Dr FA Wickramasinghe Oration - 2018/19
The College of Community Physicians of Sri Lanka

Twenty-five years of Baby Friendly Hospital Initiative in Sri Lanka: 1992-2017

Past achievements, present challenges and the way forward

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DOI: https://doi.org/10.4038/jccpsl.v25i4.8238

Received on: 6 Dec 2019
Accepted on: 9 Dec 2019

The concept of Baby Friendly Hospital Initiative

From the beginning of 20th century, food industries were marketing suitable substitutes for breastmilk. Maternity care was becoming an event supervised by medical professionals, and as they were seeking 'scientific options' for their clientele, harmful practices related to breast milk substitutes spread rapidly across the globe (1). Requirement for breastmilk substitutes grew faster with the industrial revolution of 1930-40s, as more women entered the workforce. Medicalization of birth formed obstacles to initiate and establish breastfeeding. The community soon lost memories and skills to support breastfeeding, and the social model of artificial feeding was established as the norm, in many industrialized countries (2). These practices in turn spread across the globe into less developed countries.

In 1939, the renowned Paediatrician and Epidemiologist Dr Cicely Williams made a speech to the Singapore Rotary Club titled 'Milk and Murder'. She professed that "Misguided propaganda on infant feeding should be punished as the most criminal form of sedition, and infant deaths resulting should be regarded as murder". (3). After fourty years in 1979, a joint meeting hosted by the WHO and UNICEF on infant and young child feeding called for the development of 'International Code for Marketing of Breastmilk Substitutes', signifying the turning point in unethical milk formula advertising and marketing.

The International Code of Marketing of Breast Milk Substitutes alone was not successful in retrieving the breastfeeding culture in the world, and therefore a global action plan was prepared in 1990 to address the declining rates of breastfeeding. This meeting paved way to adopt the Innocenti Declaration on Protection, Promotion and Support of Breastfeeding, later endorsed by the 45th World Health Assembly (WHA) and the Executive Board of UNICEF (4). The Innocenti Declaration established four operational targets, of which the second was to ensure that every facility providing maternity services fully practises 'Ten Steps to Successful Breastfeeding'. This inspired the establishment of Baby Friendly Hospital Initiative (BFHI) and made way to put into effect the WHO/UNICEF document on 'Protecting, Promoting and Supporting Breastfeeding: the Special Role of Maternity Services' (5).

Inaugurated by the WHO and UNICEF in 1991, the BFHI forms the foundation to incentivize maternity facilities to adopt the Ten Steps to Successful Breastfeeding and recognize those that do so by introducing a BFHI (Box 1) designation methodology.

Box 1

Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health-care staff
2. Train all health-care staff in skills necessary to implement this policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Help mothers initiate breastfeeding within one half-hour of birth
5. Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants
6. Give new-born infants no food or drinks other than breast milk, unless medically indicated
7. Practice rooming-in that is allow mothers and infants to remain together 24 hours a day
8. Encourage breastfeeding on demand
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

Subsequently, many high-level policy documents have reiterated the importance of implementing the Ten Steps of BFHI. In 1992, the WHA called upon its member states to encourage and support all public and private health facilities providing maternity services to become 'baby-friendly'. The Global Strategy on Infant and Young Child Feeding (6) reiterated this statement. Also, the 2nd International Conference on Nutrition in 2014 recommended that countries implement policies, programmes and actions to ensure that health services promote, protect and support breastfeeding, including the BFHI.

Implementation of BFHI in Sri Lanka

Sri Lanka always had high ever-breastfeeding rates (98% in the Demographic and Health Survey (DHS) 1993 and 2000; 99% in DHS 2006 and 2016) (7-10), which confirms the strong breastfeeding culture in the country. According to DHS data, early initiation of breastfeeding within one hour was 85.2% in 2006 and 90% in 2016. Exclusive breastfeeding for complete four months, which was the national policy up to 2006 was 19%, 52% and 83%, respectively in 1993, 2000 and 2006. Since 2007, the national policy was exclusive breastfeeding up to 6 months of age, and the DHS 2016 showed that exclusive breastfeeding at 6 months was 82% with a median duration of 5.2 months. These impressive breastfeeding indicators enabled Sri Lanka to be number one in two successive World Breast Feeding Trends Initiative (WBTi) Assessments (11-12) conducted once in four years.

The BFHI was introduced to Sri Lanka in June 1992 (13) to incentivize hospitals with maternity facilities throughout the country to adhere to the Ten Steps to Successful Breastfeeding and comply with the International Code of Marketing of Breast-milk Substitutes. De Soysa Hospital for Women was the first hospital to be declared a BFH in Sri Lanka (14), followed by 84 other specialist hospitals (base hospital and above) in the country (13). The strong political commitment reinforced successful implementation and scaling up of BFHI in Sri Lanka. Twenty-five years since its introduction and given the achievements of the breastfeeding programme, it is useful to review the coverage and implementation of the BFHI in Sri Lanka.

• Coverage of BFHI

The over-arching goal of BFHI is to ensure that all babies born in hospital and their mothers are fully supported to initiate and establish breastfeeding, so that they exclusively breastfeed in the first six months and continue to breastfeed with adequate complementary feeding up to two years or beyond.

In Sri Lanka, 99.9% of deliveries occur in a health facility, out of which about 95% occur in government

hospitals (15). The Annual Health Bulletin 2003 (16) notes that only 18% of births in government hospitals occurred in institutions below base hospital level (i.e. non-specialist hospitals), with further declines to 16% in 2005, 12% in 2007, 5.4% in 2011 and 3.6% in 2015 (17-20), implying that 95% of the births in Sri Lanka occur in specialist hospitals where Ten Steps of BFHI are likely to be closely followed. In comparison, global estimates show that the overall coverage of births in facilities with BFHI is around 10%, with a higher coverage of 36% in the European Region, but less than 5% in Africa and Southeast Asia (21).

• Assessment and designation process of BFHI

The BFHI focuses on designation of facilities that adhere to the Ten Steps through an assessment and a designation process. Clear guidance on the assessment process and tools required were provided in WHO/ UNICEF Guidelines of 1989. Over the years, the countries that opted BFHI designation have used WHO/UNICEF Global BFHI Criteria for assessment (21), which recommends re-assessments every 3-5 years, where the facility needs to demonstrate continued adherence to Ten Steps of BFHI and the Breastfeeding Code (5).

In Sri Lanka, according to the National Survey on Breastfeeding Situation (13), 84 hospitals comprising teaching hospitals, provincial general hospitals, district general hospitals and base hospitals are 'baby friendly' hospitals, however information from key informants reveal that formal BFHI assessment and declaration as per guidelines had never been conducted in Sri Lanka. In comparison, the Global Survey on Implementation of BFHI (21) revealed that 110 out of 155 countries (71%) had an operational BFHI programme as of 2016-2017, however most of them had never gone through the designation process. There were only 22 countries who had designated the majority of hospitals as BFHs and another 21countries who had designated less than 20% of the hospitals.

Though not adopting the standard BFHI assessment and designation process, the practice of Ten Steps of BFHI has been assessed in Sri Lanka at different instances. Some of the steps are assessed in routine hospital supervisions of the maternal and neonatal units using standard tools (22). Adherence to the Sri Lanka Code for Promotion, Protection and Support of Breastfeeding and Marketing of Designated Products (14) and the relevant circulars of the Ministry of Health is monitored by the routine health system monitoring mechanisms. Lately, assessment of all the ten steps of BFHI, mother baby friendly practices and baby friendly neonatal care unit practices were included in the National Quality Assurance Standards for antenatal units, labour rooms, postnatal units and neonatal units (23-26), and are expected to be monitored with quality assessment.

• BFHI programme integration

In the process of making Ten Steps of BFHI the standard practice in all maternity units of health facilities in Sri Lanka, it was well-integrated into national policies, standards and guidelines for maternal and new-born care. The National Nutrition Policy (27) states that all infants should be exclusively breastfed up to complete six months and breastfeeding should be continued with adequate complementary feeding up to two years or beyond. The breastfeeding policy as addressed in the Maternal and Child Health (MCH) Policy of 2012 is to protect, promote and support breastfeeding practices with special emphasis in delivery settings (28).

The BFHI Guidelines (5) recommend that each hospital with a maternity facility has a breastfeeding policy that is informed to all healthcare staff and displayed in the most common language used in the area. In Sri Lanka, this is not practised strictly as per the guideline, however the indicators such as early initiation of breastfeeding within one hour reaching 90% and exclusive breastfeeding at 6 months reaching 82% (10) show that hospitals are conforming to the National Policy on Breastfeeding. The practice of policy is warranted by the standards set for breastfeeding in the Standards for New-born Care; for Quality Improvement of New-born Health Services in Sri Lanka (29), for example, all mothers should receive skilled practical help with early and exclusive breastfeeding, and full information on the benefits of breastfeeding should be made available to mothers and family. Guidelines to ensure the implementation of these standards are explicitly given in the National Guidelines for New-born Care (30).

With regards to capacity building of health staff, a training package, '18-hour Course' was introduced in 1993 following the launch of BFHI. This was revised in 2009 as the '20-hour BFHI Package' and includes guidance from the Global Strategy on Infant and Young

Child Feeding (6) and a module on 'mother-friendly care' (31). It has five sections:

Section 1 – Background and implementation

Section 2 – A short course for hospital directors

Section 3 – A 20-hour course for maternity staff

Section 4 – Provides tools that can be used by managers and staff for internal assessment

Section 5 – Provides guidelines and tools for external assessors for assessment and reassessment on a regular basis

Furthermore, the first in-service training programme on breastfeeding, the WHO/UNICEF 40-hour Breastfeeding Counselling Course was introduced to the country in 1995. Since then, training has been conducted in hospitals by the Family Health Bureau in collaboration with the regional directors of health services, to train the staff in hospital maternal and neonatal units and in field. Such capacity building in breastfeeding gives skills and competencies to the health staff to carry out Steps 2-9 of the BFHI. In 2006, another in-service training programme, the WHO Essential New-born Care Course (ENCC) which has a comprehensive module on breastfeeding was nationally introduced to train staff in the hospitals (Personal communication with key informants, 2018).

Despite the 40-hour Breastfeeding Counselling Course over 20 years, training profile of the doctors and nurses in maternal and neonatal units does not appear to be satisfactory. More than 50% (53.8% of doctors and 63% of nurses) were trained only in Uva Province. More than 50% of the midwives in maternal units were trained except in Central, Eastern, North Central and Sabaragamuwa Provinces (32).

With regards to integration at field level, though BFHI is an institution-based concept, two of the steps (Steps 3 and 10) have been addressed at the community level in Sri Lanka. Step 3 (informing all pregnant women about the benefits and management of breastfeeding) takes place at designated breastfeeding sessions in the field MCH clinics (33) and Step 10 (establishing breastfeeding support groups and referring mothers to them on discharge from the hospital or clinic) in a modified manner to the area public health midwife.

Implementation of the International Code on Marketing of Breast Milk Substitutes

In 1981 at the 34th WHA, the International Code of Marketing of Breast Milk Substitutes was adopted. This received the attention of many governments to address the urgent need to promote breastfeeding. In Sri Lanka, even prior to the WHO/UNICEF joint meeting, action to promote breastfeeding by publishing directions under Consumer Protection Act No 01 of 1979 was initiated. In the Gazette Extraordinary No 24, visual advertisements of infant milk foods in any manner whatsoever or advertisements in radio were banned. In September 1981, the Sri Lanka Code for Promotion of Breastfeeding and Marketing of Breast Milk Substitutes and Related Products was submitted to the Cabinet. The relevant provisions to marketing and advertising of infant foods was gazetted under Consumer Protection Act in 1983. This code was revised and updated in 2002 to overcome continued violations. Currently, the code is undergoing another revision to address present challenges.

Challenges for BFHI implementation in Sri Lanka

• Challenges in BFHI designation

About 50% of the countries included in the WHO 2017 Survey indicated significant problems with the process of assessing and designating facilities as baby friendly. There were concerns regarding the criteria used for designation, bureaucracy associated with obtaining BFHI status, length of the BFHI questionnaire, dedicated persons to conduct the assessment, cost and capacity building of the assessors.

The stipulated designation process in the guidance requires services of assessors over a period of approximately two weeks. Except in the Americas and Europe, in other areas such as in Africa, Eastern Mediterranean, Southeast Asia and Western Pacific Regions, they have used government or UN funding to conduct BFHI assessments (21). Funding for national assessors and providing facilities for assessment are considered major hindrances for BFHI accreditation.

• Challenges in programme integration

Sri Lanka has been quite successful in its attempts in integrating the concepts addressed in Ten Steps of

BFHI into the routine MCH Programme. Further improvement is possible when breastfeeding data are analysed in detail. The name BFHI has been forgotten by many and limited to a plaque in most of the hospitals. It was evident that in institutions where BFHI Ten Steps are practised, it was driven mainly by personal interest of an administrator or consultant (34).

Effective coverage of an evidence-based intervention requires achieving high coverage and standard quality. DHS 2016 shows that the percentage of children breastfed within one hour has increased from 80% to 90% during 2006-16 period (10). The percentage of children breastfed within one day has remained stable at 98% compared to 97% in 2006-07 period.

Early initiation of breastfeeding is a topic addressed in the WHO ENCC that has a module dedicated for 'Care around the time of birth'. In an evaluation of the quality of early initiation of breastfeeding in two teaching hospitals in Colombo District, it was found that 100% of the new-borns were dried and wrapped soon after birth but only 1.8% were put between mother's breast soon afterwards (35). In a more recent field-based study in Kandy District, the majority of babies (94.6%, n=335) were initiated on breastfeeding within one hour of birth while most of the babies (77.7%; n=275) were taken away from the mother before completion of the first feed (36). This implies that though early initiation of breastfeeding rate is high, its quality needs improvement.

According to DHS 2016 (10), the prevalence of exclusive breastfeeding in infants aged 0-6 months was 82%. Further analysis indicates that rates of exclusive breastfeeding decline with increasing age (93.4% in 0-1 months; 87.4% in 2-3 months; and 63.8% in 4-5 months). All these rates have improved compared to DHS 2006 rates (9) but can be further improved if the underlying concerns are addressed. In the study conducted in Kandy District (36), early discontinuation of exclusive breastfeeding was significantly associated with mother being occupied in government or private sector ($p<0.001$) and with first-born baby ($p=0.007$). Also, the prevalence of exclusive breastfeeding (EBF) up to 6 months was 50.8% (n=180). However, EBF up to 5 months or more was 81.3%, implying that the majority who failed in EBF up to 6 months had at least continued up to 5 months. Main reason for early cessation was 'breast milk not being enough for baby' (52.9%; n=92). About 25% of them were influenced by a healthcare worker to start feeds other than breastmilk during the first six months (36).

Another noteworthy finding was that more than 90% of the healthcare workers in Colombo South Teaching Hospital had correct knowledge on breastfeeding policy, educating mothers on hunger cues and on-demand feeding, and allowing mother and baby together after delivery (37). Nearly 90% of them were also confident in demonstrating positioning and attachment. However, more than 50% considered exclusive breastfeeding as a very difficult task.

Training of healthcare workers in 40-hours breast feeding counselling and 20-hours of BFHI is known to be associated with provision of better breastfeeding support. However, the proportion of healthcare workers who had received such training was not satisfactory. According to the Emergency Obstetric and New-born Care Survey (32), only 38% of the medical officers, 30% of nursing officers and 26% of midwives had been trained in breastfeeding counselling. Senarath et al. (2007) showed that in-service training as an intervention is effective for changing practices (38). Immediate skin to skin contact was 37.5% (pre-intervention) and 83.3% (post-intervention) while mother and baby kept together in labour room was 25% (pre-intervention) and 91.7% (post-intervention).

Bottle necks to ensure quality and coverage of in-service training in Sri Lanka include the absence of a database on in-service training at institutional and district levels, absence of a regular training schedule at district level, lack of training faculty, a designated person to coordinate training in district and hospital, and lack of dedicated financial allocation for continued in-service training (34).

Way forward

There is substantial evidence to show that introduction of BFHI has contributed to improvements in breastfeeding. The WHO and UNICEF conducted a re-evaluation of the BFHI programme, during which case studies, key informant interviews (21) and literature review were conducted to understand the status and impact of BFHI. The WHO convened a guideline development group to revise the WHO

Guideline on Protecting, Promoting and Supporting Breastfeeding in facilities providing maternity and new-born services. The updated BFHI Guidance is the first revision of the Ten Steps since 1989 (39). In the new guideline, the ten steps are sub-divided into two sections;

- Institutional procedures necessary to ensure that care is delivered consistently and ethically (critical management procedures)
- Standards for individual care of mothers and infants (key clinical practices)

Full application of the International Code of Marketing of Breast-milk Substitutes and relevant WHA Resolutions as well as the on-going internal monitoring of adherence to the clinical practices have been incorporated into Step 1.

As already practised in Sri Lanka, the revised guidance recommends integration of BFHI more into the healthcare system. For full implementation of the interventions and to ensure sustainability, continuum of breastfeeding interventions across lifecycle and health systems is essential. These interventions need to be delivered in the MCH Package.

It is noteworthy that most of the recommendations in new BFHI Guidance (39) are already implemented in Sri Lanka. It therefore becomes a matter of strengthening the existing practices and introducing new ones where relevant.

- **Integrating BFHI across the life cycle and health system**

Integrating BFHI and MCH/FP services means offering a broad set of services during the same appointment at the same service delivery site. In Sri Lanka, breastfeeding is already incorporated into relevant points in the lifecycle; antenatal education in the clinic setting and at domiciliary visit; at the health facility from birth until discharge from postnatal ward or neonatal unit; at postnatal domiciliary visits, postnatal clinic visits, visits to child welfare clinics and clinic visits for family planning.

- **Capacity building for BFHI**

Breastfeeding training should be integrated into all MCH/FP trainings either pre-service or in-service to achieve high coverage in capacity building. It is recommended to have designated cadre for coordinating in-service training, setup an identified training Faculty, institute regular skills drills to ensure skills retained at an optimum and compulsory refresher training and re-certification. Annual training calendar and a system of rewarding need to be incorporated to all categories of staff (34).

- **BFHI in the institutional quality improvement process**

Implementation of Section 2 of the new BFHI Guidance (key clinical practices) require integration with other initiatives for health care improvement, health systems strengthening and quality assurance. In order to ensure the standard of 'every woman and new-born receives evidence based routine care and management of complications during labour, childbirth and early postnatal period' quality improvement methodologies such as WHO/UNICEF point of care quality improvement methodologies should be utilized.

- **BFHI in routine monitoring and evaluation**

BFHI should be incorporated into the existing monitoring and evaluation mechanism, such as routine supervision and monitoring of the hospitals and field setting. In Sri Lanka, this is already incorporated. Another opportunity is to discuss issues related to BFHI at the perinatal mortality review meetings. BFHI should also be made an essential component of the quality assessment and quality assurance programmes.

In Sri Lanka, there is a well-organized field MCH review conducted quarterly at regional level and annually at the national level. Breastfeeding indicators in the field are reviewed at the field review meetings. Similar review process including BFHI indicators, is appropriate for the hospital setting. Regular monitoring and evaluation in the health system ensure sustainability and improvement of the quality of indicators.

- **Fulfilling BFHI as per 2018 BFHI Guidelines**

Countries are called upon to fulfil nine key responsibilities through a national BFHI programme, including establishing or strengthening a national coordination body, integrating the ten steps into national policies and standards, ensuring the capacity or all

health-care professionals, using external assessment to regularly evaluate adherence to the ten steps, incentivizing change, providing necessary technical assistance, monitoring implementation, continuously communicating and advocating, and identifying and allocating sufficient resources. Also, country needs to address breastfeeding promotion, protection and support in communities, workplaces as well as adequate maternity protection and code legislation.

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