Developing Capacity: Strengthening Breastfeeding Counseling in Kenya through Mentorship

Webinar Transcript

Altrena Mukuria-Ashe

Hamjambo watu wote. Good morning, good afternoon, and possibly good evening to everyone. Happy World Breastfeeding Week. Karibuni wageni wetu. Welcome everyone. On behalf of USAID Advancing Nutrition and USAID, I am honored to welcome today. I am Altrena Mukuria-Ashe, senior technical advisor with the USAID Advanced Nutrition and I'll be your moderator for this webinar.

Welcome to the second part of a three-part webinar series that's hosted by the project's capacity and strengthening team. This series aims to review the importance of nutrition competencies and how to translate them from a concept to a tangible relevant tool for designing high-quality capacity-strengthening interventions.

Each webinar focuses on a different application of competencies, capacity assessment, capacity development, and capacity evaluation. The first webinar was held in February of this year and featured a case study focused on competency assessment. Participants heard from speakers about New York Resilience and Food Security activities experience piloting a tool to assess social and behavior change skills among its staff, including the process, the results, the insights, and considerations for others interested in capacity assessment.

You can find a recording of the webinar and related resources on the USAID Advancing Nutrition website under events and linked in the chat. Today is a celebration of World Breastfeeding Week, and we are pleased to present the second webinar moving from assessment to developing capacity strengthening breastfeeding counseling in Kenya through mentorship.

Today's discussion is right in line with the theme for World Breastfeeding Week, stepping up breastfeeding education and support. Before we go any further, many of you have checked in the chat box. But those of you who've just joined, please let us know who you are and where you are coming from, what organization you're working for, and the country you are joining us in the chat. We'd love to hear. I see that Kenya's here, Indonesia, Austria, Nicaragua, Madagascar.

Welcome, everyone. Burundi. It's great to see you all here and thank you for joining us. Now, I invite Yaritza Rodriguez our USAID Advancing Nutrition Communications Officer, who is providing behind-the-scenes support to the webinar to go over a few housekeeping notes before we delve into the content of the webinar. Yaritza.

Yaritza

Thank you, Altrena. My name is Yaritza. I'm a communications officer with USAID Advancing Nutrition. I'm happy to welcome you today. I'll be going over, as Altrena said, a couple of Zoom housekeeping

items. First of all, our event today is available in French. To hear the French interpretation, please click the interpretation icon to have that option in French. Cliquez sur l'icône intitulée "interprétation" pour avoir la possibilité d'écouter le webinaire en français.

To hear the webinar only in French, select mute, original audio. Pour écouter le webinaire uniquement en français, vous pouvez désactiver l'audio original. That's for interpretation.

Next slide, please. If at any point during today's webinar, you're unable to hear the speakers or the presenters, please make sure you've connected your audio by selecting the headphones icon that'll show up in your Zoom controls. In addition, please send a message to everyone, as mentioned in the chat box, to introduce yourself. Please also use the check box to send in your comments or ask for support during today's webinar. Myself, tech support one and tech support two, are happy to assist you in any way we can and answer your questions.

Next slide, please. Today, we'll be making use of the Q&A box. Please submit your questions for the panelists in the Q&A box. Panelists will either reply to you via text in the Q&A box, or will answer your question during the live discussion portion of the webinar. Please do submit any questions you might have in the Q&A box, that's where we'll be collecting them.

Next slide, please. If you need any additional help with Zoom today or have any additional questions, please email info@advancingnutrition.org. We'll be happy to assist again however we can. Finally, please do note that we are recording this webinar and we hope to send all the link to the recording soon after so that you have that available for re-watching the webinar. Thank you all so much for joining, and I'll now pass it over to Altrena once again.

Altrena

Thank you, Yaritza. Before continuing, we'd like to do a poll of our audience on what comes to mind when you think of capacity strengthening and breastfeeding. The polls will show up in a second. Please click the link, provided in the chat box or go to the mentee.com and insert the code that you see on the screen. What one word comes to mind when you think of capacity strengthening for breastfeeding?

Yaritza

Altrena, will you let me know if you're able to see the poll?

Altrena

There it is.

Yaritza

Okay, great. Thank you.

Altrena

Do we put a link in the chat for people to click on to go to mentee? There you go.

Yaritza

Click on the link to be able to respond. Thank you.

Altrena

While you're responding to that, I want to say greetings to our participants from Somalia, Cameroon, Sudan, Ghana, Kyrgyz Republic, Uganda, Australia, DRC, Niger, Zambia, Bangladesh. Nigeria I see you just came in. Welcome, welcome. Within the US, we have folks from Washington DC, North Carolina, Colorado, Florida, New York City. The world is represented here. Welcome, welcome. The mentee is-- the word cloud is growing. We see that key is support, mentorship, training, empowerment. What else do we have here that you all-- Thank you so much.

All these words about what capacity strengthening is for breastfeeding. I can't keep up. It's moving so fast. Awareness and so on. Thank you so much for those. Now let's move on to a small quick introduction to what do we mean by competencies. When we define a set of competencies for specific roles and behaviors, those competencies outline and measure the core knowledge, attitudes, skills needed to perform well.

From this core set of skills, we can align a set of tools to strengthen and reinforce these skills. We look at assess. That is looking at whether someone we want to hire or team already in place have the right skills for this role. Two, we want to develop. Once we've hired or have someone in place, which skills do they need to do their job well?

Three, we want to evaluate. Is this person's performance in line with what is needed for this role? This alignment is critical to effective performance improvement and achieving larger scale impact. It's often referred to as competency standardization, which some of our speakers coming will go into more detail about that, and is reflected in competency frameworks, and often competency lists.

Today, we'll focus on how standardized breastfeeding competencies are being used with the baby-friendly hospital initiative to improve breastfeeding counseling skills of key health professionals working in hospitals.

Development of breastfeeding counseling skills has been approached in a variety of ways, which we will hear more about from our speakers. When looking to develop health worker skills, we must be aware of expectations for their performance of specific duties using these skills. Assessment of competencies is closely linked to the evaluation of competencies which focuses on how well the performance aligns with the expectations for that role.

Terms like these may differ across programs and services, but having agreed set of competencies at the center of clinical breastfeeding support is key to quality service delivery and ultimately breastfeeding success. Next slide. When we look at job descriptions and tools that supervisors might use to assess suitability for a role, develop skills, and evaluate performance, those tools should be aligned to a set of clearly articulated competencies.

Mentoring can be used to enhance and support the building of those competencies. Mentoring is a flexible learning and teaching process. Mentorship is defined as a dynamic reciprocal relationship in a work environment between an advanced career person, the mentor, and a beginner staff, the mentee. It aims at promoting the development of both the mentor and the mentee. Mentoring is recognized as a catalyst for facilitating career selection, advancement, and productivity. Next slide.

The objectives for this second webinar are, one, to learn about breastfeeding-related competencies in the Baby-Friendly Hospital Competency Verification Toolkit, mouthful right there, and their relevance to

the 10 steps to successful breastfeeding which many of you breastfeeding colleagues are very familiar with. Those of you who are coming from the competency and capacity-building perspective, you will learn more about those 10 steps.

Learn how these breastfeeding competencies are being incorporated in the design of a yet-to-be-tested mentoring program in Kenya that seeks to strengthen breastfeeding counseling skills among health workers. Then finally, we want to explore and discuss lessons, considerations, and recommendations for applying competency-based skills development approaches using the Kenya BFHI taskforce experience as a starting point.

Next slide, please. No further ado from me. I'd like to introduce our team of speakers who will be sharing with you today. We'll be hearing from five speakers to discuss capacity building for breastfeeding counseling. Since we have a very tight program, I will ask that you put your questions in the question and answer box and specify for which speaker that you are addressing your question. We will have the speaker answer them after their presentation or during the Q&A session at the end.

I'll ask speakers if you will put your camera on so people can at least see you at the beginning, or just turn it on to say hello. Without further ado, the speakers we have just briefly, I will say their names, but before they present, we will introduce them thoroughly.

We have Esther Mogusu from Kenya, Veronica Kirogo also from Kenya, Laurence Grummer-Strawn from WHO, and Jeniece Alvey from USA, Washington. Thank you. Now I'd like to introduce Jeniece Alvey who will be our next speaker, who is a Nutrition Advisor at USAID in the Bureau of Global Health. She is based here in Washington, DC. She will deliver a few key introductory remarks. Thank you, Jeniece.

Jeniece Alvey

Thank you, Altrena. First, I want to thank USAID Advancing Nutrition for inviting me to provide some opening remarks during such an important week and a topic that's very dear to my heart as I'm also an international board-certified lactation consultant. I want to also express my gratitude for our expert speakers and panelists that you'll be hearing from in just a few moments particularly Mrs. Veronica, Kirogo from the Kenya Ministry of Health, and to all of you who are joining us for this important discussion.

Breastfeeding has been a cornerstone of USAID's maternal and child survival program for the last 40 years. This powerful intervention can save the lives of women and children around the world. The research and evidence is sound. Breastfeeding has enormous health benefits for mothers and babies, from strengthening a baby's immune system and preventing infection and disease to reducing a mother's risk of certain breast and ovarian cancers as well as other chronic diseases like type 2 diabetes and heart disease.

From policy to practice, better ways to support mothers and families start and continue breastfeeding are needed around the world, particularly in the early months after birth when skilled support and counseling for breastfeeding is crucial. USAID's breastfeeding programs focus on providing support to lactating parents through skilled breastfeeding counseling, and also education programs to build breastfeeding champions among community and family members.

At the Nutrition for Growth Summit in 2021, USAID reinforced our commitment to scaling up breastfeeding support along with WHO and UNICEF. We were pleased to see so many other governments and organizations also demonstrating their commitment to breastfeeding.

Behind the lead of country partners, like Kenya, we must come together today as development stakeholders to bolster and sustain commitment and investment for breastfeeding and put us on the path to preventing more maternal and child deaths around the world. As we continue to see the devastating impacts of COVID-19, ongoing crises, and conflicts, especially the food security crisis on children, supporting good nutrition from the start is even more critical.

Today's event is focused on perhaps the narrow, but yet critically important aspect of breastfeeding support and counseling competencies for the knowledge, skills, and attitudes to optimally support breastfeeding. While breastfeeding may be natural, it often doesn't come naturally to most. Most breastfeeding parents will need some support, particularly in the early days and weeks after delivery and sometimes even specialized support when challenges arise.

Health workers, community health workers, and peer supporters all have an incredible role to play in supporting families during this time and need to be equipped with those competencies to support the families. Over the years, a multitude of trainings and courses on the benefits of breastfeeding and how to support breastfeeding have been given all over the world, supported by governments, universities, or even development partners.

They often have not focused on ensuring that those who go through the training retain sufficient knowledge, skills, confidence to use those skills or receive ongoing support while practicing those new skills. USAID is pleased to be working with partners like WHO and the Kenya Ministry of Health to advance our learning on how to better equip lactation supporters with the right competencies when working with breastfeeding families.

I'm really excited to hear from our speakers today, to hear the questions and experiences that all of you joining us have. Thank you again for having me, and I wish you all a really wonderful World Breastfeeding Week. Thank you.

Altrena

Thank you, Jeniece for those warm words of welcome and introduction to the topic and background information that you gave us. We really appreciate that and it sets us well to move on to the next part of the program. I just want to say, give a shout-out to some more countries that have checked in since we last did a round, Nepal, Syria, Via Jordan, Bangladesh, India, some more participants from Kenya, Tanzania, Nigeria. Welcome, welcome, welcome. As I said, we have the world represented. Before we continue, let's do another quick Zoom poll for you to answer.

You can just click on your screen. Please answer the two questions. For our French speaker audience, you will see that the translation is on the screen, but you would still click the same numbers on the English side. First of all, did you know that step 2 of the 10 steps of successful breastfeeding was changed in 2018 from only providing training to health workers to ensuring that health workers have sufficient knowledge, competence, and skills to support breastfeeding? Let us know your experience, whether you're familiar with this change. Maybe you know about the change, but didn't know the difference.

Maybe you didn't know about the change at all, or if you're totally unfamiliar with the 10 steps. We just want to know where our participants are coming from and their experience. Then number two, if you would check on that one, what is your level of familiarity with the BFHI? That's Baby-Friendly Hospital Initiative Competency Verification Toolkit that recently came out too. You can let us know if you've heard about it, or you've never heard about it, if you're aware, but haven't used it. Maybe you read it, but not been able to apply it to your work. Maybe you've read it, you're familiar with it and have actually applied. Please complete this poll and let us know your experiences.

Altrena

We have the results from the poll, final results showing up. I don't see them. Here we go. It's almost equal distribution of those who are familiar and not familiar with the 10 steps. The change, it's step number 2. Then with the breastfeeding competencies, we find that people-- the be FHI competency toolkits, there is some familiarity. There are a few who've actually applied it in their work. We'd love to hear from you during the Q&A of your experience. Thank you so much.

I think that our next speaker will fill in some of those spaces that have not familiarity with the toolkit and with the 10 steps. I'm happy and pleased to be able to introduce our next speaker, Dr. Laurence Grummer-Strawn. Larry is the unit Head of the Food and Nutrition Action in Health Systems Unit at the World Health Organization. He coordinates WHO work on infant and young child nutrition treatment of acute malnutrition and prevention of micronutrient deficiencies.

Larry also leads the Baby-friendly Hospital Initiative, the Code of Marketing of Breast Milk Substitutes, and the Global Breastfeeding Collective. Welcome, Dr. Grummer-Strawn. Remember everyone to put your questions in the Q&A box that you have for him, and we'll try to answer them.

Laurence Grummer-Strawn

Thank you Atrena, good morning. Good afternoon. Good evening to everyone. I'm happy to be joining this webinar to be talking about competency development and assessment in the context of the Baby-friendly Hospital Initiative. I can see from the last poll that you're all familiar at least to some extent, with Baby-friendly and the 10 steps but we'll give a little bit of context of this and then talk about the competency verification toolkit that we've developed. Next slide, please.

Just to start off with a little bit of a history of Baby-friendly, this actually goes back to 1989. We've been at this for quite a long time when WHO and UNICEF published a joint statement on the unique role of maternity facilities in the support, protections, and promotional breastfeeding. One of the summaries within that document was a longer document but we summarized it in the 10 steps to successful breastfeeding that have now become very widely known around the world and really became the basis of what was a call to all hospitals to implement this.

Two years later, WHO and UNICEF launched the initiative. They weren't actually tied together in the first place. It was originally to say, here's what hospitals in general ought to do. Then when the initiative came along and said, well, if the facility can demonstrate that they are doing these 10 steps and can pass a test and prove their practices have changed, they trained everyone as well as that they're complying with the code of marketing of breast milk substitutes, then they could be designated. They could get a plaque on the wall. They could be recognized as being a baby-friendly facility because they're doing what is actually needed for the support of breastfeeding within their facilities.

This was slightly updated in 2009 but really continued on with the same 10 steps. We came to 25 years. We just celebrated the 25th anniversary of the initiative. We really brought the world together to look at how was it doing, what was the success of the of the implementation, where are we seeing gaps, how do we need to think about the initiatives somewhat differently.

The next year in 2017, WHO published new guidelines that were based on a systematic review of the literature step by step to really understand how are these evidence-based. That wasn't really the standard back in 1989. At the time, it was just good practice, what we all knew, but really, we wanted to look at the science behind it. Then using that new science, we came up with new implementation guidance in 2018 to look at the 10 steps. To see if there needed to be some revisions to them, as well as to look at how to actually implement the program. Next slide, please.

First of all, the 10 steps didn't substantially change in terms of their overall intent in 2017, 2018 but the intention of each steps would remain the same, still focus on the same topics but there were some important changes in terms of the emphasis of the different steps. We're not going to take the time to go through today, to go through each of the steps and how they were reiterated a little bit differently.

We will talk a little bit more about staff competency but just to note here, the 10 steps did add a few parts of facility policies to really emphasize the code of marketing. It was always there as part of being designated as a baby-friendly facility but sometimes hospitals would say, "Oh, yes, we adhere to the 10 steps. We just haven't been designated," and yet they weren't following the codes. We thought it was important to make sure that this was integrated as a core part of it but also to emphasize internal monitoring for maintaining those changes in policies within the facility. Those are some of the major changes in the policy section, but others also had some nuances and changes. Next slide.

Let's talk a little bit about the step 2 change. The original wording back in 1989 was to train all healthcare staff in the skills necessary to implement this policy referring back to the policy from step 1. At that time, it was really a focus that the facility had the responsibility to train their staff on the skills that were needed for the support of breastfeeding. This was rethought in 2018 to, instead focus on training, it was to ensure that staff have sufficient knowledge competency and skills to support breastfeeding.

It really shifted the whole focus from there being responsible for doing the training into actually checking that staff had the knowledge, competency, and skills that were necessary. It was a real shift in focus. Next slide, please.

One of the reasons for that was that we thought that we really needed to rethink how we actually do capacity building across countries. We actually laid out within this new iteration of the Baby-friendly Hospital Initiative that national programs have a broader responsibility. It's not about designating which facilities are doing the right thing, but they have a broader coordination responsibility, setting up policies, standards of care across the country. There's actually a national responsibility to ensure that health professionals actually have the capacities that they need for delivering good care.

It really shifted the onus of the training building this into between infrastructure to being a national responsibility rather than a one hospital at a time responsibility. It shifted the focus to be thinking much more about pre-service training. We can't wait until we have nurses or physicians operating in hospitals and then telling them, "Oh, you've been doing things wrong. You need to be retrained about this here." In fact, this needs to be part of their standard as the standard of care.

Recognize that there still needs to be somebody for continuing education as new science comes out, as people have forgotten things. There needs to be in-service training for those who didn't get the pre-service training appropriately. We can't wait 30 years for everyone to go through this care but really need to focus in on getting this more national approach to it. It needs to be more skills-based. It needs to have much more face-to-face interaction. It's not just a matter of having a seat in the chair for 20 hours as you go through a curriculum, but it really has to make sure that you get that competency.

Finally, that we needed to really make sure we were doing assessments, to make sure that staff have those competencies. Next slide, please. This is what led WHO and many of our partners to develop a toolkit. We recognized that the 20-hour course that was the standard in Baby-friendly prior to that were a textbook chapter doesn't necessarily lead to the knowledge skills and attitudes that are there. Someone can sit there, maybe they're good at passing tests, maybe they're falling asleep in the classroom, maybe they're not actually applying the skills that they're getting through the course. They don't necessarily come out with the competencies.

On the other hand, we also know that some providers may have gotten those competencies when they were working in another facility or maybe they've been doing really good care for many years. Having them just sit in a classroom to go through 20 hours to check the box that they've done the training that they're supposed to get that that really wasn't the best approach. We really needed to be looking more at competency verification.

In collaboration with our partners, we developed this toolkit. Next slide. I'll talk through a little bit of what's within that. We broke down the competencies into 16 key areas, really 16 competencies. Within them, there's a lot of skills, knowledge that needs to be unpacked within it. We'll really define it as 16 competencies to focus on. We broke them down into the seven domains that really addresses the continuum of care throughout the maternity facility stay.

The first two were really more general, the management procedures that might be needed to support these within the facility. The foundational skills that are needed for communication and good counseling skills. Then walk through the prenatal steps within the 10 steps. Birth and immediate postpartum, essential issues for communicating to a breastfeeding mother and working with the breastfeeding mother, helping mothers who might have special needs, and then finally, the care that's needed through discharge.Then there are some individual competencies within each of those. Next slide, please.

It needs to go deeper than that. Within the competencies themselves, we developed performance indicators, and these are the things that really need to be assessed. When we say assessment of a competency, we need to break it down into the indicators of those competencies. We're obviously not going to go through 64 of them into today's presentation. I just pulled out three that relate to the assessment of making sure that the mothers have the knowledge that they need to support breastfeeding.

Within that competency number eight, we actually had three performance indicators highlighted here. They actually pertained to different BFHI steps. While you can break these down into steps and then the documents give that ability, you can see that many of them actually relates to multiple steps at the same time. When we assess the performance indicators, sometimes we're looking just for knowledge. These are the kinds of things that could be actually assessed on a test, might be a multiple choice test or a written test, essay exams, might be a case study that you go through.

Different ways that you could assess that, but we're really just trying to make sure, does the healthcare provider have the knowledge that they need? Other ones though actually require that they have more skills, and they need to be observed demonstrating those skills. Engaging in a conversation with a mother, does she know how to do it? Actually, can she demonstrate that she actually can sit down with a mother and have that conversation to communicate these ideas in an effective way? We break it down into sometimes it's more about skills and attitudes, sometimes more about knowledge.

We use different tools to assess these for each of the competencies. Next slide, please. There are lots of appendices in this toolkit. There's an examiner's resource that really walks through each of the performance indicators, detailed answers as to what we're looking for with a checklist of things that ought to be demonstrated within that particular performance indicator as well as a list of things that should not be observed, so lots of things that are problematic. If we're seeing answers of a certain type or behaviors of a particular type, that these are things we really need to be looking for to make sure that we're stopping those harmful practices or harmful knowledge.

There's another appendix on multiple choice questions. They can really go after that knowledge. There are case studies that can be worked through, observation tools to take a healthcare provider into a woman's environment and actually see how she works in that environment to actually demonstrate that she has these competencies. These different appendices are used as a set, a toolkit to really try to make

sure that we're working through all of the performance indicators to make sure that all of the competencies really can be demonstrated.

Next slide, please. When would you actually use this toolkit? It actually has a lot of utility at various time points. It might be used when new staff are being hired into a facility. You want to make sure that any new staff that you have is actually capable of providing the care that you say is the standard of care for your facility. You want to check with what level they're at. Those who have very poor skills might need to go for a full training course once they recommend that they have that course. On the other hand, if they come in and they already have all the skills that they need, then you don't need to put them through that. You can make that for an assessment criteria.

People might want to take it for themselves into a self-assessment when they're making decisions about continuing medical education. Is this something that I actually need to be thought on, or do I already have the skill sets that are necessary as defined by WHO and UNICEF? It might be used to plan training sessions. Someone may be saying, "Look, we know we ought to train our staff much better, but we want to know what areas we should focus in on." It might be part of a quality improvement process.

If a hospital is trying to change its care practices around breastfeeding that they'd want to say, "Well, where do we stand right now, and how do we actually move our staff through a process to get them up to date?" When we actually have a training course, we might use as a pre-test as well as a post-test to make sure that the training course actually in part of the competencies that are expected. Next slide, please.

Finally, we want to make clear that this is not something that we think is going be a cookie-cutter. It's not as if you can take these tools directly off of a WHO website, and just say, "Okay, now I'm going to start applying them today in my country." Additional performance indicators might very well be needed to make sure that the competencies are available. You might need to add additional questions, more case studies, more observational checklists to be used.

We tried to create a set that would be quite useful and manageable, but we recognized it is not going to cover every circumstance, every opportunity that is necessary. We encourage countries to add to it, share that information back with WHO, back with your UNICEF offices, so we can actually add to this over time and build a more robust set for everyone.

There are alternative assessment methods. While we went through multiple choice exams and direct observations, we could also examine methodologies within countries for oral exams, essay exams, laboratory simulations where people come in to a hypothetical environment but with an actual mother there and work with her or live case studies that we work through. Next slide, please.

I just want to point out that we don't just have the toolkit. There are many other things that are available for supporting countries in the development of better competencies. There's an IYCF counseling course that is not designed specifically for baby-friendly, but obviously has important skills for prenatal counseling, for counseling out in the communities. There's certainly a lot of overlap in the counseling skills that are necessary. Many times the staff will work both in maternity facilities as well as in outpatient clinics and such. Those tools are available.

There's the training course itself for baby-friendly that can be used to develop some of these skills. There's a training course online about the code of marketing of breast milk substitutes as I pointed out a critical part of the 10 steps. There's a model chapter on infant young child feeding that is available now, but we're also in the process at WHO of updating that chapter and hope to publish by the end of this year. There's a frequently asked questions document about the code, various resources to help with that training. Next slide, please.

I just want to acknowledge some of our collaborators on this. This is really the product of a lot of work that WHO and UNICEF did in collaboration with various civil society organizations, the BFHI network, La Leche, IBFAN, the ILCA, and WABA, and some of our key partners that we've been working with on a regular basis over the last couple of years since that 2018 guidance came out. Some of these authors on the left are volunteers from those organizations that really put a lot of time and effort into working out the details of all of the tools and pulling this toolkit together. I just want to thank them for their time. I want to thank you for your time today. Hope this has been helpful to you.

Altrena

Thank you, Larry. Thank you for that great presentation, for that overview of BFHI, 10 steps to successful breastfeeding, and the competency verification toolkit bringing us up to date on the global direction of developing and assessing breastfeeding competencies. We have seen and noted some of your questions. Please keep them. We will hold them for Larry to discuss during the Q&A period.

Now, let us drill down to the country level. Now that we've heard globally, let us learn more about Kenya and how they are approaching capacity building for breastfeeding counseling support. Our next speaker, Veronica Kirogo is the Director and Head of Nutrition and Dietetic Services in the Kenya Ministry of Health. She has worked in both health and agriculture sectors for close to three decades and has vast experience coordinating, developing, and implementing food and nutrition security programs and projects both at the policy and community levels.

Veronica successfully coordinated the writing of The Breast Milk Substitutes general regulation in 2021 and is currently overseeing the rollout of the baby-friendly community initiative in five counties under the Nutrition Improvement through Cash and health education, NICHE project. Welcome, Veronica. We look forward to learning more about what you're doing in Kenya.

Veronica Kirogo

Thank you very much, Altrena. Good morning, good afternoon, good evening participant. Allow me to just share with you what we are doing in Kenya in terms of strengthening for breastfeeding counseling. My presentation will dwell into just giving you the background of key nutrition indicators in Kenya. Then we'll look at the overarching policies and of how to translate those policies to the current Kenya nutrition action plan, and also look specifically at their policies and legislation supporting breastfeeding, give you some updates on the 9 operational targets of the global strategy, and get into strengthening capacity for breastfeeding counseling, but dwell into the Baby-Friendly Community Initiative, which is step 10 of the BFHI.

For majority, maybe who are in this webinar who may not know where Kenya is, Kenya is one of the countries in Africa continent, actually in the East Africa geographically. We have a population of 47.5 million Kenyans. Out of these, for children 0-23 months, we have about 2.2 million, and we have intercensus growth rate of 2.3%. Next slide, please.

In Kenya, one in four, which is about 26% of children under five are stunted, and 4% are wasted, and 4% are overweight, and 11% underweight. In our policy document, childhood malnutrition and sub-optimal breastfeeding have been identified as some of the leading contributors to morbidity and mortality among the infant and young children, and also in terms of the leading contributor to hospital admission. We also did a cost of hunger in 2019, and we established that, as a country, we are losing 374 billion which is approximately $4.3 billion due to child malnutrition. Next slide, please. Sorry for that.

Yaritza

Thank you for your patience. Just one moment.

Veronica

Okay. This figure is showing the status of infant and young child feeding indicators in Kenya based to the Kenya Demographic and Health Survey of 2014. I want to put a disclaimer, we are currently doing the Kenya Demographic Health Survey this year, but this figure are for 2014. At that time, only 62% of the infants were initiated to the breastfeeding as per the WHO UNICEF recommendation of within one hour of birth.

We also have 61% of infant being exclusively breastfed, meaning that they're 39% of children who actually miss on this gold standard. We have about half of the children who are continued on breastfeeding up to the period of two years or beyond. Next slide, please.

How is our policy environment in Kenya? First, I want to say that the Constitution of Kenya 2010 actually has provided for the rights. One of it is right for every person to be free from hunger and have adequate food of acceptable quality. The other right is every child, the right to basic nutrition. As a government, we have to ensure that we are facilitating every citizen to enjoy things right.

From there, we have the Kenya Vision 2030. This is our blueprint for development. Nutrition is a key driver for the human capital pillar in that vision 2030. In order to actualize the economic pillar and also the social pillar of the vision, we have the Food and Nutrition Security Policy that was developed in 2012. It has a critical policy direction in terms of nutrition, but also specifically on infant feeding, we also have the Kenya Health Policy 2014 to 2030, also has key policy direction in terms of nutrition improvement. Next slide, please.

How have we translated this policy into operation? We have done this by developing the Kenya Nutrition Action Plan. The current one is for the period 2018 to 2022. It has 19 key result area which are divided in three category, nutrition-specific key result area, multi-sectoral nutrition sensitive key results area, and enabling environment. In this policy, I said it's coming to an end next year in June. We have targeted to improve the exclusive breastfeeding rate from the 61% in 2014 to 75% by 2012. That's the document that is below the screen. Next slide, please.

In terms of now supporting breastfeeding, I can say actually we have quite a number of technical guidance and policy supporting this. On the right of the screen, you can see that is our summary statement for the national policy of Maternal Infant and Young Child Nutrition, which has included the 10 steps and also has incorporated infant feeding and HIV guidelines. This was done in 2018.

Additionally, we have the Breast Milk Substitute Regulation and Control Act of 2012. This is in line with the court. After that, we also developed the Breast Milk Substitute Regulation 2021. Actually, they came to effect on 30th May of this year. Last week, the Cabinet Secretary also inaugurated the National Committee on infant and young child feeding as provided for by the act.

We also have Health Act 2017, specifically Article 68, and this deals with maternal nutrition and micronutrient supplementation. Article 71, 72 talks to the lactation station, which is a requirement for every employer to provide that lactation station in order to support workplace breastfeeding. We also have the Employment Act 2007. Article 29 specifically is what we can call maternity protection because it provides for 13 weeks maternity leave and also gives two weeks paternity leave. Next slide, please.

In terms of the nine operational targets of the global strategy, I mentioned about the National Committee for Infant and Young Child Feeding, which was inaugurated last week. We also have included

the 10th step in the National Maternal Infant and Young Child Policy summary statement. These 10 steps have actually been implemented as the standard of care in all health facility offering maternity services and newborn care. We have also developed guidance, like the National Guidelines on Human Milk Bank. We have a pilot project going in the largest maternity referral hospital in Nairobi, Human Milk Bank.

We also have developed guidelines for Securing a Breastfeeding Friendly Environment at Workplace. This we did it at 2018, and this gives direction for employers how just to set a lactation station at the workplace. I mentioned about the maternity protection policy, and of course, the Breast Milk Substitute regulation which are already enforced.

I want to say this regulation, according to the World Health Organization report on the implementation of the code, Kenya in 2020 scored 69%. It was categorized as modestly aligned, but with the development of the regulations and now effecting this regulation, we failed in the labeling category. This regulation actually brings out now regulation on issues of labeling. Next slide, please.

Looking at the process or the chronology of how we have been strengthening breastfeeding counseling in the country, where we started in 1981, where we had health worker training on breastfeeding, and this was started at the largest national referral hospital called Kenyatta National Hospital.

From there in 1991, we actually assessed several hospital, and four hospitals were actually accredited as being a Baby-friendly Hospital. This **[unintelligible 00:49:25]** the Pumwani Maternity Hospital, Kenyatta National Hospital, Jaramogi Oginga Odinga Teaching and Referral Hospital. This is in the western part of the country. We also had Nyeri County Referral Hospital in the Central Region of the country.

Then in 1997, the breastfeeding curriculum for pre-service at the University of Nairobi Medical School was approved. I can say we have been getting a lot of support from the University of Nairobi in terms of advancing the issue of breastfeeding counseling. In 2008, we did a countrywide scale up of the World Health Organization and UNICEF Infant and Young Child Feeding Integrated Course and BFHI implementation. Then in 2009, we also conducted a nationwide BFHI assessment. This was done in 230 health facility which were accredited.

Altrena

Excuse me. Sorry to interrupt, we have just two minutes left. Can you wind up and get to the key points? Thank you.

Veronica

Okay. Thank you. We also have implemented the Baby-Friendly Community Initiative which we are rolling out. This is extension of the 10 step. This is what I would like to go briefly on, if we can move into the next stage. Next slide. For the Baby-Friendly Community Initiative, we have developed several packages. We can move to the next slide. Next slide, please.

Yes, these are the materials we have developed to guide the Baby-Friendly Community Initiative. We have the *Implementation guideline*, we have *the Trainer's guide*, we have the *Mentorship, supervision*, *self-assessment guidance tool*, and we also have a small booklet we call *The First 1000 Day* and also we have a guidance on external assessment protocols. This is one that is guiding in the rollout of Baby-Friendly Community Initiative. Even currently, we are doing, one, integrating it with a socio-protection of the cash transfer and it has been able to be seen that it is impactful. Next slide. Next slide.

In terms of the BFHI, which we'll be taken through by my colleague in the next representation, we are finalizing the contextualization. Finally, we are going to have this rolled out. Later, we also want to do implementation research as we implement breastfeeding counseling, and also strengthen the initiative to improve breastfeeding counseling and support. Thank you very much for the opportunity and have a nice evening.

Altrena

Thank you so much for that very informative presentation, Veronica, on what Kenya has been doing to stay up to date and to contextualize these global programs and policies around Baby-Friendly. Particularly, it's interesting what you've done around the Baby-Friendly Community Initiative. Our next speaker is Esther Mogusu, a public health nutritionist and maternal infant and young child nutrition expert. Esther is a specialist in policy and curriculum development, program design, implementation, and evaluation.

She is the chairperson of the BFHI Task Force and a member of the National Maternal Infant and Young Child Nutrition technical working group for the Kenyan Ministry of Health. She will tell us a lot more and go into depth about BFHI and the breastfeeding counseling competencies and the work that's being done in Kenya. Thank you, Esther. We look forward to your presentation.

Esther

Okay, thank you, Altrena. Good morning, good afternoon, good evening, colleagues from around the world. Thank you, Madam Veronica, my Director. Thank you, Larry, for going before me. I know you've explained a lot about what competency verification is about. The presentation I'm about to take you through is on the design of a breastfeeding counseling mentoring intervention in Kenya. I'd like us to keep in mind about Step 2. What has changed about Step 2 is that there is no focus being taken away from training, but on individual competencies are being verified.

Next slide, please. In this presentation, I'm going to share with you the roadmap on how we are developing our mentorship intervention design in Kenya. Just a disclaimer that this is work in progress. We have done this in three steps. The first step was trying to scan the environment around breastfeeding counseling. To that, we did a scoping exercise on breastfeeding counseling. In Step 2, we did a co-creation workshop for breastfeeding counseling intervention design. Step 3, we did contextualization workshop, and this was to develop a mentorship design and also to contextualize the 2020 BFHI package. Next slide, please.

I'll start with the first step. This is the rapid scoping exercise on breastfeeding counseling, whose objective was to understand the context of breastfeeding counseling training in Kenya. As we move to the next slide, I'll just like to highlight that this one was to look at the policy and legislative environment in Kenya. It was also supposed to review the practices at the health facility and also finally to review secondary information that was in documents and also in form of data. The findings that came out of this scoping exercise, in terms of policy legislation, just as Madam Veronica has told us, we have a strong policy and legal environment that supports breastfeeding.

In terms of the workforce job description, cadres who are specifically involved in provision of maternal and child health services. They include the medical officers, nurses, clinical officers, nutritionists, and dietitians. In terms of competencies, it was realized that follow up to assess competencies post training is not done. This is mostly due to resource constraints. In terms of supportive supervision and mentorship, there is no package for structured mentoring for breastfeeding, counseling, and funding. In

terms of resource allocation, for most of the in-service training on maternal infant and young child nutrition, there are no resources included for mentorship. Next slide, please.

The recommendations that came out of the scoping exercise were as follows, that there was need to review and adopt, or contextualize in this case, the 2020 BFHI training package so that it could suit the country, because from the policy and legislative environments that Madam Veronica discussed earlier, we have some of the clauses within the package that actually do not go together with the policy we have in Kenya. It means that we need to do a bit of adaptation and contextualization. Secondly, is to develop a structured supportive supervision and mentorship training package. This is to assess competencies of health workers.

Then incorporate mandatory clinical practice and/or practicum sessions at health facility as part of the training package in breastfeeding counseling training. Finally, to mobilize resources to develop and strengthen current pre-service curricula on breastfeeding counseling, because it was realized that we do not have a standardized training package on breastfeeding counseling in pre-service training. Next slide, please. The team that participated in the scoping exercise, just to show you that this was pretty extensive, we had a team from the Ministry of Health, the UN and the Donor agencies. UNICEF, WHO was involved.

We had our major health facilities, that is Pumwani Maternity, which is the largest maternity hospital in Kenya. Then we had county referral hospitals, Embu and Mbagathi, which is in Nairobi. We had some Maternal Infant and Young Child Nutrition master trainers to be able to give information about breastfeeding counseling and a bit about training. Research institutions were also involved, University of Nairobi. We can see a whole lot of other practitioners, the Kenya Pediatric Association, implementing partners, and county departments of health from Marsabit, Kisumu, Kiambu, Kwale, Kitui, just to represent the sub-national in Kenya. Next slide, please.

The next step was the co-creation workshop for breastfeeding counseling intervention, because having collected all the information in the scoping activity, it was important to put all this information together and share it with the Baby-Friendly Hospital Initiative task force members so that we could now think about designing an approach that was going to be useful in terms of breastfeeding counseling for the country. The workshop participants here, the bulk of the membership actually was the BFHI task force and the represented cadres, we had a range.

This is very important because in terms of mapping out capacities, it will be important to see who participated. We had medical officers, we had nurses, we had clinical officers, we had nutritionists and we had lactation consultants. The objective of this was to actually review the information that we had from the scoping exercise and design a feasible capacity-strengthening intervention for breastfeeding counseling during the six contact points of counseling. Next slide.

The outcome of this discussion, we realized that we did have some barriers to breastfeeding counseling. Some of these barriers-- there's little emphasis on breastfeeding counseling during ANC. We know that in one of the Baby-Friendly Hospital Initiative steps we talk about telling the mother about the benefits of breastfeeding and the management of breastfeeding postnatally. There is little emphasis on that during the antenatal care contact.

Then we have cultural taboos, just like other countries, I think-- I don't know whether it is African. We have a lot of mothers believing in giving pre-lacteal feeds and there are some childbirth rituals that normally almost need to be done before the mother initiates breastfeeding. There is also inadequate training and mentorship on breastfeeding counseling and lack of a standardized context-specific information for mothers. Then poor integration of growth monitoring into routine care, because then it is during the growth monitoring that the mother comes into contact with the healthcare provider.

It is during these contact points that they are able to give them further information, but it was realized that this was actually not the case. Finally, there was poor knowledge, skills, and competencies of health workers on complementary feeding, which is also a major contact point. This was the information that was lacking, and probably contributing to the nutritional status and some of the indicators performance as we saw in the previous presentation by the Director of Nutrition. Next slide.

Something else that was being looked for, another objective, was to identify the roles and responsibilities for breastfeeding counseling. The cadres that are involved in provision of maternal child health services include medical officers, nurses, clinical officers, nutritionists, and dietitians. It was actually realized that in lower-level facilities, it is about the nurse who does the breastfeeding counseling or does all the work.

As you move higher in terms of the levels of more advanced healthcare, then you realize that we are going to have an increased number of cadre variation, and so we are going to have a more complex team that is going to be dealing with a mother. One thing that came out clearly is that everybody has a responsibility to be able to offer breastfeeding counseling to the mother. In this team, it is only the nutritionists and dietitians, the nurses, and clinical officers who have breastfeeding counseling as part of their job description, but it was noted that everybody actually has a duty. Next slide.

We identified key needs for provision of skilled breastfeeding, and these ones, as had been highlighted earlier in Larry's presentation, was that we need the three key issues to be sorted. One, it is knowledge. Knowledge is about the theoretical, the practical understanding. What the person is trained on during the classroom experience. Then in terms of skills, so skills, this is the ability to properly perform a job and this includes cognitive and communication, and the interpersonal and the problem-solving techniques.

Finally, the competency, which is a combination of all the three. We were told about knowledge and skills, and attitude, in this case we are calling it behaviors. These three are the ones that are needed to successfully perform identified jobs, roles, and responsibilities. Next slide, please. Why did we need to do a mentorship package? The rationale for this was that the adaptation of the adapted BFHI training package and the BFHI Competency Verification Toolkit would be a strong foundational training and competence list to structure a mentorship program, because these have been researched, they've been proven, and so they are standardized and this would actually form a strong foundation.

The second rationale was that mentorship really is a flexible teaching and learning process. This one can be embraced in a range of hospital facilities by healthcare providers working along with other programs like the Maternal, Newborn, and Child Health programs. Finally, just as I've highlighted around issues of resources and opportunities, so there are normally limited opportunities for continued professional development and refresher training on breastfeeding counseling for healthcare workers working across various maternal neonatal child health service points.

Because of this, mentorship was identified to be this low-cost investment that can be able to support that continued capacity building and capacity strengthening to more healthcare providers beyond the classroom and beyond the training experience for breastfeeding counseling. Next slide, please. The next step after-- we did agree that we were going to design a mentorship package. We held a workshop. In this workshop, it was to design the mentorship package and to also review the BFHI package 2020 so that we could do a national contextualization.

For this, we had a five-day event. We had a range, we had a variety of cadre representation within the workshop, but most notably, we did identify three types of capacities. This was capacity for infant and young child nutrition, capacity for child and neonatal health, and also capacity for reproductive and maternal health, because we can't talk about Baby-Friendly Hospital Initiative without talking about the

mother, without talking about the neonate. These capacities had to be brought together so that we could be able to design a package that could actually be acceptable to all the cadres, so that nobody claims that it was made for only one cadre.

That involvement, we saw the synergy was actually amazing. The first three days, we did design the mentorship package, and the fourth and the fifth day we focused on the contextualization of the BFHI training package. Contextualization meant we were looking at the trainer's guide, we were looking at the participants manual, and we were also looking at the slides just to ensure that we Kenyanize them and that we also contextualize them in line with our policy and legislative environment so that we don't have any clashes in terms of policy. Next slide.

The team that participated, again, I like bringing this out because it would be nice to know that this was a process that was very interactive, and that there was a lot of participation. From the divisions in the Ministry of Health where we have what we call the Department of Family Health, we had the division of Reproductive Health and Maternal Services, Neonatal Child and Health, and Nutrition and Dietetics Services are being represented. Just to have a feel of the sub-national, we did involve the county departments of health in Kenya. Health is devolved, and so we did involve the sub-national so that we understand how this package could actually feel down at the sub-national level.

To this, we invited four counties who participated. Then we also had other partners. We had Nutrition International, we had UNICEF, we had Save the Children, we had Action Against Hunger, and IBFAN Kenya, and also USAID Advancing Nutrition. I must thank Altrena that she was here in this workshop with us to give us technical advice. Then the profile of the participants, again, as we can see, those are the people in that workshop. Remember the three capacities that we mapped out, it was infant and young child nutrition, reproductive and maternal health, and child and neonatal health. Next slide. Larry earlier told us about the competency verification toolkit, and that toolkit actually has 16 competencies and it has 7 domains and 64 indicators. For us, we were reviewing-- this is what we chose to review. We did divide our teams into four groups, and each team was assigned a set of competencies that they were going to look at. I'd like us to just look at what they came up with. Next slide.

If we could see the column on the extreme left, we have the competency that was being assessed. In the middle column, we have the performance indicator, and in the last one we had the ranking. The ranking was very important because it was contextual. These people, this is a team of practicing practitioners who are telling us that, "Well, while all of them would be important, this is what we are prioritizing." The prioritization was about high and there was medium and there was low.

What was ranked high is what we consider to be most important, and that is what was adopted as being most important for the first phase of the mentorship package design. Next slide, please. The seven competencies that were prioritized were these ones. We had competency 3, 5, 7, 8, 9, 12, and 16, and we can see the point of care where this would be applicable and the cadres that would actually be implementing this. Next slide.

I realize my time is running out. I'll request for a few more minutes so that I can complete this presentation, kindly. Once we prioritized, so we were down now to designing the mentorship experience and we had several points of care that we were looking at. One of them was ANC, that is antenatal care. The other one was the postnatal ward. The other one was the newborn unit and the sick baby unit, and the other one was now the postnatal care and the child welfare clinic. In designing the mentorship experience at ANC, we looked at different aspects. We looked at the structure, at the schedule, at the matching, and then the learner participation and the mentor participation.

For the structure, in the primary structure, we said we would adopt the traditional mentorship approach. For the secondary, there would be the mentor-led approach. Then in terms of scheduling, it would be hybrid, and so programmatic and probably open, depending on the schedule of the mentors

and the mentees. In matching mentors and mentees, this was going to be based around the roles of each and everyone. In terms of learner participation, for the learner participation, we did identify what we called the 3 Es. The 3 Es there was the entry, there was the exit, and there was the expectation.

For the entry, they would be targeted and automatic. Of course, there's going to be a criteria about who comes in and who doesn't. Then at exit, these would be probably scheduled at the program end. It would be a self-elect or non-performance. If somebody at any point feels that they do not want to continue with the mentorship, then they can actually leave. The expectation would have been defined at baseline, and so if this has been achieved, then the learner would be free to leave. The mentor participation, so they would be nominated. There will be targeted nomination.

Just as we said earlier, a mentor needs to be someone who is well versed with all the competencies and the indicators that come with them, and also the knowledge, the skills, and the right attitude for behavior change. These are people who would need to be nominated. Then exit would probably be non-performance or failure to meet expectations. Finally, the expectation was to be defined by the baseline. Next. Next slide.

Again, this seems like what we've talked about at entry, exit, and expectation. If they meet the criteria or are set in the baseline, then they would need to exit and the expectation. Let me just mention something important around expectation. We expect that at the end of the three months, the mentees will be able to be competent. It was discussed that probably at an average of three months the mentor should have done a good job so that the mentee can move over to the next level and probably become a mentor and then the mentor can pick another person to mentor.

The mentee can also be grown into being a junior mentor and will be graduated so that they also become more qualified to be able to mentor others. Next slide. In terms of mentor participation, again, it takes again the same approach. The expectation here, of course, is to convert the mentee into an expert breastfeeding counselor. Next slide. We did do a summary of the most suitable mentorship program structures for the different contact points. At antenatal care-- we did identify that there are cases where we would use the traditional mentorship approach, which is the one on one. There would be occasions where we did the mentor-led.

Then sometimes we would have the hybrid, and of course, in the postnatal care it was the same case and in the CWC it would be the same case. One thing that we realized is that in the lower facilities it would mostly be mentor-led. Again, as we move to higher and higher facilities or in areas where we have a lot of staff, then there would need to be the mentor-led that would probably even be peer to peer mentorship at some point because of the numbers that would be involved. Next slide.

Then there was a thought about having a mentoring charter. We are not just going to say we are doing a mentorship. There needs to be something that is written out, just like we do in all our service delivery points. In identifying the mentor candidates, these need to be nurses or nutritionists who are master trainers because, again, we realize that we could be having the pediatricians or the clinicians who have experience but a lot of times their schedules and the workload is not able to allow them to act as mentors.

The learner candidates, or in this case the people we are calling the mentees, we'd have all the nurses, the nutritionists, and the clinical officers who have completed the BFHI 20-hour course, or what we are now calling the 22-hour course. The program structure would be mentor-led group or one on one. This is the hybrid, depending on the area of service provision or the point of care. The program schedule, we did build consensus that would be about three months.

Then the expected investment, they're the direct costs like the airtime, the stationary, the mentorship tools, and all. Most importantly, we thought of having a recognition ceremony. Then the mentorship

program administration, we thought it wise that every BFHI-implementing facility needs to have a BFHI coordinator so that this person is able to coordinate the activities within the health facility and probably call our people for the mentorship session and just to follow up internally to ensure that the mentors and mentees are doing their work as expected. The estimated hours of investment were actually 18 hours for this entire exercise. Next slide.

Altrena

Excuse me, Esther. We have one minute, please.

Esther

Yes.

Altrena

Thank you.

Esther

Yes, this is-- I think we are in the second last slide. In the implementation, in terms of roles and responsibilities of the health management teams, again, depending on how country-- the health structures are actually done. When we have that health management team, their role would purely be oversight and offering guidance and doing supervision and administration. Then in terms of linkage to existing structures, we need to work within existing structures. Like in Kenya, what we are doing, we are not going to introduce any other new structure.

Already we have what we call quality improvement teams which are working within the health standard coordination team under the ministry's Quality Assurance Department. This is a team that we are going to work with. Also, within health facilities, we have what we call the Quality Improvement Teams and also the Work Improvement Teams. In terms of resources, these are the resources which are mentioned. I think my final slide-- Next slide, please. Yes, so the next steps, we are going to finalize the adaptation of the new guidance and then national level adaptation of the BFHI training package and the BFHI competency verification toolkit.

As you realize, Kenya has not picked all the competencies. We have prioritized the competencies that we think if we implemented those, then we are going to have a huge impact in terms of a change in breastfeeding counseling. We are going to train master trainers and select national mentors for BFHI and competence verification. Then develop a structured and facility-based mentorship program. Please note that it is facility-based, the other structures are just going to offer an oversight role. Then we would have an in-service cascade training of healthcare workers on BFHI, and then point of care quality improvement and capacity strengthening on breastfeeding counseling at health facility level.

In my next slide I'd like to just thank everyone who participated in this work. We have all these people to thank. There are people that I want to mention in person. Altrena is here. Altrena, thank you very much for the support you gave us during the workshop. Brian Njoroge who is one of the consultants for USAID Advancing Nutrition has worked with us and we have done this together. Madam Veronica Kirogo, thank you, my director, for your leadership.

Also, Caroline Aremi, who is holding brief in the MIYCN Program. Rose Wambu who started this work, she is currently indisposed and on treatment. Rose, you're in our prayers. I know she's in this meeting and she's going to be well. Thank you very much for all who have joined. If you need to reach out probably for sharing on what Kenya is doing, you can reach us through the office of the Head of Nutrition Division of Nutrition Ministry of Health, Kenya. Thank you very much.

Altrena

Thank you, Esther, for that very great presentation and the information sharing about how Kenya is going about this. There have been lots of comments in the chat congratulating Kenya on its advance moves around the Baby-Friendly Hospital Initiative and the competency-building work that you have done. We have a very little time for question and answer, but I hope that the-- our presenters, please look in the Q&A box and see if you can answer some of the questions that the participants raised that we won't be able to get to at the moment.

I did want to bring your attention to-- there are about two questions, I think, that maybe we can address right now. One to Larry about the current state of BFHI and hospitals. What are they-- Oh, I'm sorry, that question has been answered. Excuse me, let me go to my directions, high-priority questions about how facilities have gone about assessing competencies of staff pre-employment and so on.

Maybe Larry you can talk about the global experience of how they've gone about this competency assessment, how is it looking on the ground, actually being practiced when you don't have initial training and so on. Then you might also talk a little bit about the pre and post-test and how you attribute and take care of those gaps that may be identified. Larry, and then maybe Esther, if you can also share some of your thoughts on that too.

Larry

Thank you, Altrena. As far as how it's actually being used, we're still learning about that. We actually launched the toolkit during the worst of COVID. Many countries are looking at the tools and trying to see how they can use them, but the rollout hasn't been nearly as quick as we had hoped it would be at that time. I think definitely within facilities that they're looking at it-- Usually, whoever's in charge of breastfeeding for the facility, if it's their lead lactation consultant or the lead nurse who drives this, they will typically would be the ones who are conducting the assessments.

I think it's a wide variety of when they choose to do that. Whether it's truly for new staff, whether they just want to apply it for their entire staff and see where they're at, I think that that's on a one hospital at a time basis. I think that many countries are looking at ways that they can apply this more broadly. Clearly, it can be used as a pre-post test, but at this point I don't know of any specific examples doing that.

In pre-post test, sometimes you use the exact same questions. It looks good because people get the answer that they missed the first time. They get it right just because they've been tuned in to that particular question, but you can also do a post-test where you use a different set of questions but try and see, is their overall score improving as they participate in that? I think as we see more and more application of the 20-hour course, other courses on breastfeeding, there are now more and more online courses that you can apply the pre-test, post-test approach to this. I think there are many opportunities, but we're still learning what's actually being done around the globe.

Altrena

Thank you. Esther, do you have any thoughts?

Esther

Thank you very much, Altrena, and thank you Larry for what you've said. What we have thought as a country is that we are going to have a cascade. First, we are building capacity amongst our Maternal Infant and Young Child Nutrition master trainers. We are going to share this information with them. I know we are planning for a validation activity where we are going to share the contextualization details of what we have done. First, it is sharing what the changes that we have suggested from a small team around the trainer's guide, around the participant's manual, around the slides. Finally, we look at the mentorship package approach.

When we have trained the national trainers and possibly mentors, we are going to cascade this into the sub-national. This sub-national, again, as I said, they are specifically going to have an advisory role. The final area of implementation is going to be at the facility. How do we identify our mentors? Our mentors are going to be selected during the training based on their performance on their competencies. How do we select our mentees or our learners? We are going to select them based on the observations that we make around their areas of work, the performance during the trainings that we are going to do, written exams probably that we are going to do at the place of work.

The suggestion is that we have internal mentors doing the day-to-day mentorship. At a higher level, then we have external mentors who are going to be coming in periodically to come and visit the health facility. Every quarter-- as you realize, every three months we are going to be almost graduating mentees. During this quarterly assessment, and probably graduation, we are going to be doing what we call local assessment. Who will be doing the local assessment? It is the mentees who are at a higher level, probably in the health management teams.

Finally, when our facility has achieved maybe above 80% in two consecutive quarters, then they can call the national, so that is the Director, Nutritions Office. We are going to coordinate that national assessors actually go down and conduct the assessment at the health facility level, and then this facility can be declared or be accredited as baby-friendly. What, again, I can add is that this package came during the COVID pandemic. I know the rollout has been a bit slow.

As the Baby-Friendly Hospital Initiative task force which is domiciled within the technical working group that deals with Maternal Infant and Young Child Nutrition in the Division of Nutrition. We decided to actually take this upon ourselves so that we could be able to see and roll it out, but we do appreciate that USAID Advancing Nutrition actually has worked with us and we have continuously unpacked this, and we are hopeful that this is actually going to work because we have involved a lot of stakeholders, so we know that we are on the right path.

Altrena

Thank you. Thank you both, Larry and Esther, for your excellent presentations and answering of the questions. We're a little bit over time. Thank you all participants for hanging in there with us. We thank you, Ms. Veronica Kirogo for your presentation. There are questions for you in the chat box, if you could answer, to understand a little more about scaling up of BFHI, BFCI in Kenya. For everyone, we want you to know that the recording will be available soon and we'll try to have answers to your questions post our presentation today.

To alert you that there will be an upcoming-- The third in this series webinar will be happing at the end of September, so please look out in your e-mail. We'll be sending you a notice sometime later this month for you to join us for the third in this series. Thank you so much for all of your attention and participation. We wish you a wonderful World Breastfeeding Week. Thank you for joining us for our little commemoration as you continue to celebrate the week or the month. *Asante Sana*. Thank you, everyone. Have a good day.

USAID ADVANCING NUTRITION

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