

**UGANDA BREASTFEEDING AND INFANT AND
MATERNAL NUTRITION ASSESSMENT DISSEMINATION
AND PLANNING WORKSHOP TRIP**

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ACRONYMS

ACNM	American College of Nurse Midwives
ADMS	Assistant Director for Medical Services
A.I.D.	Agency for International Development
AMREF	African Medical and Research Foundation
ARI	Acute Respiratory Infection
BFHI	Baby Friendly Hospital Initiative
CDD	Control of Diarrheal Disease
CHDC	Child Health and Development Centre
CHC	Community Health Committee
CHT	Community Health Trainer
CHW	Community Health Worker
DHS	Demographic Health Surveys
DHT	District Health Team
DISH	Delivery of Improved Services for Health
DMO	District Medical Officer
DTU\LME	Diarrhea and Lactation Management Training Unit
EPI	Expanded Programme of Immunization
EPB	Expanded Promotion of Breastfeeding
GMP	Growth Monitoring and Promotion
HIV	Human Immunodeficiency Virus
HPN	Health and Population Officer (USAID)
IEC	Information, Education, and Communication
IGA	Income Generating Activities

INTRAH	Program for International Training in Health
IUGR	Intrauterine Growth Retardation
KAP	Knowledge, Attitudes and Practices
LAM	Lactational Amenorrhea Method
LBW	Low Birth Weight
LME	Lactation Management Education
MCH	Maternal and Child Health
MOH	Ministry of Health
MTT	Master Training Team
NGO	Non-governmental Organization
PID	Project Implementation Document
PVO	Private Voluntary Organization
SEATS	Family Planning Expansion and Technical Support
SIDA	Swedish International Development Agency
SMP	Safe Motherhood Project
STD	Sexually-Transmitted Disease
TBA	Traditional Birth Attendant
UFPA	Ugandan Family Planning Association
ULMET	Ugandan Lactation Management and Education Team
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
WINS	Women and Infant Nutrition Support Project

EXECUTIVE SUMMARY

At the request of the Uganda Ministry of Health (MOH), Department of Nutrition, Martha Holley Newsome traveled to Uganda to participate in a dissemination workshop on November 30th and a three day planning workshop from December 1 to 3. Ms. Mary Kroeger joined Ms. Holley Newsome from December 6 to December 12 to (1) follow up on activities planned during the workshop with the MOH, UNICEF, and ULMET and, (2) to work with the USAID Health and Population (HPN) Officer, Ms. Joan La Rosa, to incorporate breastfeeding into the USAID reproductive health project, the Delivery of Improved Services for Health (DISH) Project.

On November 30, the results and recommendations from two assessments, the Breastfeeding Assessment and the Infant Growth Faltering Assessment, completed in September, 1992, were presented to a larger audience of representatives from the MOH, NGOs, Makerere University, PVOs, and international donor agencies. Ms. Holley Newsome was asked to attend as a member of the MotherCare/Wellstart/ULMET breastfeeding assessment team. After the dissemination workshop in Kampala, Ms. Holley Newsome participated in the three day planning workshop designed to review appropriate national plans and the assessment results in order to revise and expand the draft National Breastfeeding and Weaning Action Plan. The workshop participants produced a draft three year Child Nutrition and Growth Promotion Action Plan for Uganda, which includes the promotion of breastfeeding, weaning, and infant and maternal nutrition. This workplan outlines four major intervention areas including: policy, training and research, coordination and capacity building, and community based strategies.

Following the workshops, Ms. Kroeger and Ms. Holley Newsome met with the MOH, ULMET, UNICEF, PRITECH, Child Health and Development Center staff to explore the future of activities proposed in the draft action plan and to determine what technical and financial resources exist and what resources are needed to begin implementing the Child Nutrition and Growth Promotion Action Plan in the immediate future.

In addition, Ms. Holley Newsome and Ms. Kroeger worked with Ms. La Rosa to incorporate optimal breastfeeding promotion (OBFP) into the DISH Project. After incorporating OBFP as a fourth project intervention, Ms. Kroeger and Ms. Newsome met with various family planning service providers to discuss their interest in adding OBFP to their activities. CARE's family planning project, the American College of Nurse Midwives (ACNM) private midwives project, and the MOH family planning training program expressed enthusiasm in training their trainers in OBFP as soon as possible.

The following are recommendations resulting from the trip:

To the MOH:

- 1) Finalize the Child Nutrition and Growth Promotion Action Plan and disseminate to the appropriate ministries and to all of the District Medical Officers (DMOs) and NGOs as soon as possible.
- 2) Identify priorities, immediate technical assistance, and initial budget needed to begin implementing the Action Plan.

- 3) Since the Child Nutrition and Growth Promotion Action plan has been expanded to include several areas, we recommend that a separate, non-permanent, breastfeeding coordinator be appointed for several years to ensure that optimal breastfeeding promotion is integrated within MCH\FP programs in Uganda.
- 4) Expand the Baby Friendly Hospital Initiative Committee to a long term National Breastfeeding Committee which will provide guidance and support for the breastfeeding component of the National Nutrition Program.
- 5) Integrate optimal breastfeeding promotion (OBFP) training into existing MCH\FP programs in coordination with UNICEF and ULMET.
- 6) Seek funding to send Dr. Dennis Lwamafa, ADMS for Nutrition (MOH), and a core regional team from another appropriate region, possibly Mbale, to Wellstart's Lactation Management Education course in San Diego. Funds permitting, other key members of this team could include: Louise Sserunjogi (Nutrition, CHDC), Rachel Rushota (FP Training Coordinator), and Dr. Musonge (CDD Manager).
- 7) Continue efforts to expand the scope of the Diarrhea and Lactation Management Training Unit (DTU/LME) to include or integrate acute respiratory infections (ARI), maternal and child nutrition, and other key child survival strategies. Develop a comprehensive training strategy which will address training needs at various levels in the health system, including the community level.

To USAID:

- 1) Facilitate support for breastfeeding, infant and maternal nutrition activities through existing channels (UNICEF, Title III, and any other).
- 2) With existing family planning project funds, facilitate integration of OBFP within current service delivery efforts (i.e., support training of family planning master trainers from the MOH, UPMA, CARE, and others).
- 3) Given the importance of OBFP activities in the new DISH project, seek technical assistance for the implementation of OBFP interventions from organizations like Wellstart. In addition to support of institution-based interventions, consider community-based strategies such as social marketing.
- 4) Support the appointment of a Regional Breastfeeding Advisor in Uganda and an African Regional Congress on Breastfeeding in 1994.

To Wellstart:

- 1) To maintain momentum, identify areas of the newly drafted action plan that could be supported by the EPB program, since it was not included in the MOH's 93/94 budget.
- 2) Support qualitative research on breastfeeding and weaning issues that need further exploration. (See research recommendations in Action Plan and Breastfeeding Assessment.) Use

qualitative research as a basis for developing appropriate messages and materials that will change breastfeeding behaviors at the community level.

- 3) Give serious consideration to Uganda as a site for a Regional Office in Africa. We also recommend that the Regional Advisor should have a strong background in child survival to ensure integration of OBFP into all MCH\FP programs, including community based health care.
- 4) Provide technical assistance to develop a district and community based training strategy for breastfeeding promotion. This will require close coordination with the MOH, ULMET, the DTU\LME staff, and the Community Based Health Care Association.
- 5) Explore various administrative and funding mechanisms for ensuring Wellstart's involvement in OBFP activities in Uganda. Among these could be working through SEATS or ACNM and seeking funding from the Office of Population, the Africa Bureau, A.I.D. Washington, USAID, and the World Bank.
- 6) Consider Kampala as a site for an African Regional LME Congress in early 1994.
- 7) Facilitate an additional team's attendance to Wellstart's next LME course in San Diego. (See MOH recommendation #5).
- 8) Brief Hope Sukin (Africa Bureau) on Breastfeeding and Infant\Maternal Nutrition Workshop and National Action Plan.

I. INTRODUCTION

The Uganda Ministry of Health, Department of Nutrition requested that the technical advisors from MotherCare, Wellstart, and WINS who worked on the breastfeeding and infant growth faltering\infant feeding assessment situation in Uganda return to participate in a one day dissemination seminar on November 30 and a three day planning workshop from December 1 to 3, 1992. Ms. Martha Holley Newsome, a breastfeeding assessment team member and Wellstart staff member, attended the workshops. Ms. Mary Kroeger, former Wellstart LME staff member, joined Ms. Holley following the workshop to work with the USAID Health and Population (HPN) officer, Ms. Joan La Rosa. Ms. La Rosa requested that Ms. Kroeger and Ms. Holley Newsome work with her following the workshop to develop a breastfeeding component for the reproductive health project that the mission is planning. The timing for working with the mission was ideal since it was finishing the PID for this proposed project.

In addition, Ms. Kroeger and Ms. Holley Newsome conducted follow-up visits with the MOH, UNICEF, and ULMET on activities planned during the workshop. Ms. Kroeger worked with ULMET and PRITECH in Uganda, in April and May of 1992, on a breastfeeding and diarrhea management curriculum. Her visit prompted a national workshop focusing on breastfeeding which resulted in a breastfeeding action plan and the recommendation to carry out a breastfeeding assessment. The breastfeeding assessment was completed in September and results were used to formulate national breastfeeding promotion plans during the three day planning workshop.

II. PURPOSE

The purpose of the trip was to participate in the dissemination and planning workshops, to follow up on activities proposed in the workplan (drafted during the workshop), and to assist USAID to incorporate breastfeeding within the Delivery of Improved Services for Health (DISH) reproductive health project.

III. SCOPE OF WORK

The scope of work stated that Wellstart representatives Ms. Holley Newsome and Ms. Kroeger would:

- Create a summary document of the results and recommendations of the WINS Infant Growth Faltering and the MotherCare\Wellstart\ULMET Breastfeeding Assessment for the workshop.
- Provide input to Dr. Mukasa and Dr. Lwamafa regarding the proposed workshop agenda and materials.
- Finalize the assessment report and summary document with assessment team members and WINS advisors and USAID.
- Participate in the dissemination and planning workshop.
- Work with the MOH, USAID, UNICEF and ULMET on post workshop follow-up activities.

- Work with Ms. La Rosa to explore future breastfeeding promotion activities and mission support for EPB technical assistance and program development which will be appropriate for the reproductive health project (DISH).
- Participate in writing a more detailed proposal, for the mission PID, or memorandum of understanding for EPB support of breastfeeding activities within the USAID DISH project.
- Explore the development of a lactation management training center and/or program further with the MOH, ULMET, USAID mission, and other interested parties.
- Begin to explore the possibility of holding an African Regional Lactation Congress in Kampala in early 1994.

PRODUCTS

- Joint Trip Report for Ms. Holley Newsome and Ms. Kroeger.
- Specific recommendations regarding next steps to be taken toward the development of a national breastfeeding program and/or a lactation management center.
- Recommendations regarding holding an African Regional Lactation Congress in Kampala in early 1994.
- As needed, Wellstart EPB proposal to support breastfeeding activities within the DISH project.

IV. TRIP ACTIVITIES

A. Dissemination Seminar and Planning Workshops for Breastfeeding and Infant and Maternal Nutrition

The dissemination seminar for the breastfeeding and infant and maternal nutrition assessments was held in Kampala on Monday, November 30th. Due to travel complications Ms. Holley Newsome arrived late on the 30th and missed all but the last of the seminar presentations and discussions. From all accounts the seminar was a great success and was both well attended and received. Even the Minister of Health, Dr. J. Makumbi, and the Permanent Secretary for the MOH, Dr. E.G.W. Muzira, attended the seminar, indicating the high level of commitment and interest of the Ministry (see Annex 5 for Dissemination Seminar Agenda).

Following the dissemination seminar, the WINS and Wellstart consultants (Bibi Essama, Charles Teller, and Martha Holley Newsome) met informally with Ms. La Rosa and discussed the USAID reproductive health project (DISH), a reproductive health project that focuses on family planning, sexually transmitted diseases (STDs), and AIDS. Ms. La Rosa thinks that breastfeeding will fit in with both the family planning and the AIDS components. Appropriate breastfeeding messages and support are needed for the counseling components of the project. The project is planned for implementation in ten districts.

Format and Objectives of Planning Workshop in Jinga

The planning workshop was held in Jinga District on December 1 to 3. The Ugandan workshop planners and the external consultants met and discussed the objectives and format of workshop. The committee decided to include a session covering the National Food and Nutrition Policy (NFNP) and Breastfeeding and Weaning Action Plan (see Breastfeeding Assessment). It was decided that these sessions should be followed by a review and discussion of the breastfeeding and infant growth faltering assessments. These four documents would provide the background information and overall framework needed to set priorities for breastfeeding and infant and maternal nutrition. The group felt that the prioritization process would identify the subtopics to be covered in the action plan. Finally, different subgroups would take a priority topic and develop a three year action plan. In summary the revised objectives of the workshop included:

1. Review national policies -- the National Action Plan for Promotion of Breastfeeding and Weaning.
2. Review the findings and recommendations from the Breastfeeding and Infant and Maternal Nutrition Assessments.
3. Prioritize the recommendations from all four documents.
4. Revise the National Action Plan by formulating a three year workplan for the priority areas.
5. Identify resources and loci of responsibilities for implementing the workplan.
6. Depending on priorities and time, review and revise the Growth Monitoring and Promotion (GMP) and BFHI proposals and draft workplans.

Originally the objectives included a review of the proposals for growth monitoring and the BFHI and formation of separate workplans for these smaller components. Instead, the planning committee decided to work on revising and expanding the breadth of the overall National Action Plan for the Promotion of Breastfeeding and Weaning. If time permitted, workplans for these separate pieces would be created.

Participants of the workshop included ULMET members, members from both assessment teams, the ADMS for nutrition, the CDD manager, UNICEF and WHO representatives, and member of the Ministry of Agriculture, DTU\LME trainers and staff, other technical resource persons, and three external consultants from WINS and Wellstart.

Workshop Process

The morning of the first day included sessions on the National Food and Nutrition Policy and the Draft Breastfeeding and Weaning Action Plan and the two assessments. Since there had been little time for discussions during the one day dissemination seminar, participants were given the opportunity to comment on the findings and recommendations of the two assessments during the workshop. Reactions to the Breastfeeding Assessment included the following recommendations:

- Emphasize training through DTU/LME Center (too little emphasis in report);
- Expand role of vaccinators to provide community-based promotion of breastfeeding;
- Return maternity leave to the 120 days that were given before Amin took power (although there was great debate about this point with some participants questioning the government's ability and will to enforce this recommendation).

Some of the significant comments regarding the WINS assessment were:

- Include a recommendation about the management of illness since illness was defined as the major problem;
- Include better case management of ARI, malaria etc.;
- Use home visits better through targeting and skills building;
- Community sensitization can be used to address gender concerns;
- Coordination with the NFNC is difficult without a functioning secretariat.

Following a lengthy session to establish priority recommendations, the Ugandans gave priority to the following:

- Identifying a national coordinator for breastfeeding, infant and maternal nutrition
- Establishing a maternal and infant growth and nutrition policy
- Capacity building
- Research (qualitative research on practices and operational research to identify effective interventions)
- Revitalizing child growth monitoring and promotion (GMVP)
- Pre-service and in-service training
- Community strategies to promote infant growth and maternal nutrition

Next, working groups were formed to look at four categories of priorities: community-based strategies and GMVP, capacity building and coordination, training and research, and policy. The task for each group was to develop a three-year workplan for these specific areas. The planning committee had decided that the workplans should include: specific objectives, strategies (approaches), activities, and resources. The external consultants were asked to interact as technical resource persons and facilitators.

On the second day of the workshop, December 2, the four groups met during the morning to finalize their objectives, activities, and strategies and then presented their work for comments and suggestions. Then the groups went back to work to address the appropriate targets, resources, and time periods needed to carry out the action plans (see Annex 6 for details).

Final Workplans

In the morning of the last day, the groups presented their final plans. Next, they met to make recommendations, discuss constraints, and to coin two potential names for the entire action plan. A short synopsis of each workplan is given below.

The **Policy** workplan focuses on formulating policies for the various components of a National Action Plan for breastfeeding and infant nutrition and growth promotion. The workplan suggests policies but

does not develop a detailed description of the activities needed to create, adopt, and use these policies. The policy statements include the following areas:

- Integration of services
- Sustainable community-based strategies to address infant, young child, and maternal nutrition
- Breastfeeding and weaning
- Growth monitoring and promotion
- Pre-service and in-service training
- Research
- Information, education, and communication (IEC)
- Nutrition rehabilitation centers
- Coordination of nutrition activities
- School feeding

School feeding and nutrition rehabilitation centers are two new areas added to the policy workplan that did not appear in the original recommendations from the working documents. The school feeding policy also calls for the provision of lunch for every school child each day. There was a lot of controversy about the feasibility of a school feeding plan. It is hoped that as the MOH moves forward to implement the Action Plan, more detailed policies pertaining to breastfeeding and infant and maternal nutrition will be adopted.

The **Coordination and Capacity** group worked on creating a good management structure for implementing and managing the emerging Action Plan. Central to their plan is a National Nutrition Coordinator (NNC), who will cover breastfeeding and infant and maternal nutrition, and who will liaise with the MOH Nutrition and MCH/FP divisions, and other related ministries, and will manage, coordinate, and supervise breastfeeding and nutrition activities through District Level Coordinators (DNCs). The NNC will be under the supervision of the ADMS for Nutrition, Dr. Lwamafa, within the MOH. The NNC's primary tasks will be to integrate breastfeeding and child nutrition support into existing MCH/FP activities and to assist the DNC's to develop and carry out breastfeeding and nutrition activities at the district level. The group felt that in selecting coordinators they should choose persons who are advocates for breastfeeding and infant and maternal nutrition. If skills are lacking, the coordinators could acquire the skills through appropriate training. Within this workplan, training support and coordination are well developed but the group did not have enough time to adequately develop the supervision and capacity and skills-building section.

Third, the **Training and Research** workplan outlines three areas including pre-service, in-service, and community based health worker and health-related worker training activities. The philosophy of the training strategy is to work to integrate breastfeeding within existing MCH/FP training programs. As part of the training plan, the DTU\LME curriculum and course will be expanded to include maternal and child nutrition. This center will be used for training of trainers (TOT). The group wants to see the library and training resources of the center developed further. Finally, the plan includes an objective to strengthen or develop appropriate training programs in maternal and child nutrition for community health workers (CHWs), community based trainers (CBTs), traditional birth attendants (TBAs), community health committees (CHCs), Resistance Councils (RCs who are governing councils at all levels), and extension workers of various kinds.

There was only one researcher in the **Research** working group. Consequently, research is given less priority than training. Dr. Charles Karamagi, from the Child Health and Development Center

(CHDC) outlined a research plan that includes qualitative, quantitative, and operational research. The operational research will test the effectiveness of interventions to support optimal breastfeeding and nutrition and to develop appropriate community monitoring methods. The plan suggests quantitative studies which look at the relationship between the high rates of illness and stunting and breastfeeding and infant feeding practices. The second study urges analysis of the insufficient milk "syndrome" and the quality of breastfeeding. Finally, qualitative research will look at knowledge and practices related to infant and child feeding.

The **Community-Based Strategy** group included three District Medical Officers (DMOs) and thus their groupwork included a lot of practical discussion about the feasibility of various activities in their district. Their strategy includes the empowerment of women, the improvement of preventive health services delivery, community based monitoring and nutrition surveillance, strengthening of the existing health system, enabling the community to care for their health and development by supporting a community based system that includes a training strategy for community trainers and health workers, and income generating activities.

The DMOs plan to utilize CHCs, CHWs, and CHTs to carry out nutrition activities at the local level including targeted home visits for high risk families and community self assessment and monitoring. The DMOs will provide assistance, supervision, training and materials for the mobilized communities. They also hope that income generating activities (IGA) would sustain and support these activities at the local level. Two of the DMOs participating in the workshop are likely to pilot test these strategies in their districts with MOH and WINS support. The working group acknowledged the slow process of community mobilization required to make their strategy work.

In addition, the groups developed a list of constraints and recommendations for the Action Plan. The **key constraints** to implementing the plan include: difficulty of intersectoral organization and collaboration; insistent demand of donors for results in too short a time frame; lack of adequate mobilization; inadequate knowledge and the multiple factors which relate to nutrition; poor household resource allocation; demoralized personnel; bureaucracy and delayed implementation; probable funding delays since the action plan is not included in the current budget; inadequate resources within the nutrition division; limits of integration beyond which quality is compromised; and the reality that nutrition may not be a priority in relation to other existing programs. The **recommendations for action** were:

- a maternal nutrition workshop should be held;
- the nutrition division should sensitize appropriate sectors and levels to the needs of nutrition and sell the Action Plan to the MOH and donors;
- the districts should sensitize the community to their nutrition needs;
- the MOH should endorse the Action Plan and appoint a national coordinator by January 1993.

These four workplans comprise the essential sections of the new Draft Child Nutrition and Infant Growth Action Plan. The final action plan is still quite sketchy and will need some more refining. With the ICN conference and BFHI training commitments following the workshop, neither Dr. Mukasa or Dr. Lwamafa were immediately available to finalize the action plan. They plan, however, to prepare a final draft in the next two weeks. Following revision, the process for dissemination and

and adoption by the MOH will be determined. Please refer to the draft National Child Nutrition and Infant Growth Action Plan in Annex 6.

Conclusions from Workshop Experience

Much of the workshop's success is due to the support of many different organizations, including MOH, ULMET, UNICEF, USAID, and WINS and Wellstart. The strength and level of participants also ensured quality work. Finally, the timing of the workshop illustrates the benefit of having existing policies and research results to inform the development of a program.

There were also a few ways the workshop could have been improved. Due to time constraints the workshop was not organized as much as it could have been. Dr. Mukasa was heavily involved in BFHI training up until the date of the workshop and Dr. Lwamafa was in the middle of planning for his trip to the ICN conference in Rome (although later his funding fell through). Secondly, the roles of the external consultants lacked definition. Increased communication and prior joint planning might have improved this situation as well.

Finally, caution should be exercised in the way the breastfeeding and infant growth faltering assessments are used. Their purpose is to suggest areas requiring attention. Further measures are needed to look more closely at the issues raised. For example the analysis of determinants of malnutrition in the WINS assessment was accepted as definitive by many despite the lack of specificity of the infant feeding questions and the extremely small and unrepresentative sample. The RAP approach is strong in its ability to mobilize health workers and to detect general nutrition needs and potential causes. A more detailed study with a larger sample would be necessary to uncover important interactions in the determinants of malnutrition and growth. Basing policy and programming on preliminary findings may lead to an overemphasis on disease or illness while neglecting feeding and nutritional problems. The preliminary RAP study does not take into consideration the significant body of literature documenting the relationship of suboptimal feeding and increased incidence of diarrhea and ARI. Consequently, it is especially critical to carry out additional research as the Action Plan begins to be implemented in Uganda. (See Annex 6 -- Research Workplan).

B. Workshop Follow-up Activities

Following the workshop, we met with the MOH Nutrition Division and UNICEF to explore the implementation of the Child and Growth Promotion Action Plan.

To determine the MOH's commitment and plans for the Action Plan, we met with Dr. Lwamafa in Entebbe, after learning that he had not gone to the ICN conference. He is convinced that breastfeeding promotion is needed in Uganda in order to improve infant nutrition and growth and felt that the attendance of the MOH and the Permanent Secretary demonstrated a high level of interest in the issues raised at the workshop. Consequently, he is optimistic about appointing the National Nutrition Coordinator in the near future.

To assist the government in moving towards greater integration and decentralization, he hopes to see the Wellstart Associates begin to focus on district level activities and support for breastfeeding promotion. With this strategy it becomes essential to include the district medical teams in any activities in their region.

Finally, Dr. Lwamafa is supportive of the possibility that a Regional EPB Breastfeeding Advisor be posted in Uganda. Wellstart is fortunate to have Dr. Lwamafa in the Ministry of Health because of his strengths as a manager and his desire to coordinate breastfeeding and infant nutrition activities in Uganda. His background in breastfeeding and nutrition could be strengthened further through participation in Wellstart's LME program.

In a second attempt to follow up on activities included in the Revised Draft National Child Nutrition and Infant Growth Action Plan, we met with UNICEF's Health Programme Officer, Mr. Colin Glennie. Ms. Holley Newsome gave a debriefing on the workshop and the positive results accomplished through the discussions and the working groups (UNICEF funded the workshop). Next Mr. Glennie outlined UNICEF's desire to begin working more directly with District Health Teams and less with the central level of the MOH. UNICEF is also considering moving to supporting a more packaged unit of services at district and sub-county levels. This means that health facilities would offer a more limited, but integrated number of services, rather than offering "all services and doing none well." The packages would include some standard interventions like immunizations but would also be somewhat flexible to address local needs. UNICEF is also trying to move away from vertical programs towards supporting activities which truly reach the community level.

Currently UNICEF funds the effective Community Based Health Care Association (CBHCA) but feels that more direct links between CBHCA and the District Medical Team and District health services is needed. UNICEF would like to see the DTULME training or "center" include ARI and potentially, training in other key child survival interventions. UNICEF's hope is that this will become a Training of Trainers center. The UNICEF mid-term review in March may allow UNICEF to switch to the "packaged" approach. Unfortunately, it sounds as if their new approach is mainly an effort to treat the major illnesses that "lead" to malnutrition. Mr. Glennie finds support for this approach in the WINS report which finds illness to be the major determinant of child malnutrition. Consequently, we discussed the fact that often poor breastfeeding and infant feeding and maternal malnutrition (possibly related to intra-uterine growth retardation) are the primary causes of infant morbidity and that one can not merely respond to the illness without addressing these other factors.

Mr. Glennie also told us that UNICEF's resources are going to diminish. The USAID funding will be gone by the end of 1993 or early 1994. The SIDA (Swedish) funding will become more limited because SIDA is starting to operate in Uganda directly. UNICEF will continue to support breastfeeding and nutrition through the MOH Division of Nutrition. However, he is not clear about how long this support will continue, especially once the USAID nutrition funds are finished. Meanwhile UNICEF Kampala is using ULMET to implement the BFHI initiative. UNICEF would like to see the hospitals and health centers mobilized to supervise lower level facilities. UNICEF's support of BFHI is mainly mandated from UNICEF headquarters and our impression is that the support is likely to end once enough hospitals are declared "baby friendly."

Status of Draft Breastfeeding Assessment Report

The breastfeeding assessment team members met on the morning of December 9th to review the draft report. The team members are pleased with the report and only minor additions were made.

C. Incorporation of Breastfeeding in the USAID Reproductive Health Project (DISH)

To discuss the DISH proposal and interventions we met with Ms. La Rosa on Monday, December 7. At her request, we spent the day writing concrete suggestions for inclusion in the PID, taking some of the ideas and language from the concept paper written over the weekend. In the evening, we met with Ms. La Rosa again and incorporated Optimal Breastfeeding Promotion (OBFP) into all of the family planning service activities in the country and included breastfeeding monitoring and evaluation indicators. This essentially makes optimal breastfeeding promotion the fourth intervention of the project (family planning, AIDS, and STDs are the other interventions). Finally, we provided a two page justification for including breastfeeding in family planning programs, which was lifted from the longer concept paper (see Annex 2). Some of the justification language was also included in the DISH proposal.

We discussed possible future USAID support for breastfeeding promotion in Uganda. Ms. La Rosa reported that a final draft would be completed by Friday, December 11th. She was and remains noncommittal about the possibility of an add-on and could not give us any information about USAID support to Wellstart. Ms. La Rosa thinks that ACNM may be able to support the breastfeeding activities outlined in the proposal. USAID continues to be open to Wellstart's technical assistance to support the DISH project or the National Action Plan for Child Nutrition and Growth Promotion. Ms. La Rosa also requested additional information about how breastfeeding should be included in antenatal care. This was provided to her the next day (see Annex 3). Lastly, Ms. La Rosa suggested that we contact several family planning organizations during our time in Uganda to explore their reaction to integrating breastfeeding into project activities. The next section summarizes these discussions with family planning programs.

D. Current and Potential Integration of Optimal Breastfeeding Promotion (OBFP) in Family Planning Programs

MOH/INTRAH Family Planning Training Program

We met with Rachael Rushota, Training Coordinator for the MOH Family Planning Program. Ms. Rushota not only oversees all government-sponsored family planning training and service delivery, but coordinates with all NGO sponsored family planning training programs as well. At the time of our meeting, she was accompanied by Jedida Wachira, INTRAH Deputy Regional Director for Anglophone Africa, who was in Uganda for the annual review of their program. INTRAH has sponsored family planning training activities in Uganda since 1984 and has assisted the government of Uganda in ongoing curriculum development, training and supervision activities since that time. Throughout the last eight years, a master family planning training team has been developed which coordinates all training of nurses, midwives, nurse aides and medical technicians. Along with Ms. Rushota, the Master Training Team (MTT) is made up of four full time and three part time master trainers.

Both Ms. Rushota and Ms. Wachira are enthusiastic about the possibility of more formal integration of Lactational Amenorrhea Method (LAM) and lactation management skills into the MOH's family planning training curriculum and they both agreed that simply teaching the LAM method does not necessarily guarantee that it would be promoted by providers or followed by clients. In learning about the two-module lactation portion of the DTU/LME curriculum, Ms. Rushota seems eager to initiate talks with Dr. Mukasa about possible timing and curriculum adjustments for the lactation training so that her MTT could be updated in these skills as soon as possible. She also indicated that she will be discussing these issues with Dr. Ebanyat, Assistant Director MCH/FP, MOH.

Both Ms. Rushota and Ms. Wachira showed us versions of several documents relevant to their training activities in-country:

1. Uganda National Policy Guidelines for Family Planning and Maternal Health Delivery Services

This document was reviewed in August by the Breastfeeding Assessment Team and found to be deficient in breastfeeding content. However, we learned that Dr. Ebanyat is in the process of writing and inserting a section on the LAM method very soon.

2. Family Planning Health Guide for Nurse Aides

This is a very user-friendly handbook which has clear, correct information about the LAM method. This handbook is currently being used by Nurse Aides who have been trained by the MOH MTT.

3. Guidelines for Clinical Procedures in Family Planning (A Reference Guide for Trainers)

This 1992 INTRAH publication has a comprehensive chapter (See Annex 4) on breastfeeding which includes not only information on LAM but guidelines for individual counseling and problem solving for the client planning to use LAM. There is even a section on counseling for breastfeeding problems. Each member of the MTT has a copy of this reference guide as do each of the NGO's that conduct family planning services delivery. These include: CARE, Islamic Medical Association, UFPA, UNFPA, and the Dept of OB/GYN at Makerere University.

Clearly there is keen interest on the part of the MOH Family Planning Training Coordinator to strengthen the LAM and lactation management content of their family planning services.

Uganda Private Midwives Association(UPMA)/SEATS Family Planning Project

Ms. Kroeger met with Christine Achurobwe, Project Director of the UPMA Family Planning Project. This SEATS-funded training project is focused on training nurse-midwives who practice independently of the MOH, providing complete maternal (and often infant and child) health services to a large percentage of Ugandan women. To date, Mrs. Achurobwe explained that 62 nurse-midwives have received comprehensive family planning training including two master trainers, two project administrative staff, and 58 practicing midwives.

Apparently, the curriculum used in this training varies from the MOH/INTRAH curriculum in that it incorporated LAM from the start. Ms. Achurobwe reported that the practicing midwives do utilize LAM in their service delivery, but often feel that they lack the skills to assist mothers who are having trouble with breastfeeding. In fact, during the Wellstart consultant visit in April, Mrs. Achurobwe had indicated interest in collaborating with ULMET to get her midwives trained in lactation management. She explained that she had discussed training with Dr. Mukasa a couple of months ago and that he had indicated a willingness to train, but that UPMA would need to fund the activity. Lack of funds has been the main impediment since the budget for the UPMA effort is very tight and lactation management training was not originally included. It is hoped that training funds will be identified so that this important group of MCH providers can include breastfeeding promotion in their package of services.

CARE Reproductive Health Project

We met with Cynthia Carlson, CARE Assistant Country Director, who told us that CARE has an A.I.D. centrally-funded Reproductive Health Project in three pilot districts in Uganda in which they intend to train several levels of health workers in the MOH/INTRAH basic family planning curriculum. The pilot districts, Kabale, Kisoro, and Rukungiri, are among the most populous in the country and their strategy is to train health cadres that will bring family planning services to the community level. Ms. Carlson seems very interested and open to the idea of including LAM and skills in optimal breastfeeding practices in their curricula. She reported an interesting anecdotal finding in the Southwest region. Apparently their community health workers have found some women who thought that their failure to return to menstruation by three months postpartum meant that they were pregnant and consequently, they abruptly weaned their infants. If this practice is widespread it would be important to design health education interventions to correct this misunderstanding of lactational physiology. This anecdote provides an excellent example of why further qualitative research is needed as a basis for program design.

Uganda Life Savings Skills (LSS) Project/MotherCare

In April the LSS project coordinator, Ann Otto, and resident advisor, Sandy Buffington, expressed some interest in having their master trainers receive the DTU/LME training. Unfortunately, both Ms. Otto and Ms. Buffington were on leave during our visit and so it was not possible to follow up with them directly about the training. Instead, Ms. Kroeger reviewed the training reports from this project and noted that so far the focus for TOT has been on the project's identified core competencies and that there has not been time to consider additional skills. Perhaps in early January, this can be followed up further.

E. Status of Lactation Management Training In-country

DTU/LME Training Unit

In April-May of this year, Wellstart provided technical support to the Ugandan MOH and ULMET in the development of a PRITECH-funded curriculum. The result of this effort was a seven-module Diarrheal Disease and Lactation Management Education Core Training Curriculum which included content not only in the knowledge and management of these two technical areas, but also included basic skills training in communication and counseling, training, and supervision. UNICEF also

funded the procurement of 500 copies of the newly revised edition of Savage King's textbook Helping Mothers to Breastfeed, and every participant receives a copy during the training.

The piloting of the curriculum went as scheduled and in July of this year 16 "master trainers" including administrative staff from the DTU, Wellstart associates, and some members of ULMET were trained and minor revisions made in the core curriculum. Since then two more cycles of training have occurred with 52 doctors, midwives and nurses trained from Mulago Hospital Complex and Mbarara Hospital. Selection of participants has emphasized the operational staff of the DTU, the lactation clinic, and staff of maternity, pediatric, and MCH outpatient services. Two more training courses, with 18 participants each, are scheduled for January and June 1993. Additional nurses and midwives from appropriate units at the Kampala City Council facilities are targeted as participants for the January course. The June course participants will be nursing and midwifery tutors from the training institutions in Mulago, Jinja, and several mission training schools.

With funding from PRITECH and UNICEF (and a small amount from WHO), the DTU/LME Training Unit has been nearly fully equipped for training. The current unit is a striking contrast to the shabby unpainted appearance of the unit eight months ago in April. Poor security is a concern however, and thus, the photocopy machine and some of the office furniture still have not been placed in the unit.

As previously noted, this unit is expected to eventually expand to include other technical areas such as ARI. After discussions on separate occasions with Dr. Mukasa and with Mr. Colin Glennie, Health Program Officer for UNICEF, the status of future funding is unclear. Mr. Glennie thinks that the ongoing role of the DTU/LME Training Unit should be to train trainers who will then implement their own training courses at district and community levels. So far, only hospital-based clinicians from Kampala and from Mbarara have been trained to implement this curriculum. The three Wellstart Associates based in Mbarara District have been trained as trainers and do have some training materials, but have not yet begun running their own training courses.

Sjord Postma, the PRITECH representative informed us that the November cycle of DTU/LME training was funded by USAID Title III funding and he expects that the MOH CDD Program may continue to request some training funds through this source. We also learned that a trainers "exchange" is planned involving the participation of one or two Zambians for the scheduled January 1993 course. Two Ugandans from the DTU are, in turn, to attend an upcoming DTU course in Zambia. This training exchange is being supported by PRITECH and follows their previous support for two teams, one from each country, attendance at the LME course in 1991. The intent of this exchange is to strengthen the training approaches in both countries by allowing each learn from the other's approach. It is not clear who will participate in this training exchange.

Baby Friendly Hospital Initiative (BFHI) Training Activities

At the time of the Wellstart visit in April-May very little activity had occurred in Uganda regarding BFHI. This was surprising since Uganda had more representatives than other African countries at the February WHO/UNICEF Master Assessor/Trainer Workshop in San Diego. In April, UNICEF Uganda representatives expressed frustrations with the centrally-mandated initiative. Nevertheless, in September, ULMET was approached by UNICEF to begin training health workers from five hospitals and six health centers in four districts, Kampala, Mbarara, Mbale, and Jinja with the goal of making them Baby Friendly Hospitals and Facilities by the end of this year! Dr. Mukasa is leading this effort

using the February 1992 version of the 18-hour BFHI course. A total of 194 health workers have been trained in three months. However, no assessment teams have evaluated these institutions to date, so a new more realistic goal is to make these institutions Baby Friendly during 1993. Again, after discussions with Mr. Glennie of UNICEF, there seems to be no plan for ongoing BFHI training or support beyond the targeted 11 institutions and their ultimate designation as Baby Friendly Hospitals. UNICEF Uganda representatives feel that BFHI is limited because it focuses exclusively on breastfeeding in the hospital setting and does not address other key issues related to infant health.

Potential for a LME Training Center in Kampala

These discussions demonstrate that ULMET and Wellstart Associates are well on their way to assisting the MOH in establishing lactation management curricula for in-service training. The draft National Action Plan also calls strongly for revising and updating all pre-service training to include this important intervention. Also clear is the indication that the MOH and other major donors do not want breastfeeding to evolve as a centrally structured vertical program, but rather to be integrated into established MCH/FP programs. The DTU/LME Training Unit can ensure that this priority occurs. Given this environment, Dr. Mukasa's original proposal for a university-based LME Center at Mulago Hospital Complex (September 91) is not likely to be established in the immediate future. Instead, the direction that training is taking appears to be the most appropriate for the MOH at this time. Dr. Mukasa and ULMET remain integral in this effort.

As a result of these two training initiatives, DTU/LME and BFHI, more than 200 health workers have received intensive lactation management training in the last six months. Though admirable, those trained to date and the targeted participants for the first six months of 1993 are all hospital-based cadre. As soon as possible the DTU/LME training efforts need to reach the regional and district level. Community-based health cadre need the information and skills to integrate Optimal Breastfeeding Promotion (OBFP) into their CDD, ARI, family planning and other PHC activities. To support this effort, Mbarara Hospital needs to initiate TOT activities using the DTU/LME curriculum and thus begin to decentralize the TOT activities. Some pretesting, and revisions, as well as a different strategy may need to be developed to address community training needs.

F. Rationale for Placing a Regional Breastfeeding Advisor in Uganda

In order to foster the goal of developing comprehensive, long-term national breastfeeding programs, the Africa Bureau has provided funds to support at least one regional advisor in Africa for one year. Ms. Kroeger and Ms. Holley Newsome were asked to assess the feasibility of Uganda as a site for such an advisor.

There are many supportive factors for considering Uganda as a site for the Regional Breastfeeding Advisor. The key factors are listed below.

1. **History of ULMET support of breastfeeding and NGO status:** ULMET has actively supported breastfeeding for over five years. Among its achievements was the first functioning Lactation Management Clinic in Africa. With a growing membership of health providers, ULMET has recently obtained NGO status with the Ugandan government.

2. **Wellstart LME training:** Two teams of health professionals, a total of 14 persons, have completed Wellstart's Lactation Management Training (LME) Course and one Wellstart Associate returned to San Diego to participate in the Advanced Study Fellowship Program.
3. **Ministry of Health support:** The Ministry of Health held a national breastfeeding workshop in May of 1992 which resulted in a Draft National Action Plan for Breastfeeding and Weaning and the recommendation to carry out a national breastfeeding assessment. Following an infant and maternal nutrition assessment (WINS) and the breastfeeding assessment, the MOH, Department of Nutrition held a national dissemination and planning seminar for breastfeeding and infant and maternal nutrition which resulted in a three year action plan. As part of the action plan, the Department of Nutrition intends to appoint a national coordinator for infant nutrition.
4. **Diarrhea and lactation management training unit (DTULME):** The national diarrhea and lactation management unit is currently operating MOH approved training of trainers courses for regional and district teams. The Ministry of Health and UNICEF plan to expand this unit to include training in ARI and are committed to integrating breastfeeding and nutrition training into other child survival interventions. Future plans also include replicating the training unit at regional hospitals.
5. **Baby Friendly Hospital Initiative training (BFHI):** Uganda has three BFHI Master Assessor Trainers. Since September, ULMET has begun implementing the breastfeeding hospital initiative with UNICEF support. To date ULMET has trained over 100 maternity staff with the 18 hour BFHI course towards the goal of certifying 11 BFHI hospitals, in three regions, by the end of 1993.
6. **In-country family planning program interest in OBFP:** LAM is already being included in Uganda's family planning programs and there is strong interest in supporting LAM through optimal breastfeeding promotion (OBFP).
7. **USAID support for breastfeeding within the DISH Project**
8. **History of A.I.D. support for breastfeeding:** PRITECH sponsored a six member Ugandan team to attend Wellstart's LME training in 1991. In addition, it supported the incorporation of lactation management into the CDD training curriculum. MotherCare sponsored the recent National Breastfeeding Assessment.
9. **Draft Code of Marketing of Breastmilk Substitutes:** Uganda has a draft version of the international code of marketing for breastmilk substitutes which is in the process of being signed into law.
10. **Anglophone country in central location in Eastern Africa with relative stability and an improving economy:** Uganda has proximity to the majority of the African countries with Wellstart Associates (Kenya, Tanzania, Zambia, Zimbabwe, Swaziland). Cameroon, Nigeria, Sierra Leone, and Egypt are the remaining African countries with Wellstart Associates.
11. **Longterm IBFAN African Involvement** by some of ULMET's members.

12. **Proposed Site for the African Region Breastfeeding Congress early in 1994, supported by the Office of Nutrition.**

One constraint to placing a regional advisor in Uganda is the more limited access to Kampala by air compared to several other African countries. This may be overshadowed by the fact that Uganda has been politically stable since 1986, except in isolated Northern regions. Uganda also has a good safety record and, at this point, appears safer than Nairobi. In addition, Uganda is unusual because of its broad, multisectoral support for breastfeeding. This foundation indicates that future integration of breastfeeding in MCH\FP programs is possible if sufficient resources and assistance are provided.

We explored this idea further with Ms. La Rosa and she was very supportive and excited about the possibility of a regional breastfeeding advisor in Uganda. Dr. Lwamafa (MOH ADMS for Nutrition) and Dr. Mukasa (ULMET) were equally enthusiastic. With USAID, MOH, and Wellstart Associate support and the forward momentum of breastfeeding activities in Uganda, we highly recommend that Uganda be considered as a site for a regional breastfeeding advisor.

G. Uganda as a Potential Site for an African Regional Lactation Congress

As part of Wellstart's ongoing LME program, efforts are made to convene Regional Congresses when a sufficient number of Associates, representing teams from several countries in a region have been trained in the San Diego-based course. The first of these Congresses was held for Associates from Asia and was hosted in Bali, Indonesia, in 1988. A Latin American Congress was convened last March in Oaxaca, Mexico, and included delegates from South and Central America, as well as a few from the Caribbean.

Up until 1991, relatively few African countries had participated in Wellstart's LME program. The early teams included Kenya, Nigeria, Swaziland, Uganda and Egypt. However, in the last two years several more African countries have been able to send their first teams and some have sent second teams. There have also been three Advanced Senior Fellows from Africa in the last two years. To date, there are Wellstart Associates (numbers in parentheses) from:

Kenya (20)	2 Teams	1 Senior Fellow
Nigeria (7)	2 Teams	
Swaziland (8)	2 Teams	1 Senior Fellow
Uganda (14)	2 Teams	1 Senior Fellow
Tanzania (5)	1 Team	
Zambia (5)	1 Team	
Zimbabwe (8)	1 Team	
Cameroon (6)	1 Team	
Egypt (7)	1 Team	
Sierra Leone (5)	1 Team	

Sometime early in 1994, Wellstart with Office of Nutrition funding, plans to hold an African Congress. Uganda, because of its central location, and relative political stability, is being seriously considered as a venue and we were asked to do some preliminary investigation into the feasibility of choosing Kampala as a Congress site. Dr. Mukasa and Dr. Lwamafa were enthusiastic about the prospect of their country hosting this event. Ms. La Rosa of the USAID Mission is interested as well.

Kampala has two excellent Hotels, The Sheraton, and The Nile. Both of these hotel are in close proximity to each other and are located in metro Kampala.

Attached to the Nile Hotel is an impressive Convention Center that can host events of up to 2000 delegates! There is a complete compliment of large and small meeting rooms, catering services, cafeteria, press briefing room, interpretation facilities, audio-visual (A-V) equipment and document center within the convention complex. Large group package deals can be arranged with double occupancy rooms at \$110/day plus 15% government tax as of this date. The rooms are clean and very attractive, and the hotel and convention center are located on a large, beautifully landscaped park area.

The Sheraton Hotel actually has a larger bed capacity than the Nile, but caters less to conventions. It has convention and meeting facilities, however, which include a ballroom that can accommodate 450 and which can be partitioned into smaller units. A Congress of 100-200 people could probably be easily accommodated here with the advantage of the having the housing and meeting facilities located under one roof. The group/ meeting package at the Sheraton at this date is cheaper than the Nile. Double occupancy rooms are \$73/day. This rate includes breakfast, lunch, two coffee breaks, and a meeting room, equipped with A-V capability. The rooms at the Sheraton are small but attractive and comfortable and the personal service on the part of the Sheraton staff is outstanding. The hotel is likewise located on a large, beautiful park area where it is possible to walk and relax.

We have the advantage of having stayed at the Sheraton so it is possible to recommend its consideration for the Congress with confidence. Also, given that the Congress is likely to involve relatively small numbers, the Nile Convention Complex may be larger than is necessary for Wellstart's purposes. Promotional packets from both Hotels will be forwarded to Wellstart San Diego for consideration.

Airline connections to the national airport in Entebbe are opening up again. Two months ago, British Airways reestablished services to Uganda twice a week via Nairobi. Sabena, the Belgian carrier, serves Uganda three times a week via Burundi. Many intra-african airlines serve Nairobi and Addis Abbaba, and from these two cities there are daily flights to Entebbe. Also quite a number of African carriers serve Entebbe directly at least once or twice weekly. These include: Air Malawi, Air Botswana, Air Burundi, Zambian Air, Egypt Airlines. Nigerian Airways connects with Nairobi making West African connections possible.

Aside from these logistical issues, the reasons for considering Uganda for a Regional Congress are similar to those enumerated above under the proposal for a resident regional advisor. ULMET now has PVO status (See Annex 8) and funds could be handled through this organization. Of course, if a regional advisor in Uganda were posted, the logistics management of such an event would be greatly facilitated as well.

H. Final Debriefing with USAID

On Thursday evening, we met with Ms. La Rosa for a final debriefing. We learned that indeed, breastfeeding promotion will be included in the final draft for the DISH project. She was very pleased that we had followed her suggestions and met with family planning actors in Uganda. She continues to support Wellstart's presence in Uganda and urged us to explore various administrative options with family planning organizations that are currently operating in Kampala. If Wellstart set

up an administrative arrangement with one of these family planning groups, USAID may, through the DISH project, be able to provide funds to this organization for Wellstart to provide technical assistance for the OBFP component of the DISH project. Because of the bidding process, it is impossible to know definitively which contracting agencies will be implementing the DISH project.

Ms. La Rosa was very supportive about the possibility of placing a regional breastfeeding advisor in Uganda. Other A.I.D. Washington consultants concurred that Uganda is an ideal site for a regional advisor and suggested that EPB explore sources of support for training family planning trainers in OBFP through the Office of Population at A.I.D. To conclude, USAID would like Wellstart to continue to promote breastfeeding in Uganda but would like to see creative funding and administrative options explored through both existing contracting agencies and other A.I.D. central funds.

VII. RECOMMENDATIONS

To the MOH:

- 1) Finalize the Child Nutrition and Growth Promotion Action Plan and disseminate it to the appropriate ministries and to all of the District Medical Officers (DMOs) and NGOs as soon as possible.
- 2) Identify priorities, needs for immediate technical assistance, and develop initial budget needed to begin implementing the Action Plan.
- 3) Since the Child Nutrition and Growth Promotion Action plan has been expanded to include several areas, we recommend that a breastfeeding coordinator be appointed for several years to manage the development and integration of optimal breastfeeding promotion within MCH\FP programs in Uganda.
- 4) Expand the Baby Friendly Hospital Initiative Task Force to a long term National Breastfeeding Committee which will provide guidance and support for the breastfeeding component of the National Nutrition Program.
- 5) Integrate optimal breastfeeding promotion (OBFP) training into existing MCH\FP programs in coordination with UNICEF and ULMET.
- 6) Seek funding to send Dr. Dennis Lwamafa, ADMS for Nutrition (MOH), and a core regional team from another appropriate region, possibly Mbale, to Wellstart's Lactation Management Education course in San Diego. Funds permitting, other key members of this team could include: Louise Sserunjogi (Nutrition, CHDC), Rachel Rushota (Family Planning Training Coordinator), and Dr. Musonge (CDD Manager).
- 7) Continue efforts to expand the scope of the DTU/LME to include or integrate ARI, maternal and child nutrition, and other key child survival strategies. Develop a comprehensive training strategy which will address training needs at various levels in the health system, including the community level.

To USAID:

- 1) Facilitate support for breastfeeding, infant and maternal nutrition activities through existing channels (UNICEF, Title III, and any other).
- 2) With existing family planning project funds, facilitate integration of OBFP within current service delivery efforts (i.e., support training of family planning master trainers from the MOH, UPMA, CARE, and others).
- 3) Given the importance of OBFP activities in the new DISH project, seek technical assistance for the implementation of OBFP interventions from relevant organizations like Wellstart. In addition to support of institution-based interventions, consider community-based strategies such as social marketing.
- 4) Support the appointment of a Regional Breastfeeding Advisor in Uganda and an African Regional Congress on Breastfeeding in 1994.

To Wellstart:

- 1) To maintain momentum, identify areas of the newly drafted action plan that could be supported by the EPB program, since it was not included in the MOH's 93/94 budget.
- 2) Support qualitative research on breastfeeding and weaning issues that need further exploration. (See research recommendations in Action Plan and Breastfeeding Assessment.) Use qualitative research as a basis for developing appropriate messages and materials that will change breastfeeding behaviors at the community level.
- 3) Give serious consideration to Uganda as a site for a Regional Office in Africa. We recommend that the Regional Advisor have a strong background in child survival to ensure integration of OBFP into all appropriate MCH\FP programs, including community-based health care.
- 4) Provide technical assistance to develop a district and community based training strategy for breastfeeding promotion. This will require close coordination with the MOH, ULMET, the DTU\LME staff, and the Community Based Health Care Association.
- 5) Explore various administrative and funding mechanisms for ensuring Wellstart's involvement in OBFP activities in Uganda. Among these could be working through SEATS or ACNM, and seeking funds from the Office of Population, the Africa Bureau, A.I.D. Washington, USAID, and the World Bank.
- 6) Consider Kampala as a site for an African Regional Lactation Congress in early 1994.
- 7) Facilitate an additional team's attendance at Wellstart's next LME course in San Diego (see MOH recommendation #5).
- 8) Brief Hope Sukin (Africa Bureau) on Breastfeeding and Infant\Maternal Nutrition Workshop and National Action Plan.

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ANNEX 1.

Meetings and Site Visits

Meetings and Site Visits

Date	Location	Participants	Topic
11/30	Kampala	Joan La Rosa - USAID HPN Officer	Met with WINS and Wellstart consultants and discussed USAID DISH project and possible integration of nutrition and breastfeeding
11/30	Jinga	Workshop Planning Committee Meeting	Discussed and Revised the Workshop Agenda. Decided to wait to see if the BFHI and GMVP Proposals were chosen as priorities.
12/1	Jinga	Planning Workshop	Reviewed findings of previous plans and assessment findings. Prioritized the recommendations from the four documents. Began groupwork to formulate year action plans.
12/2	Jinga	Planning Committee	Discussed group progress. Decided on groupwork and agenda for the last day of the workshop. Also discussed the name of the Action Plan and the format of the report.
12/3	Jinga	Last Day of Workshop	Presented final 3 year plans, recommendations, constraints, and final name of the Action Plan. The Jinga District Authority (DA) closed the workshop.
12/4	Kampala	ACNM accountant at MotherCare Office	Met with ACNM to work out payments for breastfeeding assessment team members.
12/5 and 12/6	Kampala	MHN	Made arrangements with USAID mission Wrote concept paper on the support of breastfeeding within Family Planning Activities
12/7	Kampala	Dr. Gelasius Mukasa	Mark Kroeger arrived. Briefing on workshop, BFHI, and DTU/LME Training.
12/8	Kampala	Cynthia Carlson - CARE Asst. Country Director	Met with CARE Asst. Country Director to discuss their Family Planning Project in Three Districts (Kisoro, Kabale, Rukungiri)
12/8	"	Dr. Mukasa	Discussed USAID developments, Future Training Schedule for DTU/LME, status of Lactation center, in country follow-up of Action Plan.
12/8	"	Colen Glennie -UNICEF Health Programme Officer	Discussed UNICEF's anticipated support for the Revised Action Plan and the MOH Nutrition Division
12/9	"	Christine Achurobwe	Project Director for UPMA-FP Project (with SEATS)
12/9	"	Breastfeeding Assessment Team Meeting	Reviewed Breastfeeding Assessment and to Fill in Gaps and Finalize the Document

12/9	"	Louise Sserunjogi - Child Health and Development Project	
12/9	"	Dr. Lwamafa - MOH ADMS for Nutrition	Met with the Assistant Administrator for Nutrition - Discussed Assessments, Workshop, and Future Plans
12/9	"	Sjoerd Postma - PRITECH Country Rep.	Discussed potential PRITECH support for DTU\LM training (especially for SEATS midwives)
12/9	"	Jedida Wachira - INTRAH Deputy Regional Director Rachel Rushota - MOH Family Planning Training Coordinator	Discussed breastfeeding component of INTRAH and Uganda Family Planning training. Also discussed possibility of family planning master trainers attending the DTU\LME course with SEATS trainers or midwives.

ANNEX 2.

**Justification for Integration of Breastfeeding
in Family Planning Programs (given to USAID for DISH)**

Justification for Integration of Breastfeeding in Family Planning Programs (given to USAID for DISH)

INTRODUCTION

The new USAID reproductive health project, DISH, is being developed to improve the reproductive health of women through improved family planning and optimal breastfeeding promotion, HIV, and STD services.

The low levels of modern contraceptive use (four percent in rural areas and 18 percent in urban areas) means that the high levels of breastfeeding in Uganda provides most of the contraceptive benefits which keep the majority of the births (61%) at birth intervals of 24 months or more. Consequently, it is imperative that while family planning programs strive to increase birth intervals through modern family planning methods that they **protect and promote** the current levels of breastfeeding in order to maintain these contraceptive benefits.

To support this effort, Wellstart International's Expanded Promotion of Breastfeeding (EPB) program is prepared to assist USAID in incorporating optimal breastfeeding promotion into the DISH project proposal.

The Need for Integration of Breastfeeding Promotion in Existing MCH\FP Programs

The numerous family planning program activities represent an ideal opportunity for the integration of optimal breastfeeding promotion and support. Family planning and increasing birth intervals through exclusive breastfeeding and increased modern contraceptive use is especially critical for improving maternal and infant health. The Ugandan Demographic and Health Survey found that the birth interval is the strongest determinant of infant mortality. Mortality for births with a birth interval of less than two years was 142 per 1000 while mortality for births following an interval of two to three years was 84 and 68 for intervals of four years or more. Consequently, increasing birth intervals through optimal breastfeeding promotion and modern contraceptive use can greatly reduce infant mortality. Early initiation of breastfeeding also reduces maternal mortality by preventing postpartum hemorrhage. Increased postpartum amenorrhea with exclusive breastfeeding also benefits maternal health by preventing further nutritional and energy depletion of an early, subsequent pregnancy.

Thanks primarily to the contraceptive benefits of the high level of breastfeeding, the majority of the births (61%) in Uganda do follow birth intervals of 24 months or more. Urban birth spacing is not as strongly linked to breastfeeding since urban women have much shorter durations of breastfeeding and amenorrhea than rural women. Increasing optimal breastfeeding among urban women provides the added benefit of increasing their contraceptive protection while also improving infant and maternal health.

Although few rural women use modern contraceptives, almost 100 percent initiate breastfeeding. Promotion of optimal breastfeeding and LAM as a family planning method provides a culturally appropriate entry point in the rural areas where cultural constraints continue to mitigate against modern contraceptives. Breastfeeding can be used to engage communities in a dialogue about the benefits of birth spacing, providing a more appropriate introduction to modern family planning.

The assessment team found that many of the programs do include a message related to the contraceptive benefits of breastfeeding. However, during interviews with these family planning providers the team found that none of them "could explain the relationship in any detail and there were no written guidelines, either verbal or written, as to when mothers can continue relying on breastfeeding for protection against pregnancy" (Breastfeeding Assessment Report).

Since 76% of prenatal health care providers are nurse\midwives and 36% of all deliveries are assisted by nurse\midwives (UDHS, 1989), midwifery training programs represent a third important logical area where breastfeeding promotion should be integrated. The relatively small SEATS family planning training program for private midwives has already included some training in the lactational amenorrhea method as has the recent INTRAH training. However the coverage and substance of these programs must be assessed and in most cases expanded to ensure the continued protection of current breastfeeding practices.

Traditional Birth Attendants (TBAs) represent a particularly important cadre of community health workers for maternal and infant health. The UDHS data reports that seven percent of rural women are assisted by a TBA and 38 percent by a relative. "However, it is highly probable that many of the attendants described as relatives are also traditional birth attendants" (UDHS, 1989, and Breastfeeding Assessment Report). The MOH and NGOs have, for more than a decade, trained TBAs to deliver babies more safely. However, the Safe Motherhood Project/Uganda reported that there is no training in some areas or that in some cases the training is inadequate or inappropriate in 1990. The MOH developed a standard national TBA training curriculum and trainer of trainers curriculum in 1989. Currently, the training addresses a large number of topics including maternal and child care, family planning, STD's and others.

From assessment interviews with TBAs it appears that TBAs do not always recall or retain the material they have been taught or may find it difficult to change long-held habits. One unpublished evaluation concluded that TBA training needs to be simplified and improved with more appropriate supervision following the training. Given these constraints, careful assessment and revision of existing TBA training and development of improved supervision strategies could maximize the skills of the TBAs to promote maternal and infant health, breastfeeding, and family planning.

Better integration of family planning and AIDS counseling is needed to magnify AIDS prevention efforts. These high rates of infection raise questions about breastfeeding as well. According to AIDS researchers interviewed during the breastfeeding assessment, most HIV infected women continue to breastfeed until they are too sick to continue. However there has been some anecdotal evidence that some women do cease to breastfeed because of their HIV status. As greater attention turns to the issue because of women's concerns and international publicity about breastfeeding transmission research in Africa, AIDS counselors must be equipped to deal with these issues and to help their clients to continue to breastfeed as optimally as possible.

Perhaps most essential is the integration of breastfeeding promotion into community based strategies. With limited modern contraceptive use and cultural pressures which mediate against modern contraceptive use in the rural areas, community acceptance and support will determine the ultimate impact of any family planning efforts. One channel for integrating breastfeeding and family planning messages is through the "field educators" and "motivators" who are trained and employed by various family planning programs at the village level or at industrial or agricultural estates. Another channel identified by the assessment team as an excellent means of reaching community health workers is the

umbrella organization of the Uganda Community Based Health Care Association (UCBHCA). "Such community health workers are currently estimated to be reaching at least 1.5 million people in villages. . ." (Breastfeeding Assessment Report).

For all breastfeeding\family planning entry points further assessment of program messages, training curricula, and existing health provider and maternal knowledge, attitudes, and practices is needed in order to successfully integrate the promotion of optimal breastfeeding into these existing activities.

ANNEX 3.

**Breastfeeding Management and Education for Antenatal Clinics
(given to USAID for DISH)**

3. **Breastfeeding Management and Education for Antenatal Clinics (given to USAID for DISH)**

**Essential Antenatal Interventions to
Ensure optimal breastfeeding practices**

- I. **Breast Examination** (as part of booking visit)
 - A. To identify anatomical variations that might effect breastfeeding success (e.g. severely inverted nipples)
 - B. To identify pathology (e.g. cancer) and refer
- II. **Essential Health Education Messages** (can be individual or group health talk)
 - A. Importance of colostrum and early initiation of breastfeeding
 - B. Importance of exclusively breastfeeding for first 4-6 months
 - C. Correct positioning and attachment
 - D. How to ensure enough breastmilk for baby (law of supply and demand)
 - E. The guidelines for the Lactational Amenorrhea Method (LAM) of childspacing
- III. **Individual Counseling/ Anticipatory Guidance**
 - A. Ask about **previous breastfeeding "failures"**
Problem-solve with client how to avoid them with this baby (e.g. past history of cracked nipples, breast infections, not enough milk, etc)
 - B. Is client at risk for **premature delivery** and/ or **Caesarian section?**
Emphasize the "how-to" and importance of breastfeeding in these situations (e.g. teach manual expression and explain that babies can be breastfed soon after surgery)
 - C. **HIV-positive status**
Discuss importance of exclusive breastfeeding and why
 - D. Other potential risk factors: **Primigravida, teenager, poor family support, very malnourished**
Problem-solve appropriately

ANNEX 4.

INTRAH Training Chapter on Breastfeeding

Guidelines for Clinical Procedures in Family Planning

A Reference for Trainers
Second Edition



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Intertek

CHAPTER 2

BREASTFEEDING AS A CONTRACEPTIVE, and CONTRACEPTION FOR BREASTFEEDING WOMEN

The best time to begin counseling a woman who wants to use breastfeeding as her sole method of contraception is during an antenatal visit. She can then be prepared to begin breastfeeding her baby immediately after birth and to follow the instructions as described in this chapter. Women who are already breastfeeding can also be counselled about using breastfeeding as a sole method of contraception during a newborn or postpartum visit.

STEP 1

Discuss the client's past experience with breastfeeding as a sole method of contraception

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If the client ever used breastfeeding as her sole method of contraception:

- was the client satisfied with breastfeeding as her sole means of contraception (e.g., convenience, pregnancy or other problems)?
- why did the client stop using breastfeeding as her sole means of contraception?

If the client has never used breastfeeding as her sole method of contraception:

- has the client ever discussed this method with her partner or friends or relatives?
- does the client think her partner or other persons would disapprove? If so, would this keep her from using breastfeeding as her sole method of contraception?

If the client has heard rumors about breastfeeding as her sole method of contraception, the following may help correct mistaken ideas:

RUMOR: Breastfeeding is not an effective family planning method.

FACT: If used correctly, breastfeeding can be as effective as other modern methods of family planning (such as pills), prior to the return of menses, during the first 6 months postpartum.

RUMOR: It's not possible to become pregnant while breastfeeding.

FACT: It is quite possible to become pregnant while breastfeeding, even before menses return. The risk of pregnancy is higher as the frequency of breastfeeding is decreased, or if the baby gets food or liquids instead of breastmilk meals, or is 6 months old or more.

STEP 2

Discuss how breastfeeding works as a sole method of contraception

Explain how breastfeeding works as a sole method of contraception. Do this in a culturally appropriate way using words and visuals the client can understand. Encourage the client to ask questions or to ask for clarification about any of the information you provide.

Breastfeeding delays the return of ovulation in the postpartum woman, particularly if she is "fully breastfeeding." "Fully breastfeeding" means breastfeeding on demand on both breasts, with any two feedings regularly no more than 6 hours apart, and not giving the baby food or liquids instead of breastmilk meals. Breastfeeding as a sole method of contraception is most reliable during the first 6 months postpartum and before the return of menses (bleeding in the first 56 days postpartum is not considered menstrual bleeding). After 6 months postpartum, many women will begin to ovulate, even if their menses have not returned. When a woman's menstrual period returns or when a woman starts regularly giving her baby other foods instead of breastmilk meals, she is at risk for pregnancy if she is sexually active. Breastfeeding still provides good protection against pregnancy for the woman who is only occasionally giving her baby small amounts of supplemental liquids or foods, as long as the woman's menses have not yet returned and before 6 months postpartum.



Illustration source: *Family Planning Methods and Practice: Africa*. Atlanta, Centers for Disease Control, 1983, p.41.

STEP 3

Describe the advantages and disadvantages of breastfeeding

While you describe the advantages and disadvantages, encourage the client to raise questions or share any doubts or apprehensions she has, especially about the disadvantages of breastfeeding.

ADVANTAGES

As a sole method of contraception

- Very effective contraceptive (98% during first 6 months postpartum, in fully or nearly fully breastfeeding women, before return of menses).

As an infant feeding method

- Helps protect the baby from life-threatening diarrhea and other infectious diseases through antibodies in the breastmilk and by not using contaminated formula.
- Provides important nutrients to the baby.
- Promotes bonding between the mother and baby.
- Economical.
- Very convenient (no need to carry around formula or bottles).
- Requires no chemical or mechanical substances.

DISADVANTAGES

As a sole method of contraception

- Not as effective as a contraceptive if any two breastfeedings are regularly more than 6 hours apart.
- Not as effective as a contraceptive once mother's menses return (bleeding in the first 56 days postpartum is not considered menstrual bleeding).
- Effectiveness as a contraceptive decreases over time after birth.
- Not as effective as a contraceptive once the mother begins regularly substituting food or drink for breastmilk meals.
- Provides no protection for the mother against acquiring or transmitting STDs, including AIDS.

As an infant feeding method

- May interfere with the woman's plans (i.e., working).
- If the mother is infected with human immunodeficiency virus (HIV, the virus causing AIDS), there is a small chance she may pass the virus to her infant through breastfeeding. However, experts including the World Health Organization agree that the possibility of infection through breastmilk is very slight^{*} in comparison to the high probability of morbidity and mortality from bottle feeding as practiced in most of the developing world. In general, exclusive breastfeeding for the first 4 to 6 months should be encouraged in developing countries, unless the mother is seriously ill from AIDS.

Adapted from: 1) Labbok MH: Consequences of Breast-feeding for Mother and Child: Breast-feeding and Fertility. *Journal of Biosocial Science* 1985 (supplement no. 9):43-54; 2) *Contemporary Patterns of Breastfeeding*. Report on the WHO Collaborative Study on Breastfeeding. Geneva, World Health Organization, 1981; 3) Hillis S, et al: *Breastfeeding and Contraception: Update* (INTRAH TIP), Chapel Hill NC, INTRAH, 1987; 4) Baumslag N: Breastfeeding and HIV Infection. *The Lancet* 1987;(August 15):401; 5) World Health Organization, Special Program on AIDS: *Breastfeeding/Breastmilk and Human Immunodeficiency Virus (HIV)*. Monograph WHO/SP/A/INF/87.8, 1987; 6) Coulter B: AIDS and Breastmilk. *Africa Health* 1987;10(January):30-31; 7) Breastfeeding, Breastmilk and AIDS. *IPPF Medical Bulletin* 1987;21(October):4; 8) Kennedy LJ, et al: Do the Benefits of Breastfeeding Outweigh the Risks of Postnatal Transmission of HIV via Breastmilk? Paper presented at the Fourth International Conference on AIDS, Stockholm Sweden, June 1988; 9) Angie MA, Davis MK: Observations on Breastfeeding and the Risk of HIV Infection. Editorial accepted for publication by *Tropical Doctor*, March 1988; and 10) World Health Organization, Global Programme on AIDS. *AIDS Prevention Guidelines for MCHFP Programme Managers: II. AIDS and Maternal and Child Health*. Monograph WHO/MCH/GPA/90.2, p 8.

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* In the event that the previously uninfected (seronegative) woman becomes infected (seropositive) while breastfeeding, the risk that she may pass on the AIDS virus (HIV) to her suckling infant may be significant.

STEP 4
**Explore the appropriateness of breastfeeding
as a sole method of contraception for the client
through a history**

PROCEDURE

- Refer below to the list of indications and precautions for breastfeeding as a sole method of contraception.
- Refer to the Appendices on General Female Reproductive History and Breast Exam.
- Refer below to the history checklist with questions and observations which are specific to breastfeeding.
- If breastfeeding is not appropriate as a sole method of contraception, help the client make an informed choice of an appropriate contraceptive method and follow that method's procedure.

N.B.: It is not necessary to do a physical exam for those clients choosing breastfeeding as their sole method of contraception. However, if the client has any complaints or concerns about breastfeeding, the family planning service provider should know how to answer these questions, and how to examine the breasts for any problems. A good guide for counseling breastfeeding mothers is *Breastfeeding: A Nurse's Guide*. New York, The Population Council, 1985.

**INDICATIONS for the use of breastfeeding as a sole method of
contraception**

Indications	Rationale
Breastfeeding <i>can be an effective contraceptive method</i> for a woman whose menses have not returned, who is less than 6 months postpartum, and who is "fully" or nearly fully breastfeeding. The definition of "fully breastfeeding" is: <ul style="list-style-type: none">• breastfeeding whenever baby desires, on both breasts with any two feedings regularly no more than 6 hours apart; and• not regularly substituting other food or liquids for breastmilk meals.	A woman must be "fully" or nearly fully breastfeeding in order to adequately suppress ovulation. Even when a woman is fully breastfeeding, and even when her menses have not returned, ovulation often resumes around 6 months postpartum.

PRECAUTIONS to use of breastfeeding as a sole method of contraception

Precautions	Rationale
Breastfeeding <i>should not be considered an effective method</i> for a woman:	
1. Who has <u>resumed her menses</u> . (Bleeding within the first 56 days postpartum is not considered menstrual bleeding). 2. Whose frequency of breastfeeding has decreased, as follows: <ul style="list-style-type: none"> • any two breastfeedings are regularly more than 6 hours apart; or • the mother starts regularly giving her baby food or liquids as substitutes for breastmilk meals. 	1. It is likely that the client has again begun ovulating once menses have resumed. 2. Frequent suckling causes the mother to have high levels of prolactin, the hormone that causes milk production. Studies show that high levels of prolactin are associated with suppression of ovulation. Once the baby suckles less, the prolactin levels will fall and ovulation will no longer be suppressed. N.B.: New research suggests that suckling stimulates the production of opioids in the hypothalamus. Opioids are naturally occurring, morphine-like substances, also called endorphins. The opioids may decrease the amount of gonadotropin-releasing-hormone (GnRH) going from the hypothalamus to the pituitary. The pituitary, in turn, decreases the amount of luteinizing hormone (LH) released. The ovaries will not release an egg when LH levels are too low, thus the suckling suppresses ovulation.
3. Whose baby is <u>6 months old</u> or older.	3. After 6 months postpartum, between 20 to 50 percent of breastfeeding women will ovulate before their first menses. However, in some countries, the average duration of lactational amenorrhea is much longer than 6 months. In such cases, local guidelines should be used.

Indications, precautions, and rationales adapted from: 1) Breast-feeding, Fertility and Family Planning. *Population Reports Series J* 1984; 24(March):J525-576; 2) Labbok MH, Chassell RJ: The Development and Use of Graphically Presented Algorithms in Community-Based Family Planning Services. *International Quarterly of Community Health Education* 1987;88(3):223-247; 3) Stein JM, et al: Nursing Behavior, Prolactin, and Postpartum Amenorrhea During Prolonged Lactation in American and Kung Mothers. *Clinical Endocrinology* 1986;25:247-258; 4) Rivera B, et al: Breastfeeding and the Return to Ovulation in Durango, Mexico. *Fertility and Sterility* 1988;49(5):780-787; 5) Gordon K, et al: Hypothalamo-pituitary Portal Blood Concentration of β -endorphine During Suckling in the Ewe. *Journal of Reproduction and Fertility* 1987;79:397-408; 6) Matrolo M, et al: Effect of Naloxone on Plasma Concentrations of Prolactin and LH in Lactating Sows. *Journal of Reproduction and Fertility* 1986;76:167-173; 7) Patosi N, et al: Galactorrhea-amenorrhoea Syndrome Associated with Heroin Addiction. *American Journal of Obstetrics and Gynecology* 1974;118; 8) Simalunga DJ, Martini L: Effects of Bromocriptine and Naloxone on Plasma Levels of Prolactin, LH and FSH During Suckling in the Female Rat: Responses to Gonadotropin Releasing Hormone. *Journal of Endocrinology* 1984;100:175-182; 9) Yen SSC, Jaffe RB: *Reproductive Endocrinology*. 2nd ed. Philadelphia, WB Saunders Co., 1966, pp 51-60; 10) Bellagio Consensus Conference on Lactational Intertity: Bellagio Consensus Statement on the Use of Breastfeeding as a Family Planning Method. *Contraception* 1989;39(5):477-496; 11) Thapa S, Short RV, Potts M: Breastfeeding, Abstinence and Their Effects on Child Survival. *Nature* 1988;335(20):679-682; and 12) Kennedy KI, Visness CM: Contraceptive Efficacy of Lactational Amenorrhea. *The Lancet* 1992;339(January 25):227-230.

History Checklist for Breastfeeding as a Sole Method of Contraception

Service Provider's Questions	NO	YES	Service Provider's Instructions
Ask the postpartum client the following questions:			If "YES" follow the instructions below:
<p>1. Have you had a period since the birth of your last baby?</p> <p>N.B.: Bleeding within the first 56 days postpartum should NOT be considered a menstrual period.</p>	<input type="checkbox"/>	<input type="checkbox"/>	1 - 4. If the answer is "YES" to ANY ONE of these questions, explain that breastfeeding is no longer an effective contraceptive method for her. Encourage her to keep breastfeeding; and help her make an informed choice of another method.
<p>2. Is your baby more than 6 months old?</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>3. Are any two breastfeedings regularly more than 6 hours apart?</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>4. Has your baby regularly started taking solid foods or liquids instead of breastmilk meals?</p>	<input type="checkbox"/>	<input type="checkbox"/>	

Adapted from: 1) Labbok MH: Breastfeeding and Contraception. (Letter) *The New England Journal of Medicine* 1983;308(January 6):51 and 2) Kennedy KI, Visness CM: Contraceptive Efficacy of Lactational Amenorrhea. *The Lancet* 1992;339(January 25):227-230.

STEP 5

Explain how to use breastfeeding as a sole method of contraception

INSTRUCTIONS TO THE SERVICE PROVIDER

For the antenatal client:

- Explain the instructions to the client, and ask her to repeat the explanation to you in her own words.
- If she anticipates any difficulty, has any questions, or has misunderstood or omitted any instruction, advise her as needed.
- Provide support and encouragement so that she can succeed in using breastfeeding as the source of nutrition for her baby and as her sole method of contraception if she follows these instructions.

For the postpartum client:

- Ask the client if she is having any difficulties breastfeeding, and advise as needed. See chart at the end of this step for counseling for common breastfeeding problems.
- Ask the client whether she is willing to use another method of contraception once breastfeeding is a less effective means of contraception. Encourage her to continue breastfeeding her baby for as long as possible. Explain that as soon as any of the following occur, she will need another method of contraception.
 - menses return;
 - baby is 6 months old; or
 - baby is not breastfeeding as frequently as before (more than 6 hours between feedings or baby taking food or liquids as substitutes for breastmilk meals).
- Offer a one-month supply of condoms for her to use until she can return to the clinic to obtain the contraceptive method of her choice. (Offer spermicides if condoms are unacceptable to her).
- After explaining instructions to the client, ask her to repeat the explanation to you in her own words. If she has misunderstood or omitted any instruction, go over that information again with her.

COUNSELING FOR BREASTFEEDING PROBLEMS

Problem	Investigation Steps	Counseling
Inadequate milk supply	A. Is she eating and drinking inadequate amounts of food and liquids? B. Is she getting inadequate amounts of sleep or rest, or is she currently under great stress?	A. Advise the mother to drink at least six to eight glasses of fluids every day and eat plenty of nutritious food, according to the local diet. B. Advise the mother that she needs additional rest. Ask if she can get relatives or friends to help her with housework during the first few weeks postpartum.

Problem	Investigation Steps	Counseling
Inadequate milk supply (continued)	C. Is she breastfeeding her baby too infrequently?	C. Advise the mother to breastfeed her baby on demand from both breasts at least every 2 to 3 hours at first. Remind her that if she is using breastfeeding as her sole method of contraception, no two breastfeedings should be regularly more than 6 hours apart.
Sore nipples	A. Are her nipples cracked?	A. Advise the mother to: <ul style="list-style-type: none"> • continue breastfeeding. Reassure her that the cracked nipples will heal; • use clean water and no soap to clean her nipples before breastfeeding; • air dry her nipples after nursing; and • use vegetable oil on her nipples for comfort between feedings.
	B. If she does not have cracked nipples, are her nipples sore only when she breastfeeds her baby?	B. The baby may not be getting the areola completely in his/her mouth. Advise on proper breastfeeding technique and positioning.
Sore breasts	A. Does she have a fever and feel tired; is/are her breast(s) red and tender?	A. Examine her breasts to confirm signs of infection. Treat with antibiotics according to local clinic procedures. Advise the mother to: <ul style="list-style-type: none"> • continue breastfeeding frequently; • get additional rest; and • frequently put warm cloths on her infected breast(s).
	B. If there are no signs of infection, ask if her breasts have localized tenderness or lumps, or are full, hard and tender.	B. These signs may indicate plugged milk ducts or engorgement, respectively. Advise the mother to: <ul style="list-style-type: none"> • breastfeed frequently in different positions, including during the night; • get additional rest; • frequently put warm cloths on her breast(s); and • hand express some milk or massage her breast(s). Explain signs of infection and tell her to return to the clinic if it develops.

Adapted from: Saunders SE, et al: *Breastfeeding: A Problem-Solving Manual*. Durant OK, Creative Informatics, Inc., 1987, pp 96-57.

INSTRUCTIONS TO THE CLIENT

How often to breastfeed:

- Breastfeed your baby on demand (at least six to ten times a day) on both breasts.
- Breastfeed your baby at least once during the night (no more than 6 hours between any two breastfeedings). **N.B.:** Breastfeeding is primarily for infant nutrition and health. Your baby may not want to breastfeed six to ten times per day, or your baby may choose to sleep through the night. This can be normal but it does mean breastfeeding will be much less effective as a contraceptive method.

When to start solid foods:

- As long as the baby is growing well and gaining weight, and as long as you are eating a balanced diet and resting in order to have a good milk supply, the baby doesn't need any other foods until he/she is 4 to 6 months old.
- Once you regularly substitute other food or drink for breastfeeding meals, the baby will suckle less, and breastfeeding will no longer be as effective as a contraceptive method.

Menstrual periods:

- When your menstrual periods return, it is very likely you are fertile again (bleeding in the first 56 days postpartum is not menstrual bleeding).

What to do when the baby stops "fully" or nearly fully breastfeeding:

- You can use condoms (or spermicides) until you can obtain the contraceptive method of your choice.

Risk of exposure to STDs, including AIDS:

- Use condoms (or spermicides) in addition to breastfeeding if you think there is any chance you or your partner are at risk for STDs, including AIDS. Seek treatment if you think you or your partner are infected with a STD.

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STEP 6 Plan for the return visit

INSTRUCTIONS TO THE SERVICE PROVIDER

- Make sure all points in the informed choice checklist (see Chapter 1: "General Guidelines for the Family Planning Visit") have been covered.

INSTRUCTIONS TO THE CLIENT

If you have no problems, return to the clinic in order to choose another method as soon as one of these things happens:

1. Your period has resumed.
2. The baby stops "fully breastfeeding:"
 - You start regularly giving the baby other foods or drink in place of breastfeeding meals.
 - Any two breastfeedings are regularly more than 6 hours apart.
3. The baby reaches 6 months of age (about the time the baby starts sitting up).
4. You or your partner no longer wish to rely on breastfeeding for contraception.
5. You or your partner suspects that you are at risk for a STD.

STEP 7

Follow procedures for return visit

- Ask the client, and her partner if possible, whether she or they were satisfied with breastfeeding as a sole method of contraception.
- Ask if there are any complaints or problems with breastfeeding. See chart in step 5 for counseling on common problems.
- Ask the client if:
 - her menses have resumed?
 - her baby has become 6 months of age or older?
 - her baby is no longer fully or nearly fully breastfeeding?(Fully breastfeeding means:
 1. breastfeeding on demand, on both breasts with any two breastfeedings no more than 6 hours apart, and
 2. not giving the baby other food or liquid as substitutes for breastmilk meals).
- If any of the above has occurred, advise the client that breastfeeding is no longer an effective means of contraception for her, and she needs to choose an appropriate contraceptive.
- Discuss the advantages and disadvantages of various contraceptives for breastfeeding women (listed on the following table). Help the client make an informed choice of an appropriate contraceptive.
- Provide the contraceptive, or refer her to a service where the contraceptive is available. Provide the client with spermicides or condoms if another contraceptive method cannot be initiated that day.

Advantages and Disadvantages of Contraceptive Methods for Breastfeeding Women Who Cannot Rely on Breastfeeding as the Sole Method of Contraception

Method	Time when the method can be introduced	Advantages	Disadvantages	Comments
Female Voluntary Surgical Contraception (VSC)	Immediately after delivery or any time thereafter.	No effect on breastfeeding. Highly effective.	Is an irreversible method. May involve mother/infant separation.	Minimize the period of mother/infant separation. Avoid general anesthesia. Counseling necessary for the couple during prenatal period. VSC provides no protection against STDs, including AIDS.
Male Voluntary Surgical Contraception (VSC)	Anytime.	Highly effective.	Is an irreversible method.	Counseling necessary for the couple. VSC provides no protection against STDs, including AIDS.
Intrauterine devices (IUDs)	Can be inserted immediately after placenta is expelled, or in first day postpartum, or after 8 weeks postpartum (when uterus has involuted).	Highly effective. No effect on breastmilk quantity or quality. Breastfeeding women who have IUDs have fewer complaints of bleeding than non-breastfeeding women who have IUDs.	In general, the IUD should not be used by a woman who desires more children in the future and who is at risk of exposure to STDs.	IUD insertion during early breastfeeding does <u>not</u> increase the risk of uterine perforation. IUDs provide no protection against STDs, including AIDS.
Progestin-only methods: progestin-only pills, injectables, or NORPLANT®	Begin as soon as 6 weeks after delivery, if baby is not fully breastfed. Begin as late as 6 months after delivery, if baby is fully breastfed <u>and</u> mother's menses have not returned.	Unlike estrogens, progestins do <u>not</u> reduce milk quality or quantity.	Most women on progestin-only methods have irregular menses.	A small amount of hormone gets into breastmilk, but there is no evidence of any adverse effect on the infant. Hormone levels are lower in pills and NORPLANT® than in injectables.

(continued on next page)

Chapter 2: Breastfeeding

Method	Time when the method can be introduced	Advantages	Disadvantages	Comments
Combined (Estrogen-containing) Oral Contraceptives (COCs)	In partially breastfeeding women, COCs can begin as soon as 6 weeks after delivery, but the <u>lowest dose</u> COC should be used. Use only if other effective methods are not acceptable to the breastfeeding woman.	Combined oral contraceptives (COCs) are widely available and provide regular menses, which is important to many clients. For mothers providing only token breastfeeding (e.g., for comfort), COCs with no more than 35 micrograms estrogen are safe.	Estrogens reduce milk volume and alter milk quality without apparent effect on the baby. Some hormone gets into breastmilk but no effect on infant growth or development has been shown.	If possible, estrogens should be avoided by breastfeeding mothers.
Diaphragm with spermicide; sponge; other spermicides	If the woman is <u>not</u> fully breastfeeding, spermicides can be begun once intercourse resumes. Diaphragm and sponge cannot be used until uterus has returned to normal size (usually 8 to 12 weeks after delivery), and postpartum bleeding has stopped.	No known effect on breastfeeding. Spermicides help protect against many STDs.	The diaphragm cannot be fitted until uterus has returned to normal postpartum size. Diaphragms may promote bladder infections in some women. Spermicides are messy and some women and men complain of skin irritation by spermicides.	Former diaphragm users may need to be refitted. (Shape of cervix and vagina may change as a consequence of delivery). Diaphragm effectiveness depends on spermicide use.
Condom	Anytime.	No effect on breastfeeding.	Dryness of vagina or complaint of decreased penile sensitivity may require additional lubrication of the condom.	Also helps protect against STDs, including AIDS.
Periodic abstinence, including postpartum abstinence	Immediately after delivery. (Effectiveness depends on return of menses and ovulatory menstrual cycles).	No effect on breastfeeding.	May be difficult to accurately assess signs and symptoms of ovulation, thus long periods of abstinence may be required.	In many cultures, breastfeeding is combined with observance of postpartum abstinence. The combination can be a highly effective contraceptive method.

Adapted from: 1) *Breastfeeding and Fertility Brochure*, draft from Coordination Meeting Between the World Health Organization, International Planned Parenthood Federation, Family Health International, and Institute for International Studies in Natural Family Planning, Geneva, World Health Organization, 1987; 2) *Contraceptive Needs of Breast-Feeding Women*, *Network* 1986;3(Autumn):1-8; 3) Gray, RHE. Reduced Risk of PID with Injectable Contraceptives. *The Lancet* 1985; (May 4):1046; 4) *IUDs: Guidelines for Informed Decision-Making and Use*. Atlanta, Division of Reproductive Health, Centers for Disease Control, 1987; 5) World Health Organization Special Programme of Research, Development and Research Training in Human Reproduction: Effects of Hormonal Contraceptives on Milk Volume and Infant Growth. *Contraception* 1984;29(6):515-521, and 6) Postpartum Contraception. *Network* 1990;11(August):10-15.

ANNEX 5.

**Proposed Agenda and Participants
for Dissemination and Planning Workshops**

PROGRAMME

NATIONAL INFORMATION DISSEMINATION SEMINAR ON BREASTFEEDING AND INFANT GROWTH

A SITUATION ANALYSIS
30TH NOVEMBER 1992

KAMPALA INTERNATIONAL CONFERENCE CENTRE

SESSION I: CHAIRMAN: PERMANENT SECRETARY/DIRECTOR OF MEDICAL SERVICES,
DR E G N MUZIRA

08.00 am Arrival and Registration
09.00 am Arrival of Invited Guests
09.15 am Welcome Statement
Outline of Objectives of Seminar
09.30 am Opening Address by the Hon. Minister of Health, Dr J Makumbi
10.00 am TEA BREAK

SESSION II: CHAIRMAN: MARTHA HOLLEY NEWSOME

10.30 am Presentation of the State of Breastfeeding in Uganda:
Practices and Promotion
10.50 am Discussion
Recommendations

SESSION III: CHAIRMAN: BIBI ESSAMA

11.30 am Presentation on Infant Growth Faltering in Uganda
11.50 am Discussion
Recommendations

SESSION IV: CHAIRMAN: DR D K W LWAMAFU

12.30 pm Closing Remarks - Prof. J Kakitahi
01.00 pm LUNCH BREAK
Departure

NATIONAL INFORMATION DISSEMINATION SEMINAR ON
BREASTFEEDING AND WEANING SITUATION ANALYSIS

INTRODUCTION:

Between August and October this year two teams of consultants carried out preliminary country situation analyses on breastfeeding and weaning in Uganda. The teams debriefed a select group of participants about their preliminary findings before they embarked on writing the final reports. It is now deemed necessary to report the results of these studies as widely as possible in a national dissemination seminar and also to provide a feedback to the key informants in the study.

SEMINAR OBJECTIVES

1. To disseminate the findings and recommendations of the situation analyses and sensitize the community about infant and young child nutrition.
2. To give a feedback to as many of the key informants as possible.
3. To stimulate discussion and generate additional recommendations from participants.

PARTICIPANTS

A. MINISTRY OF HEALTH

1. DR LWAMAFU
2. ADMS/MCH/FP
3. UNEPI PROGRAMME MANAGER
4. ADMS/PHC
5. MS R. RUSHOTA
6. ADMS/TRAINING
7. CDD PROGRAMME MANAGER
8. MS WANGWE
9. CHIEF NURSING OFFICER
10. ADMS/HEALTH EDUCATION
11. ADMS/PLANNING
12. CHIEF HEALTH INSPECTOR
13. ACP PROGRAMME MANAGER

B. NGO'S

1. WHO
2. UNICEF
3. USAID
4. AMREF
5. MOTHERCARE (UGANDA) ACINWI
6. YWCA
7. PRIVATE MIDWIVES ASSN.
8. FAMILY PLANNING ASSN. ⇒
9. TASC

EWIZUWA?

- 10. RUKUNGIRI DMO
- 11. ARUA DMO
- 12. " DHV
- 13. KINONI (RWABUNUNGA)

L. OTHERS

- 1. MS. B. LEMMA - BFHI CONSULTANT
- 2. MS K. NIMO - CASE WESTERN
- 3. DR D. GIHANGA - SAVE THE CHILDREN FUND

SEMINAR VENUE

This will be at the International Conference Centre in Kampala

TIME TABLE - 30 NOVEMBER 1992

8.00 am	-	Arrival of participants
9.00 am	-	Arrival of invited guests
9.15 am	-	Welcome address and outline of objectives
9.30 am	-	Opening address by Guest of Honour
10.00 am	-	TEA BREAK
10.30 am	-	Presentation of Breastfeeding Situation Analysis
10.50 am	-	Discussion and recommendations
11.30 am	-	Presentation of Weaning Situation Analysis
11.50 am	-	Discussion and recommendations
12.30 pm	-	Closing Remarks
1.00 pm	-	LUNCH AND DEPARTURE

PROMOTING OPTIMAL BREASTFEEDING AND WEANING PRACTICES IN UGANDA

INTRODUCTION

In May 1992, a workshop was organized by the Ministry of Health to draft an Action plan for promotion of breastfeeding and optimal weaning practices. Implementation of the plan of action is now proposed with due consideration of the findings and recommendations of the recently completed situation analyses on the current situation pertaining to breastfeeding and weaning practices in this country. As a complementary measure, the Uganda lactation management and education team (ULMET) in collaboration with the Ministry of health has embarked on a phased introduction of the baby friendly hospital initiative (BFHI) in support of this effort. In addition a child growth monitoring and promotion proposal was drafted and is in the process of being implemented in the pilot districts.

WORKSHOP OBJECTIVES

- Item I Review:
 - (i) the national action plan for promotion of breastfeeding and weaning
 - (ii) the growth monitoring and promotion proposal
 - (iii) the baby friendly hospital initiative
- 2 Review the recommendations of the situation analysis reports as well as those of the dissemination seminar.
- 3 Refine or re-define item I (i), (ii) and (iii) in the light of the recommendations and any other new development.
- 4 Draft a workplan for Item I (i), (ii) and (iii)
- 5 Identify resources and loci of responsibilities for implementing the work plan.

OUTPUT

- 1. By the end of the workshop the action plan in the three areas shall be ready for presentation to and approval by the Ministry of Health.
- 2. The workplan in the three areas shall have been completed giving the broad outlines for a three year period but with more detailed workplans for the first year of the action plans.
- 3. Responsibilities will have been assigned to individuals or organizations or departments to implement different sections of the workplan.

PARTICIPANTS:

- *1. Dr. D. Lwamafa
- 2. Ms. U. Wangwe
- 3. Dr. F. Musonge
- *4. Dr. Zirembuzi
- 5. Ms. Masaba/Akugizibwe

- 6. Dr. Kiboneka
- 7. Prof. Kakitahi
- 26. Imelda Zimbe
- 8. Ms. Bagambaki
- 9. Ms. Nshimye
- *10. Dr. Mukasa
- *11. Dr. Karamagi
- 12. Dr. Gihanga
- 13. Dr. Nakabiito
- 14. Dr. Mudusu
- 15. Ms. Serunjogi
- 16. Dr. J. Jitta
- 17. Dr. Ojoome
- 18. Dr. Engoru
- 19. Ms. Tindiweezi
- 20. Ms. H. Mateega
- 21. Ms. I. Zimbe
- 22. DMO Rukungiri
- 23. DMO Iganga
- 24. DMO Arua

- 25. USAID ←
- 26. UNICEF ←
- 27. WHO
- 28. WELLSTART
- 29. MOTHERCARE
- 30. WINS
- 31. PRITECH

* Denotes facilitators

WORKSHOP TIMETABLE
MONDAY

30/11/93

- 4.00 p.m. Depart from Kampala
- 7.00 p.m. Settling in
- 7.45 p.m. Facilitators meeting
- 8.30 p.m. Dinner

TUESDAY

1/12/92

- 7.30 a.m. Breakfast
- 8.30 a.m. Review and discussion of workshop objectives
- 9.00 a.m. Presentation of the National Action Plan for Promotion of Breastfeeding and Weaning - U. Wangwe
- 9.40 a.m. Presentation of the Baby Friendly Hospital Initiative (BFHI)
 - a) Global Perspective - Dr. Karamagi
 - b) Ugandan Perspective - Dr. Mukasa
- 10.20 a.m. Presentation of the Growth Monitoring Promotion Proposal - Dr. Mudusu
- Opening ceremony
- 11.00 a.m. Tea Break
- 11.30 a.m. Review and discussion of the recommendations of

- (i) The breastfeeding and weaning/infant feeding situation analyses report
- (ii) The National dissemination seminar

1.00 p.m. Lunch
 2.00 p.m. Group Work
 A. National Action Plan
 B. BFHI
 C. Growth Monitoring and Promotion
 4.00 P.M. Tea Break
 4.30 p.m. Continue Group work
 5.30 p.m. Facilitators meeting
 6.30 p.m. Recreation
 8.30 p.m. Dinner

WEDNESDAY

2/12/92

7.30 a.m. Breakfast
 8.30 a.m. Group A Report and discussion
 9.50 a.m. Group B Report and discussion
 11.00 a.m. Tea Break
 11.40 a.m. Group C Report and discussion
 1.00 p.m. Lunch
 2.00 p.m. Groups finalize their Action Plans
 2.40 p.m. Groups draft workplans, identify resources and responsibilities
 4.00 p.m. Tea Break
 4.30 p.m. Continue on workplans
 5.30 p.m. Facilitators Meeting
 6.30 p.m. Recreation
 8.30 p.m. Dinner

THURSDAY

3/12/92

7.30 a.m. Breakfast
 8.30 a.m. Presentation and discussion of Group A workplan
 9.10 a.m. Presentation and discussion of Group B workplan
 9.50 a.m. Presentation and discussion of Group C workplan
 11.00 a.m. Tea Break
 11.15 a.m. Groups finalize their workplans
 1.00 p.m. Lunch
 Closing and departure ,

ANNEX 6.

**Draft National Child Nutrition
and Growth Promotion Workplan**

TUESDAY 1ST DECEMBER, 1992.

Chairman Dr. G. Mukasa.

The meeting started at 9.00 am with nomination of days ' secretary.

This was followed by self introduction of members.

Dr. Mukasa invited Dr. Lwamafa to welcome participants to the Jinja

workshop. Dr. Lwamafa reminded that this was a continuation of seminar that

had been conducted at the National Conference Centre in Kampala

and was anticipated that the workshop would come out with useful work plan / this

He continued to say that all these could be intergrated in the already on going DTU programme for CDD. This could also be a centre for faacilitating and training for the strategies worked out to protect the child."

Ms. Bibi Essama wondered why () should be objective 4 when objective 3 had these broad issues addressed . She suggested that he group should look at the promotion of infant growth and not at specific vertical programmes.

It was suggested by concerns that objectives 4 should be dropped.

REVIEW OF HEALTH SECTOR - RELATED NUTRITION COMPONENT OF NATIONAL FOOD AND NUTRITION POLICY STRATEGY AND ACTION PLAN

Dr. Kuduusu reported that policy had originally started as a nutrition policy but later it was decided that it should be an intergrated food and nutrition policy.

- The policy was not meant to give details on any of the sectors that one included in the document.

ACTION PLAN WORKSHOP REPORT

WEDNESDAY 2/12/1992

The participants went straight to their groups to which they had been allocated the previous evening. The group work commenced at 8.30 a.m. After tea-break at 11.00 a.m. the groups convened into a plenary session to present:

- a) Objectives of areas of concern.
- b) Strategies
- c) Activities

GROUP 3 PRESENTATION

Area of concern : Policy

Chairperson : Dr. G. Makasa

Main Presenter : Dr. V. Ojoma

Content : See action plan.

GROUP 4 PRESENTATION

Area of concern : Capacity building and co-ordination.

Chairperson: Ms. B. Essame.

Main presenter : Dr. C. Makabite.

Content: See action plan

GROUP 1 PRESENTATION

Area of concern : Training and research.

Chair person : Dr. G. Zirembusi.

Main presenter : Dr. C. Engoru.

Content : See action plan.

The session broke up for lunch at 2.00 p.m. The afternoon activities started with the fourth and last presentation.

GROUP 2 PRESENTATIONS

Area of concern : Sustainable community strategies in maternal and infant nutrition and growth monitoring and promotion.

Chairperson : Dr. C. Karamogi.

Main presenter : Dr. Akatvijska J.

Content - See action Plans.

The group had not yet worked out the activities and were urged to hurry up and complete their work to be presented at first thing in the morning.

At 4 p.m. the groups returned to their stations to revise their activities and strategies based on the discussions from the plenary session. They then continued with identification of target groups, resources and the methods of monitoring and evaluation. Groups worked until quite late in the evening.

ACTION PLAN WORKSHOP REPORT

THURSDAY 3RD DECEMBER, 1992;

The plenary delayed a little ins starting and the presentations commenced at 9.00 a.m. after participants had checked out of their rooms. Ms. E. Nshimye was elected on the day's time keeper.

GROUP 2 PRESENTATION

Area of concern : Community strategies in maternal and infant nutrition and growth monitoring and promotion .

CHAIR ERSON: : Dr. C. Karamagi

MAIN PRESENTER : Dr. J. Akatwijuka

CONTENT: Activities, strategies, target groups and resources.

From the discussion it seemed as if we may need to empower families/communities to curative home management of illness episodes which weigh down so much on the children's nutritional well being.

GROUP I PRESENTATION

Area of concern: Training and research.

Chairperson : Dr. G. Zirembuzi.

Main presenter : Dr. C. Karamagi

Content: Targets, resources, responsible persons and indicator for monitoring. The group felt that it was difficult to identify target for research but enumerated possible sources of a funds which include WHO, UNICEF, SCF, DANIDA, SIDA, USAID, WELLSTART, WINS, PRAGMA ; Ministry of Health, Ministry of local government and various other NGO's.

Participants felt that some of the training messages and materials should be targeted at the schools through strengthening the school Health Education Project. A point was made to incorporate the training within the already existing training programmes w rather than creating new training programmes. Recommendations of this workshop should be brought to the notice of various committees or bodies reviewing different curricula. It was further suggested that the DTU/Lactation management centre be strengthened to handle most illness w.g. malaria, ARI? in addition to diarrhoea and lactation management.

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GROUP 4 PRESENTATION

Area of concern: Capacity Building and Coordination

Chairperson: Ms. B. Essama

Main presenter: Dr. C. Nakabito

Content: Targets, responsible persons/deployment and resources

The organizational framework was charted out and an accompanying timeframe elaborated. The participants again emphasized the need for multisectoral cooperation in capacity building. Hands-on practice during training activities would be desirable. The national coordinator can go beyond the extension workers and actually reach the community. There was debate as to whether the national coordinator could be selected from outside the Division of Nutrition. Generally the participants felt that this persons should preferably be from the MOH.

GROUP 3 PRESENTATION

Area of concern: Policy

Chairperson: Dr. G. Mukasa

Main Presenter:

Content: Review areas where changes had been recommended. Also examine steps to be taken to officially implement the policy.

The issue of school nutrition was emphasized before the plenary adjourned for tea. After tea, participants went back into their groups to finalize reports, list constraints, suggest the most appropriate name for the action plan, and make recommendations.

The plenary reconvened at 12:40 pm, under the chair of Dr. G. Mukasa. The group decided, after considerable debate, to name the action plan as: "CHILD NUTRITION AND GROWTH PROMOTION ACTION PLAN." The groups then listed the likely constraints to the action plan and went ahead to make recommendations:

RECOMMENDATIONS: (partial list, doesn't include Group 2 recs)

- 1) A workshop should be organized to consider issues of maternal nutrition
- 2) The Nutrition Division of the MOH should sensitize policy makers and implementers at the national and district levels about this action plan.
- 3) The district teams should sensitize the community about this action plan.
- 4) The Nutrition Division of the MOH should propagate and sell this action plan to all relevant ministries, departments, institutions and donors.
- 5) The MOH should endorse this action plan quickly and appoint a national coordinator to commence implementation by Jan. 1993.

The District Administrator of Jinja, Mr. Peter Loketasi, arrived just before the end of the workshop for the closing ceremony. He was introduced by the Ag. District Medical Officer of Jinja, Dr.

Baryego. In his closing speech, the DA said he was happy and privileged to officiate at the closing ceremony of the workshop. He stressed that breastfeeding is very important, even most so during the first 4-6 months of life. Mr. Lokeresi pointed out that the mothers' nutrition during breastfeeding is an important constraint but he know that even mothers in the village where they are likely to have poor diet, they still breastfeed their children because they love them. He lamented that some educated women choose not to breastfeed for fear of "spoiling" their breasts and said that if those women have such mentality then they should not have children in the first place. Artificial feeding is hazardous to children, the DA insisted. The country will not prosper if our children do not grow up. It is only through good breastfeeding and feeding practices that we can ensure adequate physical and intellectual development of our children. Mr. Lokeresi blamed European influences for spoiling the tradition of breastfeeding. The DA observed that we need to sensitize our people about nutrition and the proper food to eat. He noted that some areas of the country have been hit by various factors which lead to food shortages. However, given the peace and stability now prevailing, we should look for ways of alleviating such people's hunger.

Turning to the workshop, the DA said that he was pleased to see that there are people of high calibre like the workshop participants who are concerned about the nutritional well being of our people. But you are also ambassadors to take the message of nutrition back to the people and to sensitize and convince them that your action plan is workable. Mr. Lokeresi congratulated participants for having come all the way from Jinga and for having accomplished the workshop objectives. He requested participants who had been inconvenienced in any way to bear the inconveniences in good spirit for the good nutrition and growth of the children of our country. The DA wished participants a safe journey home and declared the workshop closed.

NATIONAL ACTION PLAN FOR NUTRITION AND GROWTH PROMOTION

AREA OF CONCERN: CAPACITY BUILDING AND CO-ORDINATION

<u>STRATEGIES</u>	<u>OBJECTIVES</u>	<u>ACTIVITIES</u>	<u>TARGET GROUPS</u>	<u>RESOURCES</u>
<p>- Identify and use existing and structures to organise this set up within the health care system and at the Community level</p>	<p>1. To reorganise and / set up administrative structure from the national to district level, The district Nutrition co-ordinator IS TO reach the grass roots through community health strategies</p>	<p>A Managerial set up - The Assistant Comm- for health Nutrition will identify a national Nutrition co-ordinator (NNC) with keen interest in B/F and M & C nutrition and GHP.</p> <p>2. - The NNC will liaise with the BMO to identify a district level co-ordinator (NDC) with keen interest in B/F and M & C nutrition and GHP</p>	<p>- MOH/ Nutrition Division</p> <p>The district health team</p>	<p>- ACH Nutrition</p> <p>- National co-ordinator</p>
<p>- Where there is no existing structures liaise with the Nutrition Division & MCH Div. institutions and organise set up the</p>		<p><i>Handwritten notes:</i> designate NDC identify co-ordinator interest in B/F & M & C nutrition & GHP</p>		<p><i>Handwritten notes:</i> - transport - structure</p>

STRATEGIES

structure liaison
with the nutrition

Division of the
MOE., DMO'S
institution: and
RCs to set up
the structure.

OBJECTIVES

a

ACTIVITIES

a district nutrition
co-ordinator (DNC)

with keen interest
in B/F and M/C
nutrition and GMP
3. The DNC together
with the DMO'S
office will
work with the
extension workers to
implement the
action plan to
the community

TARGET GROUP

NNC. DMO

DNC

RESOURCES

- Transport
- Strategy
- stationer

- WNC Train

stationer

6/15

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<u>OBJECTIVES</u>	<u>ACTIVITIES</u>	<u>TARGETS GROUP</u>	<u>RESOURCES</u>
To provide supervision Co-ordination and support for	7, The NNC with the help of DNC	NNC	NNC
	Out programme of supervision by visiting the district and using check lists	DNC	
	8, The DNC will receive, analyse AND SUMMARISE the reports from the extension workers , then compile and send reports to NNC	NNC DNC	DNC Stationery

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OBJECTIVES

ATI ACTIVITIES

TARGET GROUPS

RESOURCES

9. The NNC will be given a feed back to the DDC

- District team
- Co-ordinators

- NNC
- Transport

10. The DDC will give extension workers and community

- Extension workers
- Community workers

- Transport

D) Intergration of PEH Nutrition Services/ training programmes

11. The NNC has to liaise with all institutions program managers, short course organisers (MLH & DPL) both Government and NGO's to ensure that nutrition.

to ensure the intergration of all PEH nutrition service/ training programmes at all levels up to grass roots

OBJECTIVES

ACTIVITIES

Component is well interated
and covered
in all their training
programmes ;

12. The DNC will ensure
that all training
Courses in their districts
the nutrition component
is fully inte agrated and
adqately covered in
the training programmes

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TARGET GROUPS

- INNC
- Institutions
- Programme managers
- Short course
organisers
- Government and Home
GVT. extension
workers
- DNC
- all health
workers in the
district and all
Health related
workers
- Other health
related workers

RESOURCES

- INNC
- Funds
- Transport
- District
Health team
- Funds
- Transport

OBJECTIVES

ACTIVITIES

TARGET GROUP

RESOURCES

To set up a system that enables monitoring and evaluation on right down to grass root level

E, Evaluation and monitoring

- 13. Review of reports - NNC
- 14. Giving feed back - DNC
- Extension workers
- Community workers

15. site visits

- District health teams
- Extension health workers
- Community
- Health workers

16 meetings

- District health team
- extension/workers
- Community health workers

- NNC
- DNC
- Transport
- Stationery
- NNC
- DNC.
- Transport , Stationery
- NNC
- DNC
- Funds
- Transport
- NNC
- DNC
- Funds
- Transport.

ORGANISATIONAL FRAME WORK

MINISTRY OF HEALTH

ASSISTANT COMMISSIONER FOR HEALTH
(NUTRITION)

NATIONAL NUTRITION AND GROWTH PROMOTION
CO-ORDINATOR

DISTRICT MEDICAL OFFER

DISTRICT NUTRITION AND GROWTH PROMOTION

CO-ORDINATOR

EXTENSION WORKERS

CBT + CBHW, CHC

COMMUNITY

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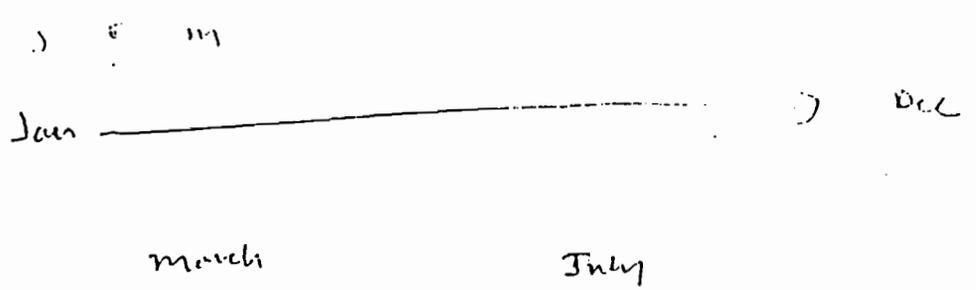
CAPACITY BUILDING / CO-ORDINATION 3 YEAR PLAN OF ACTIVITIES

YEAR	ACTIVITY	J	F	M	A	M	J	J	A	S	O	N	D
1992	IDENTIFY NNCos.												X
	TRAIN NNCos,						X						
	IDENTIFY 6 DN Cos, BY MANNC			X			X	X	X	X	X	X	
1993	TRAIN 6 DNCos.												
	EXT. W DEV. CURRIC FOR CNW, CBT			X	X	X	X	X	X	X	X	X	X
	(NNG) CBT												
	DNCos TO VISIT COMEUNITY REVIEW												
	HEALTH ACTIVITIES.												
	REVIEW EXIST. INST. PROGRAMES	X											
	CURR.												
	(NN(o))												
	TRAIN 6 DN Cos												
	Integrate												
	INTERNATIONAL NUT/BFGMP	X											
	INTO EXIST. INST. CURRIC.												

NNGo TO VISIT FROM TIME TO TIME AND ^{to receive} RECEIVE

DISTRIC REPRESENTATIVE Report

MID TERM PROGRAMME EVALUATION.



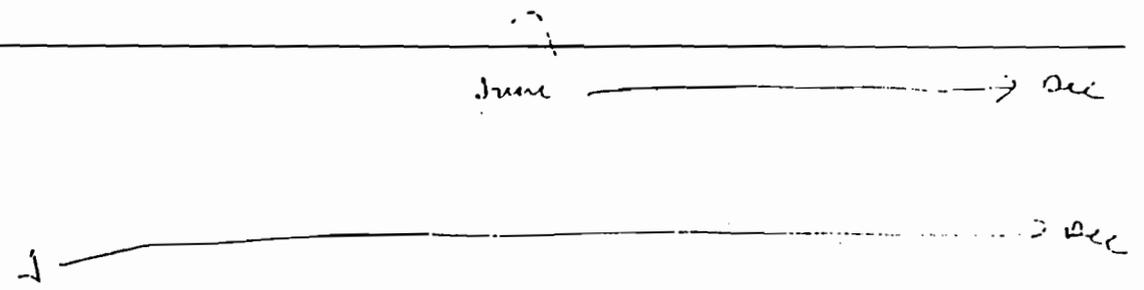
TRAIN 6 DN Cos.

INTERGRATED NUTRITION BREAST FEEDING/

GMP INTO EXISTING INST. CURRIC /

PROGRAMME.

F.T. PROGRAMME EVALUATION.



GROUP 2

CHILD NUTRITION AND GROWTH PROMOTION

CONSTRAINTS

1. Intersectoral Organisation or collaboration.
2. Insistent demand for results too soon.
3. Lack of adequate appropriate mobilisation.
4. Inadequate knowledge and multiple factors influencing Nutrition, and about community.
5. H H Resource allocation.
6. Demotivated personnel.
7. Applied education.
8. Bureaucracy -delayed endorsement.
9. Funding delay since no budget for 1992/1993 F.Y.
10. Inadequate resources especially manpower and logistics.
11. Intergration has limits beyond which quality is compromised.
12. Nutrition may not be taken as priority in relation to other existing priority programmes.

POLICY.

The overall policy of government is to create ^{an} ~~out~~ environment which is supportive of optimum maternal, infant and young child nutrition intergrated into the existing MCH/FP services. The government will put greater emphasis on strengthening activities that will contribute to prevention of malnutrition while rehabilitative services will continue to be offered to those already serverely malnourished

The overall policy will be achieved through the implementation of specific policies on:-

1. Intergration of Services.

- The nutrition services will be gradually intergrated into the existing health delivery system at national, district and community levels.
- The Ministry will undertake multisectoral collaboration with other relevant government and NGO'S agencies.
- The Food and Nutrition Policy shall form the basis for collaboration.
- The operations of the National Food and Nutrition council will be reactivated to make it an effective co-ordinating body.

2. Development of Sustainable Community Based Strategies to Address Maternal, Infant, Young Child and Maternal Nutrition.

For sustainability purposes all activities related to infant, young child and maternal nutrition ^{shall} be implemental ^{act} through the existing ^{shall}.

PHC. at district and community level.

- ### 3 - BREAST FEEDING and weaning.
- Government shall promote, protect and support successful breast feeding and weaning practices in the Country through intensive education at all levels.

Government will encourage "Baby Friendly" initiatives at Health ^{facilities} and ⁱⁿ community to protect the child.

- The MOH. will advocate for the extension of maternal leave and the creation of supportive B/F environment for working mothers.

The Ministry of Health will pursue and cause the legalisation of the regulation of marketing ^{of} breast milk substitutes.

4 Growth Monitoring and Promotion

- GMP. of infant young child growth shall be revitalised and intergrated into PHC programmes. including antenatal care .
- Every infant and young child up to age 3 years coming into contact with health providers at all levels shall be weighed the weight plotted interpreted and counselled appropriately.
- The information generated in GMP. will be used surveillance purposes.

5.

Pre and in-service training.

All relevant curricula for formal and informal training shall be basic revised to include topics on infant and maternal nutrition.

All schools will be encouraged to demonstrate what they learn in form of school meals

All health workers will be retrained through the existing training channels of MUM OPL MCH/FP and DTU/ lactation management centre.

6.

Research

- Qualitative and operational research will be encouraged
- Careful longitudinal studies on infant and young/child/ maternal and maternal nutrition shall be encouraged.
- All research results and findings shall be disseminated to the communities and utilised to improve the situation

7. EDG

- The Nutrition Division will collaborate with the Health Education Division in designing developing and disseminating relevant nutrition messages-
- Utilizing all channels of communication.

8. NUTRITION REHABILITATION CENTRES.

The existing rehabilitation centres will be rehabilitated and supported and their roles expanded to include:-

- Rehabilitation.
- Training.
- Research.
- Outreaches
- G.M./Promotion.
- Nutrition Surveillance

Co-ordination of Nutrition Activities;

The Office of the Assistant Commissioner of Health (Nutrition) will liaise with relevant sections to co-ordinate and monitor all nutrition activities in the country.

The Ministry will strengthen the training Division to enable it coordinate and monitor Nutrition activities.

STEPS:

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1. The Planning Committee to meet to adopt policy on nutrition.
Permanent Secretary /Assistant Director of Medical Services(Nutrition).
January, 1993.
2. Assistant Director of Medical Services(Nutrition) organise a sanitation meeting with Trainer District Medical Officers (ADMS(N) Entebbe Feb. 1993.
3. ^{Subject} ~~SECRET~~ ~~PLANT~~ ~~DISSEMINATE~~ ADMS(N)

/8.

4. PILOT DISTRICTS DMOs Implement ^{PHC} DEC. - February, 1993.

5. MONITOR AND EVALUATE THE IMPLEMENTING IN PILOT DISTRICTS
(DMOS & ADMS(N) CONTINUED.

6. Gradual Implementation of programme in other districts (ADMS(N)
DMOs - January, 1994.

9. SCHOOL FEEDING-

The Ministry of Health Nutrition Division will liase with Ministry of Education to ensure that a mid-day meal is provided in all day schools and that there are stardardised memms or guidelines of meals provided to all boarding schools to ensure adequate nutritious meals in schools.

CONSTRAINTS:

- Funding ✓
- Commitment of Implementors
- Problem of regarding this policy as a priority in relation to other health plans-already existing.
- Reduction in budgetry provision for social service delivery.

COMMUNITY/EMP

1. OBJECTIVES	STRATEGIES	ACTIVITIES	TARGET GROUP	RESOURCES			RESPONSIBLE PERSON PK
				TIME	MATERIAL	FUNDS	
1. Reduce stunting in children of under 3 yrs.	Empowerment of women	1. Include women on all community committees 2. local management of GMP sessions 3. Encourage women to participate in IGA. 4. Group Nutrition education meetings	Women	1-3YRS.			Extension worker D.T.T. community Resource person
	2. Improvement of preventive health services delivery	1. Target high risk families for home visit. 2. Community based growth monitoring 3. Provide CHW. nearby. 4. Establishment of a referral system	High risk homes Children under 3 yrs in mobilised communities	2-3yrs.			CHC, CHW CBT. DMO, DTP. M/S Asst. CHC CHW. extension
	3. Community based H.I.S. & Nut Sur. v. 1	1. Collect, analyse and Intergrated data 2. Hold regular feedback meetings for action	CHC. RC. CHW, Community leaders				

OBJECTIVES	STRATEGIES	ACTIVITIES	TARGET GROUP	RESOURCES		RESPONSIBLE
				TIME	MATERIALS	FUNDING PERSON ENCL.
1. ...	and nutrition r surveillance	back meetings	Community leaders			workers, teach Community lea s, Extension workers DMO, DTF.
4. Strengthening existing system	3. Operational intergra- te EP.I. ANC, CDD.		MCH staff MEDICAL extension staff.		Supportive supervision 1yr.	DMO.

LEVELS

DISTRICT

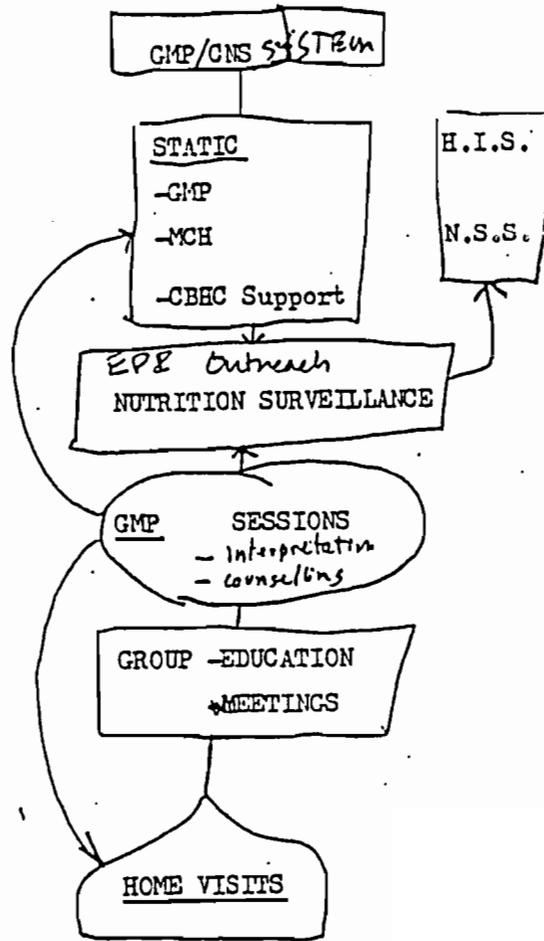
SUB-COUNTY

PARISH

VILLAGE

CELL

HH



GM/P FOLLOW-UP ACTIONS

DISTRICT - EVALUATE, SUPERVISE, TRAIN

SUB-COUNTY - Meetings - NIS
Tabulation
Analysis
Interpet
Supervise

PARISH - Meetings - Mobilization
- Targeting

VILLAGE - BF Protection
- Referrals
- TARGETING

CELL - IGA, EDUCATION
-

H H - COUNSELLING, IGA
HPS ACTIONS

3

GROUP 2 - COMMUNITY MOBILISATION

Group

AIM	OBJECTIVES	STRATEGIES	ACTIVITIES	TARGET GROUP	RESOURCES			RESPONSIBLE
					TIME	MATERIALS	FUNDS	
Encourage and enable the community to build capacity to care for their development.	To create awareness among district authorities.	1. Mobilisation 2.	1. Meetings	DA,RCV,IES.	IstYr.			DNO
			2. Dissemination (1 day)	DRC	Ist Yr.	"		
	2. To select and train the district training team	1. Training 2. Inter-sectoral collaboration.	<ul style="list-style-type: none"> Identify and select district training team (DTT). Identify facilitators for workshop. Identify co-ordinators coordinators among D.T.T. 	<ul style="list-style-type: none"> DHT,CDO, DAO,NGO,DVO Members selected M.O.H. DTT 	Ist " " " "			DA and DNO/ M.O.H./ADMS(N) DNO
	3. To sensitise and train extension workers.	1. Training 2. Intersectoral collaboration.	<ul style="list-style-type: none"> Identify ^{trainees} Conduct workshop series 	<ul style="list-style-type: none"> Health Community, Education, Vet, Agri. Extension staff. 	" " "	Teaching guidelines and training materials		<ul style="list-style-type: none"> DTT M.O.H.

....2.

ADM	OBJECTIVES	STRATEGIES	ACTIVITIES	TARGET GROUP	RESOURCES			RESPONSIBLE
					TIME	MATERIALS	FUNDS	
	4. To enable the communities to form C.H.Cs where they do not exist. b) To strengthen capacity of CHCs which exist.	1. Community Mobilisation 2. Self assessment. 3. Retraining	1. Hold meetings in all villages. 2. Elect CHC in all villages. 3. Train CHC Members	All members " " CHC members	2yrs	Teaching Guidelines and training material		Extension workers and DIT
			1. Hold workshops 2. CHC-meetings	Existing CHC Members.	2nd year	Teaching Guidelines & training material.		
	5. To create a sustainable community capacity & training for local trainers and implementors.	1. Selection Self Assessment. Community networking	1. Select CBTs 2. Select CHW 3. Hold workshop series for CBTs. 4. Hold training meetings for CHW 5. Conduct a survey.(needs assessment.) Ongoing monitoring groups	Community " CBT trainers CHWs. Community High risk	" and 3rd "	" " " " Guidelines from DMO		CHC +Community CBT's, CHC+Community Community D.M.O.=Ext. Workers CBTs. CBTs, CHW, CHCs, Extension workers. Stationery C.B.T's. CHW, C.

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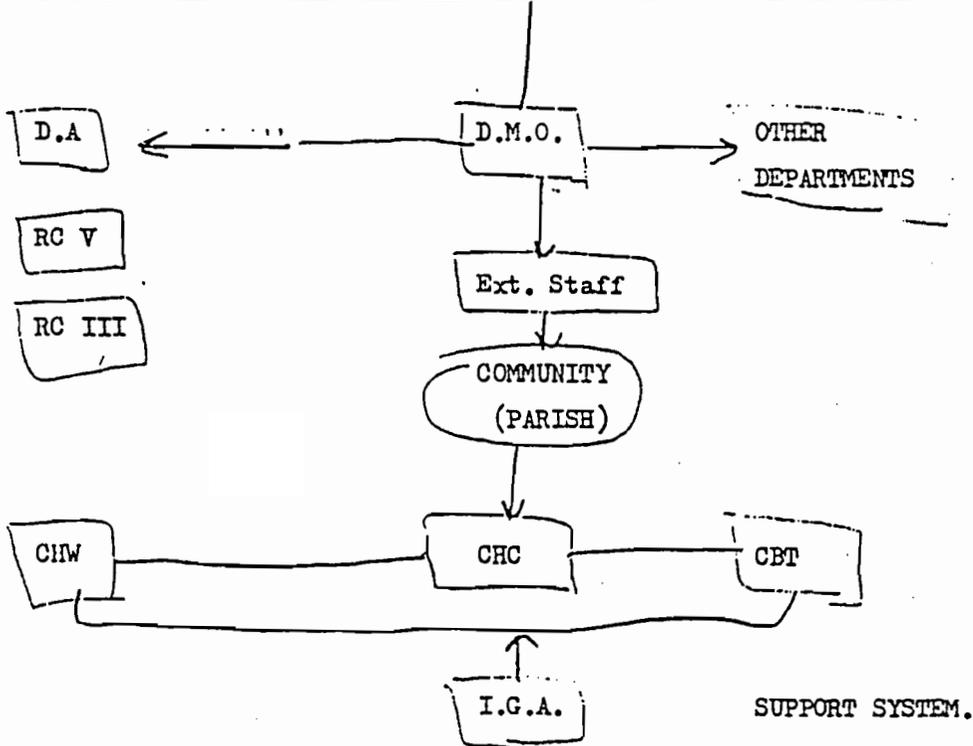
13.

AIM	OBJECTIVES	STRATEGIES	ACTIVITIES	TARGET GROUP	RESOURCES			RESPONSIBLE PERSONS
					TIME	MATERIALS	FUNDS	
			monitoring					CBTs, CHW, CHCs,
			7. Nutrition surveillance.	and communi- ties.	3yrs	Posters		Ext Workers.
			8. G.M.session					
			9. Group meetings					
			10. Home visiting					
	6. To encourage and or support communities to have income generating activities especially those that address household food security	1. Resource Mobilisation	1. Identify IGAs 2. Identify sources of	High risk groups, Community.	" "			CHC, Community, IMO, CHC, Extension Workers.
		<u>Strategy</u> motivation	1. Support Supervision 3. Exchange visits. 2. Incentives 3. External visitors. 5. Water protection. etc.	Community Community Community Community	3-4 years			CHC, Community, IMO, Extension worker

6

GROUP 2

COMMUNITY BASED STRATEGY FOR HEALTH AND DEVELOPMENT



District Staff

Dist.

Extension Staff

Counties

Trainers/Extension workers

St. Counties

CHC

Parish

CHW

H.U.

Introduction

The training aim is to provide the trainers with the necessary knowledge and skills in maternal and child nutrition with particular emphasis on breastfeeding and weaning. The content of the training will have to be adapted to the educational level and job descriptions of the trainers but should cover both maternal and child nutrition. The training methods should be as practical as possible, utilizing locally appropriate materials. The strategies adopted will emphasize integration into existing training programmes and facilities and collaboration with allied sectors and institutions will be encouraged.

Training

Area	Objectives	Strategies	Activities	Targets	Resources	Monitoring & Evaluation
Preservice Training	To strengthen the preservice training of health workers related to maternal and child nutrition with particular emphasis on breastfeeding and weaning by 1995.	<ol style="list-style-type: none">1. Coordinate with MOH (Training Div.) and MOE/Sports to sustain institutionalized training in child and mothers nutrition.2. Collaborate with S.H.E.P. with regard to school nutrition and education.3. Collaborate with ULNET	<ol style="list-style-type: none">1. Review & Strengthen existing curricula.2. Retrain the tutors3. Update and provide learning materials.4. Incorporate or stress breastfeeding, infant and maternal nutrition.	Schools of: Nursing and Midwifery, Medical Assistants, Medicine, Tutors, Hygiene & Public Health, Dental.	MOHH, MOE/Sports, NGOs, UNICEF, USAID	1993/94

Training

Area	Objectives	Strategies	Activities	Targets	Resources	Monitoring & Evaluation
Inservice Training	1. To retrain 80% of the health and health related personnel by in-service training in matters related to maternal and child nutrition with particular emphasis on breastfeeding and weaning.	Coordinate with MOH, ULMET, and existing training programmes eg. MLM, OPL, CBHCA, BFHI.	<ol style="list-style-type: none"> 1. Develop training programmes on maternal and child nutrition. 2. Identify training needs. 3. Training of trainers. 4. Provide appropriate learning materials 5. Identify priority groups. 6. Organize training courses for in-service personnel. 7. Support supervision 	<ol style="list-style-type: none"> 1. Health workers in hospitals, health centres, maternity centers and dispensaries (govt & private). 2. District health teams. 3. Tutors of health institutions. 4. Health related workers e.g. social workers, Agriculture, Community development, veterinary. 	MOH, NGOs e.g. AMREF, missionaries, DANIDA, USAID, SCF, ODA, UNICEF, WHO, MotherCare, WINS, Wellstart	# of in-service personnel trained # of training programmes developed Performance of health workers retrained

Training

Area	Objectives	Strategies	Activities	Targets	Resources	Monitoring & Evaluation
Inservice Training	2. To develop the capacity of the DTU/LMC to train health and health related personnel.	MOH Ministry of Education & Sports	<ol style="list-style-type: none"> 1. Strengthen the training programme to cover material and child nutrition. 2. Retrain the trainers. 3. Establish a pool of resource materials. 	Trainees in health institutions Health workers in hospitals District health staff	MOH MOEd/Sports USAID UNICEF WHO	# of trainers re-trained availability of resource materials performance of retrained personnel

Training

Area	Objectives	Strategies	Activities	Targets	Resources	Monitoring & Evaluation
Training of Community Outreach Persons	Strengthen or develop appropriate training programmes in maternal and child nutrition by 1995.	CBHCA, RC, Min. of Agriculture, Health Ed. Division, Ministry of Local Govt., Seek assistance and work together with CBHCA, related, ministries (Min. of Agriculture MOLG, RC system. Collaborate with existing training programmes eg. MLH, OPL, CBHC, BFHI, ULHET.	<ol style="list-style-type: none"> 1. Strengthen or develop training programmes on maternal and child nutrition. 2. Identify target groups. 3. Identify and re-train trainers. 4. Provide appropriate learning materials. 5. Organize courses. 	<ol style="list-style-type: none"> 1. Community Health Workers. 2. Community Based Trainers. 3. Traditional Birth Attendants 4. Extension Workers (health, veterinary, and agriculture assistants. 5. Health Committee 6. RC's 	MOLG MOH MOAgriculture Min of Women & Development PAPSCA	# of training programmes developed # of community health workers retrained # of courses organized

Training Constraints

1. Possible delay in endorsement of the Action Plan by the MOH may delay implementation.
2. Funding may be a problem since the Action Plan was not budgeted for the 1992/93 budget plan.
3. The inadequacy of the nutrition division in terms of manpower and other resources is a potential constraint to implementation.
4. Integration of the community level is desirable but difficult because of limited manpower. In practice the training is overloaded and diluted, and the workers are overburdened.

Recommendations

1. It is hereby recommended that the MOH endorse the Action Plan and appoint a National Coordinator for nutrition by January 1993.
2. It is also recommended that national and regional seminars be organized to disseminate the Action Plan to relevant sectors and districts.

Research

Introduction

The aim of the research component is to provide information that will be used to modify and improve interventions of the Action plan. The strategy employed will be to use, as much as possible, existing research structures and organizations to conduct the research.

Research

Area	Objectives	Strategies	Activities	Targets	Resources	Monitoring & Evaluation
Operational Research	<ol style="list-style-type: none"> 1. To develop appropriate operational research to monitor and evaluate the interventions of the Action Plan. 2. To determine which interventions are most effective in supporting optimal breastfeeding. 3. To determine appropriate methods of monitoring community nutrition. 	CHDC, CEU, Wellstart, WINS, Pragma	<ol style="list-style-type: none"> 1. Review existing baseline data. 2. Conduct appropriate baseline surveys (develop proposal, pretest, collect and analyze data, report findings). 3. Carry out follow-up surveys after interventions. 	MOH Ministry of Agriculture	MOH MOLG Min.Ed. & Sports UNICEF WHO NGOs (WINS, Pragma, Wellstart MotherCare, SCF)	# of research projects

Research

Area	Objectives	Strategies	Activities	Targets	Resources	Monitoring & Evaluation
Quantitative Research	<ol style="list-style-type: none"> 1. To carry out studies on breastfeeding and infant feeding and examine the relationship with illness. 2. To determine the adequacy of breastmilk and breastfeeding in the first 4 to 6 months among Ugandan women. 	CHDC CEU Wellstart WINS Pragma	<ol style="list-style-type: none"> 1. Identify research 2. Literature review 3. Specify objectives. 4. Develop your methods and design instruments. 5. Pretest 6. Develop budget 7. Data collection 8. Data analysis 9. Report writing and dissemination. 			# of projects completed.

Research

Area	Objectives	Strategies	Activities	Targets	Resources	Monitoring & Evaluation
Qualitative Research	1. To conduct qualitative studies on knowledge, attitudes, and practices related to infant/young child feeding and maternal feeding practices.	CHDC CEU Wellstart WINS Pragma	1. Identify research question 2. Review literature 3. Specify objectives 4. Develop methods and design instruments 5. Pretest 6. Develop budget 7. Collect and Analyze Data 8. Write report and disseminate results			# of projects completed.

ANNEX 7.

Baby Friendly Hospital Initiative Proposals

*THE BABY FRIENDLY HOSPITAL INITIATIVE
IN UGANDA*

HEALTH FACILITY PRACTICES POLICY

OCTOBER 1992

HEALTH FACILITY PRACTICES POLICY

INTRODUCE

Experts on child nutrition and development agree that breastfeeding is the single most effective way to provide a baby with care, complete food and protection against infection, disease and malnutrition. And Uganda is lucky in that we are endowed with a rich culture with a very positive breastfeeding component. But because breast feeding is a familiar, natural and universal event in Uganda, many people feel that it does not require much promotion, protection or support. Yet the 1988/89 Demographic and Health Survey revealed decreased breastfeeding among urban, educated and young mothers. It is evident then that our breastfeeding culture is being eroded by "modern" influence. Those categories of women who are at risk of decreased breastfeeding usually deliver in hospitals and maternity centres. These health facilities can therefore play a leading role in reversing the negative trend in breastfeeding. In addition to promoting breastfeeding through the TEN STEPS, our health facility will also promote other child survival and developmental strategies including growth monitoring and promotion, oral rehydration therapy, immunization and family planning.

Policy Objectives

1. To enable all expectant and lactating mothers coming into contact with the health facility to receive information concerning:
 - (i) the benefits and management of breastfeeding, including weaning
 - (ii) the necessity for them to eat a little more of nutritious foods
2. To enable all cases of normal deliveries to initiate breastfeeding within 1/2 an hour after birth.
3. To enable mothers to have unrestricted access to their babies while in the health facility.
4. to discourage prelacteal/ supplemental feeds, whether modern or traditional, being given to babies delivered in his health facility unless medically indicated.
5. Demand breastfeeding all the time, day and night.
6. To promote exclusive breastfeeding for up to 6 months.
7. To encourage appropriate weaning practices after 6 months.
8. To teach all mothers delivering in this health facility to be taught to express breastmilk in order to maintain lactation even when they are separated from their infants and to feed the expressed breast milk by cup, cup and spoon or feeding tube.
9. To encourage all mothers coming into contact with the health facility to continue breastfeeding for 2 years or more.

10. To discourage all mothers and health care staff from using feeding bottle and teats as well as feeding cups with perforated spouts.
11. To train all health care staff working in the maternal and child care areas to be trained in contemporary breast feeding and weaning management.
12. To refrain from accepting free or subsidized supplies of breast milk substitutes or feeding bottles by the health facility. Any such items required shall be obtained through the usual food procurement procedures.
13. To foster the establishment of support systems for lactating mothers after discharge from the health facility.
14. To immunize all babies delivered in this health facility with BCG and polio 0 before discharge.
15. To issue a child health card to all mothers at the time of discharge, with birth weight and immunization status clearly indicated.

ACTIONS

1. The health facility managers will constantly review its policies practices and even physical lay out of the maternity and child care areas to ensure that they are in line with these health facility practices guidelines.
2. Health facility managers shall ensure that these policy guidelines are regularly communicated to all staff working in the maternity and child care sections.
3. The staff of maternity services and clinics including doctors nurses, midwives, medical assistance and public health nurses shall receive appropriate continuing education in lactation management, which includes weaning. Such training shall be conducted by adequately trained personnel and never by personnel from infant food manufacturers and dealers.
4. Health care provides working in the antenatal area will health educate and counsel the expectant women to make them ready to initiate and maintain lactation. Information given antenatally shall include:-
 - (i) the benefits of breastfeeding
 - (ii) advice on maternal nutrition
 - (iii) the need to initiate breastfeeding immediately after delivery.
5. Staff working in the antenatal clinic shall explore the breastfeeding history of the women to identify those with no experience and those with previous breastfeeding difficulties. These at risk groups should be given more assistance, guidance and encouragement.
6. Health care provides in the antenatal clinics shall examine the breasts of the expectant women to exclude any variations which could interfere with breastfeeding and either advise appropriately or refer the client to the doctor. In caring for their breasts, women should be encouraged to avoid strong soaps, detergents, creams and ointments applied to their nipples and areolar since these can cause tissue damage.

7. Health workers coming into contact with expectant and lactating mothers shall discourage them from unnecessary medications, excess alcohol, tobacco and caffeine.
8. Health care providers in labour, delivery and post natal wards shall endeavor to create an environment supportive of breast-feeding and to make mothers physically and emotionally comfortable during labour, delivery and in the immediate post partum period. The use of sedatives, analgesics and anaesthetic shall be carefully assessed on an individual basis, given the implications for both mother and baby.
9. Health workers in labour ward shall advise mothers to have a clean bath before labour is fully established. Health workers responsible for deliveries shall then ensure that mothers and their newly delivered babies come into contact within half an hour of birth and those who can suck shall be put to the breast at that time. In cases of caesarean section, the health workers concerned shall endeavor to bring the pair together as soon as the mother is able to respond to her infant.
10. The maternity health care providers shall promote exclusive breastfeeding and ensure that infants are not provided with any other food or drink unless there is a special medical indication for such food or drink.
11. Close contact between mother and infant shall be maintained from delivery onwards. Where it is necessary to separate mothers and their infants as in the case of very sick babies, health care staff shall ensure that the mother continues to express her breast milk to maintain lactation. The expressed breast milk shall be fed to her infant by cup, cup and spoon, or by feeding tube. On demand breast feeding shall be encouraged day and night.
12. Health care staff shall discourage mothers from using feeding bottles and teats, pacifiers, as well as feeding cups with perforated spouts. *fed!*
13. The health facility shall reject all free or subsidized infant formula feeds or feeding utensils from whatever source. In the few cases, for instance orphans, where breast milk substitutes or infant foods are necessary, they shall be obtained through the normal commercial procurement procedures.
14. The health facility managers shall ensure that no posters or pictures originating from infant food manufacturer and dealers are displayed within their premises, regardless of the message, unless such items have been approved by the Uganda Lactation Management and Education Team.
15. The health facility managers shall endeavor to see that their employment policies, physical facilities, and work schedules enable their own staff to breastfeed their infants, both for the benefit of mothers and children as well as being a role model for other health facilities.
16. The health workers of this facility shall endeavor to support, advise, counsel and encourage breastfeeding mothers through the postnatal clinic and, if possible, through a lactation clinic as well as community outreach

activities.

17. Health care providers responsible for immunization shall ensure that all babies discharged from this health facility will have received B.C.G. and Polio 0.
18. All infants discharged from the health facility shall receive a child health card with the birth weight and immunization status properly recorded.
19. Mothers who come into contact with the health facility shall be advised to start ~~weaning~~ after ~~4-6~~ months. Emphasis shall be laid on nutritious weaning foods, stored and prepared hygienically and fed by cup, spoon, or fingers, but breastfeeding should continue for two years or more.
20. This health facility shall encourage the development and implementation of socially responsible policies which support breast feeding throughout the country through dialogue our and health workers, community leaders, N.G.Os, International Agencies, and Ministry of Health.

THE BABY FRIENDLY HOSPITAL
INITIATIVE

PHASE I and II

PROPOSAL BY

THE UGANDA LACTATION MANAGEMENT
AND EDUCATION TEAM (ULMET)

September 1992

THE BABY FRIENDLY HOSPITAL INITIATIVE

1. INTRODUCTION

During 1989, World Health Organization (WHO) and United Nations Children's Fund (UNICEF) issued a joint statement:

"PROTECTING, PROMOTING AND SUPPORTING BREAST-FEEDING; The special role of maternity services". This statement followed recognition of the fact that what we do to mothers or what we tell them when they come to deliver in our hospitals has long term implications for the success or failure of breastfeeding for the particular woman. In this joint statement, then, WHO/UNICEF identified ten factors which they called the TEN STEPS TO SUCCESSFUL BREASTFEEDING. It was agreed that if a hospital or maternity facility implements those ten steps it would go a long way to ensuring the success of breastfeeding among mothers who deliver in those institutions. See Annex for the ten steps.

This year, the first-ever World Breastfeeding Week took place from 1st to 7th August and the theme for the Week was the "BABY FRIENDLY HOSPITAL INITIATIVE". The Uganda Lactation Management and Education Team (ULMET), which is a registered non-governmental organization, organized a series of activities at Mulago Hospital to commemorate the importance of breastfeeding during that week. At the conclusion of the week, a set of recommendations was made, including one which urged Mulago Hospital to start its journey to the BABY FRIENDLY WORLD. This concept paper and plan of action is in pursuit of that recommendation and aims at turning not only Mulago but also many other health facilities into baby friendly ones.

2. STATEMENT OF THE PROBLEM

According to the 1988/89 Uganda Demographic and Health Survey, breastfeeding is a widespread activity in Uganda with well over 90 per cent of mothers initiating its practice sometime after delivery. Yet within a few months of life many of the children are exhibiting evidence of stunting (low height for age). At first impression, this chronic malnutrition could be blamed on diet and feeding practices. However, a recently completed breastfeeding and weaning situation analysis has indicated that the growth faltering is in most cases more related to illness episodes. Illnesses include diarrhoea, acute respiratory infection, malaria, worms.

Breastfeeding mothers receive very little support and guidance from health workers about the practice. Both mothers and health professionals have little access to quality information concerning breastfeeding, and there are no written guidelines for either group.

In a small pilot study at Mbarara University Teaching Hospital, it was revealed that 100 per cent of 60 newborn infants received prelacteal/supplemental feeds whereas WHO/UNICEF recommend giving

nothing but colostrum and breastmilk except in very special circumstances.

Similar pilot observation were carried out at Mulago hospital complex where it was found that only 27 out of 143 mothers initiated breastfeeding within one hour after delivery although WHO/UNICEF recommend initiation within half an hour of birth. In New Mulago Hospital alone, 22 out of 68 mothers had not started breastfeeding even by 24 hours post-partum. Of the sample of 143 infants 59 of them had received prelacteal/supplemental feeds. In the private maternity ward, the prestigious 6D and &E, it has been observed that newborn infants are separated from their mothers and locked away in a small room to endure loneliness, hunger and hypothermia.

Of the 143 mothers in the pilot study in Mulago Hospital, 34 of them admitted that they had never received any information from any source concerning breastfeeding. And all this is taking place in an institution which should be the country's model hospital. For better child survival, protection and development, several other areas need to be focussed on. Among these are immunization, growth monitoring and promotion, as well as oral rehydration therapy. A baby friendly hospital in Uganda will also need to address these issues in the long run.

3. THE PROCESS OF BECOMING BABY FRIENDLY

- i The hospital authorities declare their interest to make the institution BABY FRIENDLY.
- ii A rapid baseline survey is carried out to establish the hospital's breastfeeding practices, support and status.
- iii A body or authority is identified to oversee the process of becoming baby friendly and to arrange and/or carry out the assessment.
- iv Goals and criteria are set for determining the baby friendliness and a written hospital policy is developed incorporating the set goals and criteria.
- v The hospital carries out a self appraisal.
- vi The overseeing body or authority identifies the areas of non-conformity to the set policy from the results of the self appraisal and advises the hospital accordingly.
- vii The hospital makes the necessary changes and carries out any additional training of hospital staff to equip them with the knowledge and skills to implement the policy.
- viii A second hospital self appraisal is carried out.
- ix The overseeing body or authority requests for certified

international assessors to assess the hospital.

x the hospital receives either

- a) BABY FRIENDLY HOSPITAL AWARD
- b) A CERTIFICATE OF COMMITMENT.

4. BABY FRIENDLY HOSPITAL INITIATIVE IN UGANDA

PLAN OF ACTION (1992 - 1993)

THE BABY FRIENDLY HOSPITAL INITIATIVE IN UGANDA

PLAN OF ACTION

General Outline

In accordance with WHO and UNICEF recommendations, the draft national action plan for breastfeeding and weaning promotion envisages the conversion of Ugandan Hospitals and maternity units into baby friendly institutions. The Uganda Lactation Management and Education Team (ULMET) proposes a three phase action plan for the implementation of BFHI in this country. The first phase will aim at a rapid implementation of the principles of a minimum package of the ten steps to successful breastfeeding in a few selected health facilities which offer maternity services. During phase two, the scope of BFHI will be expanded to widen both the criteria and definition of a baby friendly health facility as well as the number of health units involved. The third phase will be the sustenance phase in which selected health facilities will be converted into regional training and supervisory centres to continue overseeing the implementation of the action plan on a more permanent basis within their regions.

Justification:

In February 1992, UNICEF sponsored an international workshop in San Diego, California, where selected experts in breastfeeding were polished as Master Assessor/Trainers for the BABY FRIENDLY HOSPITAL INITIATIVE. Out of the 36 international assessors from 25 countries who participated in that workshop, Uganda was lucky to be represented by three doctors. These people's skill of master assessor/trainers are now dormant and we need to utilize them. Uganda is in the uncomfortable position of being called upon to assess hospitals in other countries when we ourselves have not taken any steps to implement BFHI.

Our priority in Uganda is to PROTECT the good breastfeeding practices which have been passed on to us by our foreparents, and to prevent western or so called "modern" influences from eroding our

breastfeeding culture. The 1988/89 DHS revealed a trend towards decreased breastfeeding among urban, educated and young mothers. The time is ripe not only to stop, but even to reverse this trend. These categories of women are the ones who make most use of our health facilities. Hence the urgent need to catch these women when they come to the antenatal and maternity units. Since BFHI emphasizes health education of the women during the antenatal period as well as a system of support and counselling for the nursing mothers after delivery, this will also provide an opportune entry point for nutrition support and counselling at large.

PHASE I ACTION PLAN (OCTOBER - DECEMBER 1992)

Goal

The goal of BFHI activities in Uganda during this first phase is to promote, support and protect breastfeeding particularly in the public and NGO health sector by implementing the TEN STEPS TO SUCCESSFUL BREASTFEEDING as recommended by WHO and UNICEF.

Specific Objectives

- (i) To formulate a minimum health facility practice policy which can be shared by the participating health units.
- (ii) To assist participating health units implement the policy with a view to achieving baby friendly status as defined by the WHO/UNICEF global criteria. Participating health facilities will be:

HOSPITALS

- 1. Mbale
- 2. Mbarara
- 3. Nsambya
- 4. Rubaga
- 5. Old Mulago

HEALTH CENTRES

- 1. Kawempe
- 2. Naguru
- 3. Kampala
Dispensary
- 4. Bugembe
- 5. Kanoni

- (iii) To request for international assessment so that the participating health units receive either a baby friendly hospital award or a certificate of commitment.

Activities

During phase I, ULMET will engage the three certified Ugandan Master Assessors/Trainers to carry out the following activities:

- 1. Sensitization: The selected health facilities will be visited and the principles of BFHI will be introduced and explained to the in-charges the administration and key personnel in each unit.

2. Initial Self Appraisal: Health facilities which agree to participate will be issued with the self appraisal tool and assisted to complete the questionnaire.
3. Training: Based on the results of the self appraisal, arrangements will be made to train most of the health workers involved in maternity care in the various units.
4. Implementation: After training of personnel, each unit will be encouraged to implement the BFHI principles and practices.
5. Support/Supervision: The participating health facilities will be visited by the certified Assessors/Trainers from time to time to oversee the implementation of BFHI.
6. Second Self Appraisal: By early to mid December 1992, the participating health facilities will undergo a second self appraisal before external international assessors are invited to assess the health units.
7. An ad hoc BFHI authority will be formed to oversee the BFHI designation process. This will consist of:
 - (i) The 3 certified assessors/trainers
 - (ii) A representative of Ministry of Health
 - (iii) A representative of WHO
 - (iv) A representative of UNICEF

The ad hoc committee will report to and be answerable to the Permanent Secretary/Director of Medical Services who will be the final authority on this matter.

The day-to-day implementation of the stages of phase I will be the responsibility of ULMET through the certified assessors/trainers. The provision of external international assessors will be the responsibility of UNICEF while the BFHI achievement awards and certificates of commitment will be the joint responsibility of Ministry of Health and UNICEF.

A detailed workplan and time line is annexed to this document.

PHASE II ACTION PLAN (JANUARY - DECEMBER 1993)

Goal

The goal of the second BFHI phase will be not only to consolidate the achievements of phase I but also to broaden the criteria and definition of a baby friendly health facility to include other child survival activities. The number of participating health units will be increased.

Specific Objectives:

1. To establish a model Lactation Management and Training Unit as an integral component of a multipurpose continuing education centre at Mulago Hospital. This central unit will be charged with the following specific responsibilities:
 - (i) Serve as the national training and resource centre to train staff from all parts of the country.
 - (ii) Provide lactation management service within Mulago and its neighbourhood.
 - (iii) Research into breastfeeding and other child nutrition issues
 - (iv) Follow up and supervise its graduates to ensure that they utilize the acquired skills.

2. To achieve or maintain baby friendly status in the "first tier" health units of phase I as well as 13 other health "second tier" facilities. A baby friendly health facility will:
 - (i) Implement the Ten Steps to Successful Breastfeeding in accordance with the global WHO/UNICEF criteria.
 - (ii) Have a properly functioning Diarrhoea Training Unit (DTU) or Oral Rehydration Therapy (ORT) corner which fosters growth monitoring and promotion.
 - (iii) Administer BCG and Polio 0 vaccine to all infants delivered in that health facility.

The additional health units to be recruited into the second phase include:

- | | |
|-------------------------|--------------------------------|
| 1. Tororo Hospital | 8. Kabarole (Buhinga) Hospital |
| 2. Jinja Hospital | 9. Lira Hospital |
| 3. Mengo Hospital | 10. Arua Hospital |
| 4. Masaka Hospital | 11. Buyikwe Health Centre |
| 5. Kitovu Hospital | 12. Bwama Health Centre |
| 6. Villa Maria Hospital | 13. Kinoni Health Centre |
| 7. Kawolo Hospital | |

Activities

The main activities envisaged fall in the areas of administration, publicity, training, service and evaluation.

A. Administration

1. To facilitate the development of BFHI in Uganda it is proposed that a national BFHI committee be established to organise and coordinate all BFHI activities in Uganda. The National BFHI committee should include officials from Ministry of Health, Makerere University (Obs/Paed), ULMET, UNICEF and WHO. A member of the BFHI committee should be appointed National Coordinator of the BFHI programme, to implement the decisions of the BFHI committee.

II. Baby Friendly Hospital Policy

It is proposed that a national Baby Friendly Hospital policy be formulated, by the national BFHI committee and adopted by health units. The Baby friendly hospital policy is the first step in implementation of the Ten Steps to Successful Breastfeeding.

B. Publicity (Sensitization):

It is proposed that breastfeeding and the BFHI activities be given as wide a publicity as possible in order to sensitize policy-makers, administrators, health workers and the public at large. Such publicity will ensure positive response particularly with regard to resource allocation and behaviour change by health staff and parents, even in health units where training is not yet planned.

C. Training:

Training of health workers in the latest information and skills of baby friendliness will be a major component of the BFHI programme. It is proposed that a national lactation and management unit be established at Mulago hospital. The Unit would provide training for trainers drawn from health units in Uganda, and for priority health staff from Mulago hospital. The unit would also be a resource centre on breastfeeding. Establishment of the lactation training and management unit is facilitated by the fact that Mulago hospital is the major health manpower training centre in Uganda. A small administrative unit composed of a Director, Administrator and Secretary is necessary to organise and coordinate training activities. The curriculum on lactation management has already been developed. As for trainers, there are 12 lactation management trainers in Uganda, 9 at Mulago hospital and 3 at Mbarara hospital. Since the lactation trainers will in addition to training in breastfeeding, be carrying out

other duties, it is planned that 6 additional trainers be trained to form a Lactation training team of 15 trainers based at Mulago hospital. It is planned to hold a training of trainers course (TOT) every quarter, and a training of staff course every month other than when a TOT is being held. The courses will begin in the 4th Quarter of 1992, with intakes of 20 participants. Priority will be given to trainers and to staff who hold strategic positions in the health units so as to influence implementation of BFHI.

A limited amount of training materials is already available amongst the trainers, but more books, and other publications are needed to provide adequate reading for the participants. Initially, audiovisual equipment can be borrowed from the Faculty of Medicine or the DTU, but these should be procured in the long-term for the lactation and BFHI programmes.

D. Service

It is proposed that the second phase BFHI activities will be implemented in at least 23 hospitals and health units scattered throughout the country. First and second tier health units will have been identified during phase I and priority will be given to those units which are potential health manpower training centres as this would greatly facilitate training in BFHI activities. The following hospitals would initially aim at simply becoming baby friendly but would later be encouraged to aspire to become regional baby friendly training, management and supervisory centres. Jinja Hospital, Mbale Hospital, Mbarara Hospital, Buhinga (Kabarole) Hospital, Arua Hospital and Lira Hospital. Functional and sometimes structural changes will be required in each health unit before the baby friendly status is achieved.

E. Evaluation

Evaluation of the BFHI programme is an important component that will include establishing the baseline status on breastfeeding, monitoring progress, by use of the self-appraisal questionnaire, and national and international assessment of Baby Friendly status. The questionnaires required are ready for use perhaps with a little modification.

PHASE I ACTIVITY TIMETABLE

	Oct					Nov					DEC		
	1-4	5-11	12-18	19-25	26-31	1-7	8-14	15-21	22-28	29-30	1-7	8 - 14	15
KAWENPE	SENST.	APPRAIS	TRAIN 2 DAYS	Implementation								APPRAIS.	
NAGULU	"	"	2 DAYS										
KAMPALA DISP.	"	"											
RUBAGA	SENST.	APPRAIS		7 Training	Implementation	* TOT							
NSAMBYA	"					* TOT							
OLD MULAGO	"		1 DAY Training	Implementation		* TOT							
BUGEMDE		Apprais. Sensit.				Training		Implementation			Superv. Visits		App
NDALE		Apprais. Sensit.					* TOT						
NBARARA			Sensit. Apprais.		Training		* TOT						
KINONI			Sensit. Apprais.		Training		Implementation						

BUDGET: PHASE 1

A. SENSITIZATION (KAMPALA AREA)

1.	Transport	-	20L x 940/= x 4d	=	75,200/=
2.	Lunch Allowance	-	3p x 2500/= x 4d	=	30,000/=
3.	BFHI literature		(in kind)		-
Sub Total				=	105,200/=

B. SELF-APPRAISAL (KAMPALA AREA)

1.	Transport	-	20L x 940/= x 5d	=	94,000/=
2.	Lunch Allowance	-	2p x 2500/= x 5d	=	25,000/=
3.	Assessment forms		(in kind)		-
Sub Total				=	119,000/=

C. SENSITIZATION/SELF APPRAISAL (EASTERN)

1.	Transport		(in kind)		
2.	Per Diem	-	1p x 32,000/= x 5d	=	160,000/=
3.	BFHI Literature/Assessment forms		(in kind)		
Sub Total				=	160,000/=

D. TRAINING (KAMPALA CITY COUNCIL UNITS (3))

1.	Transport	-	20L x 940/= x 5	=	94,000/=
2.	Lunch allowance	-	22p x 2500/= x 5	=	275,000/=
3.	Honorarium	-	20p x 2100/= x 5	=	210,000/=
4.	Training Materials		(in kind)		-
Sub Total				=	579,000/=

E. SENSITIZATION/APPRAISAL (WESTERN - 2 UNITS)

1.	Transport		(in kind)		
2.	Per Diem	-	1p x 32,000/= x 5d	=	160,000/=
3.	Literature/Assessment forms		(in kind)		-
Sub Total				=	160,000/=

BUDGET - PHASE I CONTN.

F. TRAINING (KAMPALA AREA - RUBAGA/NSAMBYA/MULAGO)

1.	Transport (in kind)			
2.	Lunch allowance	-	23p x 2500/= x 5d	= 287,500/=
3.	Honorarium	-	20p x 2100/= x 5d	= 210,000/=
4.	Training materials		(in kind)	-
				<hr/>
			Sub Total	= 497,500/=

G. TRAINING (WESTERN - 2 UNITS)

1.	Transport (in kind)			
2.	Training Materials (in kind)			
3.	Lunch Allowance	-	20p x 2500/= x 5d	= 250,000/=
4.	Honorarium	-	20p x 2100/= x 5d	= 210,000/=
5.	Per Diem	-	3p x 32,000/= x 5d	= 480,000/=
				<hr/>
			Sub Total	= 490,000/=

H. TRAINING (EASTERN - 2 UNITS)

1.	Transport (in kind)			
2.	Training Materials (in kind)			
3.	Lunch Allowance	-	20p x 2500/= x 5d	= 250,000/=
4.	Honorarium	-	20p x 2100/= x 5d	= 210,000/=
5.	Per Diem	-	3p x 32,000/= x 5d	= 480,000/=
				<hr/>
			Sub Total	= 940,000/=

I.	TRAINING OF TRAINERS COURSE (15 PARTICIPANTS)	
1.	Transport (in kind)	
2.	Transport refund for 15 participants	80,000/=
3.	Accommodation/meals - 18 p x 25,000/= x 5d	2,250,000/=
4.	Out of Pocket - 15p x 2,800/= x 5d	210,000/=
5.	Training materials (in kind)	-----
	Sub total	2,540,000/=
J.	SUPERVISORY VISITS (KAMPALA AREA)	
1.	Transport (in kind)	
2.	Lunch allowance - 3 p x 2500/= x 5d =	37,500/=
K.	SUPERVISORY VISITS (WESTERN)	
1.	Transport (in kind)	
2.	Per Diem 2p x 32,000/= x 5d	320,000/=
L.	SUPERVISORY VISITS (EASTERN)	
1.	Transport (in kind)	
2.	Per diem - 2p x 32,000/= x 5d	320,000/=
M.	NATIONAL ASSESSMENT (KAMPALA AREA)	
1.	Transport (in kind)	
2.	Lunch Allowance - 3 p x 2500/= x 5d	37,500/=
N.	NATIONAL ASSESSMENT (WESTERN AND EASTERN)	
1.	Transport (in kind)	
2.	Per Diem - 3 p x 32,000/= x 5d	480,000/=

Total		7,235,700/=
Contingency (10%)		723,570/=
Grand total		7,959,270/=
		=====

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PHASE II JAN - DEC 1993

BUDGET

A.	Administration (central)	225,000/=	
	Salaries (Coordinator, Secretary)	800,000/=	
	Office equipment and stationery	800,000/=	
	Meetings (refreshments, allowances)	900,000/=	
	Transport	9,000,000/=	
	Communication	500,000/=	12,250,000/=
B.	Baseline survey-(already partly funded)	3,000,000/=	3,000,000/=
C.	Publicity/Sensitization		
	Materials/Media	1,600,000/=	
	Allowances	1,600,000/=	
	Transport	1,500,000/=	4,700,000/=
D.	Training Centre		
	Training materials	1,500,000/=	1,500,000/=
E.	BFHI Course		
	4 TOT course @ 15,000,000/ -----	60,000,000/=	
	8 TOP course @ 10,000,000/=------	80,000,000/=	140,000,000/=
	BFHI Implementation		
	Supervisory visits 12 @ 400,000 ----	4,800,000/=	
	Materials (books, posters) 5@ 300,000 --	1,500,000/=	
	Allowances 6 hosp x 80,000 x 8 courses	3,840,000/=	10,140,000/=
G.	Self-assessment0000		
	Questionnaires	200,000/=	
	Transport	1,500,000/=	
	Allowances 6Hx 80,000 x 1	480,000/=	480,000/=
H.	International assessment		
	Questionnaires	1,200,000/=	7,500/=
	Allowances (3 inter assessment 10dyx250x3 US\$ 7,500.00		
	6 national assess 10 x 12,500	750,000/=	
	Transport 3 drivers 10 x 9,400 x 3	282,000/=	
	Transport	1,500,000/=	3,732,000/=

Sub-total =
 5% Contingency =
 Total Budget =

177,477,000/=

2,373,350/=

 180,350,350/=

- US\$ 7,500.

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ANNEX 8.

Letter to Ms. La Rosa from Dr. Lwamafa

TELEGRAMS: "MEDMIN."
TELEPHONES: GENERAL OFFICE 20201.
ACCOUNTS OFFICE 20201.
TELEX NO. 61372 HEALTH UGA.
IN ANY CORRESPONDENCE ON
THIS SUBJECT PLEASE QUOTE NO.



MINISTRY OF HEALTH.

P.O. BOX 8,

ENTEBBE, UGANDA.

December 8, 1992

The Director
USAID Mission
Kampala.

Attention: Joan LaRosa
Health Population & Nutrition Officer

Re: REQUEST FOR FUNDING AND TECHNICAL SUPPORT
FOR THE BREASTFEEDING AND CHILD NUTRITION
AND GROWTH SITUATION ANALYSIS FOLLOW-ON ACTIVITIES

Permit me to extend to you our deep gratitude for the support and assistance that USAID provided towards the successful accomplishment of the Situational Assessments on Breastfeeding and Infant and Young Child Nutrition and Health. The findings were received with keen interest by a cross section of the public and private health sectors and the recommendations arising out of the assessments provided the framework for the planning workshop, whose outcome was the development of the National Plan of Action for Child Nutrition and Growth Promotion.

This document is now in the process of being edited and will be made available to you at the earliest opportunity.

The purpose of this letter therefore is to officially forward to you the Ministry of Health request for the WINS Project continued financial support, technical assistance and collaboration in follow-up to the recommendations of the assessment reports and also during the implementation phase of the Action Plan activities.

I trust that this request will meet with your kind consideration.

Yours sincerely,

Dr. D.K. W. Lwamafa
for: PERMANENT SECRETARY/
DIRECTOR OF MEDICAL SERVICES

cc: Dr. J. H. Kyabaggu,
1st Commissioner for Medical Services
Ministry of Health
Entebbe

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ANNEX 9.

ULMET Certificate of NGO Status

MARTIN

FORM B



THE REPUBLIC OF UGANDA

THE NON-GOVERNMENTAL ORGANISATIONS
REGISTRATION STATUTE, 1989

NO. 456

CERTIFICATE OF REGISTRATION

I HEREBY CERTIFY that..... UGANDA LACTATION MANAGEMENT AND EDUCATION
TEAM (ULMET) (S.5914/619)
BOX 10202 KAMPALA

has this..... 7th..... day of..... April....., 1982
been duly registered under the Non-Governmental Organisations Registration Statute, 1989.

This Certificate is subject to the following conditions/directions—

a) The Organisation shall carry out its activities in the fields
of promoting, protecting and supporting breast-feeding and
weaning, research information and education.

b) The Organisation will operate Country wide,

c) The staffing of the Organisation must conform to its
Constitution.

d) This Certificate is issued in the first instance, for a
period of twelve months from the date of issue of the
Certificate.

Issued in Kampala, this..... 7th..... day of..... April....., 1982

Mr. B. Kainamura

MEMBER

Mr. Swanika-Bbaale

Member

Mr. Anzelo Ddani Ddadrija

Chairman, National Board for Non-
Governmental Organisations.

Mr. Francis B. Nshemaire

Member