MINISTRY OF HEALTH

Baby Friendly Community Initiative

Implementation Guidelines

May 2016

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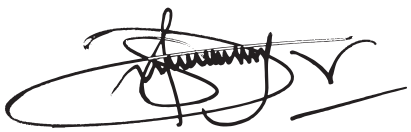
FOREWORD

The government of Kenya is committed to the achievement of Global, Regional and National targets for nutrition, including the sustainable development goals (SDGs) post 2015 – 2030, which highlights nutrition in SDG 2 (end hunger, achieve food security and improved nutrition, and promote sustainable agriculture) and SDG 3 (ensure healthy lives and promote well-being for all at all ages). The Kenyan constitution also provides for citizens' rights to good health and nutrition which has an important role in economic growth, poverty reduction and the realisation of Kenya's Vision 2030. The achievement of a long term development agenda for Kenya, anchored in Vision 2030, calls for a healthy and productive Labour force. Interventions targeting optimal maternal infant and young child feeding (MIYCN) have been proven to significantly contribute to achievement of the development agenda. Increases in exclusive breastfeeding rates from 32% to 61%, and reductions in undernutrition, including stunting (35% to 26%), wasting (7% to 4%) and underweight (16% to 11%) from 2008-2014 have been documented.[1] Despite these improvements, poor complementary feeding practices are still rampant in the country, as only one in five children consume the minimum acceptable diet[2]. In addition, the country has not yet achieved the MDG targets for stunting (16%). Poor maternal infant and young child nutrition practices are the main cause of child malnutrition in Kenya.[2]

The Ministry of Health recognises the immediate and long-term social and economic repercussions of malnutrition amongst infants and young children. The BFCI implementation guidelines has been developed to operationalize MIYCN policy whose aim is to protect, promote and support optimal maternal and infant and young child feeding practices and improve child survival. These guidelines will also actualize the National Nutrition Action Plan (NNAP) and County Nutrition Action Plans (CNAP). The BFCI implementation guidelines also provide strategic guidance for implementation of community focused interventions, which is detailed in Kenya's Community Health Strategy, as part of the Kenya National Health Sector Strategic Plan (KHSSP) to deliver the Kenya Essential Package for Health (KEPH).

The Kenya Government is committed to allocate human and material resources and provide effective coordination to protect, facilitate and encourage optimal MIYCN at community level and create an environment that fosters nutrition well-being, affirming the right of every child and every pregnant and lactating woman to be adequately nourished. I urge all stakeholders to play their role in actualizing the implementation of this BFCI guideline.



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1 Kenya National Bureau of Statistics, Kenya and MEASURE DHS, ICF Macro "Kenya Demographic and Health Survey 2014," (Calverton, Maryland, USA2015).

2 Kenya Ministry of Health, "National Strategy for Maternal Infant and Young Child Nutrition 2012-2017," ed. Department of Public Health and Sanitation (Nairobi, Kenya: Kenya Ministry of Health, 2012).

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We express our sincere gratitude and indebtedness to Community Health Unit section in the Ministry of Health, United States Agency for International Development (USAID)/MCSP, USAID/ Nutrition Health Program (NHP) plus, UNICEF Kenya, APHRC, Concern Worldwide, Save the Children International, Global Alliance for Improved Nutrition (GAIN), Kenyatta University, Feed the Children, World Vision Kenya (WVK), IMC, Action Against Hunger (ACF), National AIDS and STI Coordination Program (NASCOP), Food for the Hungry Kenya (FHK), Aga Khan Foundation (AKF), Micronutrient Initiative (MI), Comitato Internazionenale Per Lo Suiluppo Popoli (CISP) and World Health Organization (WHO) for their technical support in the development and finalization of the BFCI Guidelines. Further, we highly appreciate USAID/MCSP, UNICEF, APHRC, ACF and USAID/ NHP plus for financial support in the BFCI workshops and meetings held for the development of this document.

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EXECUTIVE SUMMARY

To achieve the sustainable development goals (SDGs), realize objectives of vision 2030, and to ensure optimal health and nutrition for all populations, there is need to continually come up with appropriate strategies. A lot of efforts have been done to reduce malnutrition and improve the health of mothers and children. Thus, the rate of exclusive breastfeeding has increased from 32% to 61%, stunting rates reduced from 35% to 26%, wasting from 7% to 4% and underweight from 16% to 11%. However, the immediate and long-term social and economic repercussion of malnutrition among infants and young children still persist. Much has not been achieved due to existing gaps like lack of appropriate community based initiatives. Baby Friendly Hospital Initiatives (BFHI) which has been in place has played a major role in improving maternity services, enabling mothers to breastfeed thus having the best start in life. The few gaps remaining can be achieved through extending the work to the community level through Baby Friendly Community Initiative (BFCI) which is a community-based initiative to protect, promote, and support breastfeeding, optimal complementary feeding and maternal nutrition. The BFCI implementation guidelines are designed to help the government and development partners to improve maternal infant and young child nutrition (MIYCN) practices through implementation of activities at community level. This include; promotion, protection and support of exclusive breastfeeding for the first six months of life, care, support and follow up for pregnant and lactating women, defining the roles and responsibilities of partners in promoting appropriate MIYCN practices and providing guidance on how to sustain baby friendly supportive environment at community level. The guidelines are intended for use by health managers, health care workers, implementing partners, community workers, training institutions and NGOs in all their efforts to promote optimal health. The guidelines complement other existing materials available in the health and nutrition practice. The guidelines have been developed through bringing together all the stakeholders involved in health and nutrition in Kenya, through consultative forums organized by the MOH. These guidelines provide step by step process of formation and training of community mother support groups, conducting home visits, linkage of community activities to primary health care facilities, hygiene and early childhood stimulation, among others. The guideline has a component of monitoring and evaluation and give highlights the process of making communities baby friendly. Tools have been provided in the annex which will help the community, sub county county and national level to assess and accredit communities as baby friendly. Also included are routine monitoring tools that will assist community health volunteers (CHVs) to conduct day to day monitoring of maternal infant and young child nutrition practices at community level. A separate external assessment tolls for baby friendly communities have been developed for the purposes of assessing communities and accrediting them baby friendly.

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
CHCs	Community Health Committees
CHEWs	Community Health Extension Workers
CHMTs	County Health Management Teams
CHS	Community Health Strategy
CHVs	Community Health Volunteers
CMEs	Continuous Medical Education
CMSG	Community Mother Support Group
CNC	County Nutrition Coordinator
CNTF	County Nutrition Technical Forum
CU	Community Unit
eMTCT	Elimination of Mother to Child Transmission
FANC	Focused Antenatal Care
HIV	Human Immunodeficiency Virus
HMT	Health Management Team
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorders
IEC	Information Education Communication
IPC	Inter personal Communication
IYCF	Infant and Young Child Feeding
IYCN	Infant and Young Child Nutrition
KDHS	Kenya Demographic and Health Survey

KEPH	Kenya Essential Package for Health
KHSSP	Kenya Health Sector Strategic Plan
M2MSG	Mother to Mother Support Group
MCA	Member of County Assembly
MCH	Maternal Child Health
MDGs	Millennium Development Goals
MIYCN	Maternal Infant and Young Child Nutrition
MNCWC	Maternal Neonatal Child Welfare Clinic
MOH	Ministry of Health
MSG	Mother Support Group
NGO	Non-Governmental Organization
NNTF	National Nutrition Technical Forum
NTF	Nutrition Technical Forum
PHCF	Primary Health Care Facility
PMTCT	Prevention of Mother-to-Child Transmission
SCHMT	Sub-County Health Management Teams
SCNTF	Sub-County Nutrition Technical Forum
SDG	Sustainable Development Goals
TOT	Trainer of Trainers
UNICEF	United Nations Children's Fund
VAD	Vitamin A Deficiency
WHO	World Health Organization

OPERATIONAL DEFINITIONS OF TERMS

Baby Friendly Community Initiative: A Community-based initiative to protect, promote, and support breastfeeding**,** optimal complementary feeding and maternal nutrition and is conducted through formation and training of "Community Mother Support Groups (CMSG)", formation of mother to mother support groups, conducting home visits and close links to primary health care facilities. It also includes feeding of sick children, hygiene, early childhood stimulation, referral to and from Maternal and Child Health (MCH) clinic and elimination of mother to child transmission (eMTCT).

Baby Friendly Hospital Initiative (BFHI): a global effort launched by WHO and UNICEF in 1991 for improving the role of maternity services to enable mothers to breastfeed babies for the best start in life. To be accredited as "baby-friendly", a hospital must meet a series of standards. Among other requirements, hospitals must avoid all promotion of breast-milk substitutes and related products, bottles and teats, not accept free or low-cost supplies nor give out samples of those products.

Bi-monthly: This is once in every two months.

Bottle-feeding: This is when a child receive liquid or semi-solid food from a bottle with a nipple/teat.

Breastfeeding: Consumption of breast milk by an infant either directly from the breast or expressed.

Community Health Committee: A governance structure in tier one (the community level). It comprises of 9 to 13 members whose role is to provide oversight for activities in the community. Members are drawn from a representation of all groups within the community.

Community Health Volunteers: Any person within the community willing to work on voluntary basis, is able to read and write, is a permanent resident in the community, has served and/or is committed to the service of neighbours. They should be vetted by the community in an open meeting before they are recruited.

Complementary Feeding: Giving other foods in addition to breast milk after the first 6 months of life when breast milk alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed along with breastmilk. These other foods are called complementary foods. The target age range for complementary feeding is 6 to 24 months of age.[3]

Complementary foods: Any food, whether manufactured or locally prepared, suitable as a complement to breast milk or to breast milk substitute when either becomes insufficient to satisfy the nutritional requirements of the infant.[4]

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3 WHO/PAHO Guiding principles for complementary feeding of the breastfed child World Health Organization 2003

4 Ibid

Community Mother Support Group: This is a group that has membership drawn from the community health committee, lead mothers, chief, religious leaders, and other community leaders whose overall responsibility is to ensure that the community works towards baby friendliness.

Early Initiation of Breastfeeding: This is when a baby is put to the breast within one hour of birth

Exclusive Breastfeeding: Giving a baby breastmilk only (including milk expressed or from a wet nurse) and no other liquids or solids, not even water for the first 6 months of life. Drops or syrups consisting of vitamins, mineral supplements or medicines are permitted as prescribed by health care worker.

Influencer: Any individual with the capacity or power to affect or sway actions and practises of the community in relation to MIYCN.

Lead Mother: A mother who belongs to the M2MSG and models the MIYCN, care and stimulation practices and is chosen by the M2MSG members. She is trained on MIYCN as well as on basic group facilitation techniques. This person will be responsible for engaging group members in discussion about MIYCN and providing basic health education in an interactive, participatory manner.

Malnutrition: This is inadequate or excessive energy intake leading to undernutrition or over nutrition; undernutrition can be in the form of wasting, stunting and underweight, while over nutrition results into overweight and obesity.

Maternal Infant and Young Child Nutrition (MIYCN): This includes all messages and practices on maternal, infant and young child nutrition together with care and stimulation as implemented in BFCI

Mother Baby Friendly Resource Centre: Any area within the health facility or community that has been identified and set aside for mothers and other clients, to get information and support on MIYCN and child stimulation. It may be a designated corner or a room.

Mother-to-Mother Support Groups: This is a group of mothers, pregnant and lactating, who meet on a regular basis to discuss and support each other on maternal, infant and young child nutrition.

Obesity: This is an abnormal or excessive fat accumulation that presents a risk to health. A crude population measure of obesity is the body mass index (BMI), a person's weight (in kilograms) divided by the square of his or her height (in meters). A person with a BMI of 30 or more is generally considered obese. A child with a Z-score of +3 and above is obese.

Opinion Leaders: Any well-known individual in the community who can influence the opinion of the community members towards baby friendliness, e.g. politicians, religious leaders, business people, prominent individuals.

Primary Health Care Facility: Any health facility within the catchment area of the community unit that offers maternal, neonatal, child health, and nutrition services.

Role Models: A person who exhibits behaviour (MIYCN, care and stimulation practises) that is correct and acceptable, and can be emulated by the community.

Stunting: Height (or length)-for-age more than two standard deviations below the median of the WHO growth reference. Any child with a Z score of -2SD and below is stunted.

Underweight: Weight for age < –2 standard deviations (SD) of the WHO Child Growth Standards median. Any child with a weight for age of -2SD and below is underweight.

Wasting: Weight for height < –2 SD of the WHO Child Growth Standards median

Welcoming and Supportive Environment: Any place within the community where families can receive information, practical support, feel safe and welcome and are ensured of confidentiality. It should also be culturally sensitive.

SUMMARY OF BFCI IMPLEMENTATION PACKAGE

Baby Friendly Community Initiative Implementation Package is composed of the following components:

1. BFCI Implementation guidelines
2. BFCI Training package
3. BFCI Communication and advocacy materials
4. BFCI External assessment tools

Component 1: BFCI Implementation Guidelines

The implementation guideline is this book. It is organized into five sections. The following aspects are covered: introduction, how to establish and maintain BFCI, partnerships, roles and responsibilities, advocacy and communication for BFCI, monitoring and evaluation.

Component 2: BFCI Training Package

This includes the curricula for training all partners, staff, and volunteers involved in BFCI implementation.

Component 3: BFCI Communication and Advocacy Material

These are job aids and IEC materials on BFCI which have messages on MIYCN, care and stimulation.

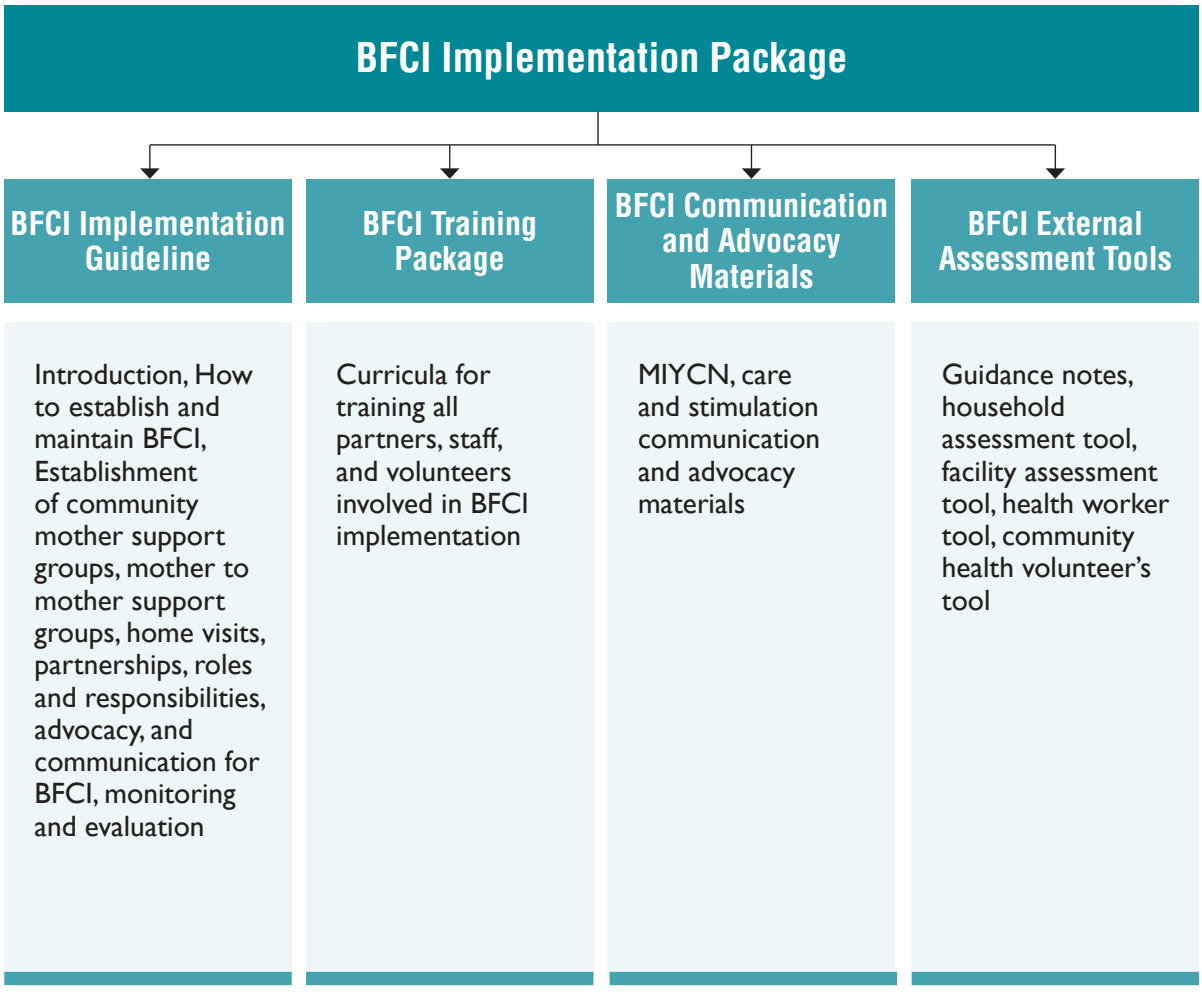
Component 4: BFCI External Assessment Tools

These are tools for external assessment which contain the following: guidance notes, household assessment tool, facility assessment tool, health workers tool and community health volunteers tool. This external assessment tools will be used by external assessors at county and national level to assess communities for baby friendliness.

SECTION 1

INTRODUCTION

BFCI IMPLEMENTATION PACKAGE STRUCTURE



1.1 BACKGROUND

Nutrition plays an important role in boosting economic growth, poverty reduction, and the realisation of social goals in Kenya.[5] Nutrition is central to human, social, and economic development, health and survival, and should thus be a priority at all levels—sub-national, national, and global. Malnourished children are exposed to an increased risk of morbidity and mortality, delayed cognitive development, and reduced productivity into adulthood. Malnutrition is a key hindrance to optimal child growth and development, maternal and child health, and work performance and thus reduced productivity. Prevention of maternal and child malnutrition is a long-term investment that will benefit the current and future generations.[6]

The 2013 Lancet Series provides systematic evidence on the impact of malnutrition on infant and child mortality and its largely irreversible long-term effects on health, cognitive, and physical development. It also demonstrates the availability of proven, high cost-effective interventions, focusing on the "window of opportunity" for the first 1,000 days (from pregnancy through the first two years of life).[7]

The nutritional status of a woman before and during pregnancy is important for a healthy pregnancy outcome. Low maternal body-mass index is associated with intra-uterine growth restriction, and is a risk factor for perinatal conditions, and influences the concentration of some micronutrients in breast milk.

Exclusive breastfeeding has been identified as one of the most cost effective, preventive public health interventions for ensuring child survival, growth, and development.[8]It greatly improves the quality of life for infants and young children through its nutritional, immunological, and psychological benefits. It is estimated to prevent 13% of all under five deaths and is strongly correlated with lowered risk of illness, from diarrhea and respiratory tract infections, reduced risk of obesity, allergies, heart disease, and diabetes in adulthood.[9] The introduction of appropriate complementary foods from six months to 24 months of age could save 6% of all under-five deaths. By combining these two interventions, breastfeeding and complementary feeding, up to 19% of child mortality may be prevented.

Many children however are not fed according to the recommendations. Many mothers, who initiate breastfeeding satisfactorily, often start complementary feeds too early, prior to 6 months of age or stop breastfeeding within a few weeks of delivery. In addition, many children, even those who have grown well for the first six months of life, do not receive complementary feeds at 6 months of age. It is estimated that 165 million children below 2 years of age are

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5 Ministry of Health, Kenya. "National Policy for Maternal Infant and Young Child Nutrition ". Nairobi, Kenya: KenyaMinistry of Health, 2013.

6 Harold Alderman Robert E Blackemail, Zulfiqar A Bhutta, Stuart Gillespie, Lawrence Haddad, Susan Horton, Anna Lartey, Venkatesh Mannar, Marie Ruel, Cesar G Victora, Susan P Walker, Patrick Webb, "Maternal and Child Nutrition: Building Momentum for Impact," The Lancet 382, no. 9890 (2013).

7 Ibid.

8 Cesar G Victora Robert E Black, Susan P Walker, Zulfi qar A Bhutta*, Parul Christian*, Mercedes de Onis*, Majid Ezzati*, and Joanne Katz* Sally Grantham-McGregor*, Reynaldo Martorell*, Ricardo Uauy*, and the Maternal and Child Nutrition Study Group, "Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries," *The Lancet* 382, no. 9890 (2013).

9 Ibid.

stunted globally.[10] Stunted children are at an elevated risk of mortality, cognitive deficits, and increased risk of adult obesity and other non-communicable diseases. Vitamin A, zinc, and other micronutrients have important developmental consequence and their deficiencies in young children increase the risk of death from infections. Globally, malnutrition (fetal growth restriction, stunting, wasting, and deficiencies of vitamin A and zinc) is responsible for 45% of all under five child deaths, representing more than 3 million deaths annually. Fetal growth restriction and sub-optimal breastfeeding together are responsible for more than 1.3 million deaths, or 19.4% of all under five deaths.[11]

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) developed the Global Strategy for Infant and Young Child Feeding (IYCF) in 2002, which brought global attention to the impact of feeding practices on the nutritional status, growth, development, health, and survival of infants and young children. This strategy recommends protection, promotion and support for exclusive breastfeeding for the first six months of life, with timely, adequate, safe, and appropriate complementary feeding, whilst continuing breastfeeding for two years and beyond. It also acknowledges the importance of maternal nutrition, and social and community support.

1.2 KENYA NUTRITION SITUATION

Kenya is taking important steps aimed at laying the foundation to overcome development obstacles and improve socio-economic status of its citizens, including health. Between 2008 and 2014, significant progress has been made in tackling malnutrition amongst children under five years of age. Figure 1 shows trends in malnutrition from 1993 to 2014.

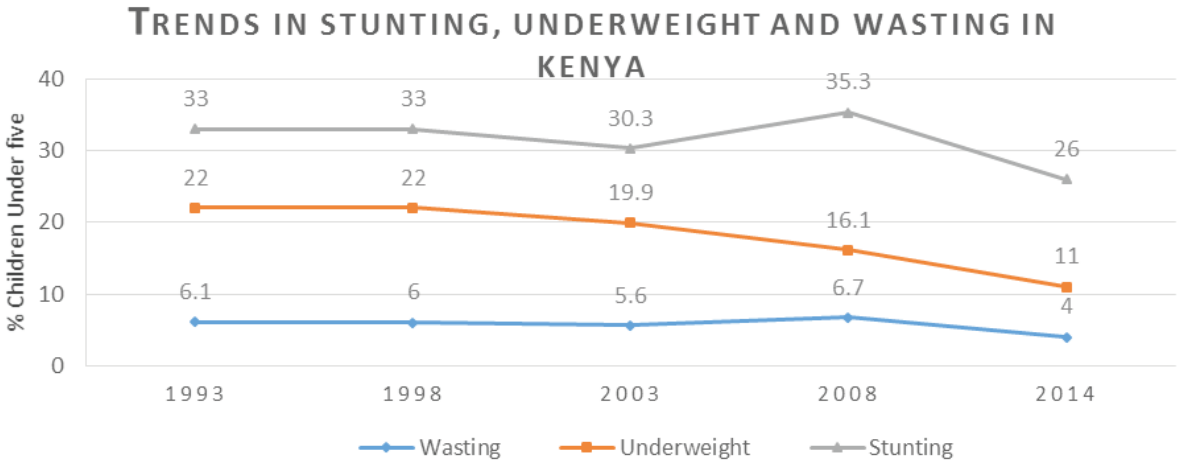

Figure 1: TRENDS IN STUNTING, UNDERWEIGHT AND WASTING IN KENYA. SOURCE: KDHS 2014

10 UNICEF. "State of the World's Children Report 2015." edited by UNICEF, 124: UNICEF, 2014.

11 Robert E Black and Sally Grantham-McGregor*, "Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries."

Stunting has decreased from 35% to 26%, wasting from 7% to 4%, and underweight from 16% to 11% from 2008 to 2014. Despite this progress, the country is still lagging behind in terms of stunting, falling well short of its 16.3% Millennium Development Goals (MDG) target by 9.7%. In addition, substantial regional disparities still exist in the country. Figure 2 shows the regional distribution of stunting and wasting.

Micronutrient deficiencies are highly prevalent among children under the age of five years and women. According to 1999 national micronutrient survey in Kenya, the most common deficiencies include vitamin A deficiency (VAD), iron deficiency anemia (IDA), iodine deficiency disorders (IDD) and zinc deficiency. VAD among under-fives (84.4%); IDA among 6-72 month olds (69%) and among pregnant women (55.1%); IDD (36.8%); and zinc deficiency among mothers (52%) and among children under 5 years (51%). The results of the 2012 Micronutrient survey are yet to be disseminated.

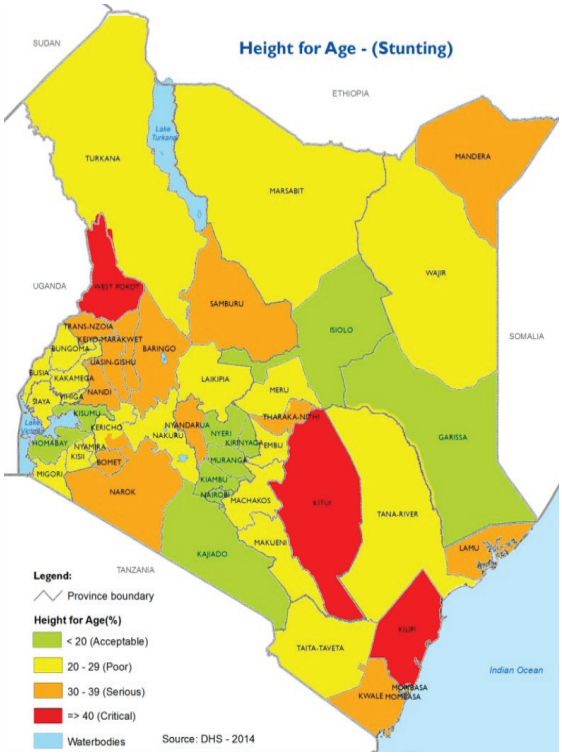

Figure 2: REGIONAL DISTRIBUTION OF STUNTING IN KENYA

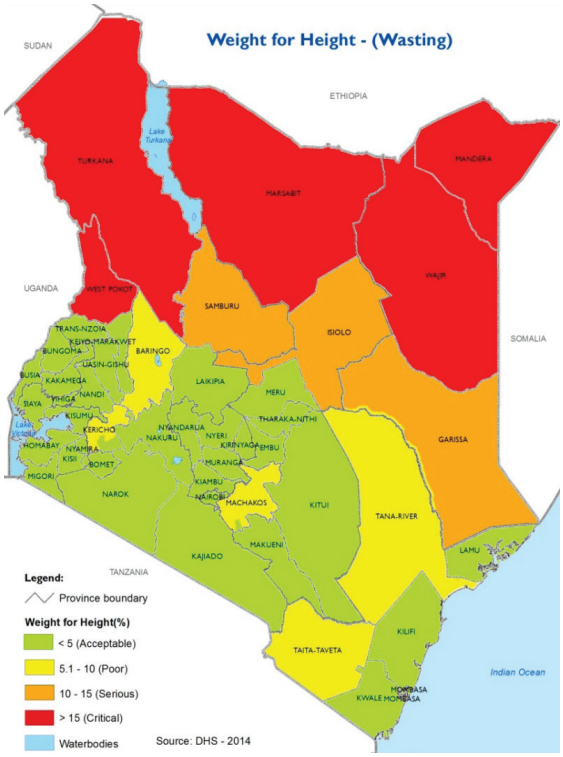

Figure 3: REGIONAL DISTRIBUTION OF WASTING IN KENYA

The 2014 KDHS indicates that West Pokot, Kilifi, and Kitui counties have the highest proportions of stunted children at 45.9%, 45.8% and 39.1%, respectively. The highest proportion of wasted children is in Marsabit (16.3%), Wajir (14.2%) and Mandera (14.8%).

BREASTFEEDING STATUS

Breastfeeding practices in Kenya have improved remarkably over the last 5 years. Figure 4 indicates the country's breastfeeding status according to the recent National Demographic and Health Survey (KDHS, 2014).

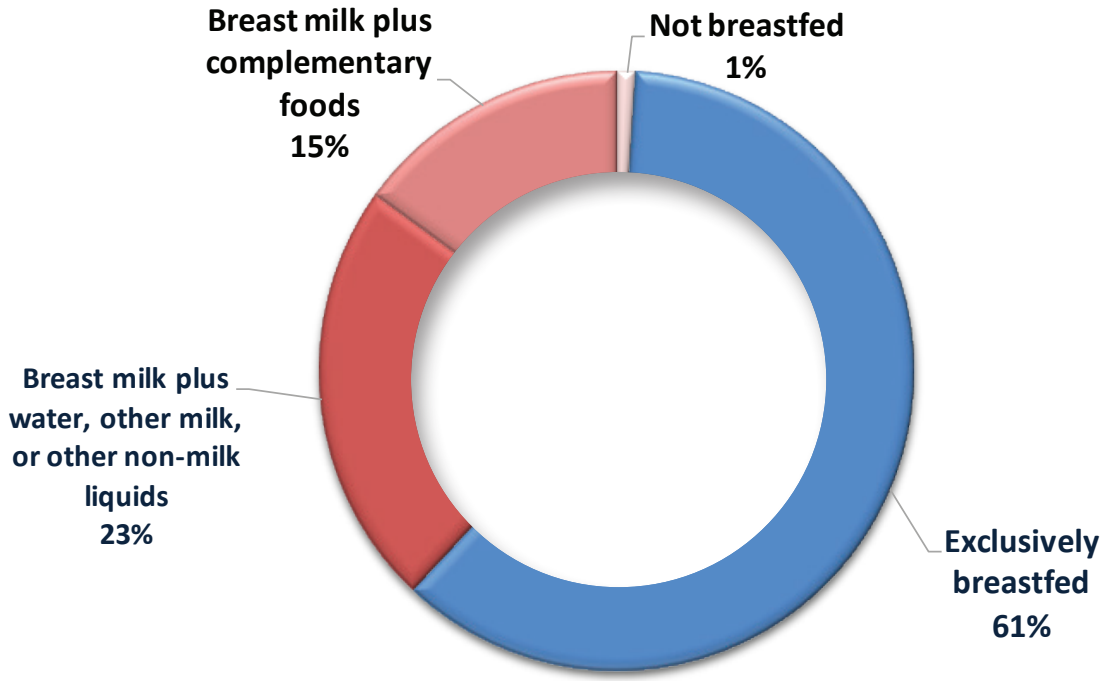

Figure 4: STATUS OF BREASTFEEDING

The proportion of children younger than six months of age who are exclusively breastfed has markedly increased over the years since 2008 from 32% to 61% in 2014. The proportion of children less than six months of age using a bottle with a nipple has decreased from 25% to 11%. Despite the progress made in exclusive breastfeeding, four out of ten children are still not exclusively breastfed. The proportion of breastfed children declines with age; breastfeeding is nearly universal in a child's first month of life, but the proportion breastfed drops to 61 percent by the time a child is 18-23 months. In addition, to breast milk, 15% of children less than 6 months are fed complementary foods, 10% consume plain water, 10% consume other milks, and 3% consume non- milk liquids. Thirty percent of children aged 6-9 months use a bottle with a nipple while only 21% children aged 6-23 months consume an acceptable diet. Children aged 12-17 months are slightly more likely (24%) than children in other age groups to consume an acceptable diet[12].

12 Kenya Demographic and Health Survey 2014

1.3 RATIONALE

For progress to be achieved in prevention and reduction of maternal and child malnutrition, and for women and children to enjoy their rights to health, the country must scale up proven interventions to prevent foetal growth restriction, stunting, wasting, micronutrient deficiencies, and poor cognitive development through improvement of maternal, infant and young child nutrition (MIYCN). The Baby-Friendly Hospital Initiative (BFHI), a global effort to implement practices that protect, promote and support breastfeeding, is one of the initiatives that Kenya has joined, in support of breastfeeding and MIYCN. The initiative includes implementation of ten steps to successful breastfeeding at the facility level to enhance successful breastfeeding and ensure that newborns get the best start of life. However, in Kenya, especially in rural areas, two out of every five mothers (39%) give birth at home and moreover, those that deliver in the hospital are discharged into the community and require a continuity of care at the community level.[13] Therefore, BFHI is not able to provide the necessary reach to address the needs of some women during the postpartum period at the community level. New strategies could fill this gap. A new community initiative, the Baby Friendly Community Initiative (BFCI) has been developed as a model for improving infant feeding practices at community level. The BFCI, based on BFHI's "ten steps to successful breastfeeding," extends these steps to the community level to provide a comprehensive support system for improving MIYCN.

Kenya adopted a community health strategy in line with the primary health care principles as its overarching approach to health promotion in communities.[14] This recognises that communities are already actively engaged in health activities to improve their own health. Their actions for health could be strengthened through improved knowledge and skills, as well as better planning of activities and integrated approaches to address child health and nutrition issues. The BFCI model is based on this existing structure.

The BFCI model has been proven to work in a few other countries, including the Gambia where its implementation led to a 40% (60% to100%) increment in initiation of breastfeeding in the first day of life, and about 90% decline in introduction of complementary feeding at four months. In Cambodia, the implementation of BFCI model led to an increase in exclusive breastfeeding from 17% to 73%.[15] In Kenya, studies on BFCI have been conducted in six counties (Kiambu, Kwale, Vihiga, Nairobi, Kajiado, Machakos and Baringo that was very informative in the development process of this guideline. In addition, a study tour was conducted to Cambodia and this has been very informative in the development of these guideline.

Therefore, if implemented in Kenya, this model could foster improvement of the maternal infant and young child nutrition indicators, with specific focus on optimal exclusive breastfeeding, complementary feeding and maternal nutrition. The model also helps to introduce other community based services such as bed nets, HIV/AIDS awareness, immunisation support, and reproductive healthcare.[16]

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13 Kenya National Bureau of Statistics, "Kenya Demographic and Health Survey 2014."

14 Kenya Ministry of Health, "Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services," ed. Health Sector Reform Secretariat (Nairobi, Kenya: Kenya Ministry of Health, 2006).

15 Cambodia Ministry of Health, "Implementation Guidelines for Baby Friendly Community Initiative.," (Phnom Penh, Cambodia: Cambodia Ministry of Health 2009).

16 UNICEF World Health Organization, "Baby-Friendly Hospital Initiative Strengthening and Sustaining the Baby-Friendly Hospital Initiative: A Course for Decision-Makers," ed. World Health Organization (Geneva, Switzerland: World Health Organization 2009).

1.4 GOAL AND OBJECTIVES

The National Baby Friendly Community Initiative Implementation Guideline was developed as a tool to help the government and development partners have a focused attention to community initiatives to improve maternal infant and young child feeding practices. The guideline will focus on implementation of MIYCN activities at community level.

The aim of the guideline is to provide the framework for enhancing the nutrition, health, growth and development of infants and young children, as well as strengthening care and support for their parents/caretakers to achieve optimal maternal, infant and young child feeding.

The specific objectives of the guideline are to:

- Assist communities implement interventions to promote, protect and support exclusive breastfeeding for the first six months of life, optimal complementary feeding and maternal nutrition.

- Strengthen care, support and follow up for pregnant women, mothers and caretakers to practice optimal MIYCN.

- Specify roles and responsibilities of partners in promoting appropriate MIYCN practices
- Provide guidance on how to sustain baby friendly supportive environment at community level

INTENDED READERS

The Baby Friendly Community Initiative Implementation Guideline is intended for use by health managers, health care workers, implementing partners and community workers supported by the required level of training and with adequate resources to perform the activities and deliver maternal infant and young child nutrition interventions at community level. Job aids will be developed to assist in the implementation. The guidelines can also be used by training institutions to orient new graduates joining the health force.

The guideline will also help NGOs involved in nutrition to guide and standardize community interventions for MIYCN. Whilst some local adaptations may be made, these should be only done with the collaboration and consent of MOH.

The guidelines complement other material developed by the MOH, including the Baby Friendly Hospital Initiative package, National MIYCN strategy and National MIYCN health workers operational guidelines.

SECTION 2

HOW TO ESTABLISH AND MAINTAIN BABY FRIENDLY COMMUNITIES

2.1 STEPS FOR ESTABLISHMENT OF BFCI

The Ministry of Health (MOH), in collaboration with other key stakeholders play a critical role in successful implementation of BFCI. Partners should work closely with government health officers at all levels (National, County, Sub-County, and Community) for sustainable implementation of BFCI. The community health units (CHUs) will be used as the main entry point for BFCI implementation. The MOH will facilitate the implementation of BFCI through the existing community health structures and the strengthening and/or establishment of CMSG and mother-to-mother support groups (M2MSG). The following are the steps for establishment of baby friendly communities:

STEP 1: ORIENTATION OF THE NATIONAL POLICY AND DECISION MAKERS

The National policy and decision makers should be sensitized on BFCI and its envisaged positive impact on maternal infant and young child nutrition and health, to gain their commitment to promote and sustain this initiative. The key decision makers include directors, key administrators, representatives from other line ministries and key stakeholders. Enlightened decision-makers play a vital role in enabling the transformation needed at the community level. It is recommended that the National MIYCN Steering committee oversees the planning, implementation, and follow-up of BFCI activities at all levels.

STEP 2: ORIENTATION OF COUNTY AND SUB-COUNTY HEALTH MANAGEMENT TEAMS TOGETHER WITH KEY STAKEHOLDERS

County Health Management Teams (CHMTs), Sub-county Health Management Teams (SCHMT), and key stakeholders should receive a one day orientation on the BFCI package so that they can support its implementation. Key stakeholders to be oriented on BFCI will include other line ministries, such as the Ministry of Agriculture, Livestock and Fisheries, Ministry of Education Science and Technology, Ministry of Labour, Social Security and Services, Ministry of Interior and Coordination of National Government, development and implementing partners, opinion leaders and any other stakeholders who will be identified by the county as integral to BFCI implementation.

STEP 3: TRAINING OF TOTS ON BFCI

A BFCI trainer of trainers (TOT) should be an individual who has received prior training on MIYCN package for health workers. BFCI TOT training will be five days in duration and will be conducted for the National, County and Sub-County members of the CHMTs and SCHMTs who will cascade the training to lower levels. The TOT trainings will incorporate the community health extension workers (CHEW) and nutritionists, who will be the primary personnel in BFCI implementation at the community level. Key persons from other line ministries and partners may be co-opted as TOTs, as needed.

STEP 4: TRAINING CHEWS AND HEALTH CARE WORKERS

The TOT will conduct a five days training for the CHEWs and health care workers on BFCI as the key implementers of BFCI. At this level other key stakeholders, such as Ministry of Agriculture, relevant to supporting the BFCI activities will also be trained. The training should be practical oriented as much as possible to achieve the required knowledge, skills, and competencies. The CHEWs will develop a work plan for establishment of CMSGs.

STEP 5: ORIENTATION OF COMMUNITY HEALTH COMMITTEE, PRIMARY HEALTH CARE FACILITY COMMITTEE, AND OTHER COMMUNITY LEADERS ON BFCI

CHMTs and SCHMTs with participation of the CHEWs will conduct a one day orientation for the community health committee (CHC), Primary Health Care Facility committee (PCFC), and local opinion and political leaders. The participation of community leaders and other local authority leaders, such as the sub-county commissioners, birth companions, and other line ministries, such as agriculture, is very important to the success of BFCI. Opinion leaders (Members of County Assembly [MCA], Sub-County administrators, town administrators, ward administrators, religious leaders, chiefs, and assistant chiefs) are key in mobilising resources and enhancing ownership of BFCI.

STEP 6: MAPPING OF HOUSEHOLDS

This will involve two sub steps as follows:

1. Selection and training of Community Health Volunteers for mapping

CHVs will be selected through the existing Ministry of Health structures in the Community Units. Where there are no community Units, volunteers (who can read and write, are permanent residents of the community, have been vetted and accepted by the community) will be selected by the community leaders. After selection, they will then undergo an orientation to enable them map the required households.

2. Mapping of households

Mapping of households is an important exercise that identifies the number and place where the primary target audience can be found and will be done every six months. Household registration

is intended to provide information for planning BFCI activities through identifying households with pregnant and lactating mothers and with children below two years of age as the primary target for BFCI. A household registry (MOH 513) is developed for each community health volunteer (CHV) with the number of households.[17] In addition, community resources, assets, manpower, networks etc. will be reviewed. The community health situation and the causes of the current health situation are summarized in the community profile, based on information in the household register (i.e. population structure, environment, immunization, place of delivery, insecticide-treated bed nets, use of family planning, diseases, births and deaths by age and sex, education, food, income) which are also reviewed.

STEP 7: ESTABLISHMENT OF COMMUNITY MOTHER SUPPORT GROUPS

CMSG is a group of community members that oversee, plans and executes community baby friendly meetings and mobilizes all the community members to participate in BFCI activities. BFCI CMSG members should be selected from the community with the help of local leaders and the primary health care management committee. The health worker at the Primary Health Care Facility (PHCF), CHC and CHVs, together with the CHEW and nutritionist will support the identification of the appropriate members in the community. The CMSG should include the CHEW, nutritionist, representatives from CHCs and CHVs, local administrators (chiefs or assistant chief), and the lead mother. The CMSG could also include religious leaders, opinion leaders, birth companions and other representatives in the community e.g. young mothers. The CMSG will be undertaken through a 5 day BFCI orientation, to build their capacity on BFCI implementation. A lead mother is a mother who belongs to the M2MSG and models the MIYCN, care and stimulation practices and is chosen by the M2MSG members. The lead mothers should be from the local community and act as a link between the CMSGs and the M2MSG. It is recommended that CMSGs have 9-11 members.

A CMSG oversees, monitors, and documents the maternal, infant, and child nutrition activities in the community on a monthly basis. The activities include:

1. Supporting the CHEW and Nutritionist in monitoring and documentation of monthly BFCI activities at the community level
2. Conducting Annual planning/review meetings with the CHEW and nutritionist
3. Advocate for allocations of funds to BFCI activities in the community

STEP 8: TRAINING OF CHVS AND COMMUNITY MOTHER SUPPORT GROUP (CMSG) ON BFCI

The CHVs and CMSG will be trained on a five days training module focusing on the eight point plan (a summary of eight key points on MIYCN), how to establish M2MSG and conducting home visits. It is recommended that the trainings be conducted within the community and be practical oriented.

17 Health, "Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services."

STEP 9: ESTABLISHMENT OF MOTHER-TO-MOTHER SUPPORT GROUPS (M2MSG)

M2MSG are groups of women, who come together to learn and discuss issues on MIYCN, including addressing any problems with breastfeeding and how to resolve these problems, to aid in maintaining exclusive breastfeeding for the full 6 month duration. They also support one another on issues of maternal nutrition (during pre-pregnancy, pregnancy and lactation) and all aspects of complementary feeding. The mothers are recruited by the CHVs and the lead mothers during home visitations, antenatal care (ANC), MCH, and any other community gatherings and groups. M2MSG have membership of between 9 and 15 participants. If the groups become larger than 15 members, they should be split into smaller manageable groups. The groups meet at least once per month at a convenient place agreed by the group. For a M2MSG to be functional it should have:

1. Regular meetings with clear documentation
2. Active participation of all members
3. Monthly reporting by CHVs, with assistance of the lead mother
4. Schedule of the planned activities

2.2 BFCI INTERVENTIONS/ACTIVITIES

The following are outlined as BFCI intervention activities:

1. Trainings on BFCI
2. Targeted home visits
3. Baby friendly community meetings/community dialogue/Action days
4. Education sessions for the mothers at Maternal Neonatal Child Welfare Clinic (MNCWC)
5. Monthly M2MSG meetings
6. Monthly CHVs meetings
7. Bi-monthly CMSG meetings
8. Mentorship and supervision
9. Establishment of Mother and Baby Friendly Resource Centre
10. Monitoring, evaluation and reporting of BFCI activities
11. Periodic BFCI assessments- self assessments and external assessment

CONTENT OF THE TRAININGS FOR CHVS AND CMSG

The training content for BFCI at all levels is based on the eight step point plan. Each step has key messages for MIYCN. The trainings should also include the basic module eight for community health volunteers developed by the community health unit and information on how to establish and maintain BFCI at the community level. The following are the eight step point plan for BFCI that will be included in CHVs and CMSG trainings:

1. Have a written MIYCN policy summary statement that is routinely communicated to all health providers, community health volunteers, and the community members.

2. Train all healthcare providers and community health volunteers, to equip them with the knowledge and skills necessary to implement the MIYCN policy

3. Promote optimal maternal nutrition amongst women and their families

4. Inform all pregnant women and lactating women and their families about the benefits of breastfeeding and risks of artificial feeding

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.

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.

7. Provide a welcoming and supportive environment for breastfeeding families

8. Promote collaboration between healthcare staff, CMSG, M2MSG and the local community

Content has been developed for each step to guide the CHVs in counselling. In addition, community strategy module eight is used to give basic information on nutrition. Refresher trainings should be conducted during monthly CHV meetings by the CHEW/Nutritionist. Trainings for new recruits or replacement CHVs and lead mothers should be conducted on the entire BFCI package. Linkages with agriculture will also be fostered, such as discussing how to cook locally available foods through cooking demonstrations/ local recipes, availability and utilization of seasonal fruits and vegetables, as well as kitchen gardens, and raising small animals.

TARGETED HOME VISITS

There are two main ways that CHVs can share information about MIYCN, care and stimulation with mothers in the community: (1) through targeted visits with individual mothers, and (2) formal or informal group sessions with multiple mothers (two to three mothers, or more) at once.

Targeted visits are with individual mothers where the information shared is tailored for that individual mother. In BFCI, it is recommended that a CHV, with assistance of the lead mother, visit and counsel a pregnant mother on optimal maternal nutrition on monthly basis throughout

the pregnancy (including counselling on healthy foods to eat during pregnancy, weight gain during pregnancy and preparing for the postpartum period). In the last month of pregnancy, it is recommended that pregnant mothers be visited more frequently and be accompanied by a birth companion or CHV to the facility for delivery. The birth companion, together with the health facility staff, should ensure that breastfeeding is initiated within one hour of birth and no pre- lacteal feeds are given. Soon after birth, frequent visits by the CHV and/or lead mother are recommended to provide support for proper attachment, positioning, and optimal breastfeeding and to address any problems with breastfeeding (i.e. perceptions of insufficient milk, early introduction of foods and liquids), as well as care and stimulation. Thereafter, a mother should be visited at least once a month for up to one year. Beyond one year, the mother is visited at least every two months up to 24 months for continued support for optimal MIYCN practices, including feeding during illness, child spacing, growth monitoring, and immunisation/supplementation, care and stimulation. Targeted home visits can also be done when the mother misses a support group visit or when there is a barrier within the household to practising the optimal MIYCN practises.

Targeted home visits can take place at home (the volunteer/lead mother goes to visit the woman at her home), in the volunteer's home (if the mother comes to the volunteer/lead mother for advice), or any other convenient place where the women normally meet in the community.

BI-MONTHLY "BABY-FRIENDLY MEETING"

A baby friendly meeting is a meeting organized by the CMSG within the community whose agenda is MIYCN, care and stimulation. Every two months, the CMSG members work together with the CHEW/nutritionist to mobilize pregnant women and mothers of children less than two years of age as the primary targets for community meetings. Women of reproductive age, fathers, grandmothers, and other caregivers of the children are secondary targets. All members of the community should be mobilized to attend these meetings. During these meetings, health and nutrition promotion, including cooking demonstrations, hygiene and sanitation, stimulation amongst other topics should be discussed.

CMSG members together with the CHVs will support and guide mothers on the cooking demonstration on how to make recipes for nutritious complementary foods that meets the frequency, amount, texture, variety, active feeding and hygiene (FATVAH) criteria and healthy diets for pregnant and lactating women.

In addition, to community baby friendly meetings, community dialogues and community action days will be conducted monthly and quarterly, respectively. CHVs will use this opportunity to promote baby friendly community activities.

BI-MONTHLY CMSG MEETINGS

The CMSG members should hold a meeting after the community baby friendly meeting to deliberate on the achievements, challenges, and plan for other activities in the community. The CHEW with the support of the chairman who may be the chief or any other member of the CMSG will call and organize for the meeting.

M2MSG MEETINGS

M2MSGs will be established within each community and be linked to a Primary Health Care Facility. There may be more than one M2MSG in one community, if the community is large in size or the community would like to have more than one group. Each group will have a lead mother who will work with the CHV in facilitating group activities. The lead mother will be responsible for engaging group members in discussions about MIYCN, care and stimulation and providing basic health education, in an interactive, participatory manner. This will be an opportunity to address problems mothers have with MIYCN, including breastfeeding and early introduction of foods and liquids that impede exclusive breastfeeding, and discuss solutions as a group.

MONTHLY CHVS MEETINGS

The CHVs will hold monthly meetings with the CHEWs and nutritionist for routine reporting and experience sharing in BFCI implementation in their communities. During these meetings, they will identify areas of challenge during home visits and possible solutions to these challenges. The CHEW and nutritionist will guide and provide any MIYCN updates to the CHVs. The meetings will be in the regular monthly CHV meetings where CUs exist.

EDUCATION SESSIONS FOR THE MOTHERS AT MATERNAL NEONATAL CHILD WELFARE CLINICS (MNCWC)

The education sessions will be conducted at MNCWCs by the CHVs, health facility staff or the CHEW. The CHEW/Health Facility in charge will document the topics covered and the attendance. Other avenues for health and nutrition promotion will be during baby friendly community meetings and other gatherings within the community, such as market places, chiefs' barazas, and other social gatherings. Sharing MIYCN information informally is a strategic vehicle for educating mothers, but should not replace formal routine contacts for counselling mothers, such as targeted home visits and monthly M2MSG meetings.

MENTORSHIP AND SUPERVISION

The SCHMT will supervise and mentor the Primary Health Care Facility (PCF) staff at least once per month for the initial six months of establishment to support and strengthen the BFCI, and quarterly thereafter. The SCHMT should visit each PHCF, using the supervision checklists to provide guidance and support for both geographic and programmatic areas that need strengthening. Action points to be acted upon will be developed based on the findings and verified in subsequent visits. Supervision checklists for SCHMT and CHEW are provided as part of the implementation guidelines (Annex 1).

The CHEW and nutritionist will continuously supervise and mentor the CHVs for quality improvement in the implementation of BFCI activities. They should follow-up the CHVs on monthly basis, and may also accompany the CHVs during the targeted home visits to observe their activities and ensure they are counselling the mothers appropriately. CHVs will mentor lead mothers.

ESTABLISHMENT OF MOTHER AND BABY FRIENDLY RESOURCE CENTRE

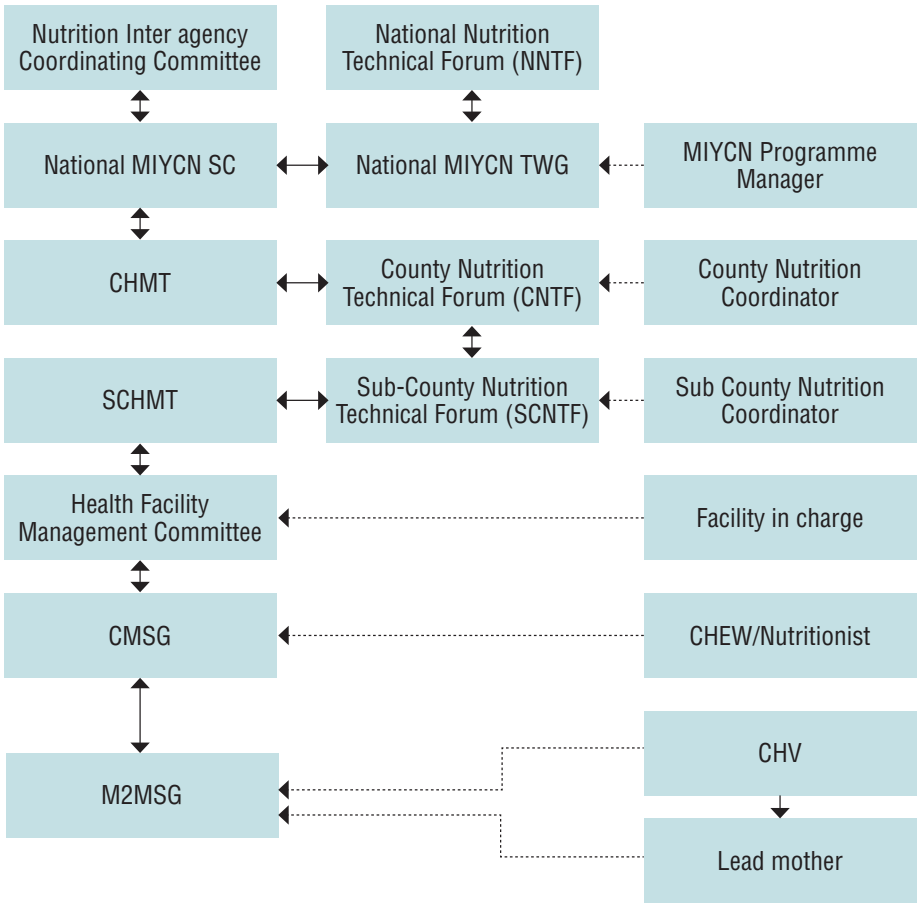
The site for the resource center will be identified by the M2MSG in consultation with the CSGM and the facility staff. It may be located anywhere within the community. Simple furniture for sitting and writing will be sourced locally. IEC on materials on MIYCN, care and stimulation will be placed in the identified venue. CMSG, CHVs, M2MSG and health care workers who have been trained will then manage the Centre, giving information and offering practical support to any person who comes to the center.

SECTION 3

ROLES AND RESPONSIBILITIES OF KEY STAKEHOLDERS IN BFCI

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

3.1 BFCI COORDINATION AND IMPLEMENTATION STRUCTURE



Key:

Reporting and sharing of information ⟷ The lead within the group ⟵

3.2 ROLES AND RESPONSIBILITIES OF KEY ACTORS IN BFCI IMPLEMENTATION

Table1: ROLES AND RESPONSIBILITIES OF BFCI COMMITTEES AND GROUPS

Maternal Infant Young Child Nutrition (MIYCN) Steering Committee	• Formulate policy and guidelines for implementation of BFCI • Develop and disseminate BFCI package to the counties • Oversee the implementation of BFCI activities • Facilitate the timely and regular meetings of the National MIYCN steering committee • Facilitate capacity development on BFCI at national and county level • Conduct sensitization of CHMT, partners, and stakeholders on BFCI • Facilitate advocacy and resource mobilization in support of BFCI • Facilitate the coordination of partners involved in BFCI implementation • Validate research carried out on BFCI • Coordinate the monitoring and evaluation of BFCI implementation • Verify external BFCI assessments, accredit, and designate communities as "baby friendly"
County Health Management Team (CHMT)	• Adopt and implement MIYCN guidelines • Coordinate implementation of BFCI activities • Provide regular BFCI supportive supervision in the county • Prepare quarterly and annual BFCI work plans based on SCNTF plans • Coordinate sensitization of the SCHMT, partners, and other stakeholders on BFCI • Coordinate selection and capacity building of TOTs • Coordinate the monitoring and evaluation of BFCI • Facilitate advocacy and resource mobilization in support of BFCI activities • Coordinate the external BFCI assessment • Coordinate the orientation of CHMT, key line ministries and other stakeholders

Sub County Health Management Team (SCHMT)	• Facilitate the implementation of BFCI activities at sub-county level • Coordinate and facilitate the training of health workers, partners and other stakeholders on BFCI package • Coordinate sensitization of community leaders on BFCI • Conduct regular supervision, mentorship, documentation and reporting of BFCI activities • Facilitate and coordinate advocacy and resource mobilization for BFCI activities from local leaders and county government • Conduct mentorship for CHEW and CHVs • Provide feedback and guidance to the CHEW on BFCI implementation • Provide BFCI activity reports to the county/national team • Monitoring and evaluation of the implementation process • Conduct BFCI self-assessment • Verify community self-assessment
Health Facility Management Committee (HFMC)	• Advise community on matters related to the promotion of BFCI • Represent and articulate community interests on BFCI matters in local development forums • Facilitate a feedback process to the community pertaining to the operations and management of the health facility • Document all the BFCI activities • Oversee referral of mothers to the community from the facility • Execute community decisions in the facility pertaining to BFCI implementation • Mobilize community resources towards BFCI activities within the area
Community Mother Support Group(CMSG)	• Provide leadership and oversight in the implementation of BFCI in the community • Collaborate with the CHEWs and nutritionists to prepare the BFCI operational plans • Network with other stakeholders on matters related to BFCI, e.g. Ministries of Water, Agriculture, Education, etc. • Facilitate resource mobilization at the community level for implementing BFCI • Plan, coordinate and mobilize the community to participate in the community baby friendly meetings and other health promotion activities in the community • Lead in advocacy, communication and social mobilization for BFCI at the community level • Participate in bi-monthly planning and review meetings • Reporting to CHEWs and nutritionist on BFCI activities they have been involved in and any specific health problems they have encountered that need to be brought to the attention of Sub county or county health management teams • Maintaining and keeping records of BFCI activities conducted in the community • Lead self-assessment of BFCI activities in the communities

Table 2: ROLES AND RESPONSIBILITIES OF KEY ACTORS IN BFCI

Community Health Extension Worker (CHEW)	• Organizing and facilitating CHV training on BFCI module • Support the CHVs in assigned tasks and mentor them on BFCI to ensure achievement of desired outputs and outcomes • Establishing and supervising CMSG • Collating information gathered by the CHVs to display summaries at strategic sites to provide relevant feedback as well as material for dialogue at household and community levels • Compiling BFCI reports from CHVs • Receiving feedback from PHCF and passing it on the CMSG and CHVs through dialogue and planning that leads to actions to improve identified issues • Organize monthly and quarterly review meetings for CHVs • Advocate for BFCI community awareness at community level • Coordinate and supervise CMSG and M2MSG activities • Coordinate self-assessment for BFCI • Coordinate bi monthly CMSG planning and review meetings • Ensure BFCI is incorporated during education sessions at MNCWC • Provide refresher trainings and updates to CHVs
Nutritionist	• Facilitating CHV training on BFCI module • Support the CHVs in assigned tasks and mentor them on BFCI to ensure achievement of desired outputs and outcomes • Supervising CMSG • Compiling BFCI reports from CHVs • Ensure that feedback is passed on to the CMSG and CHVs through dialogue and planning is done to address issues raised • Advocate for BFCI community awareness at all levels • Supervise CMSG and M2MSG activities • Coordinate self-assessment for BFCI • Supervise bi monthly CMSG planning and review meetings • Ensure BFCI is incorporated during education sessions at MNCWC • Provide refresher trainings and updates to CHVs • Facilitate the implementation of BFCI activities at all levels • Coordinate and facilitate the training of health workers, partners and other stakeholders on BFCI package • Coordinate sensitization of community leaders on BFCI • Conduct regular supervision, mentorship, documentation and reporting of BFCI activities • Facilitate and coordinate advocacy and resource mobilization for BFCI activities from local leaders and county government • Conduct mentorship for CHEW and CHVs • Provide feedback and guidance to the CHEW on BFCI implementation • Monitoring of the implementation process

Community Health Volunteers (CHVs)	• Facilitate formation of M2MSGs • Conduct targeted home visits • Conduct education and counselling on MIYCN, care and stimulation including addressing any problems mothers face • Conduct community mobilization for uptake of BFCI • Mobilize the identified influencers on MIYCN • Participating in baby friendly community meetings • Mapping the primary audience within their area of operation • Reporting to the CHEW on the activities they have been involved in and keeping records • Participate in resource mobilization for community baby friendly meetings • Referral of cases to the nearest health facility • Promoting care seeking and uptake of optimal MIYCN practices • Participate in CHVs monthly meetings
Lead Mother	• Convene monthly M2MSG meetings • Deliver key messages for MIYCN, care and stimulation and discuss with mothers how to address any problems • A link between the M2MSG and the CMSG • Models the health and nutrition behaviors inM2MSG and community • Support the CHV in collecting BFCI data • Referral of mothers to CHVs, other mother support groups
Assistant chief/ village chief	• Participate in planning for BFCI activities together with other CMSG members • Mobilize the community members for community meetings on cooking demonstration. • Participates in the CMSG meetings in the PHCF every two months • Calls the meetings for the CMSG • Mobilization of community members to provide for materials and food e.g. green vegetables, rice, to be used during cooking demonstrations • Allocates responsibilities in the baby friendly community meetings and cooking demonstrations.

3.3 PARTNERSHIPS

Partnership with implementing partners, development partners, the private sector, and line ministries at all levels is vital to the success of BFCI. With more resources, BFCI can gain the type of support needed by the Ministry of Health to accomplish the goals and objectives of improving MIYCN, care and stimulation.

The following are partners and their respective roles in the implementation of BFCI:

Table 3: ROLES OF PARTNERS IN BFCI IMPLEMENTATION

Development and implementing partners	• Provide technical and financial support in the development and review of BFCI Policies and Guidelines. • Provide technical and financial support to national government, county government and community efforts in capacity building, advocacy, and social mobilization for successful implementation of BFCI.
Line ministries	• Collaborate and synergise activities at all levels with the Ministry of Health with the aim of improving MIYCN, care and stimulation
Private sector, industries and enterprises	• Support implementation of BFCI
Media agencies	• Support BFCI advocacy, communications components and social mobilization. • Disseminate correct information on optimal MIYCN, care and stimulation. • Be actively involved in advocacy and social mobilization for BFCI
Universities and research institutions	• Provide technical support to relevant agencies and organizations in conducting research on various components BFCI • Evidence Generation for BFCI

SECTION 4

ADVOCACY AND COMMUNICATION FOR BFCI

Advocacy for BFCI involves a process of educating and motivating influential audiences. The objective of advocacy and communication is to galvanize support for the buy-in and implementation of BFCI. This will target audiences in both health and non-health sectors.

4.1 STAKEHOLDER IN BFCI

STAKEHOLDERS IN THE HEALTH SECTOR AT THE NATIONAL LEVEL

a Policy and decision makers at national level- cabinet secretary, principal secretary

b. Director of medical services

c. Administrators, heads of departments, heads of divisions, heads of units

d. Programme managers/officers

e. Health workforce

STAKEHOLDER IN THE HEALTH SECTOR AT THE COUNTY LEVEL

a Chief executive committee member of health

b. Chief officer of health

c. Health workforce

STAKEHOLDERS OUTSIDE OF THE HEALTH SECTOR

a. Media–national and local (newspapers, radio, and television)

b. Leaders of government agencies, various government bodies, and top leadership in ministries such as the Ministry of Education, Ministry of Agriculture, Livestock and Fisheries, Ministry of Devolution & Planning, Ministry of Labour, Social Security and Services e.t.c.

c. Legislators – senators, members of parliament, Women representatives, relevant parliamentary committees

d. Key donors and developmental partners

e. Academia – heads of schools, universities, training institutes

f. Civil society organization– international, national, and local civil society organisations

g. County level leaders – governors, members of county assemblies, county executive committee members, administrators

h. Religious leaders of all denominations at national, county, and local levels

i. Community

   i. Administrative – commissioners, chiefs, administrators,

   ii. Opinion holders – village elders,

   iii. CBOs – women, youth,

   iv. Individuals in the community

4.2 AUDIENCES

The audiences being targeted in BFCI are categorized into primary, secondary and tertiary. The actions to achieve the outlined outcome entail what is done to the target audience in order for the stated communication outcomes to be achieved.

Audience segmentation:

a. Primary Audience

b. Secondary audience

c. Tertiary

Table 4: TARGET AUDIENCE, COMMUNICATION GOALS, AND PROPOSED ACTIONS

Objective: Improve access and uptake of accurate MIYCN care and stimulation messages			
Category	**Target Audience**	**Communication outcomes**	**Actions to achieve the Outcomes**
Primary audience	Pregnant & lactating women, immediate caregivers (spouses/partners, siblings, households, daycare attendants) and other Women of reproductive age	a) Increased and improved knowledge and practice of MIYCN, care and stimulation b) Improved optimal MIYCN practices c) Increased and sustained uptake of good nutrition practices including the uptake of health services d) Increased number of champions practicing and advocating for optimal MIYCN, care and stimulation	a) Raise awareness and sensitize communities on good nutrition, care an stimulation practices, using clear messages disseminated through CMSG, M2MSG, baby friendly meetings, targeted home visits, and other health promotion activities through community outreach, community dialogues, campaigns, nutrition days, and health fairs b) Provision of communication content materials such as fliers

Secondary audience	Spouse/partners, mothers-in-laws, and grandmothers	a) Improved family and social support system for best MIYCN, care and stimulation practices b) Increased family resources allocated for optimal MIYCN, care and stimulation c) Increased knowledge translating to support of optimal MIYCN practices d) Increased number of nutrition role models at community level supporting positive behavior change and more citizen engagement	a) Use participatory community engagement through photo voice, and digital media with key nutrition messages and the right to good nutrition for communities b) Raise awareness and sensitization of communities on good nutrition practices, using clear messages disseminated through CMSG, baby friendly meetings, targeted home visits and other health promotion activities through community outreach, community dialogues, campaigns, nutrition days, health fairs, chiefs barazas c) Provision of take home fliers
	Health professionals	Increased and improved knowledge and understanding of BFCI Improved services including counselling, interpersonal communication	a) Capacity building of health workers on BFCI b) Provision of Job Aids and IEC materials c) Support the establishment of community feedback mechanisms and referrals on BFCI d) Provision and adherence to the guidelines
	CHVs	a) Increased and improved knowledge and understanding of BFCI b) Effective and accessible feedback and participation CHVs to engage in and influence BFCI activities c) Improved uptake of health and nutrition services in the community d) Create and increase demand for Health and nutrition services	a) Capacity building of CHVs b) Provision of Job aids and IEC materials c) Monthly reporting of community activities

	Media – National and local media	Increased frequency and improved quality (diversity, profile, technical accuracy) of MIYCN care and stimulation messaging by the media	a) Building and maintaining stronger relationships with media through advocacy(media breakfast, joint field visits, media briefing, media package) b) Build the capacity of media professionals on MIYCN c) Broadening the scope and type of media channels used to advocate for and communicate MIYCN messages d) Building the communication and media skills of nutrition professionals for effective media engagement on MIYCN issues e) Develop appropriate MIYCN media content
	Community opinion leaders and influencers (e.g. birth companion, religious leaders, based on community profiling) a) Social support groups (e.g. peer groups, women's groups, "*chama**", farmer groups)	a) Improved knowledge and understanding of MIYCN b) Increased number of leaders and champions advocating for positive behaviour change in MIYCN	a) Orientation and sensitization of opinion leaders and influencers through CMSG, barazas, formal meetings and dissemination of MIYCN Social, Behaviour Change Communication (SBCC) materials b) Support the establishment of MIYCN role models/champions (traditional/religious/local/media leaders) to be spokespeople for communities in advocating for MIYCN
Tertiary Audience	a) Policy and decision makers b) Legislators c) County level leaders	a) conducive legal/legislative framework for MIYCN at national and county level	a) Sensitization on the value and impact of prioritizing MIYCN at all level through BFCI implementation b) Identify national and county BFCI champions and empower

	d) Religious leaders e) Academia f) Donors and development partners g) Civil society organizations h) Leaders of government agencies, ministries and other government bodies	b) Adherence and application of polies and guidelines at county level Increased and sustained multi-sectoral collaboration on advancing and integrating MIYCN with other sectors c) Increased funding, allocated and spent on MIYCN at both national and county levels d) Increased health workforce and their distribution across counties based on needs and geographical outreach	them with key facts/data and communication tools to support and advocate for MIYCN at all levels (first ladies, media personalities, county leaders) c) Advocacy for resource allocation d) Establish and promote the value of multi-sectoral collaboration on BFCI within and outside the sector at national and county levels, highlighting clear benefits of engagement by other sectors e) Hire and deploy healthcare service providers f) Advocate for budget allocations for BFCI, based on clear analysis of financing gaps, funding commitments, and cost-effective investments g) Raise awareness of BFCI amongst the Members of the County Assembly (MCAs) to influence the inclusion of BFCI within the county health plans h) Promote the need for increased health staff capacity especially nutrition, CHEWs and CHVs linked to the implementation of the national community strategy and the realization of baby friendly communities i) Develop advocacy and communications materials for BFCI with key MIYCN messages and the right to good nutrition for communities

4.3 RECOMMENDED COMMUNICATION CHANNELS

Different types of media channels will be used to advocate for and communicate MIYCN, Care and stimulation messages. These are:

- Print – policy briefs, advocacy packs, SBCC materials
- Electronic – TV, radio, social media, video/tele-conferencing
- Interpersonal communication – advocacy workshops, community dialogues, personalized counseling, Community barazas, and Engagement meetings
- Traditional media -songs, drama, artefacts

SECTION 5

MONITORING AND EVALUATION OF BFCI

Monitoring of BFCI activities will be conducted routinely at all levels and is essential to the success of BFCI. Five key outcome indicators have been identified for monitoring and reporting of BFCI activities as described below:

1. Proportion of infants who are put to the breast within one hour after delivery (early initiation of breastfeeding) (zero to twelve months of age)
2. Proportion of infants who are exclusively breastfed in the first six months of life (zero to six months of age)
3. Proportion of children who receive any pre-lacteal feeds within the first three days of life
4. Proportion of children aged six to eight months who receive complementary foods (semi-solid or solid) in addition to breast milk
5. Proportion of children aged six months who ate any animal-source, iron-rich foods in the last 24 hours

Table 5: GUIDANCE QUESTIONS FOR KEY BFCI INDICATORS

	For this indicator	Questions to ask mothers
1	Early Initiation of Breastfeeding (for children 0-11.9 months)	Was the child put to the breast? • within 1 hour after delivery(Y/N) • later than 1 hour after delivery (Y/N)
2	Pre-lacteal feeding (for children 0-11.9 months)	In addition to breastmilk, what was the child given to drink/ eat in the first three days of life? • Water/other liquids • Milk (not breastmilk)/infant formula • Other: _____ • Nothing
3	Exclusive breastfeeding (for children zero to six months)	Is (NAME) still breastfeeding? Was (NAME) breastfed yesterday during the day and at night? Did (NAME) take ANY liquids or semi-solid/solid foods yesterday day and night? Liquids: MILK (other than breast milk), plain water, sugar/ glucose water, gripe water, sugar/salt solution, fruit juice, infant formula, tea/infusions, coffee, honey etc. Semi-solid/solid foods: cereals, vegetables, fruits, meats, pulses/legumes, etc. (Exclusive breastfeeding means Yes to the first question above, and No to the second and third questions above)

	For this indicator	Questions to ask mothers
4	Proportion of children 6-8.9 months of age who had complementary feeding in addition to breastmilk.	Was the child given solid or semi-solid foods in the last 24 hours? (Y/N)
5	Animal source in complementary feeding (for children 6-11.9 months of age)	Was the baby given meat, poultry, fish or eggs in the last 24 hours? (Y/N)

LEVELS OF REPORTING

Table 6: REPORTING LEVELS

Levels	Responsible person	Tools used
Level 1	CHV	Form 1: Individual child feeding and growth monitoring form
Level 2	CHEW/Nutritionist with the support of CMSG members	BFCI Form 2:Village report
Level 3	Facility in charge with the support of the CHEW/Nutritionist	BFCI Form 3: Primary Health Care Facility report
Level 4	Sub-County Nutrition Coordinator	BFCI Form 4: Sub-county report
Level 5	County Nutrition Coordinator	BFCI Form 5: County report

BFCI activities will be implemented by the CHV with close monitoring and supervision by the CHEW/Nutritionist. The CHV, with the support of the lead mother, will complete Form 1 (individual child record) every month, because this record is not only for the purpose of monitoring, it is also for the purpose of guiding appropriate counselling from the CHV to the mother. The CHEW with the support of the nutritionist should supervise completion of Form 1 every month. During the routine monthly meetings, the CHVs will present Form 1 to the CHEW for data extraction and then retain it until the child reaches one year of age. Form 1 will be provided for every newborn.

Every six months, in July and January of each year, the CHEWwill compile data from the previous months overseen by the nutritionist. The CHEW will summarise the data and report to the SCNTF, who will then compile the reports from various communities and forward the summary to the CNTF. The County Nutrition Coordinator will then compile the BFCI reports from the various sub-counties and submit to the national level.

Programmatic indicators will also be collected every six months (July and January) on the following:

1. Number of communities implementing BFCI
2. Number of CHVs trained in the last six months
3. Number of BFCI trainings conducted in the last six months
4. Number of staff in the PCF trained on BFCI
5. Number of sub-counties implementing BFCI

There will be two categories of monitoring for BFCI activities, which will include:

1. Routine monitoring and supervision
2. BFCI Assessments

5.1 ROUTINE MONITORING AND SUPERVISION

Monitoring and assessment of BFCI activities at all levels is essential to the success of BFCI. The CHEW and nutritionist, with the support of CMSG members, will primarily be responsible for providing monitoring and supervision of BFCI activities at the community level.

The CHEW and nutritionist will conduct a simple rapid assessment to CHVs and mothers in order to ensure that BFCI activities are being implemented successfully.

The SCHMT will visit each PHCF to mentor and supervise BFCI activities in order to identify areas (both geographic and programmatic) that need strengthening. The SCHMT will provide mentorship for the gaps identified during this visits and draw action points for improvement.

5.2 BFCI ASSESSMENTS

The CHEW and nutritionist, with support from the CMSG members, will conduct a self-assessment for BFCI using the checklist provided in the annex. The sub-county will review and ascertain whether the community is 'baby friendly' and request for an external assessment from the CHMT. The CHMT will use the external assessment tools for certification of communities as 'baby friendly', which are comprised of the household, health workers, CHVs, and facility assessment tools. If some criteria are not being met, the problematic areas should be addressed and resolved accordingly. Once the criteria is met, (80% or above) the CHMT will recommend consideration for accreditation to the national MIYCN Steering Committee for accreditation consideration. The national external assessors will verify the CHMT processes, reports, and documentation as needed to conduct spot checks to ascertain baby friendliness. Accreditation will be awarded if all criteria are met, and the community will then will be designated as baby friendly. A permanent sign will be displayed in a strategic location in the community, such as the entrance road, the center of the community, PCF, market place or at the chiefs/assistant chief's office, declaring that "(Name of Community) is a Baby-Friendly Community". The community members themselves or the local leaders should support the installation of this sign during a community ceremony.

The benefits of maintaining "BFCI" status include continued support and trainings for BFCI volunteers, continued support from local leaders, and recognition from the county and national governments.

Summary of tools to be used for monitoring and assessment of BFCI:

Table 7: BFCI MONITORING AND ASSESSMENT TOOLS

Type of assessment	Responsible person	Tools used
Rapid assessment	CHEW/Nutritionist	The CHEW rapid assessment form for CHVs and mothers
Self-assessment for baby friendliness	CHEW / Nutritionist with the support of CMSG members	Community self-assessment form
Sub-county monitoring of BFCI	SCHMT	SCHMT Mentorship and supervision checklist for BFCI
External assessment of BFCI	CHMT/National MIYCN Steering Committee	External assessment tools

ANNEX 1: SCHMT MENTORSHIP AND SUPERVISION CHECKLIST FOR BFCI

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? [_____] How many members in the M2MSG? [_____] If more than oneM2MSG, provide membership for each	Yes (☐)	No (☐) and reason
	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 PMTCT clinic ☐ Yes ☐ No ☐ Area does not exist Waiting Bay ☐ Yes ☐ No ☐ Area does not exist Paediatric ward ☐ Yes ☐ No ☐ Area does not exist	Yes (☐)	No (☐) and reason
	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

ANNEX 2: COMMUNITY SELF-ASSESSMENT TOOL FOR BFCI

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:			
Step 1: 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/CHVs 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
Step 4: 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 six 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/ dayababy6-8months, 9-23 months should receive every day?	☐ Yes	☐ No
	Do mothers/CHV and health workers have information on the amount of food ababy6-8months, 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 6-23 month'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 6-23 months 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
Step 7: 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 3: INDIVIDUAL INFANT AND YOUNG CHILD FEEDING AND GROWTH MONITORING RECORD

Form 1 —Individual Infant Child Feeding Practices

1. Village name: _____

Household number: _____

CHVs Name:

Annex 3: Individual Infant and Young Child Feeding and Growth Monitoring Record

MOTHER

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

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

INFANT InfantsName: .....

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) ☐

EARLY INITIATION

8. The child put to the breast/breastfed?

8.1. within 1hour after delivery☐;

8.2. later than 1 hour after delivery ☐

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 breastfed 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 FORM 1– INFANT AND YOUNG CHILD FEEDING 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 weigh less than 2,500 g, tick the box for Low Birth Weight Baby;
    - For question 8, tick "Ö" 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 is the child 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 particular 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 diarrhoea;
   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.

ANNEX 4: BFCI FORM 2 —VILLAGE REPORT

To be completed by the CHEW, using Form 1 data from the months of January 1st to June 30th and July 1st to 31st December.

The CHEW/PCF staff must compile the data in early January and July for the preceding 6 months. Reporting deadlines: from facility to sub-county is 5th of the subsequent month, from the sub-county to the county is 10th of the subsequent month, and from county to national is 15th of the subsequent month.

Indicator 1 **0-11.9 mo** **Early BF** (Q8 from Form 1)		**Total 0-11.9 mo.**	**% early BF**	**Indicator 2** **0-11.9 mo** **Pre-lacteal feeding** (Q9 from Form 1)		**Total 0-11.9 mo.**	**% pre-lacteal feeding**	**Indicator 3** **0-5.9 mo** **Exclusive breastfeeding** (Q13, 14, 15, 16 from Form 1)		**Total 0-5.9 mo.**	**% Excl BF**	**Indicator 4** **6-8.9 mo** **Child received breastmilk and semi-solid food** (Q13, 16 from Form 1)		**Total 6-8.9 mo.**	**% semi-solid food**	**Indicator 5** **6-11.9 mo** **Child received iron-rich (animal or fortified) food in past 24 hrs** (Q18 from Form 1)		**Total 6-11.9 mo.**	**% iron rich food**
Y	**N**	**Y+N**		**Y**	**N**	**Y+N**		**Y**	**N**	**Y+N**	**%**	**Y**	**N**	**Y+N**	**%**	**Y**	**N**	**Y+N**	**%**
(a)	(b)	(c)* =a+b	(a/c) x100= %	(e)	(f)	(g)* =e+f	(e/g) x100= %	(h)	(i)	(j)* =h+i	(h/j) x100= %	(k)	(l)	(m) =k+l	(k/m) x100=%	(n)	(o)	(p)* =n+o	(n/p) x100= %

Name of Village: _____ **Date of reporting (Day, Month, Year):** _____

Total number of children, age 0-11.9 mo, active with BFCI this month	**Total number of children in this village, age 0-11.9 mo, (data from EPI record)**	**Percentage of children 0-11.9 months being reached by BFCI (coverage)**
(c)* Same as above	**(d)**	**(c/d) x 100 = %**

*Quality Check!

* (c) should be equal to (g)
* (j) + (p) should be equal to (c)

EXAMPLE

To be completed by the CHEW, using Form 1 data from the months of January 1st to June 30th and July 1st to 31st December.

The CHEW must compile the data in early January and July for the preceding 6 months. Reporting deadlines: from facility to sub-county is 5th of the subsequent month, from the sub-county to the county is 10th of the subsequent month, and from county to national is 15th of the subsequent month.

Indicator 1 **0-11.9 mo** **Early BF** (Q8 from Form 1)		**Total 0-11.9 mo.**	**% early BF**	**Indicator 2** **0-11.9 mo** **Pre-lacteal feeding** (Q9 from Form 1)		**Total 0-11.9 mo.**	**% pre-lacteal feeding**	**Indicator 3** **0-5.9 mo** **Exclusive breastfeeding** (Q13, 14, 15, 16 from Form 1)		**Total 0-5.9 mo.**	**% Excl BF**	**Indicator 4** **6-8.9 mo** **Child received breastmilk and semi-solid food** (Q13, 16 from Form 1)		**Total 6-8.9 mo.**	**% semi-solid food**	**Indicator 5** **6-11.9 mo** **Child received iron-rich (animal or fortified) food in past 24 hrs** (Q18 from Form 1)		**Total 6-11.9 mo.**	**% iron rich food**
Y	**N**	**Y+N**		**Y**	**N**	**Y+N**		**Y**	**N**	**Y+N**	**%**	**Y**	**N**	**Y+N**	**%**	**Y**	**N**	**Y+N**	**%**
//////// ////	/////// /			////////// /	////////// /			////////	////			///	//			//////	//		
12	8	20	(12/20) 60%	10	10	2o	(10/20) 50%	8	4	12	(8/12) 67%	3	2	5	(3/5) 60%	6	2	8	(6/8) 75%
(a)	(b)	(c)* =a+b	(a/c) x100= %	(e)	(f)	(g)* =e+f	(e/g) x100= %	(h)	(i)	(j)* =h+i	(h/j) x100= %	(k)	(l)	(m) =k+l	(k/m) x100=%	(n)	(o)	(p)* =n+o	(n/p) x100= %

Name of Village: ____Gambogi ___ **Date of reporting (Day, Month, Year):** __4 July 2015___

Total number of children, age 0-11.9 mo, active with BFCI this month	**Total number of children in this village, age 0-11.9 mo, (data from EPI record)**	**Percentage of children 0-11.9 months being reached by BFCI (coverage)**
20	26	(20/26)= 77%
(c)* Same as above	**(d)**	**(c/d) x 100 = %**

*Quality Check!

* (c) should be equal to (g)
* (j) + (p) should be equal to (c)

GUIDELINES FOR COMPLETING FORM 2 – VILLAGE REPORT

1. Write the name of the village and the date of reporting in the space at the top of Form 2.

2. The data entered in Form 2 is a summary of the key information in Form 1. Use the Form 1 records that have current information for the month of reporting (January to June or July to December). In other words, do not enter the data for a child that was recorded in previous 6 months in the current reporting period.

3. Go through the Form 1 booklet one record at a time, and transfer the information to Form 2.

    a. Indicator 1 (Early Breastfeeding): If the child is 0-11.9 months old in the current month, refer to Q8 on Form 1. If the child was put to the breast within 1 hour of delivery (Q8.1), tally in the "Y" column under Indicator 1 on Form 2. If the child was put to the breast later than one hour after delivery (Q8.2), tally in the "N" column under Indicator 1 on Form 2.

    b. Indicator 2 (Pre-lacteal feeding): If the child is 0-11.9 months old in the current month, refer to Q9 on Form 1. If the child was given water/liquids (Q9.1), milk/infant formula (Q9.2), or other food/drink (Q9.3) in the first three days of life, tally in the "Y" column under Indicator 2 on Form 2. If the child did not receive anything other than breastmilk (Q9.4), tally in the "N" column under Indicator 2 on Form 2.

    c. Indicator 3 (Exclusive Breastfeeding): If the child is 0-5.9 months old in the current month, refer to Q13, Q14, Q15, and Q16 on Form 1. If the child is 6 months or older, do not record anything under Indicator 3. If the child 0-5.9 months old received only breastmilk in the last 24 hours (Q13 is "yes", Q14, Q15, and Q16 are "no"), tally in the "Y" column under Indicator 3 on Form 2. If the child 0-5.9 months old received anything other than breastmilk (Q14 or Q15 or Q16 is "yes"), tally in the "N" column under Indicator 3 on Form 2.

    d. Indicator 4 (Breastmilk and Semi-solid food): If the child is 6-8.9 months old in the current month, refer to Q13 and Q16 on Form 1. If the child is not 6-8.9 months, do not record anything under Indicator 4. If the child 6-8.9 months old received breastmilk and semi-solid food in the last 24 hours (Q13 and Q16 are both "yes"), tally in the "Y" column under Indicator 4 on Form 2. If either Q13 or Q16 is "no" for the child 6-8.9 months, then tally in the "N" column under Indicator 4 on Form 2.

    e. Indicator 5 (Iron-rich foods): If the child is 6-11.9 months old in the current month, refer to Q18 on Form 1. If the child is not 6-11.9 months old, do not record anything under Indicator 5. If the child 6-11.9 months old ate meat, poultry, fish, or eggs in the last 24 hours (Q18 is "yes"), tally in the "Y" column under Indicator 5 on Form 2. If the child 6-11.9 months old did not eat meat, poultry, fish, or eggs in the last 24 hours (Q18 is "no"), tally in the "N" column under Indicator 5 on Form 2.

4. Total the number of marks under each of the "Y" and "N" columns for Indicators 1 to 5 on Form 2. This means (a), (b), (e), (f), (h), (i), (k), (l), (n) and (o).

5. Add (a)+(b) to calculate (c). Add (e)+(f) to calculate (g). *Note that (c) and (g) should be the same number because it represents the number of children aged 0-11.9 months with current data for the month of reporting.

6. Add (h)+(i) to calculate (j). Add (k)+(l) to calculate (m). Add (n)+(o) tocalculate (p). *Note that (j)+(p) should be equal to (c) because the number of children 0-5.9 months of age (j), plus the number of children 6-11.9 months of age (p), is the same as the number of children 0-11.9 months of age (c).

7. For each indicator, divide the "Y" (numerator) by "Total" (denominator), and multiply by 100 to calculate the percentages:

    a. Divide (a)/(c) and multiply by 100 to calculate the percentage (%) for Indicator 1.

    a. Divide (e)/(g) and multiply by 100 to calculate the percentage (%) for Indicator 2.

    a. Divide (h)/(j) and multiply by 100 to calculate the percentage (%) for Indicator 3.

    a. Divide (k)/(m) and multiply by 100 to calculate the percentage (%) for Indicator 4.

    a. Divide (n)/(p) and multiply by 100 to calculate the percentage (%) for Indicator 5.

    Congratulations! You have just calculated the 5 BFCI Indicators amongst children that were active with BFCI in the current month of reporting (January to June or July to December). Now, you should calculate the coverage of BFCI in the village (Steps 8-10).

8. In the first column at the bottom of Form 2, write the number (c), which is the same number that was calculated for Indicator 1.

9. In the second column at the bottom of Form 2, refer to the village mapping records, and write the total number of children 0-11.9 months registered in the village in the current month of reporting (January to June or July to December)

10. In the third column at the bottom of form 2, divide (c)/(d) and multiply by 100 to calculate the coverage of BFCI in the village.

ANNEX 5: BFCI FORM 3—PRIMARY HEALTH CARE FACILITY REPORT

To be completed by the PCF staff, using Form 2 data.PCF staff must compile the data in early January and early July.

Reporting deadlines: from facility to sub-county is 5th of the subsequent month, from the sub-county to the county is 10th of the subsequent month, and from county to national is 15th of the subsequent month.

Name of Health Centre: _____ **Date of reporting:** _____

No.	**Name of village**	**Indicator 1: early BF (Y)**	Total 0-11.9 mo	**Indicator 2: pre-lacteal feeding (Y)**	Total 0-11.9 mo	**Indicator 3: exclusive BF (Y)**	Total 0-5.9 mo	**Indicator 4: semi-solid food (Y)**	Total 6-8.9 mo	**Indicator 5: iron-rich food (Y)**	Total 6-11.9 mo	**BFCI Coverage** Total no. children 0-11.9 months in village (data from EPI record)	
		(a)	(c)	(e)	(g)	(h)	(j)	(k)	(m)	(n)	(p)		(d)
1													
2													
3													
4													
5													
	TOTAL												
		(a)	(c)*	(e)	(g)*	(h)	(j)*	(k)	(m)	(n)	(p)*	(c)	(d)
	PERCENTAGE (%)												
		(a/c)x100=	%	(e/g)x100=	%	(h/j)x100=	%	(k/m)x100=	%	(n/p)x100=	%	(c/d)x100=	%

***QUALITY CHECK! (c) is equal to (g), and (j)+(p)=(c)**

Total number of BFCI villages in the HC area: _____
Number of BFCI trainings conducted in the past 6 months: _____
Number of BFCI volunteers trained in the past 6 months: _____

EXAMPLE

To be completed by the PCF staff, using Form 2 data.HC staff must compile the data in early January and early July.
Reporting deadlines: from facility to sub-county is 5th of the subsequent month, from the sub-county to the county is 10th of the subsequent month, and from county to national is 15th of the subsequent month.
Name of Primary Health Care Facility: ___Jandoni Health Centre _____Date of reporting: ___3rd July 2015_____

No.	Name of village	**Indicator 1: early BF (Y)**	Total 0-11.9 mo	**Indicator 2: pre-lacteal feeding (Y)**	Total 0-11.9 mo	**Indicator 3: exclusive BF (Y)**	Total 0-5.9 mo	**Indicator 4: semi-solid food (Y)**	Total 6-8.9 mo	**Indicator 5: iron-rich food (Y)**	Total 6-11.9 mo	**BFCI Coverage** Total no. children 0-11.9 months in village (data from EPI record)	
		(a)	(c)	(e)	(g)	(h)	(j)	(k)	(m)	(n)	(p)		(d)
1	Kulungu	12	20	10	20	8	12	3	5	6	8		26
2	Siala	10	22	9	22	8	11	5	6	6	11		24
3	Chango	9	18	8	18	5	9	5	5	7	9		24
4	Amalemba	6	12	7	12	3	5	4	4	6	7		15
5	Chaka	15	16	12	16	6	9	3	3	6	7		18
	TOTAL	52	88	46	88	30	46	20	23	31	42	88	107
		(a)	(c)*	(e)	(g)*	(h)	(j)*	(k)	(m)	(n)	(p)*	(c)	(d)
	PERCENTAGE (%)	(52/88) x100	59%	(46/88) x100	52%	(30/46) x100	65%	(20/23) x100	87%	(31/42) x100	74%	(88/107) x100	82%
		(a/c)x100=	%	(e/g)x100=	%	(h/j)x100=	%	(k/m)x100=	%	(n/p)x100=	%	(c/d)x100=	%

ANNEX 6: BFCI FORM 4— SUB-COUNTY REPORT

To be completed by the sub-county nutrition coordinator, using Form 3 data.
Reporting deadlines: From facility to sub-county is 5th of the subsequent month, from the sub-county to the county is 10th of the subsequent month, and from county to national is 15th of the subsequent month.
Name of Sub-County: _____ Date of reporting: _____

No.	Name of Health Centre	**Indicator 1: early BF (Y)**	Total 0-11.9 mo	**Indicator 2: pre-lacteal feeding (Y)**	Total 0-11.9 mo	**Indicator 3: exclusive BF (Y)**	Total 0-5.9 mo	**Indicator 4: semi-solid food (Y)**	Total 6-8.9 mo	**Indicator 5: iron-rich food (Y)**	Total 6-11.9 mo	**BFCI Coverage** Total no. children 0-11.9 months in BFCI villages (data from EPI records)	
		(a)	(c)	(e)	(g)	(h)	(j)	(k)	(m)	(n)	(p)		(d)
	TOTAL												
		(a)	(c)*	(e)	(g)*	(h)	(j)*	(k)	(m)	(n)	(p)*	(c)	(d)
	PERCENTAGE (%)												
		(a/c)x100=	%	(e/g)x100=	%	(h/j)x100=	%	(k/m)x100=	%	(n/p)x100=	%	(c/d)x100=	%

***QUALITY CHECK! (c) is equal to (g), and (j)+(p)=(c)**

EXAMPLE

To be completed by the sub-county nutrition coordinator, using Form 3 data.
Reporting deadlines: from facility to sub-county is 5th of the subsequent month, from the sub-county to the county is 10th of the subsequent month, and from county to national is 15th of the subsequent month.

Name of Sub-County: _____Karamoja North_____Date of reporting: _____9th July 2015_____

No.	**Name of Primary Health Care Facility**	**Indicator 1: early BF (Y)**	Total 0-11.9 mo	**Indicator 2: pre-lacteal feeding (Y)**	Total 0-11.9 mo	**Indicator 3: exclusive BF (Y)**	Total 0-5.9 mo	**Indicator 4: semi-solid food (Y)**	Total 6-8.9 mo	**Indicator 5: iron-rich food (Y)**	Total 6-11.9 mo	**BFCI Coverage** Total no. children 0-11.9 months in BFCI villages (data from EPI records)	
		(a)	(c)	(e)	(g)	(h)	(j)	(k)	(m)	(n)	(p)		(d)
1	Facility 1	52	88	46	88	30	46	20	23	31	42		107
2	Facility 2	51	90	77	90	32	40	25	25	34	50		95
3	Facility 3	66	100	50	100	32	43	24	27	36	57		105
4	Facility 4	75	114	66	114	55	69	18	19	20	45		120
5	Facility 5	67	75	46	75	40	44	15	17	19	31		86
6	Facility 6	51	60	44	60	27	33	14	14	7	27		62
7	Facility 7	79	105	65	105	40	59	23	25	18	46		108
8	Facility 8	79	96	30	96	30	49	24	25	21	47		99
	TOTAL	520	728	424	728	286	383	163	175	186	345	728	782
		(a)	(c)*	(e)	(g)*	(h)	(j)*	(k)	(m)	(n)	(p)*	(c)	(d)
	PERCENTAGE (%)	520/728 x100	71%	424/728 x100	58%	286/383 x100	75%	163/175 x100	93%	186/345 x100	54%	728/782 x100	93%
		(a/c)x100=	%	(e/g)x100=	%	(h/j)x100=	%	(k/m)x100=	%	(n/p)x100=	%	(c/d)x100=	%

***QUALITY CHECK! (c) is equal to (g), and (j)+(p)=(c)**

Total number of BFCI villages in the sub-county: _____
Total number of BFCI PCF in the sub-county: _____
Number of BFCI trainings conducted in the sub-county in the past 6 months: _____
Number of CHVs trained on BFCI in the sub-county in the past 6 months: _____

ANNEX 7: BFCI FORM 5— COUNTY REPORT

To be completed by the county nutrition coordinator, using Form 4 data.
Reporting deadlines: from facility to sub-county is 5th of the subsequent month, from the sub-county to the county is 10th of the subsequent month, and from county to national is 15th of the subsequent month.

Name of County: _____ Date of reporting: _____

No.	Name of sub-county	**Indicator 1: early BF (Y)**	Total 0-11.9 mo	**Indicator 2: pre-lacteal feeding (Y)**	Total 0-11.9 mo	**Indicator 3: exclusive BF (Y)**	Total 0-5.9 mo	**Indicator 4: semi-solid food (Y)**	Total 6-8.9 mo	**Indicator 5: iron-rich food (Y)**	Total 6-11.9 mo	**BFCI Coverage** Total no. children 0-11.9 months in BFCI villages (data from EPI records)	
		(a)	(c)	(e)	(g)	(h)	(j)	(k)	(m)	(n)	(p)		(d)
	TOTAL												
		(a)	(c)*	(e)	(g)*	(h)	(j)*	(k)	(m)	(n)	(p)*	(c)	(d)
	PERCENTAGE (%)												
		(a/c)x100=	%	(e/g)x100=	%	(h/j)x100=	%	(k/m)x100=	%	(n/p)x100=	%	(c/d)x100=	%

***QUALITY CHECK! (c) is equal to (g), and (j)+(p)=(c)**

Total number of BFCI communities in the county: _____
Total number of BFCI PCF in the county: _____
Total number of BFCI sub-counties in the county: _____
Number of BFCI trainings conducted in the county in the past 6 months: _____
Number of CHVs trained on BFCI in the county in the past 6 months: _____

EXAMPLE

To be completed by the county nutrition coordinator, using Form 4 data.
Reporting deadlines: From facility to sub-county is 5th of the subsequent month, from the sub-county to the county is 10th of the subsequent month, and from county to national is 15th of the subsequent month.

Name of County: Kisumu Date of reporting: 14th July 2015

No.	Name of sub-county	**Indicator 1: early BF (Y)**	Total 0-11.9 mo	**Indicator 2: pre-lacteal feeding (Y)**	Total 0-11.9 mo	**Indicator 3: exclusive BF (Y)**	Total 0-5.9 mo	**Indicator 4: semi-solid food (Y)**	Total 6-8.9 mo	**Indicator 5: iron-rich food (Y)**	Total 6-11.9 mo	**BFCI Coverage** Total no. children 0-11.9 months in BFCI villages (data from EPI records)	
		(a)	(c)	(e)	(g)	(h)	(j)	(k)	(m)	(n)	(p)		(d)
1	Seme	520	728	424	728	286	383	163	175	186	345		782
2	Nyakach	547	647	600	647	222	320	156	169	150	327		714
3	Muhoroni	493	598	495	598	215	288	135	147	155	310		630
	TOTAL	1560	1973	1519	1973	723	991	454	491	491	982	1973	2126
		(a)	(c)*	(e)	(g)*	(h)	(j)*	(k)	(m)	(n)	(p)*	(c)	(d)
	PERCENTAGE (%)	1560/ 1973 x100	79%	1519/ 1973 x100	77%	723/991 x100	73%	454/491 x100	92%	491/982 x100	50%	1973/ 2126 x100	93%
		(a/c)x100=	%	(e/g)x100=	%	(h/j)x100=	%	(k/m)x100=	%	(n/p)x100=	%	(c/d)x100=	%

***QUALITY CHECK! (c) is equal to (g), and (j)+(p)=(c)**

ANNEX 8: CRITERIA FOR ASSESSING BABY FRIENDLY COMMUNITIES IN KENYA

Once BFCI activities have started in the community, a criteria will be used to establish whether the community is moving towards baby friendliness through mentorship, monitoring and supportive supervision. For a community to be "Baby-Friendly", the following criteria must be met:

1. Existence of functional CMSG
2. Functional M2MSG
3. Targeted home visits by the CHVs
4. Bi-monthly baby friendly community meetings
5. Monthly meetings for CHVs
6. Regular Trainings for CHVs on BFCI
7. Support for HIV positive mothers
8. Baby Friendly Community resource centre
9. Monitoring and Supervision
10. Facility observation

The 10 criteria for establishment and maintaining "Baby-Friendly Communities" are specific and measurable, as described below:

CRITERIA 1: FUNCTIONAL CMSG

a. Existence of a community mother support group
b. Existence of a clear outline of CMSG membership
c. Core members of the group listed include the five core members (CHEW, Nutritionist, CHCs and CHVs representatives, lead mother, and the chief/assistant chief)
d. Evidence of the CMSG bi-monthly meeting
e. A plan for bi- monthly (after every two months) baby friendly meetings with clear roles of key players available
f. Evidence of clear documentation of activities

CRITERIA 2: FUNCTIONAL M2MSG

a. The M2MSG has between 9-15 members
b. Evidence of the M2MSG meeting monthly
c. Clear documentation of activities
d. Functional referral system from facility to the community and vice versa

CRITERIA 3: TARGETED HOME VISITS BY THE CHVs

a. Monthly targeted home visits from pregnancy up to one year thereafter bi monthly till end of 2 years
b. Clear documentation of number of women reached
c. CHV completes the monthly monitoring forms (Form 1) for all children under 1 year of age, every month.

CRITERIA 4: BI-MONTHLY BABY FRIENDLY COMMUNITY MEETINGS FOR CHVs

a. Documentation of baby friendly meetings
b. Documentation shows activities include cooking demonstration
c. Other health promotion activities included during the baby friendly community meetings?
d. Other members of the community in addition to pregnant and lactating mothers attend the meetings

CRITERIA 5: MONTHLY MEETINGS FOR CHVs

a. Monthly meetings of CHVs members
b. Documentation of MIYCN activities during the meeting

CRITERIA 6: REGULAR TRAININGS FOR CHVS ON BFCI

a. All CHVs trained on BFCI
b. Once a year, the complete training is offered to CHVs (new volunteers that replace drop-out volunteers

CRITERIA 7: SUPPORT FOR HIV POSITIVE MOTHERS

a. The facility offer PMTCT HIV services
b. Facility fully independent in offering PMTCT services

CRITERIA 8: BABY FRIENDLY COMMUNITY RESOURCE CENTRE

a. Existence of BFCI resource centre in the facility or community.
b. Adequate IEC materials in the resource centre
c. Evidence of use for the resource centre (Check attendees to the centre)

CRITERIA 9: MONITORING AND SUPERVISION

a. The CHEW monitors activities of the CHV using the CHEW monitoring forms.
b. Two reports per year from the compiled by the CHEW from individual child feeding and growth monitoring form

CRITERIA 10: FACILITY OBSERVATION

a. Facility has a written MIYCN policy summary statement present and displayed in all relevant areas of the health facility (MCH, maternity, pediatric wards, notice boards, Critical Care Centre)
b. MIYCNpolicy statement displayed, illustrated in a pictorial and/or any other possible way of simplifying, contextualized and understood by the local population
c. Pregnant women attending the MNCWC are given IFAS supplementation at the health facility
d. PCF conduct health talks to educate mothers on the benefits of breast feeding
e. PCF have hand washing facilities in points accessible by mothers/caregivers

Community mother support groups are trained on how to lead a cooking demonstration and are provided with recipes for nutritious complementary foods.

The community will collectively provide resources to support cooking demonstrations at Baby-Friendly meetings. Here are tips for organizing cooking demonstrations:

a. The mothers will need: a cooking space, wood or cooking fuel, large pot, cooking utensils (knife, large spoon, etc.), locally available foods to make "enriched foods", iodized salt, a tablespoon, and a 250ml measuring cup (to measure correct portions).
b. Mothers will be asked to bring contribution(s) to the cooking demonstration: a half-can of rice, some iodized salt, an egg, vegetables from their garden, peanuts, coconut, etc.
c. Mothers should also bring one bowl and spoon for their child (6 months or older) and one bowl and spoon for themselves. Local leaders or other local partners will donate funds to help support the supplies and ingredients for cooking demonstrations Activities during cooking demonstrations

Gather together all mothers and have to work together first they give information then look at the target thus before pregnancy, pregnancy, after delivery. If they see more pregnant women attending they have to choose the topic related to pregnancy, if more children above 6 months have to give the topic related to complementary feeding. During cooking demonstrations they have time for counseling or teaching depending on target.

During Cooking demonstration hygiene is taught- what you do before cooking demonstration-washing hand, vegetable, how to know the vegetable is clean hence hygiene is very key in the meeting.

The mothers are taught how to make balanced complementary feeds for the child

- Cut green vegetable into pieces
- Smash make small pieces of meat
- People have to work together and do cooking and they do one by one

REFERENCES

Cambodia Ministry of Health. “Implementation Guidelines for Baby Friendly Community Initiative.”. Phnom Penh, Cambodia: Cambodia Ministry of Health 2009.

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