BOOSTING BREASTFEEDING
Bringing postnatal care to the doorstep in Gaza, State of Palestine
Personalized postnatal care is helping mothers and babies in Gaza start their breastfeeding relationship out right. Since 2011, UNICEF has been providing breastfeeding support, counselling and health services to new mothers in their own homes in the face of a complex humanitarian crisis. Postnatal care services are critical in the Gaza Strip, where only about one-third of children are exclusively breastfed in the first six months of life. Despite the challenging context, the programme has provided vulnerable mothers with access to counselling and care across all five governorates in Gaza, contributing to improved breastfeeding practices. Gaza’s experience of integrating high-quality counselling and support for infant and young child nutrition within the health system offers important lessons for other countries.

A protracted crisis – with the greatest impact on mothers and children

Mothers and babies in the Gaza Strip face important health and nutrition challenges as the result of the protracted political and humanitarian crisis affecting the occupied Palestinian territory. A UNICEF mapping of the multidimensional aspects of poverty for Palestinian children under 5 found that malnutrition, violence and limited access to clean water were the most common forms of deprivation. Since 1967, Israeli military occupation has imposed severe restrictions on access and movement, with sporadic escalations of unrest and violence. The poverty rate in Gaza has reached nearly 60 per cent, with deep poverty at more than 42 per cent.

Maternal health services in Gaza are severely overstretched. The relatively high total fertility rate of 4.5 among women aged 15–49 in Gaza creates significant demand for services. Almost all deliveries – more than 55,000 annually – take place in a health facility. Around one-quarter of all pregnancies are classified as high-risk; indeed, around 10,000 neonates require transfer to neonatal intensive care units for immediate health care and early intervention every year.

Breastfeeding practices are suboptimal in Gaza. Less than half of children begin breastfeeding in the first hour after birth and only 36 per cent of children under 6 months of age are exclusively breastfed. High levels of formula feeding increase the risk of contamination from unsafe water, particularly given the severe shortages of clean drinking water. With the combined impact of these factors, under-five mortality in Gaza is around 24 for every 1,000 live births – and the vast majority of these deaths occur in the first year of life.

From evidence to action

Within this challenging humanitarian context, UNICEF State of Palestine works with the Palestinian Authority, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and other partners to protect the rights of Palestinian children and women and give them the best chance to survive and thrive.

A comprehensive situational analysis carried out by UNICEF and the Ministry of Planning and Administrative Development found two core health and nutrition issues that were curtailling the rights of Palestinian children: the relatively high levels of neonatal mortality and the low rates of exclusive breastfeeding.

Based on this evidence, UNICEF devised and supported multiple strategies to address these core issues and their underlying and root causes. Strengthening postnatal care, in particular, was identified as an effective entry point for reaching mothers and newborns with services to improve health and survival, including support for optimal breastfeeding practices.
Successful breastfeeding requires knowledge about the practice and its benefits, skilled support and counselling before and after birth and an enabling environment within the health facility, home, work and community. In Gaza, however, mothers face multiple barriers to accessing these important levels of breastfeeding support (Box 1). This Field Report describes how one programme – Postnatal Home Visiting Programme – is addressing some of these gaps and extending care and support to the mothers and babies most at risk.

**Bridging the gaps in care: The Postnatal Home Visiting Programme**

The UNICEF-supported Postnatal Home Visiting Programme in Gaza was launched in 2011 with the Ministry of Health as the implementing partner, and funded by the Government of Iceland. Its objective was to reduce maternal and neonatal mortality and morbidity by ensuring continued quality postnatal care for high-risk mothers and their newborns after discharge from the maternity ward (Box 2). Before the programme was established, the level of postnatal care being provided was unacceptably low in terms of coverage, quality of services, and the frequency of visits. Hospital overcrowding at the time of delivery was a key barrier, and due to the burden on health services, early discharge of mothers and their babies (within 2–3 hours after birth) is the norm. More than half of mothers (58 per cent) stay less than six hours in the health facility post-delivery, at a time when skilled support to establish breastfeeding is critical.

Given these health system constraints, limited attention was given to the post-delivery phase before the launch of the home visiting programme. This lack of postnatal care hindered the early detection of potential medical complications and the provision of services and interventions to support new mothers and their newborns.

The Postnatal Home Visiting Programme was launched to respond directly to these gaps in

**Box 1: Factors resulting in low exclusive breastfeeding**

<table>
<thead>
<tr>
<th>IMMEDIATE CAUSES</th>
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<tr>
<td>Postnatal policies and practices:</td>
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<tr>
<td>• Low awareness about the benefits and practice of exclusive breastfeeding</td>
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<tr>
<td>• Low prevalence of early initiation of breastfeeding (within one hour of birth)</td>
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<tr>
<td>• No mother/child ‘rooming-in’ immediately post-delivery</td>
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<tr>
<th>UNDERLYING CAUSES</th>
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<tr>
<td>Service-related issues:</td>
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<tr>
<td>• Inadequate postnatal care (shortages of qualified health staff)</td>
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<tr>
<td>• Early discharge from hospital after birth and lack of a supportive environment for new mothers</td>
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<tr>
<td>• Insufficient enforcement of the International Code of Marketing of Breast-milk Substitutes</td>
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<tr>
<td>• Lack of time/opportunity for counselling and poor counselling skills</td>
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| Mother’s health care seeking behaviour: |
| • Lack of information and knowledge on appropriate pre- and postnatal care |
| • Traditional beliefs and practices (e.g. feeding herbal teas to infants < 6 months) |
| • Difficulty for mother to travel to facility-based clinics (including security issues) |

<table>
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<tr>
<th>ROOT CAUSES</th>
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<tr>
<td>Governance and management issues:</td>
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<tr>
<td>• Weakness in accountability and policy implementation</td>
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<td>• Weak coordination of referrals</td>
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| Social norms: |
| • Early marriage |
| • Family pressure and influence of mother/mother-in-law |
| • Women discouraged from leaving home after giving birth |
Box 2: The Postnatal Home Visiting Programme

Key programme components include:

- Conducting home visits by nurses and midwives focusing on high-risk women and their newborns within 48–72 hours after delivery. If needed, a second visit is conducted after one week, and a third visit at the end of the six-week period.

- During home visits:
  - Supporting breastfeeding, including positioning the baby and troubleshooting problems.
  - Checking or measuring the mother’s temperature, pulse, respiration and blood pressure; hemoglobin and blood glucose levels; uterus; and incision (in the case of caesarean section or episiotomy).
  - Weighing and measuring the baby’s length; checking the umbilical cord; checking suckling; assessing the newborn for any developmental delays and making a referral if needed.
  - Providing counselling and advice, if needed, on danger signs, hygiene, nutrition, birth spacing and family planning, immunization of mother and newborn, maternal and newborn psychosocial needs, and wound care.

- Providing postnatal kits to new mothers, which include equipment, devices and supplies.

- Providing capacity development trainings to midwives and nurses on postnatal care skills and home-based child health care. Nurses and midwives receive a yearly two to three-day in-service training covering basic care for mothers and newborns.

Contents of the home visit bag: Copies of postnatal records, referral forms; maternal and child health handbook and pens; oral thermometer; rectal thermometer; stethoscope; sphygmomanometer; glucometer and strips; haemoglobin testing device (Hemocue); hand-held weighing scale; length measuring tape; flash light/torch, and emergency light; soap/gel; health education materials; dressing set (sterile cotton, gauze, disinfectant and gloves); iron/folate tablets; reporting forms and/or paper for recording findings/observations; sharps box.
services. The programme contributes to the early detection of physical and mental health problems and integrates preventive care, including exercise, good nutrition, hygiene and family planning. The programme also promotes follow-up visits at the health centre for postnatal check-ups and immunization and provides critical support for improving breastfeeding practices.

**Scaling-up support to reach mothers and newborns**

Launched as part of the humanitarian response, the programme aimed to promote equity by providing the most vulnerable high-risk mothers and babies with access to basic health care services through community outreach undertaken, leveraging support from the existing health system.

From the start, the Postnatal Home Visiting Programme covered all five governorates of Gaza in 2011, with the Ministry of Health as implementing partner. The programme was scaled-up in 2014 and 2015 by engaging health workers through local implementing partners to conduct home visits in their working districts. These partners were recruited to support and complement the work of the Ministry of Health, expanding reach (rather than duplicating efforts), with UNICEF financially supporting their work.

Between 2012 and 2016, the number of mothers reached through the home visiting programme more than doubled, from 3,195 women to 7,503 women (*Figure 1*). During this time, the focus centred on achieving and maintaining high quality services and personalizing care to mothers as they bonded with their newborns.

While the intention is to eventually reach all high-risk mothers in Gaza, it has taken time to build the necessary capacity to deliver the programme...
UNICEF and partners have faced challenges in accessing hard-to-reach areas and securing enough nurses and midwives from the Ministry of Health to deliver services. The lack of continued financial support to the programme, the limited number of trained staff and the absence of up-to-date guidelines and protocols have posed a challenge to service delivery and quality. In addition, ongoing conflict created significant security issues, making it challenging to ensure staff safety during home visits.

To mitigate some of these risks, nurses and midwives often conducted home visits in pairs. Further, efforts were made to link them with mothers living close to their own communities, both facilitating their safety and allowing them to reach more mothers in need, even when movement was restricted.

With UNICEF technical assistance and financial support, new elements were introduced to the programme to promote early child development, stimulation and the early detection of children with developmental delays and disabilities. Nurses and midwives promoted responsive feeding and interaction between mothers and babies and its impact on child growth and brain development. Additionally, mothers learned about child
development and the influence of a conducive home environment on children’s social, emotional and cognitive development and behaviour.

**The power of personalized care on breastfeeding**

A mixed-method evaluation of the programme undertaken in 2017–2018, funded by the Government of Iceland, showed its positive influence on breastfeeding practices. The qualitative analysis found that women felt encouraged to breastfeed and recognized its benefits. First-time mothers especially benefitted from practical tips, such as how to position the baby at the breast. Yet even experienced mothers mentioned they had learned new things about breastfeeding that allowed them to exclusively breastfeed for longer compared with their previous pregnancies. Many women also noted they had learned about safely storing expressed milk in the refrigerator.

Several factors were identified as contributors to this positive influence on breastfeeding. The home visits allowed for more time and focused attention on the mother, whereas postnatal check-ups in the clinic tended to focus on vaccination and a quick standardized health check of the newborn. Many of the mothers said that they did not seek care for themselves at the clinic, whereas during the home visits they appreciated the personal attention and advice. The home visits reassured mothers that their babies were doing well, and they felt more valued and cared for knowing that someone had taken the trouble to visit them.

The programme also increased mutual understanding and respect between health care providers and mothers. Visiting nurses and midwives stated that the home visits made them more caring and attentive and improved their relationship with the mothers and their families. They also reported being pleased with the training they received on breastfeeding and felt better equipped with knowledge and skills to help make breastfeeding successful. The visiting nurses and midwives were identified as strong agents of change, who often had to correct misguided beliefs about the benefits of infant formula over breastmilk,
not only from the community but also from some doctors who prescribe formula to treat jaundice.

There is some evidence that the Postnatal Home Visiting Programme also fostered better support for breastfeeding and child-care within families. While there is a general belief in Gaza that men do not have a role in ‘women’s affairs’, some nurses and midwives reported that husbands were encouraged by the programme and benefitted from the home visits. Some husbands reported feeling valued and having increased motivation to support their wives and children.

With the support of postnatal home visits, most newborns in Gaza are now being breastfed – one of the programme’s greatest impacts. This is reflected in the high-quality qualitative data gathered on the experiences of mothers and in the high percentage of women in the programme who are exclusively breastfeeding in the weeks after their child’s birth. Programme data from throughout the programme period shows that around 80 per cent of the women visited during the first week of their child’s life were exclusively breastfeeding.

Between 2000 and 2014, rates of exclusive breastfeeding for children under 6 months in Gaza more than doubled, rising from 14.5 percent to 36.4 percent. Due to the absence of a baseline and control site, it is not possible to determine whether these changes were only related to the intervention; and the increasing trend also began before the programme was introduced. However, the remarkable increase between 2010 and 2014 after the programme was introduced is an absolute difference of 8.6 percentage points and is statistically significant (p<0.001), suggesting that the programme was likely a trigger for this improvement in exclusive breastfeeding.

The home visits facilitated a more individualized approach and provided an opportunity to troubleshoot problems that women were having with breastfeeding. This practical support was valued and facilitated the continuation of exclusive breastfeeding while improving the self-esteem of the women visited.

Making care personal – Lessons learned from scaling-up breastfeeding support

Gaza's Postnatal Home Visiting Programme demonstrates how an individualized approach to care can positively affect breastfeeding practices. This story offers important lessons for programmers everywhere:

• **Keep mothers and children at the centre of programming:** Focused attention to the individualized needs of each mother and baby should be provided along the continuum of care, from the hospital, to the primary care setting and home. Facility care can be complemented with home-based care for high-risk mothers and those unable to come to the clinic, and supplemented with additional mobile- or web-based contacts.

• **Identify and fill gaps along the continuum of care to provide more comprehensive services to improve breastfeeding practices:** A detailed situational analysis identified low quality and coverage of postnatal care as a barrier to improving breastfeeding practices. Based on this information, it was possible to design a solution that sought to improve implementation of an existing policy to deliver postnatal care services through home visits.

• **Develop national capacity to strengthen postnatal care:** A comprehensive approach was taken to train nurses and midwives to deliver essential postnatal nutrition and health services to mothers and babies, supported by supervision, mentoring and coaching. On a practical level, home visitors were equipped with postnatal home visit kits, transportation and telecommunication to support their work.

• **Ensure sufficient time is provided for individual counselling on nutrition and health:** An important time investment from postnatal care providers is essential for breastfeeding to succeed. This time investment provides the opportunity to enhance the services provided and foster mutual understanding and respect between health providers and mothers.

• **Raise awareness about the benefits of postnatal care for women and children:** Many new mothers in Gaza did not realize that they could also benefit from home visits and
not only their infants. Developing strategies to raise awareness about the availability of postnatal services to improve health and nutrition care and its benefits is important.

- **Invest in and harmonize existing health management information systems:** The lack of a centralized health information system made it difficult to coordinate care between different levels of the health system (hospitals, clinics, home visits) and between different providers. Improving information systems can support improved communication and coordination, helping to tailor care appropriately and ensure families are not left behind.

- **Remain responsive to gender dynamics, with special consideration of the engagement of fathers and extended families:** It is beneficial to develop a specific strategy for engaging with fathers and families that is reflected into programme design and training of home visitors. In the Gaza context, men are not allowed in many health facilities and therefore do not participate in antenatal care visits. Home visits thus provide an opportunity to engage with fathers that can be harnessed to involve them more in support for improving the health and nutritional status of newborns and their mothers.

**Sustaining high-quality support for all mothers and babies**

Based on the findings of the independent evaluation, the Postnatal Home Visiting Programme is being further strengthened, scaled-up and incorporated into the postnatal health care provided by the Ministry of Health and partners to foster sustainability.
To enhance the quality of postnatal care, including breastfeeding support, UNICEF is working with the Ministry of Health, academia and other key partners to revise, standardize and implement postnatal care protocols. UNICEF has already supported the training of nurses and midwives on the use of updated tools and will lead the roll-out to partners helping scale-up the programme.

The programme will also benefit from improved harmonization of data collection, monitoring and reporting on the provision of maternal and child health services among different health care providers.

UNICEF will work towards enhancing the integration of postnatal care into broader maternal and child health services, making it an equal component and ensuring that these interventions are sustained throughout the continuum of care for mothers and children.

Endnotes


4 Palestinian Ministry of Health, Annual Report of Hospitals (2016). According to the report, in 2015, 25 per cent of pregnant women were classified as high risk. Therefore, out of 80,000 pregnant women, 25 per cent were high risk and 12.5 per cent will require special neonatal treatment within a 12-month period.

5 A high-risk pregnancy is defined by specific criteria related to medical and obstetric history (e.g., age, previous caesarean section, pre-existing diabetes or hypertension, etc.) and/or risks related to the current pregnancy (e.g., gestational age, anaemia, signs of pre-eclampsia, etc.).


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