding and Code Compliance.
ii. The Organisational and Employee Development Department and the Baby-Friendly Coordinator shall ensure that training includes educating mothers on choices that are acceptable, feasible, affordable, sustainable and safe (AFASS).
iii. The Organisational and Employee Development Department shall collaborate with the Baby-Friendly Coordinator to ensure that a curriculum and a schedule for training is developed and communicated to all relevant stakeholders.
iv. The Organisational and Employee Development Department shall collaborate with the Baby-Friendly Coordinator to ensure that all new staff to the Maternity Department are trained within the first six (6) months of employment.
v. All staff providing maternal and child health care must be capable of providing adequate education to clients based on accurate and up-to-date information.
vi. The BFHI and Maternity Unit shall coordinate discharge so that parents and their infants have timely access to ongoing support and care.
vii. The BFHI Coordinator shall develop a mechanism to engage in community-based activities that promote continuous education regarding breastfeeding.

Step 3: ANTENATAL CARE

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

Goals-

i. Educate all pregnant women, support partners and their families utilizing teaching plans- Breastfeeding form A.

ii. All pregnant women are to be given information and support as outlined by WHO in making a decision regarding breast feeding and infant feeding.

iii. All clinical staff must support all pregnant women and their families regardless of their breast feeding and infant feeding decisions.

iv. Clinical staff must ensure documentation of all breastfeeding and infant feeding topics.

v. All non-breastfeeding/mixed feeding mothers, partners and family must be referred to the Dietitian for guidance and support on safe feeding practices for infants.

Educational activities are to be guided by the recognition that artificial feeding should not be idealized in any way. Mothers shall be advised as follows -

- The importance of maternal nutrition in preparation for breastfeeding.
- Exclusive and sustained breastfeeding (no supplementary feeding including juice, water or formula should be given for the first 6 months of life).
- The benefits of breastfeeding must also be communicated and promoted to encourage mothers to practice and adhere to the established feeding guidelines as outlined by the WHO.
- Importance of breastfeeding on demand/responsive feeding by the infant Positioning/postpartum/attachment.
- The adverse effects of teats, pacifiers, dummies or soothers, inclusive of bottle feeding.
- The adverse effects of milk substitutes e.g. formulas.
- Introduction of complementary foods at six months old.
- The importance of attending Ante-natal Clinics regularly.
- Techniques of milk expression.
- Breastfeeding and the working mother.
- Pre and post-test HIV counselling.
- HIV & Infant Feeding

Step 4: CARE RIGHT AFTER BIRTH

Facilitate initiation of breastfeeding and uninterrupted skin-to-skin contact right after birth

Goals-

i. Midwives must ensure that all healthy full-term babies have initiation and skin to skin contact with mother immediately after birth for at least (sixty) 60 minutes uninterrupted.

ii. The baby should not be taken away from the mother during skin-to-skin unless medically indicated.

iii. Clients will be encouraged to have a birth companion of their choice to facilitate support throughout labor, delivery and breastfeeding.

iv. Clinical staff must advocate for reduction of invasive procedures that can delay breastfeeding initiation.

v. Clinical staff shall explore alternatives to pain relief to minimize sedation.

vi. Any justification for delayed skin-to-skin must be documented in clients' record.

vii. Skin-to-skin contact for Caesarean section mothers must be initiated as soon as mothers are alert and responsive.

viii. Infants in NICU must also receive skin-to-skin once stable, unless medically contraindicated.

ix. Clinical staff shall encourage visits from ill mothers to the NICU area as soon as she is physically able to do so.

x. Clinical staff must educate mothers on feeding cues.

xi. Spinal anesthesia shall be advocated by clinical staff as the preferred choice as opposed to general anesthesia for operative delivery.

xii. All post-natal mothers must be supervised by Nurse/Midwife to establish good latching-on and sucking techniques and to provide any other needed support when breastfeeding.

xiii. Wherever possible, premature babies shall be given expressed breast milk, using a cup and spoon method and or tube.

xiv. Mothers of infants in NICU shall be encouraged and supported to start expressing as soon as possible after baby's birth.

xv. No teats/pacifiers/dummies/bottles or soothers shall be allowed on the Ward unless where medically indicated.

- ***N.B. Bottles, teats and pacifiers or other devices likely to compromise breastfeeding shall not be permitted in Maternity Units, Neonatal Intensive Care Unit, Special Care Baby Units or Paediatric Unit.***

Step 5: SUPPORT FOR MOTHERS

Support mothers to initiate and maintain breastfeeding and manage common difficulties

Goals

i. Clinical staff must encourage mothers to breastfeed on demand or express breastmilk at least 7-8 times within 24hrs and to breastfeed at night to maintain milk supply.
ii. Mothers of term neonates must be assisted by clinical staff to breastfeed within 6hrs of birth, which includes positioning and attachment of their baby.
iii. Clinical staff must assist all mothers of pre-term or sick neonates with breastfeeding within 1-2hrs after birth or as soon as possible by encouraging expression of milk.
iv. Mothers in isolation must also be encouraged to breastfeed and receive support by clinical staff.
v. All non-breastfeeding/mixed feeding mothers and their partners must be referred to the Dietitian for guidance and support.
vi. All breastfeeding and non-breastfeeding mothers must be counselled on care of the breast.

Step 6: SUPPLEMENTATION

Do not provide infants any food or fluids other than breast-milk, unless medically indicated

Goals

i. Supplemental feeds must not be given to infants except in cases of justified clinical indication or on parental request after counselling.
ii. Expressed breast-milk should be the primary option for mothers before supplemental feeds are considered, except where medically contra-indicated.
iii. A breast-milk substitute log book must be kept at the Maternity Unit/NICU for record keeping of all feeds with corresponding reasons.
iv. All expressed breast-milk must be appropriately labelled to avoid misadministration. Labels with patient's name, date and time breast milk was expressed, must be checked by two (2) clinical staff members on receipt from parents and before feeding infants.
v. Clinical staff must prohibit the use of bottles, teats and pacifiers unless medically indicated.
vi. All non-breastfeeding infants shall be cup fed in accordance with guidelines and information outlined by WHO.
vii. The facility must have a separate room/area designated for education and demonstration of how to safely prepare formula/supplements.

viii. All material promoting breast-milk substitutes must be prohibited and removed from all facilities.

ix. There must be adequate facilities for breast-milk expression and storage in postnatal and neonatal areas.

x. Supplies of breast milk substitutes for use in the hospital will be purchased by the Authority on request by the designated Dietician who will supervise the distribution to the clinical areas.

xi. Special counselling and advice shall be given to the mothers of babies in Neonatal Intensive Care Units or other Special Baby Units, on breastfeeding and the use of the 'cup feeding' method, to feed their infants expressed breast-milk.

xii. Emergency supply of breastmilk substitutes are to be kept on the Maternity Unit, monitored and accounted for by staff.

Step 7: ROOMING IN

Enabling mothers and their infants to remain together and to practice rooming-in 24hrs a day

Goals-

i. All mothers and babies shall be roomed-in immediately after birth unless there is a medically justifiable reason which shall be documented in the mother's medical records.

ii. Mothers who have had caesarean section or other procedures must be assisted by clinical staff in caring for their baby's needs at the bedside.

iii. Parents shall have unrestricted access to the neonatal Ward at all times.

iv. Mothers must be assessed on capabilities for caring and feeding their infants before discharge.

v. Mothers who have been readmitted to the Hospital shall be supported in breastfeeding and milk expression as well as maintaining breast-milk supply for the duration of Hospital stay.

Step 8: RESPONSIVE FEEDING

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

Goals-

i. Clinical staff must educate mothers on breastfeeding on demand, feeding cues, and how to respond to them. Babies should feed as long and as often as baby wants; no specific times should be given as to when mothers should feed.

ii. Mothers and support partners of preterm or ill infants shall be encouraged by clinical staff to be present during infant feeding while in the NICU department.
iii. All information related to responsive feeding must be documented in the client's medical records.

Step 9: BOTTLES, TEATS & PACIFIERS

Mothers are to be counselled in the use and risk of feeding bottles, teats and pacifiers.

Goals

i. Mothers must be educated on the risks associated with bottles, teats and pacifiers.
ii. Cup feeding shall be utilized for supplementing infants.
iii. Care for babies must be provided without the use of infant bottles, teats and pacifiers, unless medically justifiable.
iv. Mothers, support partners and caregivers must be taught how to safely cup feed their infants.
v. All information related to the use of bottles, teats and pacifiers must be documented in client medical records.

Step 10: DISCHARGE

Establish breastfeeding support group and refer clients upon discharge from Hospital.

Goals

i. Prior to discharge, clinical staff must discuss feeding plans with mothers and support partners.
ii. Written educational material on breastfeeding support shall be given to clients upon discharge.
iii. The ERHA will establish and coordinate mother care support groups.
iv. Mothers must have follow-up support via home visits, teleconference and clinic checkups.
v. Referrals to support groups must be documented in clients' notes.
vi. All postnatal discharges will be referred by the Community Liaison Unit (CLU) Staff to the BFHI Unit and Primary Health Care as per organizational policy.

HIV AND INFANT FEEDING-

Providing support regarding HIV and infant feeding

Goals-

i. The Eastern Regional Health Authority shall establish a PMTCT/EMTCT department.

ii. Clinical staff must educate and provide HIV testing and counselling for all pregnant women. Education sessions must include:
   - The risk of HIV transmission during pregnancy, labor and delivery and breastfeeding
   - Prevention of HIV transmission
   - The importance of counselling and testing
   - The National and local policies regarding HIV and infant feeding
   - Safe supplementation and risks of bottles, teats and pacifiers
   - Educating mothers on choices that are acceptable, feasible, affordable, sustainable and safe (AFASS)

iii. Clinical staff must educate all pregnant women on mother-child transmission and steps to maintain a negative status.

iv. All HIV positive mothers must be referred to the PMTCT/EMTCT Nurse and Medical Social Worker.

v. Privacy and confidentiality of all women and mothers must be maintained.

vi. All HIV positive mothers must receive follow-up care.

vii. Infants born to retroviral positive mothers must be fed with a breast-milk substitute according to National guidelines.

MOTHER-FRIENDLY & RESPECTFUL MATERNAL CARE-

Protecting women's rights

Goals

i. Antenatal clients must receive care from competent staff (Midwives and other Clinical Staff including Obstetricians).

ii. Clients' must be treated and cared for in a respectable manner.

iii. Clients' information must be maintained in accordance with organizational policies related to maintaining privacy and confidentiality.

iv. Antenatal clients must receive education at each clinic visit to utilize as a guide throughout prenatal care, labour and delivery.

v. Antenatal clients shall be allowed a support person present at all clinic visits and during labour and delivery (vaginal birth or Caesarean Section).

vi. Clients shall be allowed light food or fluids during labour and delivery unless medically contraindicated.

vii. Clients shall be given the options during labour and delivery including position for delivery, mobility, birth companion etc.

viii. Clients and their support partners shall be updated regularly regarding clients progress while warded.

ix. Family bonding shall be encouraged during visiting hours.

x. Respectful maternal care must be maintained throughout all Antenatal, Postnatal and Child welfare visits at all out Primary Care Facilities.

11 ROLES AND RESPONSIBILITIES

Party / Parties	Roles and responsibilities
General Manager - Nursing	Strategic Oversight and Implementation
Hospital Medical Director	Oversight
Hospital Nursing Manager/Nursing Supervisors	Implementation and Monitoring
Head Nurse – Maternity Department	Education and Implementation
Primary Care Nurse Manager	Community Implementation
Senior District Health Visitor	Education and Monitoring
District Health Visitor	Education, Implementation at the Primary Care Level and Reporting
Baby friendly Co-ordinator	Coordination, Implementation and Monitoring. Conducts training programs and evaluate its implementation
Dietician	Attend to dietary referrals of clients
Quality	Monitoring and Evaluation

MONITORING, EVALUATION AND REVIEW

Monitoring for compliance to the ERHA's Baby Friendly Policy will be done through scheduled and spot audits by the Quality Department. and This will be done on a continuous process by the monitoring and evaluating committee to ensure that the policy procedures and protocols are met.

Indicators:

- Evidence of approved Baby Friendly policy
- Dissemination of Policy to all facilities/Departments
- Number of Stakeholder Policy Sensitization sessions.
- Established Baby Friendly Hospital Initiative Unit
- Established Data Management System and Monthly reporting framework
- 85% of all clinical staff completing the 21-hour BFHI training;
- 90% of non-clinical staff completing the BFHI 3-hour sensitization session;
- 85% exclusive breastfeeding rate of new-born infants at the Sangre Grande Hospital;
- 100% of mothers experiencing uninterrupted skin-to-skin contact for 60 minutes with their new-born immediately or within the first 5 mins of birth unless medically contraindicated;
- 100% of mothers receiving mother friendly care as outlined by the WHO global criteria

Evaluation

- BFHI Training and Sensitization will be evaluated every two (2) years
- The ERHA's Baby Friendly status will be evaluated every three (3) years by a team compromising internal as well as external health personnel and a relevant non-governmental organization.

12. Appendix I

1. INTERNATIONAL CODE OF MARKETING OR BREASTMILK SUBSTITUTES

(ARTICLES 1 – 11)

WHO, Geneva, 1981)

Article 1. Aim of the Code

The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

Article 2. Scope of the Code

The Code applies to the marketing and practices related thereto, of the following products: breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable with or without modification, for use as a partial or total replacement of breast-milk; feeding bottles and teats. It also applies to their quality and availability, and to information concerning their use.

Article 3. Definitions

For the purpose of this Code:

"Breast-milk substitute"

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

"Complimentary food"

Means any food, whether manufactured or locally prepared, suitable as a complement to breast-milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant. Such food is also commonly called "weaning food" or "breast-milk supplement".

"Container"

Means any form of packaging of products for sale as a normal retail unit, including wrappers.

"Distributor"

Means a person, corporation of any other entity in the public or private sector engaged in the business (whether directly or indirectly) of marketing at the wholesale or retail level a product within the scope of this Code. A "primary distributor" is a manufacturer's sales agent, representative, national distributor or broker.

"Health care system"

Means government, non-governmental or private institutions or organizations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or child-care institutions. It also includes health workers in private practice. For the purpose of this Code, the health care system does not include pharmacies or other established sales outlets.

"Health worker"

Means a person working in a component of such a health care system, whether professional or non-professional, including voluntary, unpaid workers.

"Infant formula"

Means a breast-milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to between four and six months of age, and adapted to their physiological characteristics. Infant formula may also be prepared at home, in which case it is described as "home-prepared".

"Label"

Means any tag, brand, mark pictorial or other descriptive matte, written, printed, stencilled, marked, embossed or impressed on, or attached to, a container (see above) of any products within the scope of this Code.

"Manufacturer"

Means a corporation or other entity in the public or private sector engaged in the business or function (whether directly or through an agent or through an entity controlled by or under contract with it) of manufacturing a product within the scope of this Code.

"Marketing"

Means product promotion, distribution, selling, advertising, product public relations and information services.

"Marketing personnel"

Means any persons whose functions involve the marketing of a product or products coming within the scope of this Code.

"Sample"

Means single or small quantities of a product provided without cost.

"Supplies"

Means quantities of a product provided for use over an extended period, free or at a low price, for social purposes, including those provided to families in need.

Article 4. Information and education

4.1 Government should have the responsibility to ensure that objective and consistent information is provided on infant and young child feeding for use by families and those involved in the field of infant and young child nutrition. This responsibility should cover either the planning, provision, design and dissemination of information, or their control.

4.2 Informational and educational materials, whether written audio, or visual, dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children, should include clear information on all the following points: (a) the benefits and superiority of breastfeeding: (b) maternal nutrition, and the preparation for and maintenance of breastfeeding: (c) the negative effect on breastfeeding of introducing partial bottle feeding: (d) the difficulty of reversing the decision not to breastfeed: and (e) where needed the proper use of infant formula, whether manufactured industrially or home-prepared. When such materials contain information about the use of infant formula, they should include the social and financial implications of its use, the health hazards of inappropriate foods of feeding methods, and in particular, the health hazards of unnecessary of improper use of infant formula and other breast milk substitutes. Such materials should not use any pictures or text which may idealize the use of breast-milk substitutes.

4.3 Donations of informational or educational equipment or materials by manufacturers or distributors should be made only at the request and with the written approval of the appropriate government authority or within guidelines given by governments for this purpose. Such equipment or materials may bear the donating scope of this Code, and should be distributed only through the health care system.

Article 5. The general public and mothers

5.1 There should be no advertising or other form of promotion to the general public of products within the scope of this Code.

5.2 Manufacturers and distributors should not provide, directly or indirectly, to pregnant women, mothers or members of their families, samples of products within the scope of this Code.

5.3 In conformity with paragraphs 1 and 2 of this Article, there should be no point-of-sale advertising, giving of samples, or any other promotion device to induce sales directly to the consumer at the retail level, such as special displays, discount coupons, premiums, special sales, loss-leaders and tie-in sales, for products within the scope of this Code. This provision should not restrict the establishment of pricing policies and practices intended to provide products at lower prices on a long-term basis.

5.4 Manufacturers and distributors should not distribute to pregnant women or mothers of infants and young children any gifts of articles or utensils which may promote the use of breast-milk substitutes or bottle-feeding.

5.5 Marketing personnel, in their business capacity, should not seek direct or indirect contact of any kind with pregnant women or with mothers of infants and young children.

Article 6. Health Care System

6.1 The Health Authority should take appropriate measures to encourage and protect breast-feeding and promote the principles of this Code, and should give appropriate information and advice to health workers in regard to their responsibilities, including the information specified in Article 4.2.

6.2 No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code. This Code does not, however, preclude the dissemination of information to health professionals as provided in Article 7.2.

6.3 Facilities of health care systems should not be used for the display of products within the scope of this Code, for placards or posters concerning such products, or for the

distribution of material provided by a manufacturer or distributor other than that specified in Article 4.3.

6.4 The use by the health care system of "professional service representatives", "mothercraft nurses" or similar personnel, provided or paid for by manufacturers or distributors, should not be permitted.

6.5 Feeding with infant formula, whether manufactured or home-prepared, should be demonstrated only by health workers, or other community workers if necessary; and only to the mothers or family members who need to use it; and the information given should include a clear explanation of the hazards of improper use.

6.6 Donations or low-price sales to institutions or organizations or supplies of infant formula or other products within the scope of this Code, whether for use in the institutions or for distributions outside them, may be made. Such supplies should only be used or distributed for infants who have to be fed on breast-milk substitutes. If these supplies are distributed for use outside the institutions, this should be done only by the institutions or organizations concerned. Such donations or low-price sales should not be used by manufacturers or distributors as a sales inducement.

6.7 Where donated supplies of infant formula or other products within the scope of this code is distributed outside an institution, the institution or organization should take steps to ensure that supplies can be continued as long as the infants concerned need them. Donors, as well as institutions or organizations concerned, should bear in mind this responsibility.

6.8 Equipment and materials, in addition to those referred to in Article 4.3, donated to a health care system may bear a company's name or logo, but should not refer to any proprietary product within the scope of this Code.

Article 7. Health Workers

7.1 Health workers should encourage and protect breast-feeding; and those who are concerned in particular with maternal and infant nutrition should make themselves familiar with their responsibilities under this Code, including the information specified in Article 4.2.

7.2 Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters, and such information should not imply or create a belief that bottle feeding is equivalent or superior to breast-feeding. It should also include the information specified in Article 4.2.

7.3 No financial or material inducements to promote products within the scope of this Code should be offered by manufacturers or distributors to health workers or

members of their families, not should these be accepted by health workers or members of their families.

7.4 Samples of infant formula or other products within the scope of this Code, or of equipment or utensils for their preparation or use, should not be provided to health workers except when necessary for the purpose of professional evaluation or research at the institutional level. Health workers should not give samples of infant formula to pregnant women, mothers of infants and young children, or members of their families.

7.5 Manufacturers and distributors of products within the scope of this Code should disclose to the institution to which a recipient health worker is affiliated any contribution made to him or on his behalf for fellowships, study tours, research grants, attendance at professional conferences, or the like. Similar disclosures should be made by the recipient.

Article 8. Persons Employed by Manufacturers and Distributors

8.1 In systems of sales incentives for marketing personnel, the volume of sales of products within the scope of this Code should not be included in the calculation of bonuses, nor should quotas be set specifically for sales of these products. This should not be understood to prevent the payment of bonuses based on the overall sales by a company of other products marketed by it.

8.2 Personnel employed in marketing products within the scope of this Code should not, as part of their job responsibilities, perform educational functions in relation to pregnant women or mothers of infants and young children. This should not be understood as preventing such personnel from being used for other functions by the health care system at the request and with the written approval of the appropriate authority of the government concerned.

Article 9. Labelling

9.1 Labels should be designed to provide the necessary information about the appropriate use of the product, and so as not to discourage breast-feeding.

9.2 Manufacturers and distributors of infant formula should ensure that each container has a clear, conspicuous, and easily readable and understandable message printed on it, or on a label which cannot readily become separated from it, in an appropriate language, which includes all the follow points: (a) the words "Important Notice" or their equivalent: (b) a statement of the superiority of breastfeeding: (c) statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use: (d) instructions for appropriate preparation, and a warning against health hazards of inappropriate preparation. Neither the container nor the labels should have pictures or infants, nor should they have other pictures or

text which may idealize the use of infant formula. They may, however, have graphics for easy identification of the product as a breast-milk substitute and for illustrating methods of preparation. The terms "humanized", "maternalized" or similar terms should not be used. Inserts giving additional information about the product and its proper use, subject to the above conditions, may be included in the package or retail unit. When labels give instructions for modifying a product into infant formula, the above should apply.

9.3 Food products within the scope of this Code, marketed for infant-feeding, which do not meet all the requirements of an infant formula, but which can be modified to do so should carry on the label a warning that the unmodified product should not be the sole source of nourishment of an infant. Since sweetened condensed milk is not suitable for infant feeding, nor for use as a main ingredient of infant formula, its label should not contain purported instructions on how to modify it for that purpose.

9.4 The label of food products within the scope of this Code should also state all the following points: (a) the ingredients used: (b) the composition/analysis of the product: (c) the storage conditions required: and (d) the batch number and the date before which the product is to be consumed, taking into account the climatic and storage conditions of the country concerned.

Article 10. Quality

10.1 The quality of products is an essential element for the protection of the health of infants and therefore should be of a high recognized standard.

10.2 Food products within the scope of this Code should, when sold or otherwise distributed, meet applicable standards recommended by the Codex Alimentarius Commission and also the Codex Code of Hygienic Practice for Foods for Infants and Children.

Article 11. Implementation and Monitoring

11.1 Government should take action to give effect to the principles and aim of this Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures. For this purpose, governments should seek, when necessary, the cooperation of WHO, UNICEF and other agencies of the United Nations system. National policies and measures, including laws and regulations, which are adopted to give effect to the principles and aim of this Code should be publicly stated, and should apply on the same basis to all those involved in the manufacture and marketing of products within the scope of this Code.

11.2 Monitoring the application of this Code lies with governments acting individually, and collectively through the World Health Organization as provided in paragraphs 6 and

7 of this Article. The manufacturers and distributors of products within the scope of this Code, and appropriate non-governmental organizations, professional groups, and consumer organizations should collaborate with governments to this end.

11.3 Independently of any other measures taken for implementation of this Code, manufacturers and distributors of products within the scope of this Code should regard themselves as responsible for monitoring their marketing practices according to the principles and aim of this Code, and for taking steps to ensure that their conduct at every level conforms to them.

11.4 Non-governmental organizations, professional groups, institutions, and individuals concerned should have the responsibility of drawing the attention of manufacturers or distributors to activities which are incompatible with the principles and aim of this Code, so that appropriate action can be taken. The appropriate governmental authority should also be informed.

11.5 Manufacturers and primary distributors of products within the scope of this Code should apprise each member of their marketing personnel of the Code and of their responsibilities under it.

11.6 In accordance with Article 62 of the Constitution of the World Health Organization, Member States shall communicate annually to the Director-General information on action taken to give effect to the principles and aim of this Code.

11.7 The Director-General shall report in even years to the World Health Assembly on the status of implementation of the Code, and shall, on request, provide technical support to Member States preparing national legislation or regulations, or taking other appropriate measures in implementation and furtherance of the principles and aim of this Code.

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