Baby Friendly Community Initiative (BFCI): Implementation Experience from Kenya

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The Maternal and Child Survival Program (MCSP) is the U.S. Agency for International Development's Bureau for Global Health flagship program for preventing maternal and child deaths, focusing on 25 countries. The program introduces and supports high-impact, sustainable reproductive, maternal, newborn and child health (RMNCH) interventions in partnership with ministries of health and other partners. This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program (MCSP) and do not necessarily reflect the views of USAID or the United States Government

Abbreviations

ANC	antenatal care
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
CHA	community health agent
CHV	community health volunteer
CHW	community health worker
CMSG	community mother support group
EBF	exclusive breastfeeding
IYCF	infant and young child feeding
M2MSG	mother-to-mother support group
MCSP	Maternal and Child Survival Program
MIYCN	maternal, infant, and young child nutrition
MOH	ministry of health
NGO	nongovernmental organization
PNC	post-natal care
TOT	training of trainers

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Background

The first 1,000 days from pregnancy to the child's second birthday is a critical window during which nutrition interventions have a far-reaching effect on a child's growth, development, and ability to thrive. (Black et al., 2008; Haddad, Cameron, & Barnett, 2015; Shrimpton, 2012; Black et al., 2013; Barker et al., 2010; Ramakrishnan et al., 2012; Özaltin, Hill, & Subramanian, 2010; USAID, 2015). Improving maternal nutrition can reduce the risk of poor pregnancy outcomes, such as fetal growth restriction, pre-term birth, low birthweight, and small-for-gestational age births, and also plays a role in the prevention of micronutrient deficiencies and childhood obesity (Christian & Stewart, 2010). Adequate maternal nutrition and weight gain during pregnancy as well as early, exclusive and continued breastfeeding to the child's second birthday with continued optimal complementary feeding are the cornerstones of health for women and their children.

Breastfeeding is one of the most cost-effective health interventions, with a myriad of health and economic benefits for mothers and children, including: protection against infant mortality, diarrhea, respiratory infections, otitis media, asthma, overweight and obesity, and type 2 diabetes as well being associated with higher intelligence quotient in children and adolescents (Victora et al., 2016; Black et al., 2008). Findings from the 2016 Lancet series showed that recommended breastfeeding practices among children younger than two years of age could prevent over 800,000 child deaths in developing countries (Victora et al., 2016). Increased risk of infections and cognitive deficits associated with "not breastfeeding" contribute to lost productivity and subsequent economic losses (Rollins et al., 2016). According to the 2018 Global Breastfeeding Scorecard, global exclusive breastfeeding (EBF) rates have remained relatively stagnant since 1990, and only 41% of children younger than six months of age are exclusively breastfeed (WHO & UNICEF, 2018). To reach the World Health Assembly target of increasing the global rate of EBF in children under 6 months of age to at least 50% by 2025, health systems barriers that impede EBF should be addressed, including access to quality breastfeeding counseling and support (WHO, 2016).

The newly updated Baby-Friendly Hospital Initiative (WHO & UNICEF, 2018) and the Ten Steps to Successful Breastfeeding (WHO & UNICEF, 1989) provides countries with a recommended evidence-based package of interventions to support optimal breastfeeding practices, including breastfeeding counseling and support). BFHI aims to establish early and uninterrupted skin-to-skin contact immediately after birth, early initiation of breastfeeding, exclusive breastfeeding for the first six months of life, within facility-based maternal and newborn health services as critical to part of a global strategy (WHO & UNICEF, 2018). The guidance emphasizes that "*sufficient breastfeeding-support structures*" at the community level are essential to sustain exclusive breastfeeding beyond the initial hours or day(s) in maternities at the health facility level (WHO & UNICEF, 2018).

Kenya has made significant gains in exclusive breastfeeding practices over the course of the last 20 years – from 15% in 1998 to 61% in 2014 (Kenya National Bureau of Statistics et al., 1998 & 2014). The country provided an enabling environment to support breastfeeding, inclusive of free maternity services and local regulations on breastmilk substitutes. Seventy percent of hospitals were designated as baby-friendly (1994-2008), which signified facility-based support for breastfeeding, through the Baby-Friendly Hospital Initiative (BFHI) from 1994-2008. Due to structural changes in the government across ministries, formation of new subnational administrative units, new staff not trained in BFHI (UNICEF & WHO, 2017), and issues around communication on infant and young child feeding (IYCF) within the context of HIV, contributed to few health facilities (11%) being designated baby-friendly by 2010 (UNICEF & WHO, 2017).

The government of Kenya has prioritized community level support for breastfeeding through the Baby-Friendly Community Initiative (BFCI) (Kavle et al 2019). The Baby-Friendly Community Initiative (BFCI) is based on the principles of the Baby-Friendly Hospital Initiative (BFHI) and expands upon the tenth step of the *Ten Steps to Successful Breastfeeding* (the Ten Steps) to promote recommended maternal, infant, and young child nutrition (MIYCN) practices at the community level (WHO & UNICEF, 2018). It aims to provide women, families, and communities with a comprehensive support system to improve maternal infant and young child nutrition (MIYCN) during the first 1,000 days of life, the critical period to prevent malnutrition through the establishment of mother-to-mother and community support groups to improve maternal, infant and nutrition outcomes . BFCI is a multisectoral approach to improve IYCF practices, provide lactation support for addressing breastfeeding challenges and integrate maternal nutrition and nutrition-sensitive interventions, such as community gardens; water, sanitation, and hygiene (WASH); and early childhood development (ECD).

BFCI has been successfully implemented in Kenya, where the USAID-funded Maternal and Child Survival Program (MCSP) supported the MOH in developing national BFCI guidelines, training materials, job aids and external assessment protocols and rolled out the initiative in Kisumu and Migori counties (Kavle et al 2019). Though difficult to attribute directly to MCSP program, improvements in infant and young child feeding practices were observed from routine health data following implementation of BFCI with MCSP support, with dramatic declines in prelacteal feeding (19% to 11%) in Kisumu county and (37.6% to 5.1%) in Migori county from 2016-2017 in BFCI implementing community units (CUs). Improvements in initiation and exclusive breastfeeding in Migori were also noted —from 85.9% to 89.3% and 75.2% to 92.3%, respectively. Large gains in consumption of iron-rich complementary foods were also seen (69.6 to 90.0% in Migori, 78% to 90.9% in Kisumu) as well as introduction of complementary foods (42.0- 83.3% in Migori) (Kavle et al., 2019). BFCI coverage among the children under one in the BFCI implementing CUs varied across counties, from 20% to 60% throughout program implementation and were largely sustained 3 months post-implementation in Migori, while coverage declined in Kisumu. A randomized controlled trial in one rural BFCI area showed improvements in minimum dietary diversity, minimum meal frequency, and minimum acceptable diet in children aged 6-23 months who were exposed to BFCI (Maingi M, Kimiywe J, & Iron-Segev, 2018).

Goals of BFCI

This document describes the roll out of BFCI in Kenya, based on program implementation experiences of USAID's MCSP and Maternal and Child Integrated Program (MCHIP). The Kenya country experience provides insight on one way a country decided to develop and sustain a supportive environment for breastfeeding at the community level, in tandem with facility-based efforts to protect, promote and support breastfeeding (i.e. ANC and PNC, and considerations for linking to BFHI).

The goals of BFCI in Kenya were:

- To promote, protect, and support breastfeeding at the community level through mother to mother and community support groups, which engage mothers, fathers, grandmothers and community leaders

- To strengthen maternal nutrition practices for pregnant and lactating women, complementary feeding for children 6- 23 months of age, and to provide care and support for adolescent mothers on infant and young child feeding (IYCF).
- To provide a multisectoral platform for integration of key activities from other sectors (i.e. early childhood development; agriculture; water, sanitation, and hygiene). In Kenya, other government ministries aside from Ministry of Health, including Ministry of Education and Ministry of Agriculture played a critical role in the national BFCI program.

BFCI Eight-Point Plan

Kenya's BFCI Eight-Point plan was based on the principles of *The Ten Steps to Successful Breastfeeding* (Table 1). The BFCI Eight-Point Plan summarized key policies that health facilities and communities can implement to support optimal breastfeeding practices, complementary feeding practices and maternal nutrition. The Eight-Point Plan also served as the foundation of all BFCI training for staff at all levels, including subnational health and nutrition managers, facility- and community-based health workers, nutritionists, community health volunteers, community leaders and members. The training package for BFCI was developed by in-country stakeholders, taking into consideration existing training packages for infant and young child feeding (IYCF), and BFHI in country. As part of BFCI and in support of Point 4 and 5, health providers were trained on the Breastmilk Substitutes Act[1], to ensure there are no violations of the act, in the promotion of breastfeeding.

Table 1. Kenya's BFCI Eight-Point Plan

1. Have a written MIYCN policy summary statement that is routinely communicated to all health providers, community health volunteers (CHVs) and the community members. This policy statement can be displayed in health facilities and be distributed to community-based providers
2. Train all health care providers and community volunteers-based providers to equip them with in the knowledge and skills necessary to implement the MIYCN policy. This includes standard IYCF counseling package, as well as counseling on maternal nutrition.
3. Promote optimal maternal nutrition among women and their families
4. Inform all pregnant and lactating women and their families about the benefits of breastfeeding and risks of artificial feeding (i.e. breastmilk substitutes)
5. Support mothers to initiate breastfeeding within the first one hour of birth and establish and exclusively breastfeed maintain EBF for the first six months. Address any breastfeeding problems.
6. Encourage sustained breastfeeding beyond six months to two years or more alongside timely introduction of appropriate, adequate, and safe complementary foods and stimulation of the child.
7. Provide a welcoming and supportive environment for breastfeeding families
8. Promote collaboration between health care staff, MIYCN support groups, and the local community

Establishment of BFCI in Kenya

For establishing BFCI, Kenya implemented their Eight Point Plan through the following Nine steps as outlined in the Kenya national BFCI Guidelines and with the involvement of cadres of health providers, see Table 2 (MOH, 2016):

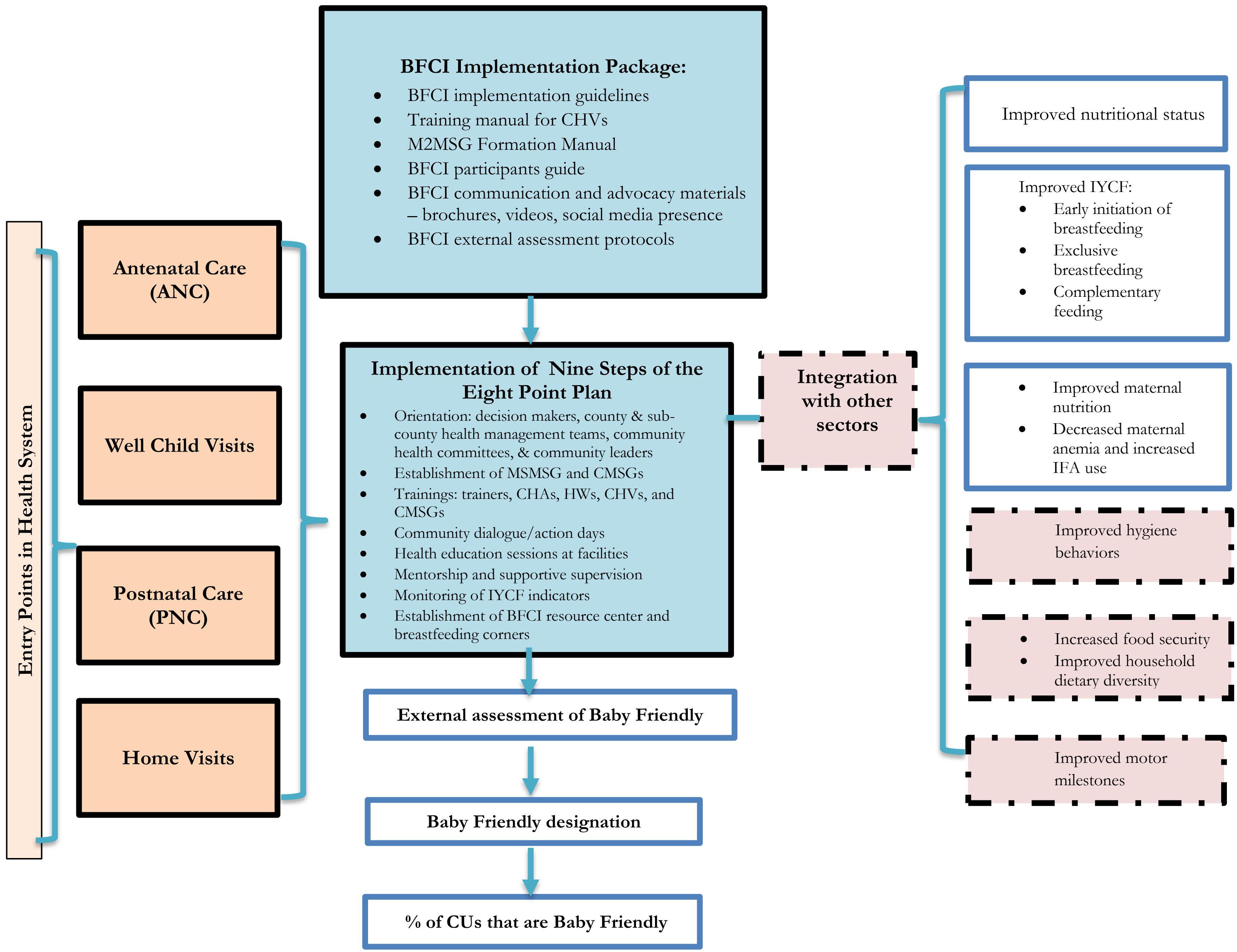
[1] The Kenya Government's Breastmilk Substitutes Act, issued in 2012, *provides for safe and adequate nutrition for infants through the promotion of breastfeeding and proper use of breast milk substitutes, where necessary, and for connected purposes*

1. Orientation of the relevant national MOH personnel, policy makers, and partners to the BFCI guidelines
2. Orientation of sub-national health management teams and relevant partners to the BFCI guidelines
3. Training of trainers (TOT) on BFCI
4. Training of health care workers including community health assistants (CHAs), who supervise community health volunteers (CHVs)
5. Orientation of relevant community health committees and other community leaders on BFCI
6. Mapping of households to identify those communities with pregnant and/or lactating women, with community defined per community unit
7. Establishment of community mother support groups (CMSGs)
8. Training of community health volunteers (CHVs) and CMSG members on BFCI
9. Establishment of mother-to-mother support groups (M2MSGs)

The roll-out of these nine steps were facilitated by the MOH through existing structures to ensure subnational government ownership and to sustain the initiative at the community level (Figure 1). It was necessary to agree upon oversight of planning, coordination, implementation and follow-up of BFCI activities, prior to roll out of the steps. This was led by county nutritionists with BFCI coordinating commitees or MIYCN committees made up of various stakeholders from different levels of the government (i.e. child health focal point, reproductive health coordinator, health promotion focal point, partner organizations).

Table 2. Definitions of community & health provider cadres BFCI, Kenya, Kavle et al 2019
• **Community Unit (CU):** Lowest level of health care in the Kenyan health system providing primary health care to a local population of 5000. Comprises ~1000 households and 5000 people who reside in the same geographical areas and share resources and challenges. • **Community Health Volunteer (CHV):** An individual chosen by the community and trained to address health issues of individuals and communities in their respective localities, working in close relationship with health facilities. A CHV acts as a catalyst and a change agent to enable people to take control and responsibility of their own health achievement efforts. CHV facilitated formation of mother-to-mother support groups and participating in monthly targeted home visits. The home visits conducted by CHVs include counselling on MIYCN, care and stimulation, community mobilization on MIYCN, and facility referral for case of acute malnutrition. • **Community Health Agents (CHA):** Community health workers with certification in nursing or public health and employed by the MOH. They act as facilitators of dialogue at the community level and provide support to CHVs. The CHA acts as a direct supervisor and mentor for CHVs; establishes and supervises community mother support groups (CMSG) and functioning; acts as the point of contract between facilities and CMSGs; as well as coordinates self-assessment for BFCI. • **Nutritionist:** Individual trained via education and experience in the science and practice of nutrition.

Figure 1. BFCI conceptual framework, adapted from Kavle et. al, 2019



This section provides more detail on the nine implementation steps of the Eight Point Plan.

Step 1: Orientation of all relevant national MOH personnel, policy makers, and partners to the BFCI guidelines

Prior to the roll-out of BFCI, it was critical to garner support and buy-in from key national-level stakeholders. National policymakers, relevant government ministries – including MOH, Ministry of Education, and Ministry of Agriculture – as well as nutrition technical working group leaders, NGOs working in community nutrition, and other key national-level stakeholders were oriented to BFCI. This orientation included background information on BFCI and the potential positive impact of BFCI on nutrition and child health outcomes. It was essential that the commitment of key decision-makers was obtained to promote and sustain the initiative.

Step 2: Orientation of sub-national health management teams and relevant partners to the BFCI guidelines

Sub-national health management teams and government ministries (Ministry of Health, Ministry of Agriculture, Ministry of Education) were oriented to BFCI. Specifically, this orientation included the goals and objectives of BFCI, implementation sites and timelines, the Eight-Point Plan, expectations from all partners, promotion of BFCI's positive impacts on early childhood health and nutrition including integration with ministry of agriculture.

Step 3: TOT on BFCI

A national level training of trainers (TOT) on BFCI was conducted for five to six days. The best master trainers for the TOT were chosen from a pool of health workers and nutritionists who were exposed to an initial training on BFCI and the MIYCN package. It is important for sustainability and integration into the health system that BFCI trainers were chosen by the MOH and had in-depth knowledge and experience in training health care workers and/or community health workers on recommended MIYCN practices. The role of BFCI trainer was filled by: nutritionists, current or former BFHI trainers, health providers with experience in providing MIYCN counseling at the facility and/or community level, and others with experience in capacity building of health workers. Other health workers who had been trained on BFCI and had implemented it in their various areas were also subsequently trained as TOTs.

Step 4: Training of health care workers and community health workers on BFCI

Training of health care workers, CHAs, and staff from line ministries (i.e. Ministry of Agriculture and Ministry of Education) on BFCI were conducted in Kisumu county, following the development of the BFCI guidelines. Participants were from Kisumu and Migori counties, which were the MCSP implementation sites for BFCI. The training was five days in length and the trainers used feedback from the training to further refine the BFCI trainer's manual. Trainings were participatory and utilized hands-on demonstrations to build the necessary knowledge, skills, and competencies to promote and support breastfeeding and other MIYCN practices at the community level. Representatives from other sectors, agricultural extension workers, and education (for early childhood development), were trained at the same time, as community gardens and ECD were part of BFCI, in MCSP supported areas.

Step 5: Orientation of relevant community health committees and other community leaders to BFCI

Community health committee members and key community leaders, including religious leaders, community administrators, village leaders (i.e. area chiefs or assistant chiefs), community-based political leaders, and other relevant stakeholders, were oriented to BFCI. Community leaders were vital for fostering local ownership of BFCI program activities.

Step 6: Mapping of households to identify those with pregnant and/or lactating women

To identify the number of households with pregnant and lactating mothers and children below the age of two years within a given community and where they are residing, it is recommended that a mapping of households be conducted. This will involve two sub-steps:

1. **Training of CHVs for mapping**
   CHVs conducted the mapping, given their permanent residence within communities. The communities where the MCSP project implemented worked with existing, functional community units and had already conducted household mapping within the previous six months, which was used as a basis for BFCI. In communities that mapping was outdated (i.e. greater than the past 6 months), CHVs were required to conduct a mapping of households. In areas where there are no CUs, new volunteers are engaged in mapping who are required to have basic reading and writing skills and receive training on the basic community package to enable them to map households.
2. **Mapping of households**
   When mapping of households is required, a household register is provided to each CHV participating in the mapping, who was responsible for visiting each household in their community and document the following: the number of pregnant and lactating women, women with children under the age of two years at each household, and the location of each household in the register. This data is summarized in a community profile and is used to assign CHVs with specific households to visit mothers within their designated villages, to provide counseling and support on MIYCN practices.

Step 7: Establishment of Community Mother Support Group (CMSG)

CMSGs, were within the catchment area of the facility and would have representation from all the CUs, which are linked to health facilities. CUs are comprised of villages, usually 1-3 CUs are affiliated with each health facility, with CHVs acting as representatives. CMSGs were defined as a group of community members including a CHA, nutritionist, representatives from Community Health Committees and CHVs, local village leaders, lead mothers, religious leaders, opinion leaders, and/or birth companions, who participated in BFCI activities. The lead mother was defined as a mother residing in a given community who was well-respected by her community members, models and practices the recommended MIYCN behaviors, and acted as a liaison between the CMSG and the mother-to-mother support group (M2MSG) members in her community. CMSGs met bi-monthly and fulfilled the following tasks:

- Conducted planning and review meetings with CHAs and nutritionists, as needed by community
- Documented monthly activities of the CMSG, which was led by a CHA
- Supported the CHAs and nutritionist in monitoring BFCI activities monthly
- Advocated for allocation of funds to support BFCI activities in their community

Step 8: Training of CMSGs on BFCI

A five-day BFCI training was provided to members of the CMSG which included the following: objectives of BFCI, the Eight-Point Plan, key BFCI activities to be rolled-out in their community, and members' expected roles and responsibilities including building capacity on MIYCN (i.e. knowledge and skills to support mothers). For CHVs, this training built upon their existing competencies to counsel and support mothers on MIYCN practices. It was recommended that these trainings be community-based, interactive, and practical with hands-on demonstrations.

Step 9: Establishment of mother-to-mother support groups

M2MSGs were groups of pregnant and lactating women from a given community who met monthly to discuss MIYCN topics and issues, including the benefits of breastfeeding, how to address breastfeeding challenges, complementary feeding, and the importance of maternal nutrition during pre-pregnancy, pregnancy, and lactation. The M2MSGs held regular meetings, convened by the lead mother. Members of the group were recruited by the CHVs and lead mothers during the mapping of households, home visits, and antenatal care (ANC) outreach activities. Each M2MSG had 9-15 participants and if groups were larger than 15 members, they were split into smaller more manageable groups. It was expected that each M2MSG:

- Held monthly meetings with clear documentation of attendees and topics discussed
- Had active participation from all members
- Conducted monthly reporting, which was documented by CHVs
- Scheduled and promoted planned activities for the M2MSG
- Carried out income generating activities and community gardens (MCSP supported areas)

Implementation experience: Key findings

- The implementation of BFCI was guided by the national BFCI guidelines, which includes the Eight-Point Plan and the Nine Steps (MOH, 2016). BFCI consists of several entry points in the health system (Figure 1), through routine contacts with mothers at health facility or household/community level, community mothers support groups (CMSGs) and mother-to-mother support groups (M2MSGs) (Kavle et al 2019). BFCI implementation built upon the MOH's Community Health Strategy and the country's health workforce, which included CHVs, selected by their communities who were trained to address health issues, and government employed community health assistants (CHAs)[2] and county and sub-county nutritionists which are part of the health system.(Table 2) (Kenya Ministry of Health, 2014). CMSGs meetings were conducted and led by CHAs, which discussed community needs around health and nutrition promotion, as well as conducting cooking demonstrations, education on hygiene behaviors and early child stimulation. The health facility committees and community leaders with support from CHAs, CHVs and the sub-county nutritionists aided to identify members of the CMSG. Nutritionists were employed and deployed to each county and subcounty by the MOH and were tasked with implementation of nutrition interventions and BFCI.

- CHVs conducted home visits, identified and invited pregnant and lactating mothers to participate in M2MSGs. M2MSGs provide a safe space where mothers discuss specific maternal nutrition, breastfeeding and complementary feeding practices, provided an opportunity to conduct cooking demonstrations, and discuss ways to resolve any challenges with breastfeeding with their peers, the lead mother and CHV in each village (Step 9).

- While no incentive was provided, per MOH BFCI guidelines, CHVs formed M2MSGs, and as fellow members of these support groups, CHVs were held accountable at the community level. For sustainability, partners organizations have advocated for CHVs to be paid stipends. In addition, some CHVs were part of income generation activities within M2MSGs they had formed, which motivated their participation in BFCI. Other CHVs started income generating activities within the community unit. CHVs visited households on a monthly basis, according to the government community health strategy. Households visited are estimated to equate the number of children less than 1 year of age in their designated catchment area based on the projected population for children under one. In addition, household visits were also made for pregnant mothers and also children aged 12 – 23 months to follow up on complementary feeding, which were identified during mapping.

- Health workers also established breastfeeding corners, which are safe, private, designated places where mothers can breastfeed in health facilities and include information on breastfeeding and provision of counseling and support, if needed. For example, in Oboch, an MCSP supported area in Kisumu county, women used the breastfeeding corner if they were shy or embarrassed to breastfeed in public of if they feared the "evil eye" , which is believed to cause infant illness. In the breastfeeding corner, comfortable chairs, privacy, social behavior change materials, a place for hand washing and a table were provided, though the corners were not used for breastmilk expression, due to the lack of a lockable door which would have offered complete privacy.

- In Kenya, the government recently enacted the Health Act (2017) which requires all employers to establish lactation stations at formal workplaces with necessary equipment and facilities (i.e. private room, table, liquid soap, handwashing facility, comfortable chairs, refrigerator). In addition, employers are required to grant all breastfeeding female employees break intervals in addition to time off to breastfeed or express breastmilk. Given this act was passed post-BFCI implementation, in MCSP areas, MCSP was only able to support women to breastfeed privately and were unable to provide a lactation room for health providers. In addition, the Kenya government mandates 3 months maternity leave after childbirth.

[2] Formerly known as Community Health Extension Workers (CHEWs)

Integration of nutrition-sensitive interventions into BFCI

BFCI provided a platform for integration of nutrition-sensitive interventions, including agriculture, early childhood development and key hygiene actions. While nutrition sensitive interventions are not explicitly monitored and discussed within Kenya's BFCI guidelines, they are part of the MIYCN counseling cards and the training manual, which are considered to be BFCI implementation materials. The community units decided which aspects would be incorporated into the BFCI platform, as not every community in each county or subcounty had the resources, staff or motivation to include all nutrition sensitive interventions.

Agriculture

In MCSP-supported areas, agricultural extension workers are trained on BFCI which also included food insecurity, food availability, and dietary diversity (i.e., increasing consumption of number of food groups) through use of locally available, crops (i.e., orange fleshed sweet potato), green leafy vegetables, and fruits (i.e. passion fruit) from community gardens in MCSP-supported areas (Kisumu only) (Kavle et al 2019). Following this orientation, agricultural extension workers, who were employed by the Ministry of Agriculture, built the capacity of CHVs to plant, maintain and cultivate kitchen gardens. They also prepared communities to protect /fence crops from animals, care for crops in harsh climatic conditions. CHVs then trained the mothers using the demonstration garden set up in the facility or community with the technical assistance of Ministry of Agriulture staff.

Families were advised to sell any surplus fruits and vegetables harvested from kitchen ("home") gardens and utilize these funds to purchase iron-rich, animal source foods (i.e., eggs, chickens), to increase dietary diversity. In two sub counties in Kisumu, CHVs and mothers were taught how to dry vegetables for preservation. Every member of the M2MSGs had a backyard "home" gardens in her household, with a total of 2000 backyard gardens and 26 community gardens in Kisumu and Migori, which were MCSP supported areas. Education on preservation of vegetables through drying techniques and how to cook and reconstitute the dried vegetables was carried out and incorporated into cooking demonstrations (Kisumu only).

Early childhood development

Through BFCI, early childhood development (ECD) teachers[3] were engaged in provision of infant and young child nutrition and health messages via ECD centers (i.e., centers which provide pre-primary school education for children 4 - 5 years of age, in every community unit) and community M2MSG meetings in some MCSP supported areas (Kavle et al 2019). ECD teachers were trained with members of CMSGs on BFCI and worked with CHVs to support early childhood development and stimulation. ECD teachers screened for acute malnutrition, using mid-upper arm circumference tapes. ECD teachers and CHVs created local toys, such as a toy shakers (i.e. made from medicine bottle, pebbles, and stick) or dolls made from clothes or paper, which were part of the BFCI resource centers in community units and used during MCH visits for early childhood stimulation.

WASH

BFCI also provided an opportunity to discuss key WASH messages from MIYCN counseling cards, including handwashing at critical times (i.e. after changing the baby's diapers, before eating or breast feeding, before cooking), use of latrines and proper disposal of feces, clean play areas away

[3] Teachers had Form 4 education with 1-year training in ECD

from animals, and food safety and hygiene. Key messages on complementary feeding and good hygiene behaviors were reinforced at the health facility, through M2MSG, and via home visits. BFCI leveraged other projects (i.e. Kenya Integrated Water and Sanitation KIWASH, AMREF) to promote key WASH practices and hygiene behaviors in the context of infrastructure (i.e. water treatment, latrine availability, and handwashing facilities (i.e. tippy taps) , which included linkages to community led total sanitation to reduce open defecation.

Maintaining BFCI

Following the roll-out of the aforementioned nine steps necessary to establish the BFCI, several routine community-level activities maintained BFCI. These activities were intended to attain support for mothers, families, and the community to perform recommended MIYCN practices, including around breastfeeding and complementary feeding. This section contains detailed descriptions of potential activities (see Table 3).

Table 3. BFCI activities and associated frequency and ownership

Activity	Frequency	Responsible Owner(s)
BFCI trainings for new recruits	As needed	BFCI trainers
Targeted home visits	Monthly up until the last month of pregnancy, and weekly thereafter until delivery. After delivery, monthly visits continue until the child's first birthday and thereafter the mother is visited every two months until the child's second birthday.	CHV, lead mother
Baby-friendly community meetings	Bi-monthly	CMSG, CHV, lead mother
Group counseling during ANC and PNC	During ANC and PNC clinics and outreach activities	CHV, health facility staff,
CHV meetings	Monthly	CHV, CHA, nutritionist
CMSG meetings	Bi-monthly	CHA
Establishment and management of Baby-friendly Resource Center	Established once with ongoing management	CMSG, CHV, health workers
Reporting and monitoring of BFCI activities and indicators	Monthly data collection; Monthly monitoring of indicators	Nutritionist CHA, CHV,
Mentorship and supportive supervision	Monthly visits by sub-county health management team during the first 6 months, and quarterly thereafter; monthly visits by the CHA and nutritionist	Sub- county health management team representatives, CHA, nutritionist
BFCI self-assessments	As needed	CMSG/Nutritionist

BFCI trainings for newly recruited community-based providers

New CHVs and lead mothers received a five-day BFCI training, based on the Eight-Point Plan. Additionally, refresher trainings for the CMSG on any areas in the Eight-Point Plan were given. Refresher training sessions were conducted during monthly CHV meetings which was led by the CHA and supported by the nutritionist and included provision of job aids from country-level training package.

Targeted home visits by community-based providers

As part of BFCI, a community-based provider who routinely conducts home visits, such as a CHV, with the assistance of a lead mother visited and counseled pregnant women in their community on optimal MIYCN. These home visits were conducted monthly, up until the last month of pregnancy, which was subsequently conducted weekly until delivery, to help ensure that breastfeeding was initiated within one hour of birth and that no pre-lacteal feeds are given.

These visits included counselling on the following topics during pregnancy and the post-partum period:

- Healthy foods to eat during pregnancy and lactation
- Iron-folic acid supplementation throughout pregnancy
- Healthy weight gain during pregnancy
- Preparing for the postpartum period
- Importance of early initiation, exclusive breastfeeding, Complementary feeding

Within the first week of birth, frequent visits by the CHV and/or lead mother were recommended to counsel the mother on proper attachment, address common breastfeeding challenges, and to support exclusive breastfeeding, and care and stimulation. After the first month of life, it was essential that a mother was visited at least once a month for the first year of her child's life to offer and provide continued support around maternal nutrition and breastfeeding and to counsel the mother on complementary feeding. Beyond the first year, mothers were visited at least every two months up to twenty-four months of life to provide continued support on MIYCN practices, including feeding during illness, child spacing, growth monitoring, vitamin/mineral supplementation, immunization, care and stimulation. Targeted home visits were increased if a mother misses a M2MSG meeting or when a mother faces additional barriers within the household to practicing the recommended MIYCN practices. Targeted home visits took place at the mother's home, the CHVs or lead mother's home, or any convenient place where the women typically meet in the community.

Baby-friendly community meetings

Bi-monthly BFCI community meetings were conducted to promote healthy MIYCN, hygiene and sanitation, proper care and stimulation, and other health and nutrition topics. Organized by the CMSG, these meetings included women of reproductive age, fathers, grandmothers, and other caregivers of children. Community members were mobilized to attend these meetings overseen by the CHAs and implemented by CHVs.

Baby friendly community meetings were used to share information about breastfeeding and to carry out cooking demonstrations on how to make nutritious recipes for children 6- 23 months of age, with mothers and grandmothers, which were subsequently led by the CHV and/or lead mother. Men were also given key messages on how to support MIYCN in their community. In addition to baby friendly community meetings, the CMSG worked with community leadership to ensure the incorporation of BFCI activities into other community dialogues and community action days to promote recommended MIYCN practices.

Group counseling during ANC and PNC

During ANC, PNC and well child clinics and outreach activities, BFCI group counseling sessions was conducted by the CHV, health facility staff, or CHA. The CHA or health facility in-charge documented the topics covered and the number of attendees. The staff involved were often based on who were delegated to these activities in a particular health facility and at times, the topic at hand. For example, if a CHA or health facility staff was more knowledgeable on maternal nutrition, they would teach on that topic, while others may be more knowledgeable on breastmilk expression.

CHV check-in meetings

CHVs held monthly meetings with local nutritionists, chaired by the CHA, for routine reporting and discussing progress and challenges with BFCI implementation in their communities. CHAs eventually held the monthly meetings, without the local nutritionists, as their technical capacity to hold monthly meetings increased. During these meetings, the CHVs and nutritionist discussed potential solutions to challenges faced during their work with BFCI communities and celebrate key achievements. Additionally, nutritionists provided any updates on related MIYCN activities and areas for integration of baby-friendly activities.

CMSG meetings

The CMSG held bi-monthly meetings to discuss achievements, challenges, areas for growth, and plan for upcoming activities. These meetings were organized by a community leader.

M2MSG meetings

Each M2MSG conducted monthly meetings, organized by the lead mother and CHV. The lead mother or CHVs were responsible for engaging group members in discussions around MIYCN, care and stimulation in an interactive, participatory manner. These meetings allowed mothers to ask questions and for problems around MIYCN to be addressed as a group. It is important that M2MSG meetings documented in terms of what was discussed, which was reviewed at the start of the next meeting.

Mentorship and supervision

Mentorship and supportive supervision were essential for sustaining BFCI, with intensive mentoring and supervision needed during the initial start-up phase. At the community level, it was essential that the CHA and nutritionist provided supportive supervision and mentorship to the CHVs at least once monthly. This included observations during targeted home visits, in which they accompanied CHVs to ensure they provided quality counseling to mothers and other caregivers. CHVs provided mentorship and supportive supervision to lead mothers during M2MSG meetings and targeted home visits.

For the first six months of establishing BFCI, members of sub-county health management team (i.e. subcounty nutritionist, sub county community focal point) visited the primary health facility corresponding to a BFCI community at least once monthly to support and strengthen BFCI efforts, and quarterly thereafter. On these visits, the sub-county health management team members used supervision checklists as a tool for providing guidance and support for both geographic and programmatic areas needing strengthening. Based on findings from each visit, action points were developed for improving BFCI efforts. Supervision checklists (examples from Kenya) are provided in Annex 1. Internal monitoring was essential to sustaining the BFCI, identifying any gaps in implementation and addressing them in a community's ongoing BFCI activities.

Establishment and management of Baby-Friendly Resource Center

To provide a space that mothers and other caregivers can access to obtain information and support around MIYCN and child stimulation, communities established a Baby Friendly Resource Center. This center was located anywhere in the community or health facility, included a designated corner or room in or nearby the health facility, and provided informational materials (e.g., pamphlets, handouts, posters) on MIYCN and child care and stimulation. The center was managed by a CMSG, CHVs, health care workers, and lead mothers, and provided educational support to visitors of the center.

Monitoring and Evaluation

Internal monitoring of BFCI activities conducted routinely was vital to the success and sustainability of the program. Recommended indicators for community-based monitoring of key MIYCN practices are listed in Table 4. Two indicators – *early initiation of breastfeeding within one hour of birth* and *exclusive breastfeeding for the first six months of life* – are considered essential and can be routinely tracked by each community for each mother-infant pair using the BFCI monitoring tools. Monitoring five BFCI indicators (see Table 4, denoted by *) was performed monthly by nutritionist, with the support of the CHA and the county teams in the initial start-up phase and monthly thereafter to track progress and note where corrective efforts are needed. Following the initial start-up phase, it was recommended that the biannual review be conducted in the community alongside the sub-national health management team in the form of a self-assessment. During these visits, the BFCI indicators were assessed to determine if a community is meeting the criteria for obtaining and/or maintaining Baby-friendly certification, using reporting and monitoring tools, interviews, and observations. Where possible, it is essential that review of monitoring, reporting and follow-up of these indicators be integrated into existing community-based quality improvement activities.

Table 4. Recommended BFCI indicators for community-based tracking of key MIYCN practices, based on the BFCI Eight-Point Plan

Key Practice	BFCI Indicator	Target to reach	Primary data source	Additional data sources
Point 3. Promote optimal maternal nutrition amongst women and their families	The percentage of mothers who reported receiving community-based counseling on maternal nutrition during pregnancy	≥80%	Interviews with mothers	
Point 4. Inform all pregnant and lactating women and their families about the benefits of breastfeeding and risks of artificial feeding	The percentage of mothers who received pre-natal counseling on the importance of breastfeeding	≥80%	Interviews with mothers	
	The percentage of mothers who have received post-natal counseling on the importance of breastfeeding	≥80%	Interviews with mothers	
Point 5. Support mothers to initiate breastfeeding within one hour of birth, establish and maintain exclusive breastfeeding for the first six months. Address any breastfeeding problems.	**Essential indicator:** The percentage of babies who were put to the breast within one of hour of birth*	≥80%	BFCI tool, Interviews with mothers	Maternity register/ MOH 711 reporting tool
	Proportion of infants who receive any pre-lacteal feeds within the first three days of life*	0%	BFCI tool, Interview with mothers	
	Essential indicator The percentage of infants in a community who received only breast milk for the first six months of life*	≥80%	BFCI tool Interviews with mothers	CHANIS** tally sheet/ MOH 711 reporting tool
	The percentage of mothers who are able to demonstrate how to position their baby for breastfeeding and that their baby can properly suckle and transfer milk	≥80%	Demonstration by mother	
	The percentage of breastfeeding mothers who can describe at least two indicators of whether a breastfed baby consumes adequate milk	≥80%	Interviews with mother	
Point 6. Encourage sustained breastfeeding beyond six months to two years or more, alongside the timely introduction of appropriate, adequate and safe complementary foods while providing holistic care (physical, psychological, spiritual and social) and stimulation of the child.	The percentage of children aged 6-24 months who are breastfed	≥80%	Interviews with mothers	
	The percentage of infants aged 6-8 months who were given complementary foods*	≥80%	BFCI tool, Interviews with mothers	
	The percentage of infants aged 6-12 months fed iron-rich animal source protein*	≥80%	BFCI tool, Interviews with mothers	
Point 7. Provide a welcoming and supportive environment for breastfeeding families	The percentage of randomly selected mothers who report a welcoming and supportive environment for breastfeeding families	≥80%	Interviews with mother	
*Kenya currently collects five BFCI indicators ** CHANIS = Child Health and Nutrition Information System				

In the MCSP experience, with supervision from the CHA, the CHV recorded the BFCI indicators in each child's Growth Monitoring and Child Feeding Form on a monthly basis (Annex 2). This data was summarized into a Village Report for all children under the age of one year which was collected by the CHA, and then the sub country nutritionist. The health facility nutritionist or CHA completed the facility report and the sub county nutritionist compiled all reports which were rolled up to the sub county level on a monthly basis. This aided to identify data issues and included continued mentorship of BFCI staff on data quality. The data was subsequently submitted to the national level MOH staff. Programmatic indicators were tracked at the national, county, and subcounty levels by the CMSG, county and sub county teams monthly, which included 1) number of communities who implemented BFCI and 2) number of active M2MSGs. While the national guidelines recommend tracking these indicators every 6 months, MCSP supported sites tracked five indicators (denoted with * in Table 4) monthly to identify, address and follow-up on any issues mothers had with IYCF practices, including addressing any documentation and reporting gaps by CHVs.

Self-Assessments

Self-assessments were essential to ascertain areas of the BFCI requiring growth and improvements as well as strengths and to determine whether a community is ready to undergo an external assessment for Baby-friendly certification. Self-assessments conducted periodically, by the CHA and nutritionist can prepare a community for an external assessment by the national external assessors. The CMSG can use all relevant clinical records and reporting and monitoring tools as well as interviews and observations to determine if a community is meeting the target of at least 80% of all BFCI indicators. Once these criteria are met, the CMSG recommends to national BFCI external assessors that their community undergo an external assessment.

Certification of Communities as Baby Friendly

Once referred for external assessment, the national assessors, visited the community to be assessed alongside the CMSG and sub-national health management team. External assessments were conducted by MOH, with donor support from UNICEF. The external assessors, which came from the national level Ministry of Health, reviewed the relevant clinical records and reporting and monitoring tools and conduct observations and interviews to determine if the community has met the criteria for baby-friendly certification, by scoring at least 80% on all BFCI indicators. Following the external assessment, the external assessors discussed with the sub-national health management team the results of the assessment and areas to strengthen If a community met the criteria for at least 80% of the BFCI indicators, they were awarded baby-friendly certification. If they do not meet this criteria, the community were not awarded baby-friendly certification but were awarded a certificate of commitment towards being baby friendly and encouraged to focus on strengthening their BFCI program by working on improving weak areas.

The community was encouraged to maintain their Baby-friendly certification by continuing their efforts in MIYCN. The external assessment team took a random sample and interviewed health workers in the health facility, CHVs, and mothers within the communities. None of the CUs externally assessed were certified as baby-friendly, and instead were given certificates of commitment to be baby-friendly. Because Kisumu was the first county to apply the national tools, the certification process may have been affected by the need to test if questions and content were appropriate. For example, the questions for mothers were similar to questions for health care workers and required simplification to facilitate better understanding by mothers. Based on this initial experience, changes and revisions to the national tools were recommended by external evaluators prior to carrying out future external assessments. In addition, the external assessment was conducted only after 10 months of implementation and moreover, during the assessment, health care workers were on strike, and some could not participate in the external assessment, which likely impacted assessment findings. Next steps are to revise the external assessment tools to address identified gap(s)and develop harmonized criteria that could be applied to all CUs within the country in the future.

Key Programmatic Considerations for Implementation and Sustainability of BFCI

Transforming community-level care and creating a supporting environment for improving breastfeeding, complementary feeding, and maternal nutrition is essential to BFCI, but cannot be done successfully without attention to sustainability. This will require ownership at all levels and a health systems approach, including key considerations outlined below.

National leadership and coordination

Sustaining BFCI required ownership by national, county and subcounty leadership, including the MOH, the country's coordination body for breastfeeding, and any relevant MIYCN partners at the national and subnational level. It was key to have one identified person at the national level responsible for coordinating high-level BFCI activities, including determining governmental and nongovernmental implementing partners and the catchment areas for which they are responsible, monitoring of BFCI communities, integration with BFHI and other MIYCN programs, and advocacy for BFCI. The national level MOH has prioritized BFCI and BFHI as key programs in the national nutrition action plan (2013-2017) and plans to continue these prioritized efforts in the future. While BFCI and BFHI implementation and external assessments have been supported via various implementing partners, inclusion of funds for external assessment in national budgets and county budgets would aid towards sustainability.

Integration with BFHI and other existing MIYCN programs

Essential to the sustainability of BFCI is its integration with all MIYCN programs and interventions when and where they exist. BFCI community activities were linked to primary health care centers and dispensaries, that referred cases they could not manage to hospitals. Additionally, BFCI can link mothers to a nearby hospitals and BFHI.

Important lessons learnt during BFCI implementation

First, systematic capacity building of implementers, with buy-in at the national level, at the beginning, as well as identifying, motivating, and working with champions were instrumental in keeping BFCI on the agenda (Kavle et al 2019). Second, mentorship of health providers and CHVs by trainers played a key role in the initial steps of BFCI. Third, implementation of BFCI as an integrated model, through working with other programs/sectors, can motivate early and frequent attendance at ANC, and encourage attendance to health facility for childbirth. Fourth, identifying, sensitizing, and engaging existing members of community support systems to promote BFCI and establish community support groups (i.e., ECD teachers, agricultural extension workers, local community, and religious leaders, etc.) were key. Fifth, supportive supervision and continuous mentorship by the county and sub-county health management teams is necessary to ensure proper implementation of BFCI. Sixth, in the future, advocacy for lactation rooms for health provider staff and county sensitization for other formal employers (i.e. companies) to provide lactation rooms is needed.

Advocacy for additional government resources is needed to support scale-up of BFCI. Stipends for CHVs, distribution of key materials and tools (i.e. MIYCN counselling cards, and BFCI monitoring tools) as well as finalization of a recently developed formal training curriculum for community-based providers (CHVs) are needed. While BFCI reporting has been parallel to other routine community reporting, with increased coverage of BFCI across Kenya, in the future, BFCI indicators should be integrated into the routine community reporting tools and DHIS2 for sustainability. Future efforts can link implementation of BFCI and BFHI, per recently released WHO Guidelines (WHO, 2018), to ensure the continuum of care from facility to community level for breastfeeding counseling and support.

Conclusion

It is essential to strengthen MIYCN programming during the "first 1,000 days" to improve nutritional status and health outcomes of women and children. In Kenya, an important component of this integrated nutrition-health programming is strong breastfeeding promotion and support at the community level for improving health and nutrition outcomes. Comprehensive breastfeeding support from the health facility to the community is essential for maximizing improvements in breastfeeding practices. BFCI will be most effective when integrated and implemented with BFHI and other facility-based breastfeeding interventions. A successfully implemented BFCI involved both governmental and nongovernmental stakeholders in implementation of MIYCN community-based, BFCI interventions. In the future, this will be most effective when integrated into national MIYCN programs, policies, protocols, guidelines, financing mechanisms, and training packages and universal health care. Further, the involvement of all actors at national, subnational, and community levels can aid in sustaining a baby friendly supportive environment. While BFCI is just one way to improve community support for breastfeeding which worked in Kenya, it is important that other community-based models and types of support are considered for other country contexts.

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Annex 1: Supervision Checklists from Kenya

When filling the form, check and verify information provided in the relevant registers, tally and summary sheets and other documentation tools used, and also observe.

BFCI Health facility tool

NAME OF PERSONS SUPERVISING:			
DATE OF VISIT (DD/MM/YY):			
NAME OF COMMUNITY UNIT ATTACHED TO THE FACILITY:			
NAME OF HEALTH FACILITY:			
CRITERIA 1: FUNCTIONAL COMMUNITY MOTHER SUPPORT GROUP (CMSG)			
	Is there a CMSG?	Yes (☐)	No (☐) and reason
	If yes, what is its composition? Core members (CHEW, Nutritionist, Chief/assistant chief, CHVS and CHCs representative, lead mothers)	Yes (☐)	No (☐) and reason
	Does the CMSG meet bi-monthly? If yes, check minutes/reports for CMSG	Yes (☐)	No (☐) and reason
	Is there a plan for bi-monthly (after every two months) baby friendly meetings with clear roles of key players available?	Yes (☐)	No (☐) and reason
	Is there evidence of clear documentation of CMSG activities?	Yes (☐)	No (☐) and reason
CRITERIA 2: FUNCTIONAL MOTHER-TO-MOTHER SUPPORT GROUP (M2MSG)			
	Are there Mother to Mother Support Groups (M2MSG)? If Yes, how many M2MSGs? [__________]	Yes (☐)	No (☐) and reason

	How many members in the M2MSG? [__________] If more than oneM2MSG, provide membership for each		
	Does the M2MSG meet monthly? If yes, check minutes/reports (Observe and check records)	Yes (☐)	No (☐) and reason
	Is there a functional referral system from the facility to M2MSG? (Check record whether there is a referral book from facility to community either through maternity or MNCWC)	Yes (☐)	No (☐) and reason
CRITERIA 3: TARGETED HOME VISITS			
	Have the CHVs conducted targeted home visits? (Check records)	Yes (☐)	No (☐) and reason
	Is there clear documentation of number of women reached? (Check records)	Yes (☐)	No (☐) and reason
	Are there reports complied by the CHEW/CHV from the individual child feeding and growth monitoring form?	Yes (☐)	No (☐) and reason
CRITERIA 4: BI-MONTHLY BABY FRIENDLY COMMUNITY MEETINGS			
	Is there clear documentation of bi monthly baby friendly meetings?	Yes (☐)	No (☐) and reason
	Did the activities conducted in the previous meeting include cooking demonstrations on appropriate adequate, safe complementary foods?	Yes (☐)	No (☐) and reason
	Was there inclusion of other health promotion activities during the baby friendly community meetings? If yes, list the activities	Yes (☐)	No (☐) and reason
	Did other community members, in addition to pregnant and lactating mothers, attend the baby friendly meetings? (Check report)	Yes (☐)	No (☐) and reason
CRITERIA 5: MONTHLY MEETING FOR COMMUNITY HEALTH VOLUNTEERS (CHVs)			
	Are monthly CHVs meetings conducted? (check evidence of documentation)	Yes (☐)	No (☐) and reason
	Was BFCI agenda included during the CHVs meetings? (check evidence of documentation)	Yes (☐)	No (☐) and reason

	Were follow-up actions for BFCI carried out? (check evidence of documentation)	Yes (☐)	No (☐) and reason
CRITERIA 6: REGULAR TRAININGS FOR CHVS ON BFCI			
	Have all CHVs been trained on BFCI? (confirm whether there are new additional after drop outs)	Yes (☐)	No (☐) and reason
	Once a year, the complete training is offered to replacement volunteers (new volunteers that replace drop-out volunteers).	Yes (☐)	No (☐) and reason
CRITERIA 7: SUPPORT FOR HIV POSITIVE MOTHERS			
	Does the facility offer PMTCT HIV services?	Yes (☐)	No (☐) and reason
	Facility fully independent in offering PMTCT services (Check records)	Yes (☐)	No (☐) and reason
CRITERIA 8:BABY FRIENDLY COMMUNITY RESOURCE CENTRE			
	Is there a BFCI resource centre in the facility or community? (Observe)	Yes (☐)	No (☐) and reason
	Are there adequate IEC materials in the resource centre? (Observe)	Yes (☐)	No (☐) and reason
	Is there evidence of use for the resource centre? (Check attendees to the centre)	Yes (☐)	No (☐) and reason
CRITERIA 9: MONITORING AND SUPERVISION			
	Does the CHEW monitor activities of the CHVs?	Yes (☐)	No (☐) and reason
	Are there compiled reports by the CHEW from individual child feeding and growth monitoring form?	Yes (☐)	No (☐) and reason
CRITERIA 10: FACILITY OBSERVATION			
	Does the facility have a written MIYCN policy summary statement present and displayed in all relevant areas of the health facility (MCH, maternity, paediatric wards, notice boards, Critical Care Centre) Labour and delivery area ☐ Yes ☐ No ☐ Area does not exist Antenatal clinic ☐ Yes ☐ No ☐ Area does not exist Postpartum ward/room ☐ Yes ☐ No ☐ Area does not exist Well baby clinics/Rooms ☐ Yes ☐ No ☐ Area does not exist ANC inpatient ward ☐ Yes ☐ No ☐ Area does not exist Consultation rooms ☐ Yes ☐ No ☐ Area does not exist Special baby units ☐ Yes ☐ No ☐ Area does not exist	Yes (☐)	No (☐) and reason

	PMTCT clinic ☐ Yes ☐ No ☐ Area does not exist Waiting Bay ☐ Yes ☐ No ☐ Area does not exist Paediatric ward ☐ Yes ☐ No ☐ Area does not exist		
	Is the MIYCN policy statement displayed, illustrated in a pictorial and/or any other possible way of simplifying, contextualized and understood by the local population?	Yes (☐)	No (☐) and reason
	Are pregnant women attending the MNCWC given IFAS supplementation at the health facility?	Yes (☐)	No (☐) and reason
	Does the PCF conduct health talks to educate mothers on the benefits of breast feeding? (If schedule and topic covered not present circle No)	Yes (☐)	No (☐) and reason
	Does the PCF have hand washing facilities in points accessible by mothers/caregivers? (Check for leaky it in close to toilets and other hand washing facilities)	Yes (☐)	No (☐) and reason

BFCI Health Worker Tool

START TIME (24HRS):			
END TIME (24 HRS):			
FIELD WORKER'S CODE:			
DATE OF INTERVIEW (DD/MM/YY):			
NAME OF FIELD WORKER:			
NAME OF COMMUNITY UNIT ATTACHED TO THE FACILITY:			
Step1: Have a written MIYCN policy summary statement that is routinely communicated to all health care workers, CHEWs and CHVs			
	(Observe) The facility has a written policy summary statement present and displayed in all relevant areas of the health facility (MCH, maternity, paediatric wards, notice boards, critical care center)?	☐ Yes	☐ No
	(Observe) Is MIYCN policy statement displayed, illustrated in a pictorial and/or any other possible way of simplifying, contextualized and understood by the local population?	☐ Yes	☐ No
	Ask and check records - minutes, health talk schedules, special/feedback CMEs. The written policy summary statement is **ROUTINELY** communicated to all Health workers/CHWs when new information comes up?	☐ Yes	☐ No
Step2: Train all healthcare providers and community health volunteers in the knowledge and skills necessary to implement the MIYCN policy			
	(Ask the health facility in charge)are all staff members and CHVs trained (classroom, orientation, OJT, CME) on BFCI?	☐ Yes	☐ No
	Does the training cover the 8 steps of BFCI?	☐ Yes	☐ No
	Are the health care workers able to answer simple questions on MIYCN (maternal nutrition, IFAS, EBF, and complementary feeding)?	☐ Yes	☐ No
	Are the CHVs able to answer simple questions on MIYCN (maternal nutrition, IFAS, EBF, and complementary feeding)?	☐ Yes	☐ No

	Are pregnant and lactating mothers able to answer simple questions on MIYCN (maternal nutrition, IFAS, EBF, and complementary feeding)?	☐ Yes	☐ No
Step 3: Promote maternal nutrition amongst women and their children			
	(Check records) Facility records (ANC register) indicate that pregnant women who attend ANC are supplemented with IFAS	☐Yes	☐ No
Step4: Inform pregnant women and their families about the benefits of breastfeeding			
	Are pregnant women receiving information about benefits of breastfeeding?	☐Yes	☐ No
	Are pregnant women able to describe the risks of giving supplements whilst breastfeeding in the first 6 months?	☐Yes	☐ No
	Are pregnant women able to describe the dangers of using bottles?	☐Yes	☐ No
	Are pregnant women able to describe the risks of giving supplements whilst breastfeeding in the first 6 months?	☐Yes	☐ No
	Are pregnant women able to describe how HIV can to be transmitted from mother to child?	☐Yes	☐ No
	Are pregnant women able to describe factors that can facilitate mother to child transmission of HIV when a woman is breast feeding?	☐Yes	☐ No
Step 5: Support mothers to initiate breastfeeding within the first one hour of birth, establish and maintain exclusive breastfeeding to 6 months			
	Are mothers supported to initiate breastfeeding within 1 hour of delivery	☐Yes	☐ No
	Are babies delivered placed in skin to skin contact with their mothers immediately after birth?	☐Yes	☐ No
	Are babies given something else other than breast milk in the first 3 days after birth before milk starts flowing?	☐Yes	☐ No

	Are all mothers helped to recognize the signs that their babies are ready to breast feed and offered help if needed?	☐Yes	☐ No
	Can staff describe the types of information and demonstrate the skills they provide to breastfeeding and non-breastfeeding mothers to assist them in successfully feeding their babies	☐Yes	☐ No
	Are breastfeeding mothers able to demonstrate correct positioning and attachment?	☐Yes	☐ No
	Are breastfeeding mothers shown how to hand express their milk or given information on expression and advised where they can get help should they need it?	☐Yes	☐ No
Step 6: Encourage sustained breastfeeding beyond 6 months to two years or more alongside timely introduction of appropriate adequate and safe complementary foods			
	Are mothers given information on the minimum age in which a child may stop breastfeeding and can give benefits of continued breastfeeding?	☐Yes	☐ No
	Are mothers given information on the age of the introduction of complementary foods in addition to breast milk?	☐Yes	☐ No
	Do mothers/ CHV and health workers have information on the number of meals/day baby 6-8months, 9-23months should receive every day?	☐Yes	☐ No
	Do mothers/ CHV and health workers have information on the amount of food a baby 6-8months, 9-23months should receive per meal every day?	☐Yes	☐ No
	Do mothers/ CHV and health workers have information on the minimum number of food groups a breastfeeding baby 6-23month's needs per day?	☐Yes	☐ No
	Do mothers/ CHV and health workers have information on the minimum number of food groups a non-breastfed baby 6-23months old needs per day?	☐Yes	☐ No
	Do mothers/ CHV and health workers have information on the critical times that a mother/ care giver should wash their hands?	☐Yes	☐ No

	Does the facility/community conduct bi-monthly cooking demonstrations on appropriate adequate, safe complementary foods?	☐Yes	☐ No
	Does the facility have hand washing facilities in points accessible to mothers/caregivers?	☐Yes	☐ No
Step7: Provide a welcoming and conducive environment to breastfeeding mothers and their families			
	(Ask and observe) Are there sitting places or a breastfeeding corner reserved for mothers to breastfeed within the community?	☐Yes	☐ No
	(Ask and observe) Are there are MIYCN/IEC materials in the breastfeeding corners/spaces at the health facility/community?	☐Yes	☐ No
Step 8: Promoting collaboration between health care staff, MIYCN support groups, and the local community			
	Is there a functional CMSG in every community?	☐Yes	☐ No
	Is there a functional M2MSG in every community?	☐Yes	☐ No
	(Are the CMSG and M2MSG activities linked with other nutrition sensitive sectors?	☐Yes	☐ No
	Are there reports for CMSG and M2MSG for their activities?	☐Yes	☐ No
	Is there an established referral system from the facility to M2MSG?	☐Yes	☐ No

Annex 2: IYCF and Growth Monitoring Record from Kenya

1. Village name: ______________________________

Household number: ____________________________

CHVs Name: ________________________________

MOTHER

2. Mother's name: ……………………………………………………

3. Mother's Age…………………… 4. Parity:……………

EARLY INITIATION

8. The child put to the breast/breastfed?

8.1. within 1hour after delivery☐;

8.2. later than 1 hour after delivery ☐

INFANT Infant's Name: ………………………

5. Baby's date of birth (day/month/year) …………../……………../…………..

6. Baby's weight at birth (kg and g)……………………………… 7. Low Birth Weight (if > 2,500 g, tick the box) ☐

PRE-LACTEAL FEEDING

9. In addition to breastmilk, what was the child given to drink/eat in the first three days of life?

9.1. Water/other liquids☐; 9.2. Milk (not breastmilk)/infant formula☐;

9.3. Others specify ______________________________ ☐ 9.4. None ☐

10. Date of the visit (day/month/year)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
11. Infant's age at the moment of the visit (in months)	0 to 0.9	1 to 1.9	2 to 2.9	3 to 3.9	4 to 4.9	5 to 5.9	6 to 6.9	7 to 7.9	8 to 8.9	9 to 9.9	10 to 10.9	11 to 11.9

12. Baby's weight during the visit (in kg and g)												
13. Did you breastfeed the child in the last 24 hours?												
14. In the last 24 hours did you give the child water or other fluids?												
15. Is the child given powder milk, condensed milk, infant formula?												
16. Was the child given solid or semi-solid foods in the last 24 hours?												
17. How many meals (complementary feeding) did the baby have in addition to breastfeeding in the last 24 hours?												
18. Was the baby given meat, poultry, fish or eggs in the last 24 hours?												
19. Feeding recommendations given to the mother												
Signature of the CHV												
Signature of the caregiver/mother												

Guidelines for completing IYCF and growth monitoring record:

1. The record is to be filled at the village level by the CHV who may be supported by the lead mother
2. One record per child is used.
3. The record is kept with the CHV assigned to the current family/child.
4. The record is initiated as soon as possible after the birth of the child and is updated on monthly basis, thereafter.
5. At the first visit (as soon as possible after delivery), the CHV should complete questions 1 through 9:
   - Question 1: write down the name of the village, household number and the name of the CHV.

- Questions 2 and 3: ask and write down the name of the mother and her age in years.
- Question 4: ask and write down child's number in the family. Is he/she the 1st, the 2nd, the 3rd, etc. child in the family?
- Questions 5 & 6: write down the name and the date of birth by indicating the day, the month, and the year of birth
- Question 7: write down the weight of the baby at birth. It is very important to weigh the child after the birth and write down his/her weight for future monitoring of the baby growth and for giving specific advice for low-birth-weight newborns [see below under follow-up actions]. Write down the weight of the baby in grams [example: 3,500 g]. If the child weighs less than 2,500 g, tick the box for Low Birth Weight Baby;
- For question 8, tick "√" in the box 8.1 if the mother put the baby to the breast within 1 hour after delivery. If the mother put the baby to the breasts later than 1 hour after delivery tick-in the box 8.2.
- For question 9, tick-in the box 9.1 if the mother gave the child water or other liquids; tick-in the box 9.2 if the mother gave milk (not breastmilk) or infant formula; and tick-in the box 9.3 if the child was given other liquids in the first 3 days after birth

6. At the first and subsequent visits, the CHV fills in the following questions:
   - For question 10, write down the date, the month and the year of your visit to the family/child
   - For question 11, ask the mother how old the child is and write down her answer.
   - For question 12, ask the mother to provide the mother child booklet and record the weight of the child indicated for that month. Write down the infant's weight in grams [example: 3,500 g].
   - For question 13, 14, 16, 17, 18 it is very important to refer to the last 24 hours.
   - For question 16 is very important to stress the consistency of the food. The liquid part of soup or broths is not considered a solid or semi-solid food. Soup with mashed vegetables is considered a semi-solid food. Examples of complementary foods include mashed potatoes; rice with vegetables, meat, fish, eggs; fruit; other family food.
   - In question 19 mention the key recommendations provided to the mother. [Examples: (a) Continue exclusive breastfeeding. Do not give water or other liquids; (b) Increase the frequency of breastfeeding sessions to at least 8 during the day and the night; etc.]
   - Please ask mother to sign the record. This will be used for monitoring purposes.

Follow-up actions:

i. At the first visit (immediately after the birth) provide support for immediate and exclusive breastfeeding;

ii. If the newborn is less than 2,500g, pay attention to the following recommendations: (a) keeping the baby warm (kangaroo method or skin-to skin care), (b) paying extra-attention to hygiene and frequent hand-washing, and (c) assisting with early & exclusive breastfeeding [provision of cup feeding if necessary]. Because babies with less than 2,500g are at higher risk of becoming ill and dying, it is important to inform the mother and other family members on the importance of seeking immediate medical care if any of the following danger signs arise in the baby:
   a. stops feeding or is not feeding well;
   b. is difficult to awake;
   c. becomes restless, irritable, or unconscious;
   d. has fever;
   e. is cold;
   f. has difficulty breathing;
   g. has diarrhea;
   h. shows any other worrying sign;
   i. Inform health workers on all the cases of birth of low-birth weight babies.

iii. At the subsequent visits, identify key breastfeeding and/or complementary problems and counsel the mother and other family members. Write down main recommendations in the record (ex. continue exclusive BF; do not give water or other liquids before 6 months of age; initiate giving meat or fish or eggs at 6 months of age, address any problems with breastfeeding (mastitis, insufficient breastmilk).

iv. Assess if the baby is growing well and make recommendations.

v. If the case is more serious and the child needs specific services or specialized nutrition advice refer the caretaker/child to the closest facility for support/advice.

At every visit, sign the record and ask the mother to sign it as well.