



Government of the Republic of Trinidad and Tobago
Ministry of Health

National Breastfeeding Policy

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- the Members of the Breastfeeding Committees;
- the Regional Health Authorities;
- the Breastfeeding Association of Trinidad and Tobago;
- the Directorate of Women's Health; and
- the Directorate of Health Policy, Research and Planning.

AUTHORISATION

Repealing Clause

This National Breastfeeding Policy replaces any previous national publications on this subject matter, including draft versions.

Effectivity Clause

The National Breastfeeding Policy becomes effective when approved and signed by the duly authorized officers, and is to be reviewed every three (3) or as needed.

DEFINITION OF TERMS

Artificial Feeding:	The feeding of a baby with food other than a mother's milk.
Bottle Feeding:	The practice of feeding an infant a substitute (formula) for breast-milk.
Breast-milk Substitutes:	Any food being marketed or otherwise represented as a partial or total replacement for breast-milk e.g. infant formula or cereals.
Complementary Food:	Any food, whether manufactured or locally prepared, suitable as a complement to breast-milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant. Complementary foods are given in addition to breast-milk. Such food may be called "weaning food" or "supplementary food".
Cup Feeding:	An alternative to bottle feeding if a baby cannot latch to the breast and needs to be given some milk.
Exclusive Breastfeeding:	Infant only receives breast-milk without any additional food or drink, not even water.
Hand Expression:	Milk expression by hand.
Infant Formula:	A breast-milk substitute specially manufactured to satisfy, by itself, the nutritional requirements of infants during the first months of life up to the introduction of appropriate complementary food.
Mixed Feeding:	The giving of other liquids and/or foods together with breast-milk to infants under six (6) months of age.
Mother Support Group:	A group which provides support for breastfeeding mothers. The main function of such a group is to counsel and educate pregnant women, lactating mothers, and their family members on matters related to breastfeeding.
Pacifier, Bottles, and Teats:	An object, usually of hard plastic or some other material permitting sterilisation, which is sucked by a nursing infant for solace. These are also called comforters or dummies.
Pre-lacteal Feeds:	Any food except mother's milk provided to a newborn before initiating breastfeeding.

ABBREVIATIONS

ARVs	Antiretrovirals
BFHI	Baby Friendly Hospital Initiative
CSGs	Civil Society Groups
CSO	Central Statistical Office, Ministry of Planning and Development
DOWH	Directorate of Women’s Health, Ministry of Health
EBR	Exclusive Breastfeeding Rate
EMTCT	Elimination of Mother to Child Transmission
ERHA	Eastern Regional Health Authority
GORTT	Government of the Republic of Trinidad and Tobago
HACU	HIV and AIDS Coordinating Unit, Ministry of Health
IMR	Infant Mortality Rate
LAC	Latin America and the Caribbean
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MSDFS	Ministry of Social Development and Family Services
NWRHA	North West Regional Health Authority
NBCU	National Breastfeeding Coordinating Unit, Ministry of Health
NICU	Neonatal Intensive Care Unit
PAHO	Pan American Health Organization
PMTCT	Prevention of Mother to Child Transmission
RHA	Regional Health Authority
SDGs	Sustainable Development Goals
SIDS	Sudden Infant Death Syndrome
TBATT	The Breastfeeding Association of Trinidad & Tobago
UNICEF	United Nations Children Emergency Fund
UWI	The University of the West Indies
WHA	World Health Assembly
WHO	World Health Organization

FOREWORD

The Ministry of Health (MOH), as the Government of the Republic of Trinidad and Tobago (GORTT) entity responsible for the health and wellbeing of the people of Trinidad and Tobago, has endeavoured to develop the National Breastfeeding Policy.

The purpose of this Policy is to promote exclusive breastfeeding by ensuring compliance among health professionals, mothers and families, and civil society with a focus on the protection, promotion, and support of breastfeeding programmes and initiatives as part of a life course approach to the overall development of the child, with emphasis on the prevention of non-communicable diseases.

The Policy is instrumental in ensuring that the health of mothers and children is protected by allowing them the opportunity to exclusively breastfeed for at least six (6) months and continue with adequate complementary foods up to two years or beyond. The support for breastfeeding from all levels of society is of paramount importance in allowing mothers to continue breastfeeding, even after returning to work following maternity leave. This Policy is benchmarked against international best practices that guide the practice of breastfeeding in Trinidad and Tobago.

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1 BACKGROUND

Breastfeeding is a non-polluting, non-resource-intensive, sustainable, and natural source of nutrition and sustenance. According to the World Health Organization (WHO), breastfeeding is the biological norm for all mammals, including humans. As such, infants should be fed breast-milk exclusively for the first six (6) months of life and continuing up to two years or beyond ⁽¹⁾. Breast-milk is a perfect food that cannot be duplicated as it provides all the energy for physical and neurological growth and development ⁽²⁾.

Studies have shown that breastfeeding may offer protection against Sudden Infant Death Syndrome (SIDS) ⁽³⁾. As adults, breastfed infants have lower blood pressure, serum cholesterol, and Type 2 diabetes ⁽⁴⁾. Furthermore, exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhoea and pneumonia as well as helps for a quicker recovery during illness ⁽⁵⁾.

Benefits of Breastfeeding

In 2017, the WHO, published the 10 Facts of Breastfeeding ⁽⁶⁾. Facts 1, 2, 3, 4, 5, and 6 detail the benefits of breastfeeding to both the mother and the child:

Fact 1. Breastfeeding for the 1st six (6) months is crucial ⁽⁶⁾

WHO recommends that:

- i. Mothers initiate breastfeeding within one (1) hour of birth;
- ii. Infants should be breastfed exclusively for the first six months of life to achieve optimal growth, development and health; and
- iii. Breastfeeding should continue for up to two years or beyond.

Fact 2: Breastfeeding protects infants from childhood illnesses ⁽⁶⁾

Breast-milk is the ideal food for newborns and infants. It gives infants all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breast-milk is readily available and affordable, which helps to ensure that infants get adequate nutrition.

Fact 3: Breastfeeding also benefits mothers ⁽⁶⁾

Breastfeeding also benefits mothers. Exclusive breastfeeding is associated with a natural (though not fail-safe) method of birth control - 98% protection in the first six months after birth. It reduces risks of breast and ovarian cancer, type II diabetes, and postpartum depression.

Fact 4: Breastfeeding has long-term benefits for children ⁽⁶⁾

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adolescents and adults who were breastfed as babies are less likely to be overweight or obese. They are less likely to have type II diabetes and perform better in intelligence tests.

Fact 5: Infant formula does not contain the antibodies found in breast-milk ⁽⁶⁾

The long-term benefits of breastfeeding for mothers and children cannot be replicated with infant formula. When infant formula is not properly prepared, there are risks arising from the use of unsafe water and unsterilised equipment or the potential presence of bacteria in powdered formula. Malnutrition can result from over-diluting infant formula to "stretch" supplies. While frequent feeding maintains breast-milk supply, if formula is used but becomes unavailable, a return to breastfeeding may not be an option due to diminished breast-milk production.

Fact 6: Transmission of HIV through breastfeeding can be reduced with drugs ⁽⁶⁾

An HIV-infected mother can pass the infection to her infant during pregnancy, delivery, and through breastfeeding. However, antiretroviral (ARV) drugs given to either the mother or HIV-exposed infant reduces the risk of transmission. Together, breastfeeding and ARVs have the potential to significantly improve infants' chances of surviving while remaining HIV uninfected. WHO recommends that when HIV-infected mothers breastfeed, they should receive ARVs and follow WHO guidance for infant feeding.

2 SITUATION ANALYSIS

2.1 Global Context

The Innocenti Declaration of 1990¹ and 2005² established that the practice of breastfeeding is the nutrition of choice for infants. The MOH is guided by this principle and is working towards implementing the Revised Baby Friendly Hospital Initiative (BFHI) at all maternal and child health facilities in Trinidad and Tobago. There are two (2) guidelines contained in the BFHI namely, the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes⁽⁷⁾. These guidelines must be implemented at all public and private health facilities to accomplish BFHI standards.

The 2003 WHO/United Nations International Children's Fund (UNICEF) Global Strategy for Infant and Young Child Feeding recommends breastfeeding as an unequalled way of providing infants with the nutrients they need for healthy growth and development ⁽¹⁾. It further recommends:

- a. infants should be exclusively breastfed for the first six months of life; and
- b. infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.

The WHO Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013- 2020 supports breastfeeding promotion as part of a life course approach to the prevention of non-communicable diseases ⁽⁸⁾. This is because breastfeeding helps to reduce the risk of developing conditions such as obesity and non-communicable diseases later in life.

¹ Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. 1990. Available from: https://www.unicef.org/nutrition/index_24807.html.

² Innocent Declaration 2005 On Infant and Young Child Feeding. 2005. Available from: https://www.unicef-irc.org/publications/pdf/declaration_eng_v.pdf.

The global nutrition target set by WHO and UNICEF is ⁽⁹⁾:

- Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50% by 2025;

WHO Baby Friendly Hospital Initiative

In 1991, the WHO and UNICEF launched the BFHI to implement practices that protect, promote, and support breastfeeding. In 2015, the WHO and UNICEF re-evaluated and reinvigorated the BFHI with a focus on protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. In 2017, the Ten Steps to Successful Breastfeeding were developed as part of the BFHI to achieve the recommendations stated above.

In 2018, the implementation guidelines for the BFHI, which focus on the Ten Step to Successful Breastfeeding, were published and identified nine responsibilities of Member States for the success of this initiative. These nine responsibilities include ⁽⁷⁾:

1. Establish or strengthen a national breastfeeding coordination body;
2. Integrate the Ten Steps into relevant national policy documents and professional standards of care;
3. Ensure the competency of health professionals and managers in implementation of the Ten Steps;
4. Utilise external assessment systems to regularly evaluate adherence to the Ten Steps;
5. Develop and implement incentives for compliance and/or sanctions for non-compliance with the Ten Steps;
6. Provide technical assistance to facilities that are making changes to adopt the Ten Steps;
7. Monitor implementation of the initiative;
8. Advocate for the BFHI to relevant audiences; and
9. Identify and allocate sufficient resources to ensure the ongoing funding of the initiative.

Among high-income countries, there are wide variations in the proportions of babies who are breastfed. For instance, in countries such as Oman, Sweden, and Uruguay, almost all babies are breastfed and in others such as the USA, 74% of babies have ever received breastmilk and in Ireland, only 55% ⁽¹⁰⁾.

In countries such as Sri Lanka and Turkmenistan, the promotion of Baby Friendly hospitals, which comply with the Ten Steps to Successful Breastfeeding, has been instrumental in increasing rates of breastfeeding. Almost 90% of women in Turkmenistan, and almost all mothers in Sri Lanka give birth in hospitals certified as Baby Friendly and both of the countries have nearly universal rates of breastfeeding ⁽¹⁰⁾.

2.2 Latin America and the Caribbean (LAC)

In LAC, 54% of babies born are given the opportunity to initiate breastfeeding during their first hour of life. Only 38% are exclusively breastfed for a period of five (5) months and 32% continue breastfeeding for two (2) years ⁽¹¹⁾. However, these figures varied from country to country as seen in the table below ⁽¹¹⁾:

Table 1: Breastfeeding Rates in LAC

Country	Year	Early initiation of Breastfeeding: children breastfed within one hour of birth (%)	Exclusive breastfeeding under 6 months: children 0 to 5 months old fed exclusively with breast milk (%)
Trinidad and Tobago ¹²	2011	46.3	21.5
Barbados ¹¹	2012	40.3	19.7
Costa Rica ¹¹	2011	59.6	32.5
Ecuador ¹¹	2012	54.6	43.8
Guyana ¹¹	2014	49.2	23.3
Jamaica ¹¹	2011	64.7	23.8
Peru ¹¹	2014	55.1	68.4

2.3 Local Context

In 1986, Trinidad and Tobago took the lead in the Caribbean region in developing the legal framework to manage the practice of marketing and promotion of breast-milk substitutes. This is seen in Regulation 16A of the Food and Drugs Regulations of the Food and Drugs Act Chapter

30:01³. This Policy also supports the reform of this Act to include the restrictions stipulated in the International Code of Marketing of Breast-milk Substitutes⁴ and World Health Assembly (WHA) regulations.

Trinidad and Tobago continues to strive to make breastfeeding the norm for mothers and newborns. During the period 2013 to 2015, several working groups and committees were formed to review and assess the maternal and child health programmes and initiatives due to the significant increase in maternal and child mortality ratios.

The National Development Strategy of Trinidad and Tobago 2016-2030 articulates the broad policy framework for development and the transformative reforms in our public sector administration, management institutions and systems, our values, attitudes, and behaviours⁽¹³⁾. Under Theme 1, '**Putting People First**' the government will ensure that our society evolves into one in which no one is left behind, where all citizens are afforded equal opportunity to access social services, and all our citizens, including the most vulnerable, are cared for and treated with dignity and respect⁽¹³⁾.

The overall intended use of the Policy is to attain the Sustainable Development Goals (SDGs), including those in areas such as health, poverty, hunger, gender equality and education, which are all linked to breastfeeding⁽¹⁴⁾.

In 2017, the Ministry of Health established the Directorate of Women's Health (DOWH) and the National Breastfeeding Coordinating Unit (NBCU) to improve the clinical care and services for maternal and child health with the ultimate goal of reducing the maternal, perinatal, and neonatal mortality ratios. Towards this end, the work activities of these units have focused on improving:

- the time for initiation of breastfeeding;
- the number of months a child is breastfed on average; and

³ Food and Drugs Act of 1960 Chapter 30:01. 2005. Available from: <http://laws.gov.tt/ttdll-web/revision/download/106042?type=act>.

⁴ International Code of Marketing of Breast-milk Substitutes. 1981. Available from: https://www.who.int/nutrition/publications/code_english.pdf.

- the training of medical personnel in breastfeeding.

Data from the 2006 Multiple Indicator Cluster Survey (MICS), conducted by the Ministry of Social Development and Family Services (MSDFS) and the Central Statistical Office (CSO) in collaboration with UNICEF, in Trinidad and Tobago, only 41.2% of babies received timely initiation of breastfeeding while the exclusive breastfeeding rate (EBR) for the first six (6) months of life was a mere 12.8% ⁽¹⁵⁾. Improvement of these figures was observed in the 2011 MICS as 46.3% of babies were breastfed in the first hour of life and the EBR was 21.5% for babies in the 0-5 months age group ⁽¹³⁾.

National data collected by the MOH through the DOWH from 2017 to 2019, revealed that 91% of births occurred in the public health sector. Additionally, over 95% of pregnant women encountered a public sector antenatal service at some point in their pregnancies. This suggests that the public health system's maternity services are able to provide counselling for all matters related to their programmes, including breastfeeding, to the majority of pregnant women in Trinidad and Tobago.

At present, there are no hospitals in Trinidad and Tobago that are BFHI accredited. Each RHA has a written breastfeeding policy which contains the BFHI guidelines. Approximately 65% of medical professionals have been trained to implement the guidelines outlined in the Ten Steps and the International Code.

Trinidad and Tobago is a signatory to relevant treaties that protect, promote and support breastfeeding practices. These include:

- The Convention on the Rights of the Child⁵
- The Innocenti Declaration^{1,2}
- The International Code of Marketing of Breast-milk Substitutes⁴

⁵ Convention of the Rights of the Child. 1990. Available from: <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

- The Sustainable Development Goals⁶
- Protecting, Promoting and Supporting Breastfeeding in Facilities providing Maternity and Newborn Services: The Revised Baby Friendly Hospital Initiative Implementation Guidance 2018 ⁽⁷⁾.

2.4 Challenges Affecting Breastfeeding in Trinidad and Tobago

There are several challenges at the strategic and operational levels in the management as well as challenges with the use of resources at the programme level of breastfeeding initiatives and plans. These constraints have limited the scope and function of the programme and the ability to transform its current functions with international development in terms of the rolling out of key policy initiatives and programmes. These constraints are as follows:

- i. Insufficient number of trained personnel in the area;
- ii. Insufficient coverage of trained staff to patient population on each shift;
- iii. The need for appropriate policies and protocols to facilitate the promotion of breastfeeding among institutions;
- iv. Inadequate legislation to support the International Code for Marketing Breast-milk Substitutes;
- v. The need for a breastfeeding information campaign targeting the general public;
- vi. Proper infrastructure to support the BFHI in the health institutions;
- vii. Support for breastfeeding mothers are lacking in some communities;
- viii. Limited discussion with external stakeholders about encouraging breastfeeding in the workplace; and
- ix. Lack of data collection on breastfeeding metrics and standardised reporting mechanism.

⁶ Sustainable Development, Department of Economic and Social Affairs, United Nations. The 17 Goals. Available from: <https://sdgs.un.org/goals>.

3 POLICY STATEMENT

3.1 Vision

To promote, protect, and re-establish breastfeeding as the preferred choice for infants for healthy growth and development and supported by all stakeholders, directly or indirectly involved in breastfeeding, in Trinidad and Tobago.

3.2 Mission

To provide leadership and improve the management of breastfeeding services with supporting evidence-based research, standards, and protocols according to international best practice.

3.3 Guiding Principles and Values of the Policy

The National Breastfeeding Policy was developed based on the following principles:

Confidentiality

All patients' information will be kept confidential, with respect to their choice to breastfeed or not to breastfeed their infant for medical or "non-medical" reasons;

Discrimination and Stigmatisation

There will be no discrimination and/or stigmatisation against any mother who wishes to breastfeed at the workplace or otherwise, and even if the choice is not to breastfeed whether it is for medically indicated reasons or otherwise;

Empowerment

All pregnant women and mothers will be empowered to make informed choices as it relates to the nutrition of their infant through breastfeeding as the preferred choice;

Quality Assurance

The systems implemented for breastfeeding will be informed by evidence and best practice to optimise outcomes for mothers, babies, health care staff and the wider community with quality assurance and control;

Ethical Practice





The following ethical considerations are essential for this Policy:

- a) The proven scientific facts and accepted practices in the field will be presented to the mother honestly and completely with the mother having the final decision on whether to breastfeed or not;
- b) Health care workers must make every effort to distance themselves from marketing attempts by producers and distributors of breast-milk substitutes; and
- c) Patients' privacy must be honoured and patient information will be dealt with utmost confidentiality.

3.4 Goal of the Policy

The goal of the policy is to reinvigorate and reinforce a breastfeeding culture aimed at promoting breastfeeding from birth and improving infant and young child feeding practices for the attainment of a target of at least 50% of babies exclusively breastfed in Trinidad and Tobago by 2025.

3.5 Objectives of the Policy

-  Provide the framework for the implementation of the Revised BFHI Guidance 2018 and the “Ten Steps to Successful Breastfeeding” in all public healthcare facilities;
-  Provide the framework for a plan of action that ensures breastfeeding is promoted, supported, and incorporated into the whole of government and the whole of society approaches inclusive of health professionals, employers, manufacturers, importers, community, and family;
-  Increase the percentage of babies who receive immediate and uninterrupted skin-to-skin contact and start breastfeeding within the first hour after birth;
-  Advocate for the enforcement of regulations concerning the production and marketing of breast-milk substitutes as contained in the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes;

- Increase the proportion of health professionals who receive adequate breastfeeding education and training;
- Facilitate breastfeeding education and community support for breastfeeding mothers and their families;
- Increase the number of breastfeeding-friendly settings/environments; and
- Strengthen breastfeeding information systems for evidence-based decision making.

3.6 Policy Scope and Coverage

This Policy applies to all stakeholders in the private and public sectors of Trinidad and Tobago offering services and products related to breastfeeding. This includes relevant health care staff and family support, the community and NGOs, civil society and other support groups, and manufacturers and marketing personnel employed in the sale and promotion of breast-milk substitutes and complementary foods using international standards.

The scope of this policy is as follows: -

- To integrate breastfeeding services into the model of care for mothers and newborns in order to reduce the risk of obesity in children, and protect women against breast and ovarian cancer and diabetes;
- To develop appropriate strategies, programmes, and intervention for breastfeeding services;
- To develop and monitor plans and targets through information systems and reporting;
- To facilitate the incorporation of the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes in local legislation; and
- To develop appropriate and effective communication and education programmes on breastfeeding as the preferred choice for infant and child health development.

4 BREASTFEEDING CARE SERVICE MODEL

In order to strengthen and promote the implementation of the Ten Steps initiative, WHO and UNICEF coordinated a process to review the scientific evidence behind the Ten Steps in 2015, which included systematic literature reviews, a thorough examination of the success factors and challenges of the BFHI, and a BFHI Congress in 2016, where 130 countries came together to discuss the new directions needed to reach universal coverage and sustainability of the BFHI.

This collaborative effort was to build a more robust programme that will sustain improved quality of care over time as it describes practical steps that countries can and must take to protect, promote, and support breastfeeding in facilities providing maternity and newborn services. This will ultimately promote breastfeeding as an effective and cost-effective way to ensure the survival, nutrition, and growth and development of infants and young children; to protect the health and well-being of their mothers; and to help all children to reach their full potential.

The core intent of the steps is to protect, promote, and support breastfeeding in facilities providing maternity and newborn services. The Ten Steps summarise a package of policies and procedures that facilities providing maternity and newborn services should implement to support breastfeeding. Figure 1 identifies the Ten Steps to successful breastfeeding.



Figure 1: TEN STEPS to Successful Breastfeeding ⁽¹⁶⁾

4.1 Critical Management Procedures to Support Breastfeeding

All facilities providing maternity and newborn services must adopt and maintain four critical management procedures to ensure universal and sustained application of the key clinical practices. These four critical management procedures are ⁽⁷⁾:

1. *Step 1 – Facility Policies*

- a. **Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.**

The WHA has called upon health workers and health-care systems to comply with the International Code of Marketing of Breast-milk Substitutes. The responsibilities of health-care systems according to the Code are ⁽¹⁷⁾:

- ✓ Not to promote infant formula, feeding bottles teats or pacifiers;
- ✓ Not to be used by manufacturers and distributors of products under the scope of the Code for this purpose;

- ✓ the provision that all facilities providing maternity and newborn services must acquire any breast-milk substitutes, feeding bottles or teats through public procurement process and must not receive free or subsidized supplies;
- ✓ staff of facilities providing maternity and newborn services should not engage in any form of promotion or permit the display of any type of advertising of breast-milk substitutes including the display or distribution of any equipment or materials bearing the brand of manufacturers of breast-milk substitutes, or discount coupons;
- ✓ should not give samples of infant formula to mothers to use in the facility or to take home;
- ✓ health workers and health systems should avoid conflicts of interest with companies that market foods for infants and young children; and
- ✓ health professional meetings should never be sponsored by industry and industry should not participate in parenting education.

b. Development of written policies

The clinical practices articulated in the Ten Steps need to be incorporated into facility policies to guarantee that appropriate care is equitably provided to all mothers and babies and is not dependent on the preferences of each care provider.

It is necessary that all health facilities providing maternity and newborn services have a written breastfeeding policy that addresses the implementation of all eight key clinical practices of the Ten Steps and Code implementation. This policy should be routinely communicated to staff and patients. A review of all clinical protocols or standards related to breastfeeding and infant feeding used by the maternity services should be in line with BFHI standards and current evidence-based guidelines.

c. Monitoring and data-management systems

All facilities providing maternity and newborn services need to integrate ongoing recording and monitoring of the clinical practices related to breastfeeding into their quality-improvement and monitoring systems.

2. *Step 2 – Staff Competency*

Ensure the capacity of all facility staff who provide infant feeding services, including breastfeeding support, have sufficient knowledge, competence, and skills to support women to breastfeed. These include critical skills in listening and learning to counsel a mother, and knowledge of processes and procedures to initiate and maintain breastfeeding and manage common breastfeeding difficulties.

4.2 **Key Clinical Practices to Support Breastfeeding**

The updated BFHI highlights eight key clinical practices to support breastfeeding. These include clinical practices on antenatal information, immediate postnatal care, support with breastfeeding, supplementation, rooming-in, responsive feeding and care at discharge ⁽⁷⁾.

3. *Step 3 – Antenatal Care*

All pregnant women must have basic information about breastfeeding, in order to make informed decisions. The information should include but is not limited to the following:

- ✓ the importance of breastfeeding;
- ✓ global recommendations on exclusive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other complementary foods are given;
- ✓ the importance of immediate and sustained skin-to-skin contact;
- ✓ the importance of early initiation of breastfeeding;
- ✓ the importance of rooming-in;
- ✓ the basics of good positioning and attachment;
- ✓ recognition of feeding cues;
- ✓ challenges they might encounter (such as engorgement, or a perception of not producing enough milk) and how to address them.

Antenatal breastfeeding information dissemination must be tailored to the individual needs of the woman and her family and consider the social and cultural context of the family. Dissemination of information on breastfeeding should begin with the first or second antenatal visit.

4. *Step 4 – Care Right After Birth*

Immediate and uninterrupted skin-to-skin contact between mothers and infants should be facilitated and encouraged as soon as possible after birth. Skin-to-skin contact is when the infant is placed prone on the mother's abdomen or chest with no clothing separating them. It is recommended that skin-to-skin contact begin immediately, regardless of method of delivery. It should be uninterrupted for at least 60 minutes. All mothers should be supported to initiate breastfeeding as soon as possible after birth, within the first hour after delivery.

Caesarean Section

Immediate skin-to-skin care and initiation of breastfeeding is feasible following a caesarean section with local anaesthesia (epidural). After a caesarean section with general anaesthesia, skin-to-skin contact and initiation of breastfeeding can begin when the mother is sufficiently alert to hold the infant. Mothers or infants who are medically unstable following delivery may need to delay the initiation of breastfeeding.

Preterm and Low- Birth-Weight Infants

Skin-to-skin contact is particularly important for preterm and low-birth-weight infants. Kangaroo mother care involves early, continuous, and prolonged skin-to-skin contact between the mother and the baby and should be used as the main mode of care as soon as the baby is stable (defined as the absence of severe apnoea, desaturation and bradycardia). The infant is generally firmly held or supported on the mother's chest, often between the breasts, with the mother in a semi-reclined and supported position.

5. *Step 5 – Supporting Mothers with Breastfeeding*

Mothers should receive practical support to enable them to initiate and maintain breastfeeding and manage common breastfeeding difficulties. Practical support includes providing emotional and motivational support, imparting information and teaching concrete skills to enable mothers to breastfeed successfully. The following outlines the information that should be included in teaching mothers to breastfeed:

- ✓ demonstrate good positioning and attachment at the breast;
- ✓ management of engorged breasts;
- ✓ ways to ensure a good milk supply;

- ✓ prevention of cracked and sore nipples;
- ✓ evaluation of milk intake; and
- ✓ coached on how to express breast-milk as a means of maintaining lactation in the event of their being separated temporarily from their infants.

6. *Step 6 – Supplementation*

Mothers should be discouraged from giving any food or fluids other than breast-milk, unless medically indicated. Infants should be assessed for signs of inadequate milk intake and supplemented when indicated.

Mothers who intend to “mixed feed” (a combination of both breastfeeding and feeding with breast-milk substitutes) should be counselled on the importance of exclusive breastfeeding in the first six months of life, and how to establish a milk supply and to ensure that the infant is able to suckle and transfer milk from the breast. This practice should be discouraged and the mother referred to the dietitian for counselling.

Mothers who report they have chosen not to breastfeed should be counselled on the importance of breastfeeding. Mothers who are feeding breast-milk substitutes, by necessity or by choice, must be taught about safe preparation and storage of formula and how to respond adequately to their child’s feeding cues.

7. *Step 7 – Rooming-in*

Facilities providing maternity and newborn services should enable mothers and their infants to remain together and to practise rooming-in throughout the day and night. Rooming-in involves keeping mothers and infants together in the same room, immediately after vaginal birth or caesarean section, or from the time when the mother is able to respond to the infant, until discharge.

Nursing staff need to visit the ward regularly to ensure the babies are safe. Babies should only be separated from their mothers for justifiable medical and safety reasons. When a mother is placed in a dedicated ward to recover from a caesarean section, the baby should be accommodated in the same room with her, close by. She will need practical support to position her baby to breastfeed, especially when the baby is in a separate cot or bed.

Rooming-in may not be possible in circumstances when infants need to be moved for specialised medical care. If preterm or sick infants need to be in a separate room to allow for adequate treatment and observation, efforts must be made for the mother to recuperate postpartum with her infant, or to have no restrictions for visiting her infant.

8. *Step 8 – Responsive Feeding*

Responsive feeding (also called on-demand or baby-led feeding) puts no restrictions on the frequency or length of the infant’s feeds, and mothers are advised to breastfeed whenever the infant is hungry or as often as the infant wants.

Mothers should be supported to practise responsive feeding as part of nurturing care. Regardless of whether they breastfeed or not, mothers should be supported to recognise and respond to their infants’ cues for feeding, closeness and comfort, and enabled to respond accordingly to these cues with a variety of options, during their stay at the facility providing maternity and newborn services.

9. *Step 9 – Feeding Bottles, Teats and Pacifiers*

Proper guidance and counselling of mothers and other family members enables them to make informed decisions on the avoidance of pacifiers and/or feeding bottles and teats.

If expressed milk or other feeds are medically indicated for term infants, feeding methods such as a cup can be used. Facility staff should also inform mothers and family members of the hygiene risks related to inadequate cleaning of feeding utensils, so that they can make an informed choice of the feeding method. According to the Code, there should be no promotion of feeding bottles or teats in any part of facilities providing maternity and newborn services, or by any of the staff.

10. *Step 10 - Discharge*

As part of protecting, promoting and supporting breastfeeding, discharge from facilities providing maternity and newborn services should be planned for and coordinated, so that parents and their infants have access to ongoing support and receive appropriate care.

Facilities need to provide appropriate referrals to ensure that mothers and babies are seen by a health worker 2–4 days after birth and again in the second week, to assess the feeding situation. Facilities providing maternity and newborn services need to identify appropriate community resources for continued and consistent breastfeeding support that is culturally and socially sensitive to their needs. Community resources include primary health care centres, community health workers, home visitors, breastfeeding clinics, nurses/midwives, lactation consultants, peer counsellors, mother-to-mother support groups, or phone lines (“hot lines”).

5 AREAS OF ACTIONS

5.1 Governance and Leadership

The Ministry of Health shall strengthen governance and leadership of breastfeeding services at all levels.

The NBCU will govern the implementation, execution, and monitoring and evaluation of this policy to optimise outcomes. The NBCU has a leadership and oversight role over all other stakeholders and partners for breastfeeding related activities.

As a repository for best practice, Government liaison with external agents, and principal stakeholder in monitoring, surveillance, and evaluation, the NBCU will have consultation with relevant stakeholders in all matters relating to breastfeeding. This is to ensure consistency of information, communication and coherence in data generation.

The NBCU shall promote and support scientific research in breastfeeding and work along with national, regional, sub-regional and international agencies in providing useful information from findings to improve best practice.

The NBCU shall:

- i. Achieve the goals of this National Breastfeeding Policy;
- ii. Lead intersectoral and subnational collaboration to implement sustainable breastfeeding friendly initiatives throughout society;
- iii. Lead activities to increase national breastfeeding rates in accordance with the National Breastfeeding Policy;
- iv. Guide the MOH in programme development and its implementation relating to the protection, promotion, and support of breastfeeding and the infant and young child feeding. This will include the promotion of the Code and certification of all maternity facilities as Baby Friendly and the facilitation of mother friendly workplaces and public spaces;

- v. Work with the RHAs and private health facilities to gain international accreditation as Baby Friendly hospitals;
- vi. Promote the implementation of the International Code of Marketing of Breast-milk Substitutes in all public and private health facilities;
- vii. Deal and resolve complaints relating to violations of the Code;
- viii. Coordinate lactation training to all health care workers involved in maternal and child health;
- ix. Coordinate antenatal and postnatal breastfeeding classes for mothers and fathers at health facilities that deliver maternal and infant care;
- x. Extend Baby Friendly concepts to communities, workplaces and public health spaces through health promotion activities;
- xi. Coordinate national breastfeeding training programmes; and
- xii. Report to the DOWH on the programmes, policy, and indicators related to all aspects of breastfeeding;

5.2 Quality Management for Breastfeeding

The Ministry of Health shall ensure that guidance and support is provided to all stakeholders in the provision of high-quality breastfeeding services based on the principles of the BFHI.

- i. The protection, promotion, and support of breastfeeding in facilities providing maternity and newborn services need to be integrated into all relevant policy and planning documents;
- ii. The key clinical practices and global standards of the revised Ten Steps and other key breastfeeding initiatives should be included in the standards of care for professional bodies, such as for nursing, midwifery, family medicine, obstetrics, paediatrics, neonatology, dietetics and anaesthesiology;
- iii. The management procedures for key breastfeeding initiatives including the Ten Steps should be reflected in relevant guidance documents for clinical professionals;
- iv. The development of new, or the review and update of, guidelines and protocols to support services in alignment with the key breastfeeding initiatives and the BFHI; and

- v. Ensure that breastfeeding guidelines are developed and implemented for cases of special consideration such as, HIV positive mothers, mothers and babies in ICU, and cases of caesarean sections, preterm, and low-weight babies.

5.3 Health Professional Competency Building

The Ministry of Health shall ensure that all health professionals involved in breastfeeding are appropriately educated, skilled and trained to deliver breastfeeding care.

- i. At all levels of the health-care system, health professionals need to have adequate knowledge, competence, and skills to implement globally recommended practices and procedures for the protection, promotion, and support of breastfeeding in facilities providing maternity and newborn services;
- ii. Pre-service training for all professions required to interact with pregnant women, deliveries and newborns shall include adequate time and attention on breastfeeding, including on the Ten Steps, and should include theoretical and practical sessions;
- iii. Training on breastfeeding needs to include clinical and administrative practices related to the protection, promotion, and support of breastfeeding, as well as health-worker responsibilities under the Code;
- iv. All health professionals working with pregnant women, mothers, and infants already in practice need to be educated on timely and appropriate care;
- v. On-the-job refresher training sessions and continuing education are needed, and should be competency based, focusing on practical skills rather than only on theoretical knowledge; and
- vi. To ensure long-term sustainable capacity-strengthening, teaching staff with appropriate qualifications, education and experience, should be appointed to teach and, if necessary, adapt or develop the new materials.

5.4 Regulations of Breastfeeding Services

The Ministry of Health shall, through consultation with the relevant stakeholders, facilitate the drafting of guidelines, regulations, and legislation to support breastfeeding services in alignment with the BFHI.

The Ministry shall ensure that regulations and guidelines are kept current and up to date with international best practice for breastfeeding. This shall include review and amendments to the various relevant legislations and if necessary, the formulation of new legislation and regulations.

5.5 Communications and Advocacy

The Ministry of Health shall provide accurate, evidence-based information on a continuous basis to staff, the family and the whole community on a continuous basis.

A communications plan shall be developed for ongoing communications and advocacy efforts to ensure sustained implementation of breastfeeding services. Key audiences will be engaged such as:

- i. Facility leaders (both governmental and non-governmental) such as hospital directors or chiefs of obstetrics, who are critical decision-makers;
- ii. Professional associations of nurses, midwives, paediatricians, obstetricians, neonatologists, and dietitians who are directly affected by changes in standards for breastfeeding care;
- iii. Legislators and funders (including the Ministry of Finance and donors) to ensure their ongoing engagement with and investment in breastfeeding;
- iv. Pregnant women, their families, and other community members are a pivotal audience to increase the demand for improved protection, promotion, and support of breastfeeding in facilities providing maternity and newborn services;
- v. The information being shared, and the method used for dissemination, should be tailored to each audience and informed by each audience's knowledge and attitudes, as well as their expected role in supporting breastfeeding services; and
- vi. Improved community support for breastfeeding, including improved quality of primary health care and strong peer networks, is critically important to ensure that mothers are able to successfully breastfeed. The Ministry will foster the development of numerous types of community breastfeeding support through primary health-care centres, community health workers, home visitors, breastfeeding clinics, nurses/midwives, lactation consultants, peer counsellors, and mother-to-mother support groups.

5.6 Breastfeeding Information Systems

The Ministry of Health shall facilitate the development and implementation of an information system for breastfeeding services.

Information is required to make evidence-based decisions. A system is needed for information production/collection, analysis, and dissemination. This will involve identifying the type of information needs, the appropriate sources of the information, and standardisation of tools for collection and analysis.

5.7 Research into Breastfeeding

The Ministry of Health shall facilitate the development and implementation of a Research agenda into breastfeeding services.

A national research agenda will also be developed in collaboration with the UWI and other relevant stakeholders. There shall be collaboration among researchers, policy makers, service providers, and other key stakeholders to ensure research is prioritised and conducted with high ethical standards and designed to inform decision-making related to the strategic areas.

6 ROLES AND RESPONSIBILITIES

The principal aim of the MOH is to promote successful exclusive breastfeeding through the healthcare facilities operated by the RHAs and other private health facilities. The success of the BFHI is incumbent on several departments of the MOH, the RHAs, all private MCH facilities, civil society groups, medical and nursing institutions, and international, regional, and sub - regional agencies. A brief description is given below of the responsibilities of ascribed to each organisation/department.

6.1 The Ministry of Health

The MOH is responsible for working along with international, regional, and local organisations to provide oversight for breastfeeding. The MOH will coordinate the national support for the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes.

6.2 The Directorate of Women’s Health and the National Breastfeeding Coordinating Unit

To develop and implement breastfeeding initiatives, including the Ten Steps, with supporting monitoring and evaluation assessments as aligned to international and local reporting indicators.

The Manager of the NBCU acts as Program Manager for the National Breastfeeding Programme. The Manager was appointed in September 2018 and is supervised by the Director of Women’s Health.

6.3 The Health Education Division (MOH)

The NBCU works in collaboration with this Division to promote breastfeeding on a national level as well as to test all educational material produced by the NBCU for dissemination to the public.

6.4 The Corporate Communications Department (MOH)

The Corporate Communications Department is responsible for providing an avenue for narrative of breastfeeding, generated by the NBCU, to all facets of the media. The promotion of all national activities such as conferences, training, and effective relaying of information to all sectors in the public and private domain falls under the purview of this Department.

6.5 International and Regional Bodies (WHO, PAHO, UNICEF)

These agencies collaborate with the Ministry of Health in establishing key breastfeeding initiatives, including the Ten Steps ⁽¹⁶⁾. These are outlined below:

1. Establish or strengthen a national breastfeeding coordination body in Trinidad and Tobago;
2. Integrate the Ten Steps and other key approved breastfeeding initiatives into relevant national policy documents and professional standards of care;
3. Provide training and enhancement of skills and competency of health professionals and managers in implementation of the breastfeeding initiatives, including the Ten Steps;
4. Utilise external assessment systems to regularly evaluate adherence to breastfeeding initiatives, including the Ten Steps;
5. Develop and implement incentives for compliance and/or sanctions for non-compliance with key breastfeeding initiatives, including the Ten Steps;
6. Provide technical assistance to facilities that are making changes to adopt key breastfeeding initiatives, including the Ten Steps;
7. Enhance the monitoring and evaluation tools used to assess the implementation of key breastfeeding initiatives including the Ten Steps;
8. Advocate for breastfeeding initiatives, including the Ten Steps, to relevant audiences; and
9. Identify sufficient resources to ensure the ongoing funding of the initiative.

6.6 Regional and Sub-Regional Breastfeeding Agencies

These agencies provide the technical and financial support needed for the expansion of breastfeeding. They play a significant role in uniting the countries to generate the support that is needed in the Region for breastfeeding. The expertise necessary in developing the Breast-milk Bank is incumbent on our Government collaborating with our regional and sub-regional partners.

6.7 Regional Health Authorities and other Private Health Facilities

1. Hospital Policy:

Each RHA must have a written hospital breastfeeding policy which must entail the prohibition of promotion of infant formula bottles, teats, and pacifiers. Each policy must contain standard operating procedures for every category of staff and a monitoring and evaluation tool for breastfeeding. This RHA breastfeeding policy should be routinely communicated and reinforced to the staff. RHAs will file intent for Baby Friendly certification, facilitate NBCU site visits as well as assessment, re-assessment, and training by the NBCU.

The RHAs and private institutions will provide internal and external reports on relevant indicators using the mechanism supplied by the NBCU.

2. Staff Competencies:

Training of staff must be done in keeping with the gold standard. Staff must be trained at the appropriate level in line with their professional capacities. Levels of competencies must be checked periodically. The RHA must respond to the jurisdiction and standards for training for matters pertaining to breastfeeding.

3. Antenatal care:

Medical professionals must educate pregnant women and their families on the importance of breastfeeding. All pregnant women must be educated on how to feed their babies.

4. Care right after birth:

Mothers must be allowed uninterrupted skin to skin contact with her baby immediately after birth for a period of at least one hour, unless medically indicated. Mothers must be assisted to initiate breastfeeding.

5. Support mothers with breastfeeding:

Medical professionals must observe and assist mothers with positioning attachment and suckling for the infant. They must offer practical breastfeeding support. Mothers must receive assistance from staff to overcome breastfeeding challenges.

6. Supplementing:

The policy of each RHA is to allow each infant to breastfeed unless medically indicated. Mothers who decide not to breastfeed must be educated on the safe preparation and proper use of alternative methods of nutrition. Hospital policy must include the use of donor milk as a priority over infant formula when supplementary feeds are needed.

7. Rooming-in:

Each hospital must continue to practice rooming in to allow mother and baby to stay together during hospitalisation and mothers with babies who need special care should be allowed to stay with their babies.

8. Responsive feeding:

Medical professionals must educate mothers about feeding cues to know when their baby is hungry. Mothers must be educated on feeding on demand so as not to limit breastfeeding times.

9. Bottles teats and pacifiers:

Hospital breastfeeding must include the risk of bottle, teats, and pacifiers and all mothers should be counselled against the use of bottles teats and pacifiers.

10. Discharge:

Each RHA must have in their policy an appropriate referral system for mothers to receive breastfeeding support in the community. The RHA must work with civil society groups in the community to improve breastfeeding support services.

6.8 Civil Society Groups

The value of these groups is to work in tandem with the NBCU to protect, promote, and support breastfeeding. These groups also provide a service for the pregnant and nursing mothers with the counselling support needed to successfully breastfeed. The GORTT has shared a long-standing relationship with one of these groups, namely The Breastfeeding Association of Trinidad and Tobago (TBATT).

6.9 Trainers and Assessors

Step 2 of the Ten Steps to Successful Breastfeeding requires that all healthcare staff be trained in the BFHI and staff competency is required to accomplish this goal. Trainers and Assessors are required to maintain their skills relevant and up to date with fulfil the duty of accessing the health facilities for accreditation by the WHO. Training of BFHI Assessors and Trainers is the sole responsibility of the MOH.

6.10 Medical and Nursing Schools

Pre-service training is a requirement of the BFHI for all persons training to become health care and clinical professionals. This ensures that on entry to the practical setting the student is well prepared to assist the pregnant or nursing mother with breastfeeding.

6.11 Families

Families will be encouraged, through the RHA as well as through media and other sensitisation methods, on the importance of supporting breastfeeding mothers. Family members, especially fathers, will be expected to assist breastfeeding mothers by encouraging them to continue breastfeeding as long as possible including in public, share responsibility for caring for the infant, and communicate openly about breastfeeding together and with health care professionals or breastfeeding support groups.

6.12 Information, Communication and Technology (ICT)

Information and communication technology have to be leveraged for breastfeeding support. This includes providing online breastfeeding information to health care workers, breastfeeding support groups, and to the community through breastfeeding interviews; and information sharing using radio, television, email, social media and online networking.

Specific support for breastfeeding mothers may include telephone calls, SMS, email, 24-hour online counselling services, video, and recordings that mothers share and discuss amongst themselves in an informed environment.

7 MONITORING AND EVALUATION

7.1 Main Outcome Indicator:

Increase in the national rate of exclusive breastfeeding up to six (6) months of age.

A full list of performance, outcome, and monitoring and evaluation indicators and corresponding statistical data will be disseminated as follows in the tables below:

The Exclusive Breastfeeding Rate (EBR) is calculated as:

$$\frac{\text{\# of infants 0- < 6 months exclusively breastfed}}{\text{total \# of infants 0- < 6 months}} \times 100$$

Yearly increase is % for a given year – previous year

7.2 Monitoring and Evaluation - Assessment

RHA stakeholders will be assessed in compliance with the Ten Steps. The monitoring and evaluation include key indicators detailed in Table 2 ⁽¹⁸⁾:

Table 2: Key Indicators for Monitoring and Evaluation of Breastfeeding ⁽¹⁸⁾.

Monitoring and Evaluation Tool	Period of Data Collection
<p>Exclusive Breastfeeding Rate (EBR) The percent of infants aged 0 - <6 months (0-182 days) who are being exclusively breastfed. An infant is considered to be exclusively breastfed if he/she receives only breast-milk with no other liquids or solids, with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines</p> $\frac{\text{\textit{\# of infants 0– < 6 months exclusively breastfed}}}{\text{\textit{total \# of infants 0– < 6 months}}} \times 100$	Each RHA and private MCH facility to provide a monthly report.
<p>Never Breastfed Rate (NBR) The proportion of infants never given breast-milk over the proportion of live births, in a reference time period. # of children never receiving breast-milk / # of live births per time period (*100)</p> $\frac{\text{\textit{\# of children never receiving breastmilk}}}{\text{\textit{\# of live births}}} \times 100$	Each RHA and private MCH facility to provide a monthly report.
<p>Initiation of Breastfeeding in the First Hour of Life (IBR) The percentage infant 0 - <12 months of age who were put to the breast within one hour of birth.</p> $\frac{\text{\textit{number of infants discharged during reference period who were put to the breast one hour after birth}}}{\text{\textit{total \# of infants discharged during reference period}}} \times 100$	Each RHA and private MCH facility to provide a monthly report.
<p>Continued Breastfeeding Rate at 12 Months (CBR12) The percentage of children 12 - <16 months of age (366-426 days) who are breastfed</p> $\frac{\text{\textit{number of children 12–< 16 months of age breastfed in the last 24 hours}}}{\text{\textit{\# live children 12– < 16 months of age}}} \times 100$	Each RHA and private MCH facility to provide a monthly report.
<p>Continued Breastfeeding Rate at 24 Months (CBR24) The percentage of children 20 - <24 months of age (608-730 days) who are breastfeeding children</p> $\frac{\text{\textit{number of children 20–< 24 months of age breastfed in the last 24 hours}}}{\text{\textit{\# live children 20– < 24 months of age}}} \times 100$	Each RHA and private MCH facility to provide a monthly report.

Monitoring and Evaluation Tool	Period of Data Collection
<p>Full/Partial/Token Breastfeeding (FPTB) Breastfeeding patterns are highly variable. Full or nearly full breastfeeding is also defined clinically as a pattern that will maintain both milk supply and amenorrhea. This is calculated by making the “number of times breastfed” the numerator and the “number of times of any food or liquids are given” the denominator (see Figure 2). The definitions are:</p> <ul style="list-style-type: none"> • Full Breastfeeding: at least 85% of feeds are breastfeeds, • Partial: 15-85% of feeds are breastfeeds, and • Token: fewer than 15% of feeds are breastfeeds. 	Each RHA and private MCH facility to provide a monthly report.

Infant A:
Infant A received 4 Breastfeeds, 1 water feed, 3 juice and 2 ice waters. The percentage of all feeds that are breastfeeds would be:

$$4 / (4+1+3+2) \times 100 = 40\%$$
Infant A is only **“Partially Breastfed”**

Infant B:
Infant B received 8 breastfeeds and 1 water feed. The percentage of all the feeds that are breastfeeds would be:

$$8 / (8+1) \times 100 = 89\%$$
Infant B is **“Fully or Nearly Fully breastfed”**

Infant C:
Infant C received 9 breastfeed and 1 vitamin feed.
Infant C is **“Fully Breastfed”**

Infant D:
Infant D received 3 breastfeeds, 8 formula feeds, 6 juice feeds as well as vitamins and medicines. The percentage of all the feeds that are breastfeeds would be:

$$3 / 8 \times 100 = 18\%$$
Infant D is **“Token Breastfeed”**

Figure 2: Illustrative Computation - Full/ Partial/ Token Breastfeeding ⁽¹⁸⁾.

7.3 Activities and Process Indicators

Initial number and percentage increase of public sector health facilities accredited “Baby Friendly” by BFHI WHO assessors.

- a. Number and percentage increase of local healthcare workers trained or re-certified in the BFHI 20-hour programme or as breastfeeding counsellors, in RHAs and private sector facilities.
- b. Number of BFHI collaboration activities by MOH / multilaterals per year.
- c. Number of attendants to NBCU / DOWH scheduled events, with brief description.
- d. Amount of target breastfeeding communication products developed by NBCU / DOWH / MOH / multilaterals, and distributed by NBCU to relevant stakeholders, with brief description.
- e. Number of non-health private sector or state companies actively supporting employees to continue breastfeeding by providing staff Lactation Rooms.
- f. Existence of amendments to relevant legal instruments, including legislation conducive to best practice in breastfeeding, to support measures against code violations.

7.4 Quantitative Indicators

- a. Increase in the percentage of infants who had immediate and uninterrupted skin to skin within the first hour of life.
- b. Increase in the percentage of infants who received initiation of breastfeeding in the first hour of life.
- c. Increase in the percentage of infants exclusively breastfed for six months.
- d. Decrease in the percentage of infants admitted to hospital for childhood illnesses related to increased number of exclusive breastfeeding.

8 CONCLUSION

The GORTT is committed to ensuring that all health facilities achieve Baby Friendly status as this will be beneficial to all citizens. The National Breastfeeding Policy has been developed to guide the practice of breastfeeding in Trinidad and Tobago. The aim is to ensure that the infant mortality rate improves by increasing the exclusive breastfeeding rate. Science supports the significant role that breastfeeding plays in the reduction of non-communicable diseases. As a nation, we must utilise all resources to mobilise the national community to acknowledge the importance of breastfeeding.

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