

REPUBLIC OF NAMIBIA



MINISTRY OF HEALTH AND SOCIAL SERVICES

**NATIONAL POLICY ON
INFANT AND YOUNG CHILD FEEDING**

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NATIONAL POLICY ON INFANT AND YOUNG CHILD FEEDING

Directorate: Primary Health Care
Division: Family Health
Subdivision: Food and Nutrition
Private Bag 13198

Tel: + 264 61 2032712

Fax: + 264 61 2032735

WINDHOEK

REPUBLIC OF NAMIBIA

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FOREWORD

The Government of Namibia is committed to the improvement of the welfare of its people as evidenced by its constitution that guarantees equal access to basic social services for all people especially the vulnerable women and children. This is evidenced by the Government's ratification of the Convention for Elimination of all Forms of Discrimination against Women (CEDAW) 1997, and the Convention on the Rights of the Child and the Declaration of the National Plan of Action for Children in 1992, in order to achieve the goals of the World Summit for Children of 1990.

The National Policy on Infant and Young Child Feeding was developed to create an environment that promote, protect and support sound infant and young child feeding practices in Namibia. The policy places particular emphasis on the need to promote, protect and support breastfeeding for the majority of infants whose mothers is HIV negative, and for whom breastfeeding is a lifesaver. The policy ensures that those whose mothers is HIV positive, or who are unable to breastfeed for whatever reason, are cared for and nourished to the best possible standards and are protected from the disadvantages that arise from inability to breastfeed.

I urge the United Nations agencies, Non-governmental organizations, community structures, the University of Namibia, other training and research institutions operating in Namibia and other Bilateral Agencies to contribute to the implementation of the policy through their organizational structures and financial resources and to ensure that their leaders, managers and employees abide by this policy.

I call upon all government Ministries, parliamentarians, the Judiciary, parastatal bodies, health professionals and health workers, at all levels, to play their part, as stipulated in this document.

DR LIBERTINA I. AMATHILA
MINISTER

PREFACE

The government, through this policy, is re-affirming its commitment to breastfeeding, and defines ways to manage HIV within the overall strategy of prevention of mother to child transmission, and the National Strategic Plan for HIV/AIDS (Medium Term Plan II, 1999-2004). Exclusive breastfeeding for six months will be promoted for all mothers as a public health measure, and from six months mothers will be advised to introduce nutritious foods with continued breastfeeding to about two years. All mothers shall be informed about the benefits of breastfeeding, the risk of artificial feeding and the importance of prevention of HIV/AIDS, including how to prevent mother to child transmission.

The prevalence of HIV/AIDS demands a policy to clarify the government position on breastfeeding and HIV AIDS and to provide guidance on how best to ensure that every child has access to the best feeding possible, irrespective of the HIV status of his/her biological mother.

The National Policy on Infant and Young Child Feeding was developed to create an environment that promote, protect and support sound infant and young child feeding practices in Namibia. The introduction provides a historical background to the breastfeeding programme since its inception. The situation analysis aims to summarise the current situation regarding HIV/AIDS prevalence rates, morbidity and mortality of childhood diseases and breastfeeding practices.

The policy framework reflects the goal, principles, objectives, policy statement and ends with strategies identified for policy implementation. The institutional framework for policy implementation recognises the different levels and structures for implementation, with special reference to the important line ministries and non-governmental agencies.

With policy implementation, major resources will be spent initially on capacity development and training to equip health workers with knowledge and skills necessary to promote, protect and support breastfeeding and to ensure safe and optimal feeding practices for children who have to be fed on breastmilk substitutes. Additional resources need to be mobilised from our partners for effective and efficient implementation of the policy.

The key implementation phase provide guidance on the strategies and activities to be implemented over a five-year period. Monitoring and evaluation is inbuilt to guide the review of the policy, including incorporation of new and updated information, lessons learnt from policy implementation, as well as programme planning and management.

Guidelines have been developed to support health workers implement this policy. Orientation and training will be offered to equip health workers with skills to counsel and support mothers and child caregivers. However health workers have the responsibility to update their knowledge and take the initiative to be familiar with the policy, the guidelines and to practice what is recommended.

The Ministry of Health and Social Services is grateful to all those who contributed to the preparation of the policy, in particular the Primary Health Care Directorate, UNAM, the French Cooperation and medical practitioners from Oshakati and Swakopmund State Hospitals. I would like to acknowledge UNICEF for the technical and financial support for the development and implementation of this policy and guidelines.

DR KALUMBI SHANGULA
PERMANENT SECRETARY

ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
ARI	Acute Respiratory Infection
ARVs	Antiretroviral drugs
BMI	Body Mass Index
BFHI	Baby Friendly Hospital Initiative
BMFI	Baby and Mother Friendly Initiative
CEDAW	Convention for the Elimination of all forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
GNP	Gross National Product
HIS	Health Information Systems
HIV	Human Immuno-Deficiency Virus
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
MMR	Maternal Mortality Ratio
MTCT	Mother to Child Transmission
NAC	National AIDS Committee
NACOP	National AIDS Co-ordination Programme
NAEC	National AIDS Executive Committee
NAMACOC	National Multisectoral AIDS Coordination Committee
NDHS	Namibia Demographic and Health Survey
NGO	Non Governmental Organisation
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child transmission
RACOC	The Regional AIDS Coordination Committee
U5MR	Under five mortality rate
UN	United Nations
UNAIDS	United Nations AIDS Programme
UNICEF	United Nations Children's Educational Fund
VCCT	Voluntary Confidential Counselling and Testing
WHA	World Health Assembly
WHO	World Health Organization
WBW	World Breastfeeding Week

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CHAPTER 1 INTRODUCTION

Every child has a right to adequate nutrition, health and care. Breastfeeding provides substantial benefits to both children and mothers. It significantly improves child survival by protecting against diarrhoeal diseases, pneumonia and other potential fatal infections, while it enhances quality of life through its nutritional, psychosocial and many other benefits. According to the World Health Organization, over 1.5 million babies' lives are saved every year through breastfeeding. A recent WHO collaborative study to assess the effect of breastfeeding on infant mortality due to infections in the less developed countries, has clearly indicated that formula fed infants are 4 to 6 times more likely to die. Earlier studies in Philippines and Brazil, have documented risks of death of over 14 times greater in non-breastfed infants compared to breastfed infants. In addition to these benefits, mother's milk makes a substantial contribution to the economy of most developing countries, though this is still not accounted for in the gross national product (GNP). Breastfeeding contributes to mother's health, by reducing the risk of cancer and postnatal haemorrhage. Exclusive breastfeeding contributes to child spacing and in Africa, it is considered to be a most effective method of contraception because of the low utilisation of modern contraception. In Namibia only 38% of women are reported to use modern contraceptives and this figure excludes dropout rates (NDHS, 2000).

Various global instruments have guided implementation of policies on infant feeding. These include *The International Code of Marketing of Breastmilk Substitutes* (1981), adopted by the 34th World Health Assembly and subsequent WHA 10 resolutions; the *Innocenti Declaration on the promotion of exclusive breastfeeding for six months*, (1990); and the historical *World Summit for Children* (1990), which includes a major goal to “**empower all women to breastfeed exclusively for six months and continue with adequate complementary foods for two years or beyond**” by 2000. The UN Secretary General's report on the progress towards the World Summit Goals presented to the Special Session on Children, held in May 2002, indicated that rates of breastfeeding have increased over the last ten years. This shows that the strategies adopted by countries, including Namibia, not only reversed the decline in breastfeeding but also helped bring about this global increase rates of exclusive breastfeeding. One of the most effective strategies was the global Baby Friendly Hospital Initiative launched by WHO and UNICEF in 1989, to transform maternity facilities to support and practise breastfeeding and ensure quality care for mother and baby, by implementing “the Ten Steps to Successful Breastfeeding” as a minimum requirement.

His Excellency, Dr Sam Nujoma, the President of Namibia, demonstrated Government commitment to breastfeeding, when he spearheaded the **Baby and Mother Friendly Initiative of 1992**. This was part of the global *WHO/UNICEF Baby Friendly Hospital Initiative*. In Namibia the initiative was not limited to babies and hospitals alone, but extended to women, workplaces and whole communities. Some of the objectives of this policy were to achieve 75% exclusive breastfeeding rates for 4-6 months, improve breastfeeding for working women, adoption of laws to implement the International Code

of Marketing of Breastmilk Substitutes and make at least 80% of hospitals baby and mother friendly.

Although the success of the policy implementation has not been evaluated, 100% of Namibia's state and state subsidized missionary hospitals have achieved baby and mother friendly status according to the implementation of the Ten Steps to Successful Breastfeeding. This means the majority of mothers are being reached with support for breastfeeding.

The National Health Bill incorporates the legal provisions to regulate the marketing of artificial feeding products to protect health workers and mothers from baby milk industry propaganda. Namibia's Food and Nutrition Policy of 1995, and the draft HIV/AIDS Policy, endorsed by the National AIDS Committee in 2001, are both supportive of breastfeeding.

Exclusive breastfeeding remains low in Namibia, at only 25% up to three months, and only 3% between 4-6 months (NDHS, 2000). The rise of HIV has made the picture further complex. The pandemic demands that the Government seek the most effective ways to prevent the spread of HIV/AIDS. However, in seeking the best ways to prevent mother to child transmission, the Government recognizes the need to prevent other diseases that could result from a rush to use breastmilk substitutes. It is for this reason that the Government is taking firm action to ensure that breastfeeding will continue to be protected and that children born to HIV positive mothers will have the best possible nutrition, and above all that any artificial feeding will not spill over to the populations that should be breastfeeding.

This policy is designed to strengthen strategies to promote, protect and support sound infant and young child feeding practices and breastfeeding for the majority of women who can still breastfeed and facilitate practical support to those few who may not be able to breastfeed.

This policy was developed in a consultative process coordinated by the Ministry of Health and Social Services, specifically the Primary Health Care Directorate, United Nations Agencies, including UNICEF and WHO, healthcare practitioners and mothers and health workers in Katutura and Otjiwarongo. A rapid appraisal of infant feeding practices was undertaken through focus groups discussions with health workers and mothers of children under the age of two years. The objective was to assess mothers, health workers and caretaker related knowledge, attitudes, practices; and constraints related to exclusive breastfeeding, infant feeding in HIV and infant feeding in general. The staff of the Food and Nutrition Subdivision developed the first draft with technical support from UNICEF and shared with relevant stakeholders.

The policy was finalised at a technical working group consultation comprised of representatives from MOHSS, UNICEF, University of Namibia (UNAM), French Cooperation and medical practitioners from Swakopmund and Oshakati State Hospitals. The final document was then presented to the Primary Health Care management for their

review, input and approval. After incorporating the PHC managements contributions, the policy was presented to the Policy Management Development Review Committee for approval.

CHAPTER 2 SITUATION ANALYSIS

Namibia, a country with a population of 1.8 million people, is also a country with great disparities (Census 2002). About 5% of the population control over 75% of the nation's resources. The majority (60%) of the population lives in rural areas, with about 40% living in urban areas. The crude birth rate is 40 and the total fertility rate is 4.2 (El Obeid *et al.* 2001).

According to the 2002 HIV Sentinel Sero-Survey among pregnant women, the HIV prevalence rate ranged from a high of 43% in Katima Mulilo to a low of 9% in Opuwo, with an overall prevalence rate of 22.0%. The highest prevalence was found in urban areas and also in rural areas close to main roads. Currently, 20% of antenatal care (ANC) attendants are less than 20 years of age. The HIV prevalence increases rapidly from 10.7% in the age group 15 – 19 years to 22% in the age group 20 – 25 years and reaches its peak (27%) at the age of 30 – 34 years. This data shows that it is a matter of urgency to focus interventions towards the prevention of teenage pregnancy, HIV infection among the youth, and most importantly, prevention of mother to child transmission of HIV.

The national HIV prevalence rate shows that 22 in every 100 pregnant mothers attending antenatal care are HIV positive (HIV sentinel survey, 2002). About 30% of these 22 mothers are estimated to transmit the virus to their babies. This means 6.6 of the 22 mothers may transmit the virus to the baby and the remaining 15.4 infants will remain negative. Out of these 6.6 mothers, 4.6 will transmit the virus while the baby is still in the uterus or during birth, and 2 will transmit the HIV virus through breastfeeding. *The majority of the babies therefore still remain negative even when they continue to breastfeed up to two years.* There are additional factors that can further reduce transmission, as explained in the Infant and Young Child Feeding National Guidelines for Health workers. The problem is the inability to predict which mother will transmit or not transmit HIV and how and when she will transmit it.

With the increasing HIV prevalence among pregnant women, from 17.4% in 1998 to 19.3% in 2000 and 22% in 2002 (HIV sentinel survey, 1999, 2001, 2002) the Government has taken serious measures to prevent mother to child transmission including, preventing pregnancy in HIV positive women, treatment of HIV infected women with antiretroviral drugs (ARVs) and adjusting guidance on infant feeding to minimize postpartum transmission. The HIVNET 012 randomised trial in Uganda showed that nevirapine lowered the risk of HIV-1 transmission during the first 14-16 weeks of life by 47% in a breastfeeding population (Guay, L., Musoke, P., Fleming, T. *et al.* 1999). The 18-month follow-up of the HIVNET trial in Uganda showed that nevirapine was also associated with a 41% reduction in HIV transmission up to the age of 18 months (Jackson, J.B., Musoke, P., Fleming T. *et al.* 2003). The government has also taken a clear position to protect breastfeeding for the majority of infants whose mothers are not infected with HIV and, whose survival still depends on breastmilk. Other actions are directed at interventions that reduce the risks of transmission, such as improved maternal nutrition to improve immunity and reduce viral loads and improved

management of breastfeeding to reduce sore or cracked nipples, mastitis and other problems that could increase the risk of transmission through breastfeeding.

The common diseases among children under five years in Namibia during 1995-1999 were: acute respiratory infections (ARI), malaria, diarrhoea, ear, nose and throat and skin diseases. The common causes of death among children 1 to 4 years in state hospitals during 1995 – 1999 were: malnutrition, AIDS, malaria, gastroenteritis and acute respiratory infections (El Obeid *et al.* 2001). The infant and child mortality rates are at 38 and 62 per 1,000 live births, respectively (NDHS, 2000). With HIV/AIDS, these may increase. Breastfeeding and appropriate infant and young child feeding, if well practiced, would help reduce deaths from acute respiratory infections and diarrhoea. If breastfeeding is allowed to decline further, infant and child mortality would increase and there would be an extra burden on the healthcare system that is already being overloaded with AIDS patients.

According to the Namibia Demographic and Health Survey 2000 report, 23% of children were found stunted, 26% were underweight and 9.1% were wasted. It was also found that very few children (2%) below the age of 6 months are wasted. At the age of 6 months, 6% of children were stunted. This shows that stunting starts at an early age. Although this report indicates some improvement in the nutritional status data, compared to NDHS 1992 data, AIDS is likely to contribute to stagnation or a decrease. Consequently, there is a need for urgent and firm action.

According to the Demographic and Health Survey 1992, almost 14% of women had a body mass index (BMI) of below 18.5, suggesting chronic energy deficiency. Women whose growth has been compromised, either through malnutrition during childhood or in early adolescence, are at greater risk of maternal mortality, have poor pregnancy outcomes and low birth weight infants.

Maternal mortality ratio has gone up from 225 in 1992 to 271 in 2000 per 100,000 live births. Poor maternal nutrition leads to low birth weight infants (less than 2,500g), which is the most powerful predictor of neonatal deaths. Low birth weight also exposes newborn babies to greater risks of disease and long-term malnutrition. Although Namibia's mean birth weight is 3,071 kg, low birth weight has not improved much from 15.9% to 12.1% between 1992 and 2000.

Namibia has a strong breastfeeding culture. According to the NDHS 2000, about 94% of mothers initiate breastfeeding. Of much concern however, is the prevalence and duration of exclusive breastfeeding, which is 25% at 3 months and 3% at 4-6 months. Although Namibia has a sound policy to promote, protect and support breastfeeding, "the Baby and Mother Friendly Initiative" of 1992, actions to promote, protect and support breastfeeding have currently declined due to the dilemma of HIV/AIDS and transmission of HIV through breastfeeding. A recent study in Durban, South Africa, by Coutsoodis, *et al.*, concluded that exclusive breastfeeding does not have a significant risk of transmission of HIV compared with those never breastfed. Mixed feeding (breastmilk and artificial feeding) has the highest risk of HIV transmission. There is a need for extensive and

strong promotion of exclusive breastfeeding up to six months. Breastfeeding remains important in Namibia and is the natural and the best way to feed all infants. It provides complete nutrition for the first 6 months of life, 50% of nutritional needs of an infant between 6 and 12 months and 30% of nutritional needs between the ages of one and two years. Not breastfeeding is a greater risk for infant morbidity and mortality; exclusive breastfeeding is the safest infant feeding option in many living conditions.

Mothers supplement breastmilk with water, liquids and solid or mushy food at a very young age. Many local diets used for complementing infants are poor in energy, minerals and vitamins and predispose infants to malnutrition. It is reported that by 6-7 months, the majority of children (68%) receive complementary foods in addition to breastmilk, rising to 80% by the age of 8 to 11 months (NDHS 1992). There is a possibility that breastmilk is being replaced too soon during the period up to 6 months. The optimum number of daily feeds during the complementation period up to under 5 years of age is 4-6, and the majority of children in the sample were on average receiving this frequency for only up to 18 months. By the beginning of the second year the frequency of feeding begins to drop fairly rapidly, levelling off to a standard pattern of adult feeding, three times a day, amongst the 22-24 months age group (NDHS 1992). This is the time when the frequency should be about five times a day.

The results of the informal focus groups discussions with mothers in Katutura and Otjiwarongo's low income, informal settlements, clearly indicate that there will be much danger in a move away from breastfeeding in Namibia. Four groups of about twenty mothers each were interviewed and all indicated that the use of artificial feeding was difficult due to many factors, including unhygienic conditions, expense and logistical factors such as waking up at night. Also, most mothers had never prepared any other milk in their lives, never seen their mothers prepare it and did not have confidence managing them.

While exclusive breastfeeding is very low and introduction of other liquids especially water is done much too early, it was evident that mothers were willing to change practices if better informed on the benefits of exclusive breastfeeding and provided with skills on how to achieve it. The mothers had positive attitudes towards exclusive breastfeeding, although, they thought it would be difficult to manage it for six months, "*as the baby would cry after what the mother eats*". The conditions of living in all the four areas visited were not at all conducive for artificial feeding. Mothers had heard about transmission of HIV through breastfeeding but felt they had no affordable options. These observations form the basis to this policy.

Since independence in March 1990, socio-economic conditions and service delivery especially in rural areas, has improved, although the situation has been complicated by the parallel rapid growth of informal settlements in peri-urban areas. Households with sanitation facilities have gone up from 12 % in 1992 to 41% in 2000, access to safe water for human consumption has increased to 77% of households, while piped water ownership has gone up from 35% to 51.4% between 1992 and 2000 (NDHS, 1992 & 2000).

Accessibility of hospitals, health centres, and clinics is reported to have improved. In 2000, about 91% of pregnant women had access to antenatal care services and 78% had professional assistance at delivery (NDHS, 2000). The rest deliver at home with the support of a traditional birth attendant. This means that through the Baby and Mother Friendly Initiative, training all health workers how to support mothers to practice exclusive breastfeeding, has the potential to reach many mothers and lead to a rapid increase in rates of exclusive breastfeeding. The HIS 2001 shows that 99.2% of mothers who receive professional assistance at delivery are breastfeeding exclusively at discharge. If, in addition to this, the traditional birth attendants (TBAs) who assist about 28% of women were also oriented and trained in the implementation of the BMFI, then almost all women would be covered. The TBAs also need to be trained to provide continued community level support to women discharged from hospital after delivery.

A randomised controlled trial on the effect of community-based peer counsellors on exclusive breastfeeding practices in Dhaka, Bangladesh, has concluded that it is possible to increase the length of exclusive breastfeeding through repeated contact through home visits by peer counsellors (Lancet 1999). This indicates that practices being promoted can be achieved.

Health workers should ensure that all women, whether in paid employment or not, are supported to practice exclusive breastfeeding. The loss to the country in terms of human life, quality of life, and in economic terms to both parents and country, are more than the gains made if women in employment are forced to feed their babies artificially because of having to work. With HIV/AIDS claiming a huge percentage of hospital beds, any action to minimize hospitalisation due to other preventable diseases should be encouraged. There is also need for actions to support mothers with knowledge, and to adjust the childcare environment to facilitate proper complementation of breastfeeding and proper feeding of children up to five years. It is for this reason that the scope of this policy covers children up to five (5) years of age.

Other outreach workers, including those that provide immunization and family planning services, whether in government or not, need to have the skills to support mothers to feed their children well. These counselling skills should be part of their training curriculum and included in their job descriptions. The role of the community support system has been re-emphasized in controlling the spread of HIV/AIDS, including preventing transmission of HIV from pregnant and lactating mothers to their infants. The same community structures have the potential to strengthen community-based support for exclusive breastfeeding and adequate child feeding and for monitoring effects of different feeding options on children born to HIV positive mothers. The IMCI household and community component has an important role as breastfeeding and infant and young child feeding was identified as one of the 13 household and community practices.

Additional facilitating factors include national measures such as the BMFI Policy and Guidelines, the Food and Nutrition Policy, the Growth Monitoring and Promotion Programme, the Reproductive Health Policy, and the Integrated Management of

Childhood Illnesses (IMCI) strategy, which include the promotion and support to breastfeeding in their strategies and action plans. The National Public Health Bill strongly supports breastfeeding through the inclusion of regulations on infant and young child nutrition to regulate the unethical marketing of artificial feeding products.

All recent initiatives in respect of prevention of mother to child transmission shall be seen as an opportunity to strengthen breastfeeding rather than an avenue to push free formula considering the risks involved. The HIV/AIDS draft national policy, endorsed by the National AIDS Committee, continues to protect breastfeeding, as it states, “the baby will be breastfed according to the existing breastfeeding policy”.

The Technical Advisory Committee on HIV/AIDS management and anti-retroviral treatment, recommends counsellors to encourage voluntary counselling and testing. This should include counselling on exclusive breastfeeding and adequate management of infant feeding options for those who are HIV positive.

Given the magnitude of mother to child transmission of HIV, there is an interest of partnerships among stakeholders e.g. NGOs, bilateral and multilateral organizations, community-based organizations and the private sector. These partnerships and their capacity and ability to participate in interventions need to be explored. The community will be fully involved through various community-based activities and services.

CHAPTER 3 POLICY FRAMEWORK

3.1 Goal

To ensure the survival, healthy development, and protection of the child from birth up to 5 years and the healthy status of mothers.

3.2 Principles

- This policy is founded on the Namibian constitution that guarantees the rights of women and children, including the right to adequate food and nutrition and the right to social services such as health, education and housing.
- It reaffirms Namibia's commitment to implement the recommendations of the Convention of the Rights of the Child and the Convention Against all forms of Discrimination Against Women, ratified in 1989 and 1997 respectively.
- It reaffirms the critical role of breastfeeding to child survival and development as provided for in existing policies, including the National HIV/AIDS Policy (2001), the Food and Nutrition Policy (1995) and the Baby and Mother Friendly Initiative Policy (1992).
- This policy guarantees the right of every Namibian, especially mothers and fathers, to factual information, confidentiality, and justice to facilitate informed decisions regarding their reproductive rights.
- It reaffirms that every person, irrespective of their HIV/AIDS status, has the right to the best treatment and care available in Namibia.
- It reaffirms government's commitment to protect its entire people from hunger, malnutrition and diseases, especially HIV/AIDS, in accordance to the Second National Development Plan and the National Poverty Reduction Strategy.

3.3 Objectives

- To increase exclusive breastfeeding rates from the current 3% at 4 – 6 months to 15% at six months by the end of 2008.
- To increase the proportion of children still breastfeeding at 18 months from 44% to 54% by end of 2008.
- To empower health workers with knowledge, facts and skills, and support to enable them to provide quality care for mothers, children and caretakers through

at least one exposure to a minimum of 18 hours of training on lactation management, counselling on infant feeding and counselling on HIV/AIDS.

- To provide skilled support for adequate feeding to all HIV positive mothers, fathers and other caretakers of children born by HIV positive mothers.
- To transform all healthcare facilities in Namibia to be Baby and Mother Friendly through the implementation of the Ten Steps to Successful Breastfeeding.
- To create an enabling community support system for infant and young child feeding through implementation of household and community IMCI.
- To provide education and information on the feeding options listed in the guidelines for the implementation of this policy to every HIV positive pregnant woman and their partners or immediate companions that come in contact with the healthcare system, either private or state, at least once.

3.4 Policy Statement

The National Policy on Infant and Young Child Feeding serves to provide guidance on infant and young child feeding in the light of current information on mother to child transmission of HIV (MTCT).

The policy recognises the WHO/UNICEF/UNAIDS policy guidelines on HIV and infant feeding, incorporates the Namibian situation, and reflects government commitment to:

Promote, protect and support breastfeeding in all populations, with emphasis on efforts to promote exclusive breastfeeding for the first six months, and continued breastfeeding to two years or beyond with adequate complementary foods from six months and optimal feeding for children up to 5 years.

Ensure safe and optimal feeding practices for children who have to be fed on breastmilk substitutes (medical reasons, orphans, children of HIV positive mothers opting for replacement feeding), but prevent spillover to the general population.

Counsel and support HIV positive mothers to care for themselves and practice one of the following child feeding options safely:

- exclusive replacement feeding using infant formula, modified cow's/goat's milk, where they are affordable or are available in the home; and
- exclusive breastfeeding for the first four months and abrupt weaning off to alternative feeding options.

Ensure that all health facilities and communities continue to promote, protect and support breastfeeding and support voluntary confidential counselling and testing.

Guide and support all women attending health care facilities, irrespective of their age, with regard to the importance of women's health and maternal nutrition, responsible safe sex and how to remain HIV negative, and good management of breastfeeding.

The government commits itself to prevent commercial pressure on artificial feeding through the implementation, enforcement and monitoring of the regulations for infant and young child nutrition.

The government will mobilize human, organizational and financial resources from within and from its partners for the implementation of the policy.

3.5 Strategies

This policy will be implemented through eight major strategies:

- Promotion of breastfeeding and sound infant and young child feeding practices.
- Protection of breastfeeding and young child feeding through the implementation of national and international measures namely the regulations for infant and young child nutrition, relevant World Health Assembly resolutions, the ILO Maternity Protection Convention, etc.
- Support of exclusive and continued breastfeeding and appropriate complementary feeding practices for the majority of infants who can breastfeed, as well as support of mothers who are artificially feeding their infants through the establishment of support groups for mothers with infants and young children.
- Capacity building of all health care workers at all levels (national, regional, district) in skills necessary to manage, implement, monitor and evaluate infant and young child feeding.
- Foster partnerships to expand the scope of actors and to influence human, organizational and financial resources towards improving child feeding practices, nutrition and care, and prevention of HIV transmission.
- Special support will be made available to infant and young child feeding for orphans and vulnerable children i.e. infants and young children who do not have biological mothers or whose mothers are unable to breastfeed or feed them due to illnesses (including AIDS) or other incapacities and children affected by emergencies and disasters.
- Operational research and utilization of research results to improve and amend policy and guidelines on infant and young child feeding.

- Monitoring and evaluation is an ongoing process to guide the implementation of the policy and guidelines.

CHAPTER 4

INSTITUTIONAL FRAMEWORK FOR POLICY IMPLEMENTATION

This policy takes cognisance of the concerted government effort in preventing and reducing HIV/AIDS, therefore its implementation will be linked to the existing structure of the HIV/AIDS Medium Term Plan II at all levels.

4.1 Community level

The Village Development Committee in collaboration with NGOs will promote and establish support systems (psycho-social, material) for mothers on infant and young child feeding; distribute information, education and communication materials on infant and young child feeding; identify and coordinate the feeding needs in their communities and raise awareness on infant and young child feeding.

4.2 District Level

The District Coordinating Committee in collaboration with the District Advisory Committee will be responsible to distribute information, education and communication material; mobilizing youth, mothers and fathers, families and communities; mobilizing resources for infant and young child feeding and conducting operational research on infant and young child feeding.

4.3 Regional Level

The Regional Management Teams will collaborate with the Regional AIDS Coordination Committee (RACOC) to ensure that issues on infant and young child feeding are incorporated in RACOC plans and activities. This will include the planning, implementation, supervision and evaluation of infant and young child feeding in each region as well as initiating activities aimed at the promotion of infant and young child feeding. Other activities will include resource mobilization, identification of areas for funding and support and overseeing the utilization of resources.

4.4 National level

The Ministry of Health and Social Services will be responsible for the overall coordination of the policy implementation. All sectors, including private, parastatal and nongovernmental will collaborate with the Ministry for the implementation of this policy, specifically to promote infant and young child feeding and counselling in their sectors; ensure compliance with the maternity leave laws of Namibia; promote the establishment of Baby and Mother Friendly Corners in workplaces to ensure that children up to 6 months of age are exclusively breastfed and to identify research needs; undertake research and disseminate findings related to infant and young child feeding and ensure the allocation of financial resources for infant and young child feeding in all sectors.

The National AIDS Committee is the overall overseer of the HIV/AIDS programme and is the highest policy decision-making body on matters related to HIV/AIDS. The Ministry of Health and Social Services will therefore present this policy to NAC for guidance, support and commitment.

The National Multi-sectoral AIDS Coordination Committee (NAMACOC) is responsible for the coordination and implementation of the national response on HIV/AIDS, resource management and supervision of the implementation of priority strategies, including infant and young child feeding.

The Ministry of Health and Social Services will provide technical support to all collaborating sectors and NGOs from the national to the regional level; accelerate the process of promulgation of the Public Health Bill and enforce the Code of Marketing of Breastmilk Substitutes and the Maternity Protection Laws.

The Food and Nutrition Subdivision at national level will be responsible for providing technical support and guidance, monitor performance and develop and review policies and guidelines. The subdivision will facilitate and give input and technical backstopping to lower levels on infant and young child feeding.

4.5 Other line Ministries and NGOs

4.5.1 Ministry of Trade and Industry

Encourage industry to manufacture and market quality infant and young child foods and products in Namibia.

Encourage the display of nutrition information on the packaging and/or labels of products in Namibia.

4.5.2 Ministry of Labour

Ensure the ratification and implementation of the new ILO maternity protection convention no 183 of June 2000 and its recommendations.

4.5.3 Ministry of Regional and Local Government and Housing

Promote adequate infant and young child feeding in the respective regions including those of NGOs.

Facilitate resource mobilization at regional level.

In collaboration with the Ministry of Health and Social Services, enforce the Public Health Bill when it is promulgated.

4.5.4 Ministry of Information and Broadcasting

Inform and educate the public on infant and young child feeding through national and local languages.

4.5.5 Ministry of Prisons and Correctional Services

Promote adequate infant and young child feeding for mothers in custody.

4.5.6 Ministry of Home Affairs

Ensure that displaced women and communities are provided with information and services on infant and young child feeding.

4.5.7 Ministry of Basic Education, Culture and Sport Ministry of Higher Education, Training and Employment Creation

Integrate infant and young child feeding information into all relevant curricula of formal and informal educational institutions.

4.5.8 Ministry of Women Affairs and Child Welfare

Promote infant and young child feeding to all women and men in community.
Facilitate and promote the promulgation of the ILO Maternity Protection Convention and its recommendations.

4.5.9 Ministry of Agriculture, Water and Rural Development

Ensure that infant and young child food produced and/or imported in Namibia are of high quality as required by national food standards.
Conduct research in improving quality of food, especially fortification at community level.

4.5.10 Research Institutions

Identify research needs, undertake research and disseminate findings related to infant and young child feeding, as well as HIV/AIDS.

4.5.11 NANGOF

Educate the public about infant and young child feeding.
Facilitate resource mobilization for the promotion of infant and young child feeding.

CHAPTER 5 RESOURCE IMPLICATIONS

The Government through the Ministry of Health and Social Services will mobilize adequate financial resources needed for the implementation of the Infant and Young Child Feeding Policy. Resources shall be mobilized from all partners, including the UN agencies, bilateral agencies, NGOS, and private sector who subscribe to this policy. The Ministry will also mobilize community support, as well as support from private organizations and donor agencies.

Most resource requirement for implementation of this policy will go to developing national capacity to promote, protect and support sound infant and young child feeding practices. This will include exploring the most effective way to impart knowledge and skills to as many people as possible. It will also include constant assessment and analysis of the methodologies adopted towards achieving the objectives of the policy.

5.1 Human and Institutional Resources

Human and institutional resources will have to be mobilized from the key implementing ministries, the private sector, training institutions, professional bodies, social groups and the community to support capacity development, service delivery and research. Adequate financial resources shall be mobilized to provide knowledge and skills on infant and young child feeding for personnel responsible for managing PHC programmes through pre-service and in-service refresher courses. To maintain the strong culture of breastfeeding in Namibia, the Ministry of Basic Education, Sport and Culture is to include child nutrition and lactation in the curricula for primary and secondary school education. To be cost effective in financial, human and material costs, the same staff earmarked for PMTCT will be trained on HIV/infant feeding counselling.

5.2 Capacity Development

The government will explore the feasibility of commissioning a training institution to manage large-scale training of health workers over the next two years, to ensure the BMFI is being fully implemented and that all health workers are skilled in counselling for breastfeeding and for HIV/AIDS, including PMTCT.

Training curricula will be based on documented knowledge, attitudes and practices of the lessons learnt during the implementation. The curricula will be designed to address gaps in training of health workers on breastfeeding and HIV and infant and young child feeding counselling.

All information, education and communication materials on infant feeding should be available in all relevant facilities and resource centres.

5.3 Infrastructural Resources

The Ministry of Health and Social Services and other line ministries shall in collaboration with other non-governmental organization endeavour to strengthen, consolidate and expand the provision of infrastructure needed for efficient implementation of the Infant and Young Child Feeding Policy to reach all target groups in urban as well as remote rural areas. The Infant and Young Child Feeding Policy shall be implemented through a hierarchy of facilities starting at the community level and increasing in level of care through clinics, health centres, district hospitals and ultimately referral hospitals.

All resources will be appropriately allocated and managed for promotion and implementation of infant and young child feeding programme. There should be timely access to financial resources, reasonable flexibility and procedures. All sectors, NGOs and line ministries should procure and maintain equipment for infant and young child feeding that falls in their jurisdiction.

CHAPTER 6
KEY IMPLEMENTATION PHASES

The Ministry of Health and Social Services through the Food and Nutrition Subdivision in collaboration with relevant partners will take charge of the implementation of this policy. The necessary working documents, such as the guidelines on implementation of this policy, and relevant information for health workers, mothers and fathers on mother to child transmission of HIV, exclusive breastfeeding and feeding options, will be developed. Partnerships will be fostered with relevant stakeholders with regard to advocacy, monitoring, research and resource mobilization for the implementation of the policy.

Strategies	2004	2005	2006
6.1 Promotion of breastfeeding and sound infant and young child feeding practices.			
6.1.1 Observe the National Breast-feeding Week as part of the World Breastfeeding Week, 1 – 7 August.	X	X	X
6.1.2 Implement the “WHA resolution no 54.2” to make sure that all children exclusively breastfeed for 6 months and continue breastfeed with safe, adequate and appropriate complementary foods for up to two years and beyond.	X	X	X
6.1.3 Reassess BMFI Hospitals every year.	X	X	X
6.2. Protection of breastfeeding and infant and young child feeding practices.			
6.2.1 Advocate for the promulgation of the National Health Bill.	X		
6.2.2 Draft/finalize the regulations for infant and young child nutrition.	X	X	X
6.2.3 Gazette the regulations for infant and young child nutrition.			X
6.2.4 Advocate for the adoption of the ILO Maternity Protection Convention nr 183 of June 2000 and its recommendations, as well as its implementation.	X	X	X
6.2.5 Monitor the implementation of the International Code of Marketing of Breastmilk Substitutes.	X	X	X
6.3 Support mothers with infants and young children to practice safe and appropriate feeding.			
6.3.1 Strengthen the National Baby and Mother Friendly Initiative Taskforce.	X	X	X
6.3.2 Establish/integrate and support Hospital Infant and Young Child Feeding Committees.	X	X	X
6.3.3 Establish and assist community support groups for mothers with infants and young children.	X	X	X

6.4 Capacity development.			
6.4.1 Training of health workers and TBAs on:	X	X	X
• Breastfeeding management and promotion.			
• International Code of marketing of breastmilk substitutes.	X	X	X
• ILO Maternity Protection Convention	X	X	X
• Infant and young child feeding for orphans and vulnerable children.	X	X	X
6.5 Partnerships.			
6.5.1 Foster partnerships to expand the scope of stakeholders and to influence human, organizational and financial resources towards improving child feeding practices, nutrition and care, and prevention of HIV transmission.	X	X	X
6.6 Operational research.			
6.6.1 Identify research topics and potential researchers.		X	
6.6.2 Conduct periodic reviews of research and use findings to review the PMTCT strategies and feeding options.			X
6.7 Monitoring and evaluation.			
6.7.1 Develop and continuously update monitoring and evaluation tools and procedures.	X	X	X

CHAPTER 7

MONITORING AND EVALUATION

Monitoring and evaluation shall be an in-built component of the National Policy on Infant and Young Child Feeding to guide review of policy, programme planning and management. Periodic reviews and evaluations will be undertaken to ensure that activities are carried out as planned. This will be done through progress/ review meetings, quarterly and annual reports. Indicators to monitor progress towards the objectives of the policy and data collection will be included in the existing monitoring systems, namely the Health Information System. Those responsible for these systems are accountable to ensure the relevant actions.

Monitoring and evaluation will capture information in three important areas of the policy implementation. The 1st deals with the follow-up of individual mothers and their children to ensure that their ongoing needs are addressed because they face a range of risks. This follow-up allows problems to be addressed timely and for solutions to be identified. The 2nd component addresses the monitoring of spill over i.e. whether breastfeeding practice is being undermined by anxiety over HIV and easier access generally to breastmilk substitutes. This forms an important component of monitoring the prevention of MTCT through breast-feeding to protect the very vulnerable and needy children. Finally, monitoring the impact of prevention activities will provide an essential information base for programming to determine whether activities are achieving the desired impacts on child survival.

Further, closely monitoring the progress together with government-supported formative and applied research will ascertain further options that work best for the Namibian situation to ensure that mothers have the benefit of the latest knowledge in this field.

Indicators:

- Proportion of children whose growth is monitored every month for those under the age of one year; every three months for those from 12 months to 36 months of age; and thereafter every six months up to five years of age.
- Proportion of children under five years who are stunted, low height for age.
- Proportion of children under five years who are wasted, low weight for height.
- Proportion of children under five years who are underweight low weight for age.
- Proportion of children exclusively breastfed at 6 months.
- Proportion of mothers' breastfeeding at 18 months.

- Proportion of women counselled on effective and frequent feeding and practicing it correctly at 6 months of age.
- Proportion of HIV positive mothers and fathers counselled on breastfeeding and options for alternative feeding.
- Proportion of health care facilities with at least 80% of staff caring for mothers and babies, trained in lactation promotion and management.
- Proportion of PMTCT Programme with at least 80% of staff trained in infant feeding counselling.
- Proportion of community groups involved in infant and young child feeding.
- Proportion of health care facilities with functional BMFI Task Force to ensure the implementation of the Ten Steps to Successful Breastfeeding.
- Number of hospitals reassessed and maintaining BMFI status.
- Number of supportive supervisory visits conducted by officials from national and regional levels.

CHAPTER 8 CONCLUSION

This policy aims at strengthening action for protection, support and promotion of sound infant and young child feeding practices and to improve their health and well being.

Strategies for its implementation include protecting the public from misinformation, unsuitable marketing practices and unsupportive work environments. Support to mothers through implementation of the BMFI, community support for breastfeeding, building national capacity to ensure ability to fulfil the goals of the policy, training of health professionals, celebration of the National Breastfeeding Week and implementation and monitoring of the international and national regulations on the code of marketing of breastmilk substitutes and the World Health Assembly resolutions, as well as maternity protection convention.

This policy provides the basis for strengthening effective counselling of every health worker so they can support mothers and caregivers, especially those that are HIV positive.

Monitoring and evaluation and research shall be an integral part of policy implementation and shall guide future decisions and actions according to new findings.

The government calls on all concerned to be committed to the effective implementation of this policy, in order to improve the health and nutritional status of children in Namibia.

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ANNEX I

How to Modify Cow's and Goat's Milk

1. Wash hands before preparation.
2. Use clean utensils washed in soap and water and boiled and kept covered.
3. Boil water for 5 minutes and cool to room temperature before mixing.
4. Boil milk to the boiling point and cool it to room temperature.
5. Measure the correct amount of water, milk and sugar as per table below.
6. Mix well.
7. Use a cup.
8. Hold the baby while feeding.

Baby's minimum requirements using modified animal milk

Age (months)	150ml/kg/ birth weight/day	Dilution 100ml milk + 50ml water + 10g sugar = 150ml			Total volume / day	Approximate number of feeds
		Average wt	Milk	Water		
1 st month	3kg	320ml	160ml	32g	480ml	8 x 60ml
2 nd month	4kg	420ml	210ml	42g	630ml	7 x 90ml
3 rd month	5kg	480ml	240ml	48g	720ml	6 x 120ml
4 th month	6kg	480ml	240ml	48g	720ml	6 x 120ml
5 th month	6kg	600ml	300ml	60g	900ml	6 x 150ml
6 th month	6kg	600ml	300ml	60g	900ml	6 x 150ml

Therefore, the baby requires about 92 litres for the first six months as the actual intake.

The cost is ± N\$8.00 per litre x 92 = N\$736.00. Like in the case of infant formula, this costs does not include the cost of utensils and fuel for preparation.

After six months onwards, the baby can be given full strength milk. Offer the baby clean water to drink 2 – 3 times a day to avoid constipation.

In Namibia fresh cows and goats milk may not be available all year round. The only milk available is long life milk, which is more expensive in comparison to fresh cow's milk. In addition modification of animal milk is more complicated than preparation of infant formula, which is already modified. Further, there is a need to provide supplements in the form of vitamins. Therefore this option is relatively expensive.