出國報告（出國類別：開會）

參加「第 10 屆愛嬰醫院倡議協調員會議：工業化國家、東歐和中東歐獨立國家聯盟」

服務機關：衛生福利部 國民健康署、台中榮民總醫院

姓名職稱：陳潤秋副署長、陳昭惠主任

派赴國家：荷蘭

出國期間：107 年 06 月 04 日至 06 月 10 日

報告日期：107 年 07 月 03 日

本項經費由「菸品健康福利捐」支應

摘要

本次會議為愛嬰醫院協調員每兩年一次的會議，並邀請世界衛生組織與聯合國兒童基金會參與，計有 25 個國家參加。

本會議主要針對去年及今年公布愛嬰醫院十措施指引及指南內容報告及討論，另報告各國愛嬰醫院現況，以及由荷蘭、瑞典、法國、克羅埃西亞、加拿大及英國等國報告各國執行經驗並與各協調員分享討論。

此次會議成果，分享我國母嬰親善推動成果，各國代表對於我國政府支持母乳哺育工作，並提供經費支持認證工作甚表敬佩。另外未來愛嬰醫院實施最新方向為政府應該支持將國際標準與國家系統結合、國家應該整合所有相關母乳哺育措施、建立醫療專業人員的能力，以及建立監測系統，可以作為政府推動母乳哺育之政策努力方向。

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壹、目的

1. 了解 WHO 及 UNICEF 國際愛嬰醫院標準更新及執行現況
2. 與工業化國家實際推動國際愛嬰醫院協調人員交流，並吸取他國經驗，做為未來我國推動母嬰親善醫療院所業務參考。
3. 參與國際性組織，拓展彼此間之交流及合作

貳、過程

一、舉辦單位：

愛嬰醫院聯盟 BFHI network 以及荷蘭愛嬰醫院組織

二、舉辦時間地點：

107 年 06 月 05 日至 06 月 07 日

Steenwijk-de Bult 荷蘭蒂布特（附錄一、會議議程）

三、參與人員：

來自 25 個國家的愛嬰醫院協調員及相關人員，ILCA 國際認證泌乳顧問協會及國際母乳會 LLLI 代表，及世界衛生組織/聯合國兒童基金會代表。(圖一全體會員合照)

四、會議目標

1.工業化國家愛嬰醫院協調員和聯絡人就 WHO 及 UNICEF 最新更新愛嬰醫院指引及守則的探討。

2.加強愛嬰醫院倡議協調員的網絡，並研議是否成立為一永久性國際非政府組織

-提供工業化國家協調員之間的相互支持;

- 分享有關嬰幼兒餵養和愛嬰照護的最新科學證據和研究結果的最新情況;
- 分享與愛嬰照護有關的經驗和良好做法。
- 除議程外，也讓各國以海報展示各自推行的經驗及成果。

3.分享與將守則納入愛嬰照護評估過程有關的經驗和良好做法，尤其是在工業化國家中各層級機構的愛嬰醫院評估上。

五、會議議題重點：

背景資料：母乳代用品銷售守則、愛嬰醫院相關指引沿革

1981 年	世界衛生會議中以 118 對 1 票,通過**國際母乳代用品銷售守則**.
1984 年	世界衛生會議通過決議,禁止過早使用麥粉及其他嬰兒食品的促銷.
1986 年	世界衛生組織全體一致通過,禁止免費給醫院母乳代用品.
1989 年	世界衛生組織以及聯合國兒童基金會發表產科機構促進、保護及支持哺乳的十措施
1990 年	**伊諾森蒂宣言**呼籲所有國家制定國家的母乳哺餵政策並設定國家九十年代適當的目標，包括有國家的母乳哺育協調者及組成委員會、推展愛嬰醫院、執行有效的母乳代用品銷售守則以及立法保護工作婦女的哺乳權。
1991 年	**世界衛生組織及聯合國兒童基金會開始愛嬰醫院倡議** BFHI
1992 年	第一家愛嬰親善醫院於菲律賓產生.
1994 年	世界衛生大會採用決議案 47.5 終止保健機構中所有的免費樣品
2002 年	世界衛生大會採用**全球嬰幼兒餵食策略**
2005 年	**伊諾森蒂宣言 2005 (Florence)**，除了原有的四項目標之外，另外再加上五個目標：發展、執行、監測及評估完整的嬰幼兒餵食政策；確保所有健康及相關單位保護鼓勵支持純母乳哺育六個月必持續到兩歲或兩歲以上，且提供婦女所需要的支持；鼓勵適時、安全且適當的副食品添加，並持續哺乳；對於特殊困難狀況下的嬰兒餵食提供適當的指南及對母親家庭及照顧者的支持；考慮新的立法或其他方案，確保嬰幼兒餵食政策的執行以及讓母乳代用品銷售守則以及之後的決議案可以有效的執行。 世界衛生組織西太平洋區/聯合國兒童基金會發表**區域性兒童生存策略**
2009 年	愛嬰醫院全球標準及相關工具更新
2016 年	全球愛嬰醫院大會
2017 年	世界衛生組織公告指南(Guideline)Protecting, promoting and supporting

	breastfeeding in facilities providing maternity and newborn services
2018 年	世界衛生組織-聯合國兒童基金會愛嬰醫院執行指引(guidance)-Protecting, promoting and supporting Breastfeeding in facilities providing maternity and newborn services: the revised BABY-FRIENDLY HOSPITAL INITIATIVE

(一)緣起

BFHI network 聯盟，是在 WHO 以及 UNICEF 建議下，針對國際愛嬰醫院執行狀況，各國協調者一起分享經驗及討論的會議。於 1997 年於日內瓦開始，每二到三年舉辦一次。最早只有歐洲工業化國家，第四屆後，美國及加拿大加入。台灣於 2010 年由國民健康署以及台灣母乳哺育聯合學會理事長第一次參加第六屆會議，新加坡以及日本也在當年開始參與。在會議中彼此分享執行愛嬰醫院的挑戰與成功的經驗。

去年 11 月 WHO 針對 BFHI 操作指南做了一些修正，並公告給幾個相關團體提供意見，有五個組織，包括 BFHI 聯盟, IBFAN 國際嬰兒食品行動聯盟, ILCA 國際泌乳顧問學會, ABM 國際母乳哺育醫學會， WABA 國際母乳哺育行動聯盟，一起發表聲明並且和 WHO, UNICEF 持續討論，最後 WHO 今年三月所發佈的最新 BFHI 操作指南的修正，維持了原來的十措施。然而針對其內容，仍有一些需要討論之處。因此今年會議的頭兩天特別邀請的世界衛生組織以及聯合國兒童基金會的代表到場來討論去年的指引以及今年的執行指南。

（二）BFHI 聯盟針對 WHO 操作指南的相關作為

來自義大利的 Elain 說明了這五個組織參與討論過程，以及現有指南的重點，包括:政府應該支持將國際標準與國家系統結合。醫療人員的訓練要從養成教育就放入 BFHI 內容，目前英國已經有針對這樣的教育做評估。國家應該整合所有相關母乳哺育促進及支持的措施，包括愛嬰醫院。執行過程應提供有關安全的指引，個別化的注意及照顧。應該更新生產指引的。將早產兒以及守則更明確納入，並強調持續監測。運用社區資源，加強公眾認知及文化改變。

（三）各國母嬰親善醫院現況報告（附錄二 Summary of the 2018 Country Reports）

西班牙 Maite Hernandez Aguilar 整理各個國家報告

此次有 30 個國家提供餵食以及愛嬰醫院資料，有收集資料者的比例逐年增加。收集頻率，以每年一次為主。參加者的資料中，有關第一小時的哺乳，以及住院中純哺乳率，台灣最低。六個月以下的純母乳哺育率台灣成績為第二位高。有關哺乳指標的收集，與會者對於定義部分仍是有國家間的差異，但即使這樣，持續地收集可以讓每個國家知道自己的努力成果以及變化。

有關 BFHI 的認證標準，16 個用國家標準。46%放入生產友善標準。認證時間台灣的三小時是最低，平均大約是二到三天。不過在整個參加者中，台灣是少數八個國家有政府單位的積極經費支持，這是很多國家 BFHI 聯絡者非常羨慕的部分。

我們也以「accrediting Baby-friendly institutions　in Taiwan」海報展示(圖二，海報展示)與各國交流推行母乳哺育的良好經驗以及所遇到之困難，各國都屬工業化國家，母乳哺育推行，都有其困難度，在這正面交流，有很大的助益。

（四）世界衛生組織最新愛嬰醫院指引（詳細資料: http://www.who.int/nutrition/publications/guidelines/breastfeeding-facilities-maternity-newborn/en/）

WHO 代表 Pura 提到指引的發展及建立是有其既定標準，並有 handbook 可參考。她特別提出 WHO 兩份不同資料，一份是 guideline，一份是 guidance，guideline 主要談要做什麼，至於如何執行，則需要 guidance，Documentation 或 implementation guideline 執行指南。

指引的制定過程通常是先有人提出問題，WHO 相關人員接著檢視相關資訊，提出想解決的問題，然後找各個相關發展者（5 到 8 人），確認題目是否正確。BFHI guideline 指引的發展過程，提問了 13 個問題，然後進入 systemic review (SR)team，共有 22 個 SR，用 grade 系統，分等級。最後考慮的因素除了證據等級之外，價值觀及喜好， 利益傷害的平衡，資源、問題的優先性、人權、可近性及可行性都會列入。最後做出了 15 個建議。

針對機構內的哺乳建議

即刻支持開始母乳哺育

1. 所有的母親都應該盡快在產後一小時內接受支持開始哺乳（推薦的，中等質量的證據）
2. 母親應該得到實際支持，使他們能夠啟動和建立母乳哺育並處理常見的哺乳

困難。（推薦的，高質量的證據）

3. 應該指導母親如何擠奶，以便在母乳與嬰兒暫時分開的情況下維持哺乳。（推薦的，中等質量的證據）
4. 提供產婦和新生兒服務的機構應能使母親和嬰兒不分日夜在一起。 這可能不適用於需要轉至特殊醫療照護的嬰兒（推薦的，極低質量的證據）
5. 應該支持母親將回應性餵養作為哺育照護的一部分。（推薦的，中等質量的證據）
6. 應該支持母親將回應性餵食列為滋養性照護的一部分（推薦的，極低質量的證據）

餵食措施及嬰兒額外的需求

7. 除非有醫學上的適應症，否則應該不鼓勵母親給予母乳以外的任何食物或液飲料。（推薦的，中等質量的證據）
8. 應該支持母親認識到嬰兒對餵食，親密和舒適需求的行為線索，並且讓她們停留在產科機構中的這段時間有能力可以根據這些線索以不同方式回應。（推薦的，高質量證據）。
9. 對於無法直接進行母乳哺育的早產兒，非營養性吸吮和口腔刺激直到建立母乳哺育前可能是有益於。（推薦的，低質量證據）
10. 如果足月嬰兒因為醫療需求需要擠出的母乳或其他餵食，在住院期間可以使用杯子，勺子或奶瓶和奶嘴等餵養方法（推薦的，中等質量證據）。
11. 如果早產嬰兒因為醫療需求需要擠出的母乳或其他餵食，在住院期間使用杯子，勺子比使用奶瓶和奶嘴餵養方法好（推薦的，中等質量證據）

建立增能的環境

12.提供母嬰服務機構應該有明確書面的母乳哺育政策，並經常與醫護人員和家長溝通（推薦的，質量很低的證據）。

13.提供嬰兒餵養服務（包括母乳哺育支持）的醫療工作人員應具備足夠的知識，能力和技能來支持女性進行母乳哺育（推薦的，質量很低的證據）。

14.如果機構提供產前照護，應向孕婦及其家屬提供有關母乳哺育的益處和處理的諮詢（建議的，中等質量證據）。

15.作為保護，促進和支持母乳哺育的一部分，應規劃並協調提供母嬰服務的機構的出院計畫應協調讓父母及其嬰兒獲得持續的支持並獲得適當的照顧（建議的，低質量證據）。

就這十五點建議，與會者最多的討論是在奶瓶及奶嘴的使用。雖然有些研究認為奶嘴的使用與日後的純母乳哺育率沒有關連，但是幾篇研究中，對照組以及實驗組都有接受良好的哺乳協助。有些對照組的嬰兒實際上也使用了奶嘴。另外也有研究發現會使用安撫奶嘴的母親可能意味著已經有哺乳方面的困難，或者是自信心比較少，因此使用奶嘴奶瓶與哺乳時間短兩者間究竟是因果還是其他相關性，仍待更多的研究。與會的實際參與協助哺乳母親者，對於此指引提到足月兒的添加食物方式可以採用奶瓶奶嘴的建議，覺得仍不合宜。

（五）世界衛生組織 2018 年愛嬰醫院十措施操作指南（詳細資料:http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation/en/）

操作指南中的十措施

關鍵管理措施

1a. 完全遵守『國際母乳代用品銷售守則』和世界衛生大會相關決議。

1b. 制定書面的嬰兒餵食政策，並定期將此與員工和家長溝通。

1c. 建議持續的監測和數據管理系統。

2. 確認工作人員有充足知識，能力和技能來支持母乳哺育。

重要的臨床措施

3. 跟孕婦和其家屬討論母乳哺育的重要性和處理。

4. 促進即時及無干擾的肌膚接觸，並協助母親們生產後儘快開始母乳哺育。

5. 支持母親們開始和持續母乳哺餵，以及常見問題的處理。

6. 除非醫療上有必要，否則不要提供母乳哺育的新生兒母乳以外的任何食物或液體。

7. 讓母親們和他們的嬰兒能保持在一起，並且執行 24 小時親子同室。

8. 支持母親們認識並回應她們的嬰兒之餵食徵象。

9. 忠告母親們使用奶瓶、奶嘴、安撫奶嘴的危險性。

10. 出院安排，讓家長們和他們的嬰兒需要時能及時獲得持續的支持和照護。

實施愛嬰醫院的最新方向摘要

1.適當保護，促進和支持母乳喂養是每個提供產婦和新生兒服務的機構的責任。不分私立、公立，或大小。

2. 各國需要根據最新的成功母乳喂養十項措施和全球標準，製定母嬰服務機構保護，促進和支持母乳哺育的標準。

3.愛嬰醫院倡議必須與孕產婦和新生兒健康，健康照護改善，衛生系統強化和品質保證等其他舉措結合起來。

4.為確保衛生保健提供者俱備實施愛嬰醫院的能力，這一主題需要納入職前培訓課程。此外，當能力尚未達到時，需要提供在職培訓。

5.讓公眾認可實施“十大措施”並遵守全球標準的機構是激勵品質改進的一種方式。還有其他幾種激勵措施，從符合國家機構設置標準到以表現為基礎的給付。

6.定期內部監測是品質改進和持續品質保證的關鍵要素。

7.外部評估是驗證母嬰服務品質量的寶貴工具。外部評估應該被充分精簡至可持續實施的現有機制內。

更新操作指南與舊有十措施的差別

關鍵管理措施

新指南	舊制	作法	台灣現況
1a. 完全遵守『國際母乳代用品銷售守則』和世界衛生大會相關決議。	無	工作人員可以說出至少兩點基本概念	有部分涵括： 機構中沒有廣告、展示、奶粉商不可直接接觸孕產婦，機構必須採購母乳代用品，不能有免費樣品。 但是未規範母乳代用品廠商以及醫療工作人員間，以及機構間的利益關係。（不能提供禮品、樣品，提供的資料須為同儕審查過的論文資訊）
1.b 制定書面的嬰兒餵食政策，並定期將此與員工和父母溝通。	有一個母乳哺育政策，定期和醫療工作人員溝通		目前僅要求母乳哺育政策
1.c. 建議持續的監測和數據管理系統。	無	至少每六個月會議討論	1.措施一母嬰親善推動委員會定期(至少半年召開一次)召開會議評估執行成

			效及檢討改善。 2.監測效期內機構之品質，每年機構須提具母乳率.親子同室率及肌膚接觸率等資料，並針對執行較差者做實地輔導。上述收集資料及實地認證結果，統計分析完成該年度認證結果報告。
工作人員能力：確認工作人員有充足知識，能力和技能來支持母乳哺育。	所有工作人員要接受訓練可以執行相關政策	人員在二年內（包括養成訓練或在職）有受訓，要有能力的評估方式，可以回答至少 3/4 的知識技能問題	新進人員要求訓練八小時，並未要求能力評估

重要的臨床措施

新指南	舊制	作法	台灣現況
3.產前資訊：和孕婦及家人討論哺乳的重要性及處理	一樣	提供有關哺乳更實際且完整的資訊，同時包括哺乳問題的處理。 包括有用的技能，如了解嬰兒餵食行為暗示，抱姿擺位，含乳等	有
4.產後立即照顧：促進立即沒有干擾的肌膚接觸，並儘早支持母親開始哺乳	產後半小時內開始哺乳	立即，最遲不能超過五分鐘。持續至少一小時 可以直接肌膚接觸後才斷臍帶 剖腹產者，等斷期待時可先放在母親大腿上肌膚接觸，或由鋪單下送到媽媽胸前	陰道產 20 分鐘 剖腹產 10 分鐘
5.支持母乳哺育：支持母親開始哺乳及處理常見問題	一樣	6 小時內教導，母親如何擠奶，知道飽足之行為暗示	有
6. 除非醫療上有必要，否則不要提供母乳哺育的新生兒母乳以外的任何食	一樣	添加食物的適應症建議採取 ABM 指引。選擇配方奶者，要告知還有哺	有 有關臨床適應症應該更新

物或液體。		乳，及其他餵食方式	
7. 親子同室：讓母親們和他們的嬰兒能不分日夜	讓母親們和他們的嬰兒能保持在一起，並且執行 24 小時親子同室。		要求的比例較低
8. 回應性餵食：支持母親們認識並回應她們嬰兒的餵食行為暗示。	鼓勵依照嬰兒需求哺乳	必須教導母親嬰兒的餵食行為暗示	有 但須加強母親瞭解新生兒頭三天的行為表現以及飢餓暗示
9. 奶瓶、奶嘴以及安撫奶嘴：忠告母親們使用奶瓶、奶嘴、安撫奶嘴的危險性。	對哺乳嬰兒不使用奶嘴以及安撫奶嘴	應告知奶嘴以及安撫奶嘴的危險性。在止痛的選擇上，肌膚接觸、母乳哺育、母乳應為攸縣。非營養性吸吮則列在其後。	有
10. 出院安排：讓家長們和他們的嬰兒需要時能及時獲得持續的支持和照護。	協助建立出院後哺乳支持團體，並且在出院時轉介。	應該與社區結合	有

（六）國家經驗分享（附錄三：荷蘭及瑞典資訊系統簡介）

1.荷蘭分享 BFHI 監測資訊系統

與 TRIQ 公司合作，2015 開始建立 BFHI 評估系統，2017 正式使用第一版。包括評估卡，上傳資料及檢查。受評的醫院先將母親的電子信箱上傳，監測者隨機抽樣，請母親回答綫上調查 ，上傳後系統自動產出報告。2018 五月歐盟通過 GDPR， 資料上傳者的隱私需特別注意。

2.瑞典分享 BFHI 監測系統

主要介紹現有免費線上系統，Open data kit ODK。可以運用此建立一個資料收集平台，類似 Xls 格式，可建立問卷，下載在手機或上網使用。另外有 ODK 2.0modular frame work。

針對資訊系統部分，與會者希望世界衛生組織可以建立平台，讓大家共用。有關個人隱私部分，則是需要關注的重點之一。

（七）國家應有的領導及協調角色 Marcus Stahlhofer, WHO (附錄四 BFHI National Leadership and Coordination 簡報)

要提升國家所有機構保護、促進及支持母乳哺育的品質改進，需要健康系統性的做法，包括：

- 提供服務者
- 健康服務人力
- 健康資訊系統
- 獲得基本藥物
- 經費
- 政府的領導

國家的愛嬰醫院計畫目標應該達到 100%的涵蓋率，以及建議措施的持續執行。要達到這樣的目標需要政府主責，提供經濟上的永續支持。

國家的母乳哺育整合部門應該是包括多部門，可以是政府，或現有專業團體 / NGO 主導。政府的主導性非常重要，因為可以被信賴。

愛嬰醫院應該為政府之責任（健康促進）， 政府應該關注其品質標準病定期監測。應該和其他母嬰健康或營養議題介入整合，十措施應該整合至相關政策

及專業照護標準。

應提供機構技術上的協助，可以先由較大的醫院或教學醫院開始，經驗分享， 提供標竿學習，訓練講師。此部分台灣已經有進行多年的輔導制度。

鼓勵及制裁：

根據表現提供給付。

也可列入機構成立的必要條件，但是不建議太多標準，並且要有好的外部監測。也可以公開表揚，授獎等，可以鼓勵民眾至該機構就醫，但是也是需要有持續外部監測。

或是採用認證措施。但是足以達到品質改善，還是只有在認證當下？ 外部監測和內部監測的有效性以及認證的成本績效都是需要考慮的，不過還是建議持續維持認證。

（八）銷售守則 Marcus Stahlhofer, WHO （附錄五、BFHI The International Code of Marketing of Breast-milk Substitutes簡報）

在新的愛嬰醫院操作指南中將守則納入，包括：完全遵守守則，沒有免費或降價供應，不展示相關產品或商標，且政策包含遵守守則。實際作法為專業人員至少有 80%可以說出守則至少兩點基本概念，如守則與他們角色間的關係。

在其他世界衛生組織的文件中，也有相關的規範。如：Standard for improving quality of maternal and newborn care in health facilities 中的品質聲明 Quality statement 1.9 說沒有婦女或新生兒在待產、生產及產後初期接受到不需要或有害的措施。而對母嬰有害的措施，包括廣告及促銷母乳代用品及奶瓶餵食。Standard for improving the quality of care for children and young adolescents in health facilities 的標準一中也提到，機構應該完全遵守銷售守則並且監測。標準五也提到機構應該有最新的母乳哺育政策，遵守銷售守則，並且定期向員工溝通。

守則執行上的挑戰

196 個國家中只有 136 的國家有一些相關法律，在工業化國家沒有相關立法，或只有少數立法。目前美國及加拿大和台灣一樣，是利用 BFHI 認證時，要求醫院遵循守則。

需要有法律相關人員提供是否有其他相關法律來規範廠商，例如藥商倫理規範。

另外可以運用的法律或人權相關文件為兒童權利宣言，在其第 4 及 24 調都有提及應提供兒童完整的營養。 可以和國內負責國際人權義務及監測單位聯繫，將母乳哺育列入其中內容。同時也可讓更多民眾、媒體、政府單位及民間團體知道知道相關健康權利的資料。

機構遵循守則會遇到的挑戰

健康工作人員的守則知識及監測能力

- 什麼是守則
- 如何影響我的工作
- 我的責任及義務
- 我如何得到更多相關資訊

可以提供的資料如：FAQ, Code essentials(IBFAN), WHO/UNICEF e-learning course 7 hours (UNICEF website) AGORA

將此訓練列入養成及在職教育，並且列入品質改善監測指標。

（九）提供及評估健康照護（詳細資料:

http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation/en/）

將十措施整合至國家政策中，可以是

1. 醫院必要的規定
2. 國家主要策略，可參考 WHO 母嬰標準照護，兒童照護標準 handbook for national quality policy and strategy, kagaroo mother care, 母嬰照護標準 quality of care network(WHO)

- 國家營養政策
- 哺乳行動計畫
- 兒童存活策略
- 國家發展策略
- 肥胖防治策略

3. 婦產、助產、兒科、新生兒科、護理或營養標準照護

醫療專業人員的能力建立

是國家的責任，強調職前養成訓練，持續教育以及在職教育也很重要。可以是線上互動教育以及直接觀察，要有以能力為基礎的評估。

在指引上有專業人員應有的能力

1.利用聆聽和理解技巧為母親提供諮詢;

2.利用技能建立信心並給予母親支持;

3.諮詢孕婦關於母乳哺育;

4.評估一次母乳哺育;

5.幫助母親哺乳時維持自己和寶寶的姿勢;

6.幫助母親讓寶寶含上乳房;

7.向母親解釋母乳哺育的最佳模式;

8.幫助母親擠奶：

9.幫助母親杯餵她的寶寶;

10.幫助母親在出生後一個小時內開始母乳哺育;

11.幫助一位認為自己沒有足夠奶水的母親;

12.幫助嬰兒經常哭鬧的母親;

13.幫助嬰兒拒絕哺乳的母親;

14.幫助有乳頭扁平或凹陷的母親;

15.幫助乳房腫脹的母親;

16.幫助疼痛或乳頭皸裂的母親;

17.幫助患有乳腺炎的母親;

18.幫助母親餵養低出生體重的嬰兒或生病的嬰兒;

19.向母親諮詢她的健康;

20.在衛生機構實施守則。

外部評估

是品質保證的重要因素，需與內部監測同時進行。最好與現有系統結合，如保險系統或現有醫院評鑑。建議至少每五年，至少有一些相關指標，在指南附件中總共 38 項目可以參考。

有關如何讓醫院願意接受外部監測，與會者有一些建議，如：表揚會議、媒體宣傳、強調醫療照護品質等。根據當地的文化、價值、系統，整合成為常規。美國加州以及密西西比州以將愛嬰醫院列入醫院標準/健康保險中。

（十）新生兒愛嬰醫院計畫法國及克羅埃西亞經驗（附錄五、簡報）

法國 有 517 個產科機構， 349 個新生兒單位, 每年出生數 767000 人。BFHI 出生涵蓋率為 6%. 在 33 家愛嬰醫院中有 16 家有新生兒單位，12 認證通過 neoBFHI。

2008 開始新生兒單位認證， 2011 neo BFHI 計畫加上了三個指引標準 (在

法國 BFHI 產房單位也已將此三個標準放入)，並不要求至少有多少哺乳率但要遵守守則。 內容包括提供肌膚接觸，鼓勵哺乳，父母為主要照顧者（醫院有提供父母住宿，根據其醫院狀況提供空間，可能是在病房內或附近），必須要與 BFHI 同時認證。

27 個新生兒單位調查，有認證通過者表現較好，有自我評估表。

克羅埃西亞

剖腹產率 21%。 31 所公立產科醫院，全部為 BFHI，有 11 家有 NICU。一家私立。2013 年開始新生兒病房 BFHI 計畫，2015 年開始人員訓練，包括杯餵、袋鼠照護，同時有線上課程。UNICEF 提供經費購買相關設備，如 pump 及 feeding cup。 目前每天肌膚接觸 2-4 小時者已經由 33%增加至 60%。

優勢：工作人員的參與，所有公立醫院都是 BFHI，政府支持此計劃

挑戰:缺少外部評估，如何將其整合至醫院評鑑，以及建立母乳庫。

(十一)肌膚接觸時的新生兒衰竭 neonatal collapse（附錄六、簡報）

由加拿大 Louise Dumas 分享肌膚接觸時的安全議題。

建議直接馬上將寶寶放在胸前，馬上擦乾，再蓋上溫毯，戴帽子，避免蒸發的失溫。剖腹產時嬰兒姿勢為橫放，根據產科醫師意願，請伴侶將手直接放在嬰兒屁股（不要隔著毯子），支持其位置。

新生兒猝死的危險因子：初產婦，嬰兒完全趴、母親平躺、沒人照顧、通常發生在夜班。

安全準備：

事先告知父母，準備母親肌膚接觸時的衣服不要擋住母親的視線，在母親身上擦乾，更多的皮膚面積接觸，嬰兒的鼻口是開放，不要壓著頭，濕的布單要移開，不要抱太高讓媽媽看不到嬰兒。

教導父母觀察，同時至少要有一個工作人員檢查嬰兒，包括膚色、呼吸、肌肉張力。

在產房張貼教導的海報

研究發現分離兩小時後再親子同室，嬰兒的表現不如直接肌膚接觸者。在親子同室時仍可肌膚接觸，不要包裹太緊。

親子同室時猝死的危險因子：睡覺的表面 、父母的姿勢不要平躺、周圍的枕頭

或毯子、抽菸、酗酒、肥胖、藥物。

觀察的項目一樣。

(十二)愛嬰醫院的持續性（附錄七、Sustaining the BFHI 簡報）

國家監測：

如何進行： 線上回答，國家做機構調查，列入國家調查內容

溝通及倡議

要持續支持需要與下列人員溝通及倡議

- 機構之領導者
- 醫療專業者及協會
- 立法委員
- 提供基金者
- 孕婦 社區人員

了解其現有知識

經費

政府、募款、醫院付費 、無利益衝突

(十三)愛嬰醫院執行的轉換計畫（附錄八、Transition planning to the BFHI Guidance 2018 簡報）

如果國家的愛嬰醫院計畫本來就執行良好者，可以將標準更新，與其他計畫整合，發展一個計畫。同時給機構更新相關資料 訓練、評核標準（內部、外部評核）

就台灣而言可以看一下我們的相關策略，使用品質改善方式，提供有支持策略的環境，建立監測及持續機轉，再開始告知機構如何改進，同時進行相關訓練。要有輔導機制，已經完成的機構可以為 mentor。

在這個討論會上，主辦單位將愛嬰醫院發展的旅程上以一張長海報列出，請所有參與的國家將自己的里程碑以國旗貼上，並加以註記，在國際討論會含 WHO 出席的會議上，能運用我們的國旗，我們都很感動，也立刻將大會準備的三張貼紙都用上：1.2001 年台灣 BFHI 正式展開認證；2.2010 年「公共場所母乳哺育條例」通過實施；3.2014 年發布「嬰兒與較大嬰兒配方食品廣告及促銷管理辦法」(圖三、四長條海報) (圖五、六發表照片)

與會者建議 UNICEF /WHO 提供監測工具，提供訓練用的圖片,影片，手擠奶、杯餵、臨床技能等。國際評估者可以彼此支持，定期線上討論。可以使用網路短講，鼓勵年輕世代的參與。對於不同語言母親的面談需要翻譯相關資料。

我們也需要知道目前有哪些相關的資訊、政策、如環保、氣候、人權、食品安全、health for all 、健康促進、good start into life、頭一千日、母嬰健康等都有母乳哺育相關資料可以參考。

（十四）英國愛嬰醫院經驗分享（附錄九、簡報）

英國的文化認為嬰兒應該自主，和母親分開，因此推展愛嬰醫院有一些困難。他們從 1994 UKBFHI ，1998 開始社區計畫， 2005 大學計畫，2012 進行實證回顧，2015 進入永續標準。照樣十措施的內容，但是用不同的名字。

建立了產科標準，包括：

- 孕婦的準備
- 產後密切的接觸以及餵食
- 一開始順利的哺乳
- 其他餵食方式的知情選擇（措施六，避免瓶餵者過度餵食）
- 建立密切及關愛的關係：包括母嬰之情緒心理發展、回應性的親職建立

他們將腦部發展放進此計畫中，擴展至所有嬰兒，相關工作人員都喜歡這樣的計畫

2012 開始新標準相關資料建立，2014 新標準開始使用但是不計分，給予非正式的回饋及詢問，2015 要求 50%人員滿足知識問答，30%母親的滿足照護結果，2016 標準增加至 80%人員以及 50%母親的結果，2017 對兩者的要求都達到 80%。

持續性的標準

- 建立一個領導團隊： 要有足夠的訓練時間以及能力，baby friendly guardian, 管理階級的教育（主要包括守則,3 小時）
- 建立正向文化：持續員工學習訓練，支持正向文化的機轉（安全的環境）員工、管理者以及母親的正向回饋（問母親，你覺得員工對你友善嗎）
- 架構監測過程：監測以及資料收集，分析以及行動計畫的證據，有效的內部以及外部報告

- 發展（progression）：機構展現創新及改變，預後改善整合性工作

（十五）BFHI network 組織討論

於最後一天討論愛嬰醫院聯盟之後的發展，將朝向正式的非官方組織結構發展，有三個委員會，包括外部聯繫、會議籌備以及內部網絡建立委員會，在這之上有一個協調委員會（coordinating committee）。

會中由陳昭惠醫師以台灣愛嬰醫院協調者的角色，參與內部網絡建立委員會，並爭取成為太平洋亞洲地區聯絡者，參與協調委員會，更積極主動參與相關組織的運作，亦可盡早得到相關國際動向，並適時爭取台灣參與的地位。

參、學習心得

一、政府的領導（監測、倡議以及經費）

此次會議主要重點為 BFHI network 愛嬰醫院聯盟成員與世界衛生組織以及聯合國兒童基金會代表討論最新的愛嬰醫院指南以及操作指引。為了增加涵蓋率，此次更新中特別強調政府的參與以及持續支持。此部分台灣政府國民健康署從一開始就是積極的主導者，也是與會很多國家非常羨慕的部分。如何運用 WHO 其他相關母嬰健康議題計畫文件，將母乳哺育以及守則規範整合到在其他相關母嬰照顧的議題中，另外如何持續監測，運用合適的鼓勵方式（除了現有產前檢查的增加點數之外），讓更多的醫療機構可以參與，並且持續進行，是一個需要努力的方向。

二、監測指標

在有提供資料的國家總和報告中，我國六個月以下純母乳哺育率排名第二高，然而整理者也提到在資料收集上的一個問題是，每個國家的定義可能不同。有人是用六個月以下，有人是以六個月大。這個部分仍須大家盡可能一致。但是在沒有一致前，國家仍是可以用歷年的數字，評估自己國家內的計劃成效。

- WHO 六個月以下純母乳率計算

定義：0-5 月齡嬰兒純母乳哺育

Definition: Proportion of infants 0 – 5 months of age who are fed exclusively with breast milk.

Infants 0 – 5 months of age who received only breast milk during the previous day/

Infants 0 – 5 months of age

0-5 月齡嬰兒前一天有哺育母乳/0-5 月齡嬰兒

- 我國六個月以下純母乳率計算

1.我國 105 年母乳率調查，調查對象是台灣地區 2016 年 1 月至 2016 年 4 月生產之母親，調查方法採用「電腦輔助電話訪問系統」進行，調查總計完成 12,536 個產婦。

2.問卷內容「請問這個寶寶純吃母奶吃到多大，就是只有吃母奶，沒有混合餵奶粉、果汁、葡萄糖水等食品？_____個月_____天【訪員注意：答案請直接換算成天數，回答 0 者，跳問第 8 題；只添加白開水、維他命、礦物質補充劑或藥品者，仍可算純吃母奶】 (991) 到目前還純吃母乳 (990) 其他【請記錄在工作紀錄表】 (993) 忘記了(995) 拒答(998) 不知道」。

3.各階段母乳哺育平均人日分析，進一步將各期間純母乳哺育天數乘以該期間之哺育人數，以估算各期間之純母乳哺育人日，再將各期間純母乳哺育人日加總後除以總哺育人數乘以各期間的日數，以推估各該階段內之純母乳哺育率。本署針對 N 個月以下純母乳率的計算方法是運用流行病學裡面 rate 的計算方法，分子、分母均考慮人月的數值，以人時(person-time)的概念計算。

三、母嬰親善醫院照護品質改善以及國際愛嬰醫院

我國在新生兒住院中的純哺乳是所有國家的最低，認證所耗費的時間最短（只有三小時），其他國家平均為兩天。雖然我們的母嬰親善醫院出生涵蓋率較高，但是這樣的認證結果，也比較容易為人質疑其照護品質。我國自 2010 年初次參與這樣的會議迄今，一開始這樣的認證時間就被與會者表達關心。因為我們降低了認證標準，雖然讓更多的醫院願意參與，但是經過這些年仍沒有改進，品質的確難以提升。考慮現有某些醫療人員因為工作、及評鑑文件繁瑣，而對現有母嬰親善醫院多所微詞，建議可以依照國際標準，設定相關教育訓練內容以及認證條文，邀請有意願的醫院參加，逐步提升國內愛嬰醫院的水準。根據此次會議的決論，大家認為仍先以 2009 年的版本為主，再逐步修正。

由這一次的標準更新中另外可以看到，世界衛生組織更加強對母親及家屬的教育，包括依照新生兒的行為暗示餵食。英國的經驗分享中·也提到他們的文化本來是嬰兒應該獨立自主，與母親分開的。因此他們採取促進母親及嬰兒心理發展，以及腦部發展的角度來推展愛嬰醫院。這個部分的做法值得我們參考。肌膚接觸、親子同室、依照嬰兒行為暗示餵食，本來就是所有嬰兒及家庭

的權利。應該讓所有的母親及家人能從產前就了解正常新生兒的行為（不是定食定量），以與家人有密切互動可以促進腦部發展。可以製作這個部分的衛教資料，以及影片給民眾以及醫療專業人員，完整 SDM(醫病共享決策)的所需工具與方法，而不只是現在醫病共享決策中所使用的一張 PDA 病人決策輔助表。

加強醫療工作人員的訓練，除了將現有八小時的課程擴展為二十小時的內容外，另外可以製作線上課程。也應關注醫療專業人員討論學校養成教育中的相關課程。而現有的醫學教育都一再強調，不是教導或學習多少小時，更重要的要評估實際的能力。因此制定能力評估標準及工具也是需要持續進行的，而這一部份 WHO 是否也會發展相關工具，我們會持續密切注意追蹤。

我國已經有十一位醫療專業人員於 2011 年接受過世界衛生組織的全球標準認證訓練，可以請這些受訓過的委員一起參與國際愛嬰醫院標準制定相關計畫，並可考慮至新加坡或香港參訪，或是邀請該國認證委員協助我們進行第一次國際標準認證。

四、未來方向

此次會議中已經有幾個國家報告他們運用資訊系統做持續性的內部以及外部愛嬰醫院監測，可以減少文書處理以及紙張的浪費。我們也應密切注意 WHO 是否會有平台建立。

此次會議中，我國主動參與相關組織建立活動，目前暫定明年十一月在比利時舉辦下一次的會議。建議邀請實際執行母嬰親善醫院認證的醫策會參加，以更了解國際上認證執行及監測的做法。

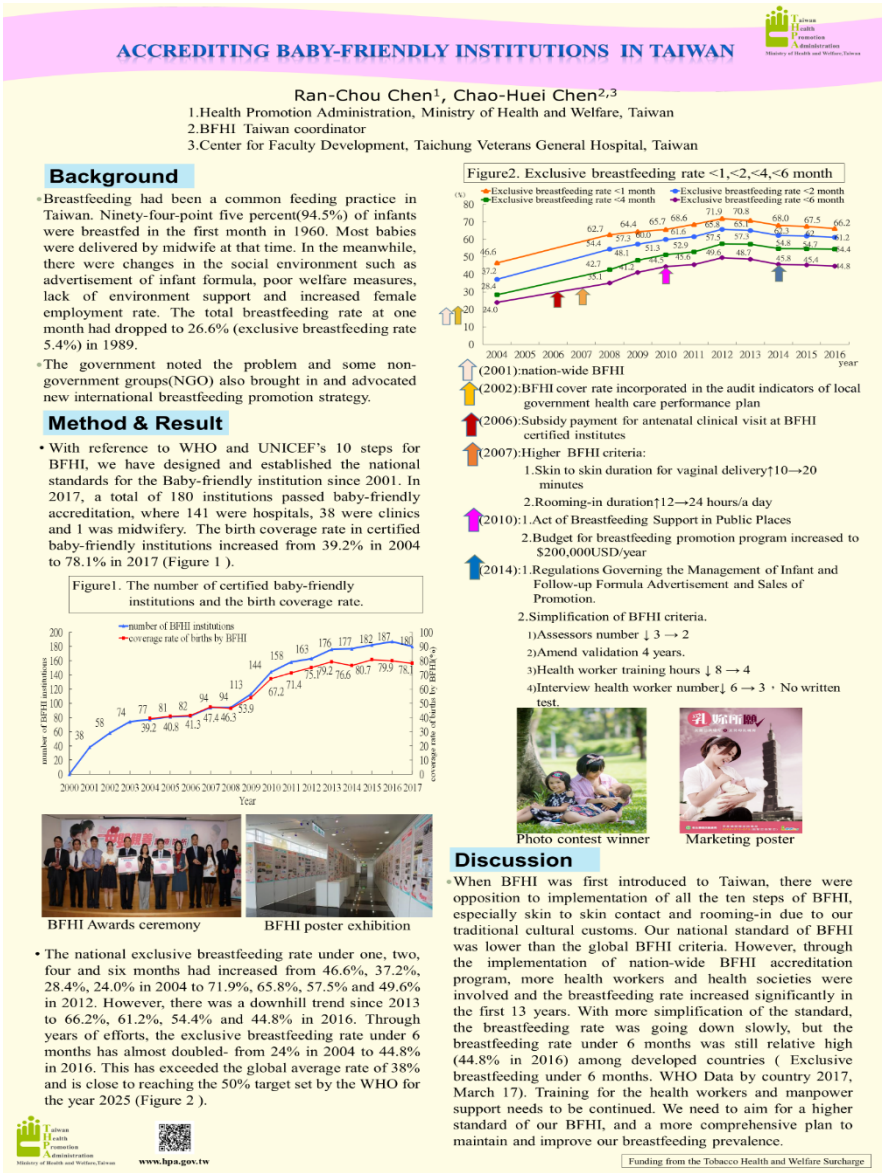
肆、建議

國際中愛嬰醫院的推行的確對於母乳哺育率有提升的作用，如何讓更多的醫療院所參與，讓更多的母親和新生兒接受到高品質的照護，是本會議的重點。根據會議內容，建議我國可以採取的行動包括：

1. 請政府持續主動積極的支持，提供經費於認證計畫，給予認證通過者實質的獎勵，並持續監測照護品質。
2. 持續落實國際母乳代用品行銷守則的執行。將母嬰親善醫院的措施以及遵守國際母乳代用品銷售守則整合至其他相關母嬰照護的計畫、措施或規範（可運用 WHO 現有相關文件）。並與兒童權利宣言相關主責單位聯繫，協助監測守則之執行。
3. 由之前受訓過的十一位委員，以 WHO 2009 年版全球標準，加上現有更新內容中沒有爭議的部分，訂定屬於全球照護品質標準的愛嬰醫院標準，並且將對象擴展至所有嬰兒及家庭，不論其餵食方式。
4. 制定相關的嬰兒餵食及新生兒照護衛教內容，包括：正常新生兒的行為表現以及餵食暗示，如何處理哺乳常見問題，如何經由肌膚接觸以及親子同室促進新生兒腦部發展，以及肌膚接觸及親子同室時的安全注意事項等。
5. 加強醫療工作人員的訓練，包括養成及在職教育，可包括線上課程，並執行能力評估。
6. 參訪新加坡及香港認證醫院，學習相關認證以及實際執行細項。
7. 持續主動參加國際愛嬰醫院聯盟組織相關活動，維持台灣在此議題的地位。

圖一、全體會員合照

圖二、海報展示



ACCREDITING BABY-FRIENDLY INSTITUTIONS IN TAIWAN

Ran-Chou Chen[1], Chao-Huei Chen[2,3]

1.Health Promotion Administration, Ministry of Health and Welfare, Taiwan
2.BFHI Taiwan coordinator
3.Center for Faculty Development, Taichung Veterans General Hospital, Taiwan

Background

- Breastfeeding had been a common feeding practice in Taiwan. Ninety-four-point five percent(94.5%) of infants were breastfed in the first month in 1960. Most babies were delivered by midwife at that time. In the meanwhile, there were changes in the social environment such as advertisement of infant formula, poor welfare measures, lack of environment support and increased female employment rate. The total breastfeeding rate at one month had dropped to 26.6% (exclusive breastfeeding rate 5.4%) in 1989.
- The government noted the problem and some non-government groups(NGO) also brought in and advocated new international breastfeeding promotion strategy.

Method & Result

- With reference to WHO and UNICEF's 10 steps for BFHI, we have designed and established the national standards for the Baby-friendly institution since 2001. In 2017, a total of 180 institutions passed baby-friendly accreditation, where 141 were hospitals, 38 were clinics and 1 was midwifery. The birth coverage rate in certified baby-friendly institutions increased from 39.2% in 2004 to 78.1% in 2017 (Figure 1).

Figure1. The number of certified baby-friendly institutions and the birth coverage rate.

BFHI Awards ceremony

BFHI poster exhibition

- The national exclusive breastfeeding rate under one, two, four and six months had increased from 46.6%, 37.2%, 28.4%, 24.0% in 2004 to 71.9%, 65.8%, 57.5% and 49.6% in 2012. However, there was a downhill trend since 2013 to 66.2%, 61.2%, 54.4% and 44.8% in 2016. Through years of efforts, the exclusive breastfeeding rate under 6 months has almost doubled- from 24% in 2004 to 44.8% in 2016. This has exceeded the global average rate of 38% and is close to reaching the 50% target set by the WHO for the year 2025 (Figure 2).

Figure2. Exclusive breastfeeding rate <1,<2,<4,<6 month

(2001):nation-wide BFHI

(2002):BFHI cover rate incorporated in the audit indicators of local government health care performance plan

(2006):Subsidy payment for antenatal clinical visit at BFHI certified institutes

(2007):Higher BFHI criteria:
1.Skin to skin duration for vaginal delivery↑10→20 minutes
2.Rooming-in duration↑12→24 hours/a day

(2010):1.Act of Breastfeeding Support in Public Places
2.Budget for breastfeeding promotion program increased to $200,000USD/year

(2014):1.Regulations Governing the Management of Infant and Follow-up Formula Advertisement and Sales of Promotion.
2.Simplification of BFHI criteria.
1)Assessors number ↓ 3 → 2
2)Amend validation 4 years.
3)Health worker training hours ↓ 8 → 4
4)Interview health worker number↓ 6 → 3 · No written test.

Photo contest winner

Marketing poster

Discussion

- When BFHI was first introduced to Taiwan, there were opposition to implementation of all the ten steps of BFHI, especially skin to skin contact and rooming-in due to our traditional cultural customs. Our national standard of BFHI was lower than the global BFHI criteria. However, through the implementation of nation-wide BFHI accreditation program, more health workers and health societies were involved and the breastfeeding rate increased significantly in the first 13 years. With more simplification of the standard, the breastfeeding rate was going down slowly, but the breastfeeding rate under 6 months was still relative high (44.8% in 2016) among developed countries (Exclusive breastfeeding under 6 months. WHO Data by country 2017, March 17). Training for the health workers and manpower support needs to be continued. We need to aim for a higher standard of our BFHI, and a more comprehensive plan to maintain and improve our breastfeeding prevalence.

Funding from the Tobacco Health and Welfare Surcharge

www.hpa.gov.tw

圖三&四、長條海報

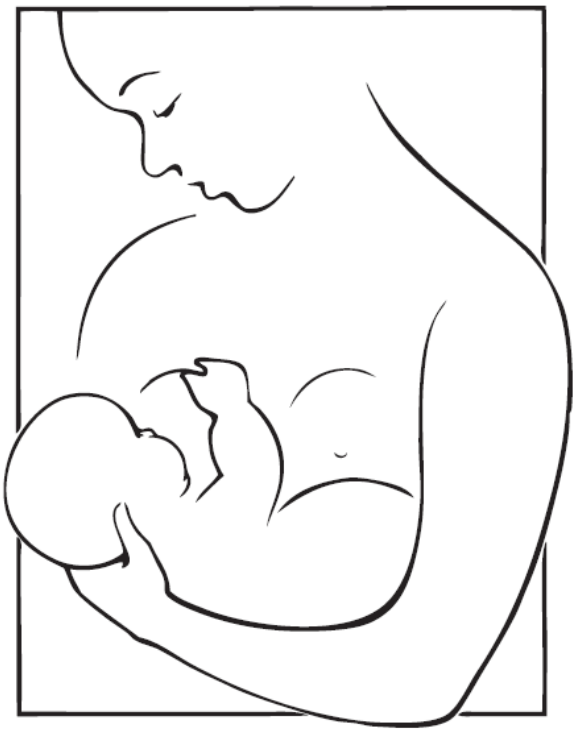

98
99
2000
01
02
Launch National BFHI
FIRST DESIGNATED HOSPITAL CANADA


- 27 BFHI
- 49 contract
08
09
2010
11
12
13
14
15

圖五&六、會議發表時照片

附錄一 會議議程

Tenth BFHI Network of Country Coordinators from Industrialized Countries, Eastern Europe and the Commonwealth of Independent States Meeting



PROGRAMME

5-7th June 2018

Steenwijk-de Bult, Netherlands

2018-04-10

OBJECTIVES

1. Share and update knowledge and experiences of baby-friendly care good practices among coordinators and focal points in industrialized countries.

2. Strengthen the network of Baby-Friendly Hospital Initiative coordinators:
   - by providing mutual support between coordinators in industrialized countries;
   - by sharing updates on recent scientific evidence and research findings on Infant and Young Child Feeding and baby-friendly care;
   - by sharing experiences and good practices related to baby-friendly care.

3. Sharing experiences and good practices related to the inclusion of the Code into baby-friendly care assessment process with emphasis on BFHI for all types of facilities that are assessed in industrialized countries.

EXPECTED OUTCOMES

1. Up-to-date information on the implementation of BFHI and other baby-friendly care strategies or activities in industrialized countries.

2. Increased knowledge of the implementation of the Code within the BFHI and baby-friendly care strategies/activities in industrialized countries.

3. Agreement on common stand to address constraints to the implementation of BFHI and baby-friendly care strategies/activities in industrialized countries.

4. Increased support to BFHI - baby-friendly care and the work of the Baby-Friendly Hospital Initiative coordinators and focal points in industrialized countries.

5. Agreement on the way forward.

TUESDAY JUNE 5, 2018 **BABY-FRIENDLY CARE IN INDUSTRIALIZED COUNTRIES**			
TIMETABLE	**TOPICS**		**SPEAKER**
10:00-10:30	**REGISTRATION**		
1. WELCOME ADDRESSES AND OVERVIEW OF ACTIVITIES			
10:30-10:40	1.1	Welcome from the BFHI Network	Trish MacEnroe, Chair BFHI Network Coordinating Committee
10:40-10:50	1.2	Welcome from Meeting Planning Committee	Mary Steen, Chair Meeting Planning Committee
10:50-11:00	1.3	Welcome to the Netherlands	Dignitary from The Netherlands
11:00-11:15	1.4	• Introduction of the meeting • Objectives and outcomes of the meeting • Presentation of the organizing committee (announcement of Chair(s)/rapporteurs/ etc.) • Brief presentation of delegates – Name, country • Timeline • Explanation of Administrative arrangements and agenda • Explanations of presentations from different countries and groups during health breaks • Explanations of reserved posting board for sharing advices, experiences	Trish MacEnroe, Chair BFHI Network Coordinating Committee
11:15-11:45	1.5	The 2018 BFHI Implementation Guidance – Overview of the BFHI Network Activities	Elise Chapin, Chair External Relations Committee
11:45–12:15	1.6	Summary Report on country-level implementation of the BFHI - results of the Questionnaire	Maite Hernandez Aguilar, Country Coordinator, Spain
12:15–13:30	**LUNCH**		
2. WHO UPDATE ON THE BABY-FRIENDLY HOSPITAL INITIATIVE			
13:30-14:00	2.1	WHO update on the Baby-Friendly Hospital Initiative: basic introduction to the published documents. Understanding the evidence and the urgency for change. 1. Protecting Promoting and supporting Breastfeeding in Facilities providing maternity and newborn services (the evidence document) 2. Protecting Promoting and supporting Breastfeeding in Facilities providing maternity and newborn services – the Revised Baby-Friendly Hospital Initiative	Pura Rayco-Solon WHO

14:00-15:00	2.2	Plenary discussion: Helping health care workers understand the evidence guideline	All participants/ Facilitators: Kristina Löfgren, Anita Pavičić Bošnjak
15:00–15.30	**HEALTH BREAK** Poster presentations: advances and experiences from different countries and groups		
3. IMPLEMENTING THE BABY-FRIENDLY HOSPITAL INITIATIVE IN MATERNITY FACILITIES			
15.30–16:00	3.1	Role of facilities providing maternity and newborn services: updated ten steps, what do they mean, what are the criteria.	Maaike Arts, UNICEF
16:00-17:00	3.2	Group discussion about implementation	All participants/ Facilitators: Kristina Löfgren, Anita Pavičić Bošnjak
17:00-17:30	3.3	Implementing the new Step 1 – Developing facility data collection and monitoring systems: Presentation of digital auditing systems	Mary Steen, Country Coordinator, Netherlands Anna Spaeth, Country Coordinator, Switzerland
17:30-17:45	Wrapping up day 1, reporting back from group discussions		Day 1 Rapporteur, Kristina/Anita
18:30-20:00	**Dinner**		
20:00-21:30	**UNICEF International meets with countries who work with UNICEF**		

WEDNESDAY JUNE 6, 2018 **COUNTRY LEVEL IMPLEMENTATION OF THE 2018 OPERATIONAL GUIDANCE**			
TIMETABLE	**TOPICS**		**SPEAKER**
8:00–8:30	**Coffee and Mingling**		
4. COUNTRY LEVEL IMPLEMENTATION OF THE 2018 OPERATIONAL GUIDANCE: PROTECTING THE BFHI			
8:30–8:45	4.1	National leadership and coordination • BFHI National authority collaboration with governments • National Monitoring • Financing • Incentivizing participation of maternity facilities	Marcus Stahlhofer, WHO
8:45-9:15		Small group discussion (3 groups): • *How can countries help each other,* • *How can WHO/UNICEF help us?* • *What are challenges and opportunities?*	All participants/ facilitators Serena Debonnet, Mary Steen
9:15 - 9:45	4.2	WHO-Code: how to address practical issues like supplementing, sponsored trainings by the industry, etc.	Marcus Stahlhofer, WHO

9:45-10:30		Plenary discussion: • Questions from the audience, collected in advance	All participants/ facilitators Serena Debonnet, Mary Steen
10:30 -11:00	**HEALTH BREAK** Poster presentations: advances and experiences from different countries and groups		
5. COUNTRY LEVEL IMPLEMENTATION OF THE 2018 OPERATIONAL GUIDANCE: SUPPORTING THE BFHI			
11:00:11:30	5.1	Providing and evaluating healthcare • Policies and Professional standards of care • Health professional competency building • External assessment	Pura Rayco-Solon, WHO
11:30-12:15		Plenary discussion	All participants/ facilitators Serena Debonnet, Mary Steen?
12:15- 12:30	5.2	The Néo BFHI-programme in France and Croatia	BFHI Coordinators from France and Croatia
12:03-12:45	5.3	Neonatal collapse during S2S: do we need to develop guidelines?	Louise Dumas, BFHI Canada
12:45-13:00		Plenary discussion	
13:00 – 14.15	**Group Photo (bring your camera)** **Then LUNCH**		
6. COUNTRY LEVEL IMPLEMENTATION OF THE 2018 OPERATIONAL GUIDANCE: PROMOTING THE BFHI			
14:15-14:45	6.1	Sustaining the BFHI • Communications and Advocacy • Information management • Technical assistance	Maaike Arts, UNICEF
14:45-15:15		Small group discussion (3 groups):	
15:15-15:45		Report out from small group discussion	All participants/ facilitators Serena Debon7net, Mary Steen?
15:45-16:15	**HEALTH BREAK** Poster presentations: advances and experiences from different countries and groups		
7. COUNTRY LEVEL IMPLEMENTATION OF THE 2018 OPERATIONAL GUIDANCE: MOVING FORWARD AND LOOKING OUTWARD			
16:15-16:35	7.1	Transition of BFHI implementation • Coordination of the BFHI with other breastfeeding initiatives outside facilities providing maternity and newborn services	Maaike Arts, UNICEF

16:35-17:10		Plenary discussion	All participants/ facilitators Serena Debonnet, Mary Steen?
17:10-17:45		Wrapping up day 2: Take home messages from the last 2 days.	Day 2 Rapporteurs Serena Debonnet, Mary Steen

THURSDAY 7 JUNE 2018 - RESERVED FOR BFHI NATIONAL COORDINATORS			
TIMETABLE	**TOPICS**		**SPEAKER**
8:00–8:30	**Coffee and Mingling**		
1. WELCOME ADDRESSES AND OVERVIEW OF ACTIVITIES			
8:30 -8:45	1.1	Objectives and outcomes of the meeting Presentation of the organizing committee (election of Chair(s)/rapporteurs/ etc.) Explanation of Administrative arrangements and agenda	Trish MacEnroe, Chair BFHI Network Coordinating Committee
8:45- 9:30	1.2	FUTURE OF THE BFHI NETWORK: Formalization of the BFHI network Regular meetings by GoToWebinar throughout the year Selection of the coordinator(s) and coordinating committee Who will work in this group for the next two years NEXT MEETING Location (countries offering)	Maite Hernandez-Aguilar
9:30–10:00	**HEALTH BREAK** Poster presentations: advances and experiences from different countries and groups		
2. STRATEGIES FOR THE FUTURE			
10:00-12:00	2.1	***Group 1:*** what additional technical assistance, training and/or support from WHO AND UNICEF regarding BFHI National authority collaboration with governments	Facilitator:
10:00-12:00	2.2	***Group 2:*** what additional technical assistance, training and/or support from WHO AND UNICEF regarding providing and evaluating healthcare	Facilitator:
10:00-12:00	2.3	***Group 3:*** what additional technical assistance, training and/or support from WHO AND UNICEF regarding ssustaining the BFHI, moving forward and looking outward	Facilitator:
12:00–13:00	**LUNCH**		

3. FEEDBACK AND RESPONSE TO THE STRATEGIES FOR THE FUTURE CONVERSATIONS			
13.00:13:15	3.1	Group 1 feedback	Rapporteur:
13:15-13:30	3.2	Group2 feedback	Rapporteur:
13:30-13:45	3.3	Group 3 feedback	Rapporteur:
13:45-15:30	Planning our Future		
		MAKE UP OF THE INDUSTRIALIZED NATIONS BFI COORDINATORS NETWORK Tasks for committees: • Coordinating Committee • External Relations Committee • Meeting Planning Committee • Internal Relations Committee	
15:30 – 16.00	Overall practical take home messages and good-bye		

附錄二

Summary of the 2018 Country Reports

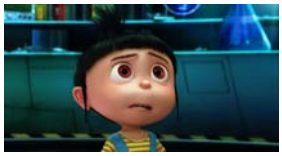
TENTH MEETING OF THE BFHI NETWORK

Steenwijk, June. 5-7, 2018

Maite Hernández –Aguilar (Spain)

on behalf of the Coordinating Committee:
Trish MacEnroe (USA)
Elise Chapin (Italy)
Serena Debonnet (Belgium)
Maite Hernández Aguilar (Spain)
Daiva Snuikate-Adner (Lithuania)
Mary Steen (Netherlands)
Anne Woods (UK)

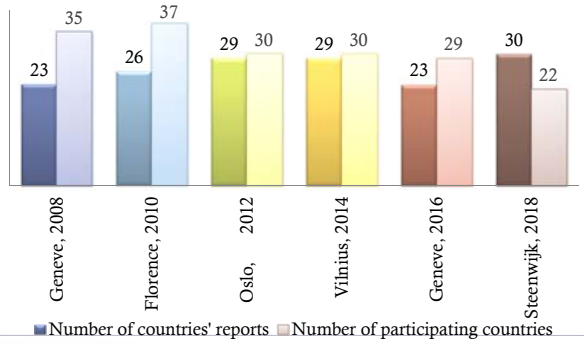
So sorry not to be able to be with you!



Congratulations!

- Most countries sent their reports.
- This year some countries have sent reports even though their representatives where not able to come to the meeting. This is the first time this happens
- This and the complete report will be sent to everyone who have come to the meeting or have sent their report.

Along these 12 years, 47 different countries have participated in biennial meetings and sent reports



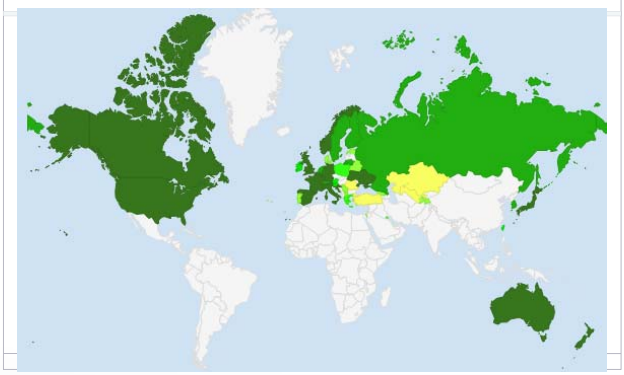
Industrialized, CEE/CIS and other: Total: 61C			
Have EVER come to a meeting: Total 47			
Albania	**France**	**Lithuania**	Slovak Republic
Andorra	**Georgia**	**Luxembourg**	**Slovenia**
Armenia	**Germany**	**Macedonia**	**Spain**
Australia	**Greece**	**Malta**	**Sweden**
Austria	**Hong Kong**	Moldova	**Switzerland**
Azerbaijan	Hungary	Montenegro	**Taiwan**
Belarus	Iceland	**Netherlands**	**Tajikistan**
Belgium	**Ireland**	**New Zealand**	**Turkey**
Bosnia	**Israel**	**Norway**	Turkmenistan
Bulgaria	**Italy**	**Poland**	**Ukraine**
Canada	**Japan**	**Portugal**	**United Kingdom**
Croatia	**Kazakhstan**	**Qatar**	**USA**
Czechia	**Korea, Republic of**	**Romania**	**Uzbekistan**
Denmark	**Kosovo**	**Russian Federation**	
Estonia	**Kuwait**	**Serbia**	
Finland	Kyrgyzstan	**Singapore**	

2018 Countries registered and sending reports

Registered countries are COLOURED

Australia	Japan	R.Korea
Belgium	Kuwait	Russian F
Canada	Lithuania	Singapore
Croatia	Luxembourg	Spain
Estonia	Malta	Sweden
Finland	Netherlands	Switzerland
France	New Zealand	Taiwan
Germany	Norway	United Kingdom
Hong Kong SAR	Poland	Ukraine
Italy	Portugal	United States

Some countries have come only once, others have not lost a single meeting.



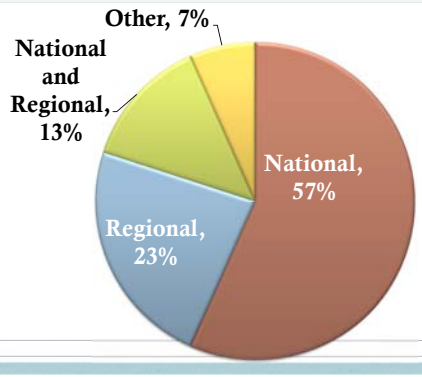
In Google you may find this map that shows all the countries that have participated in our BFHI network meetings since 2008.

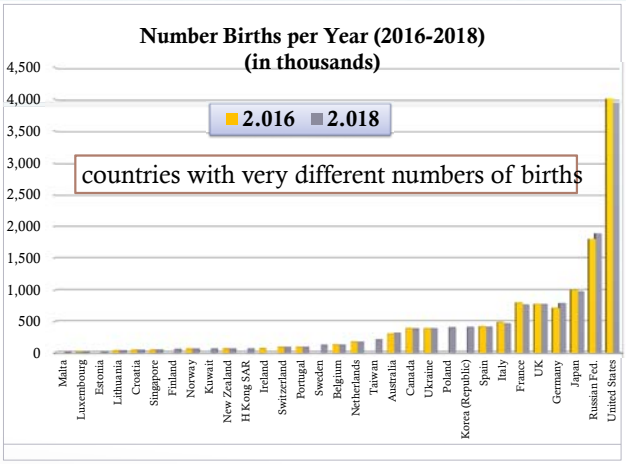
Different colors signal # times each country sent a report

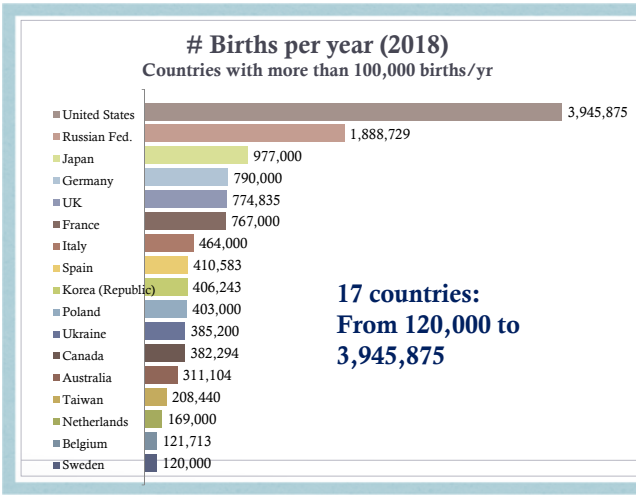
You can access it here: https://tinyurl.com/ychu377n

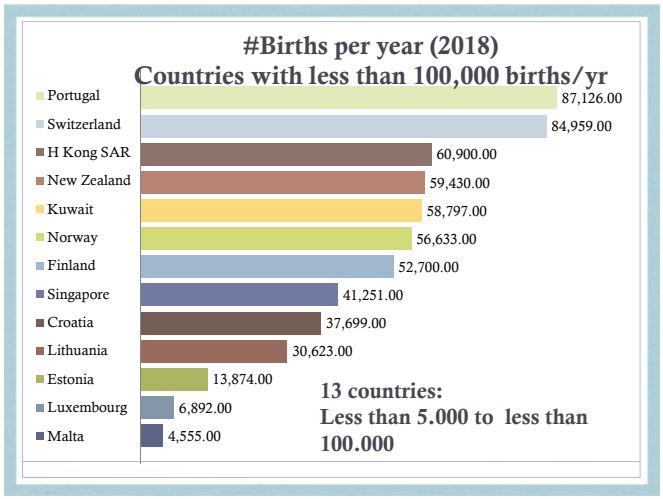
https://tinyurl.com/ychu377n

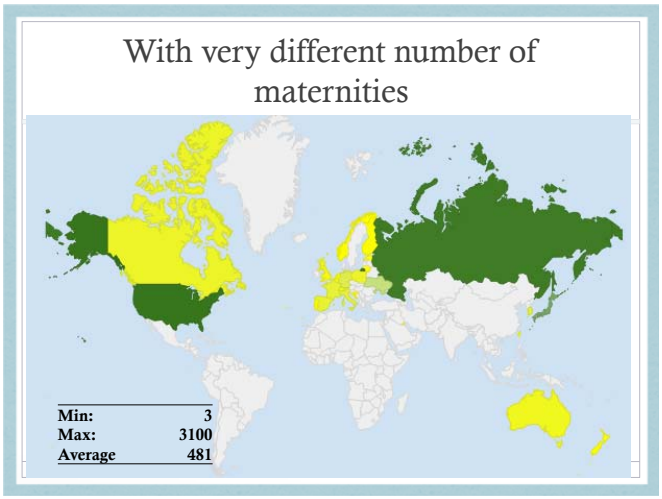
Delivery of health services is mostly national





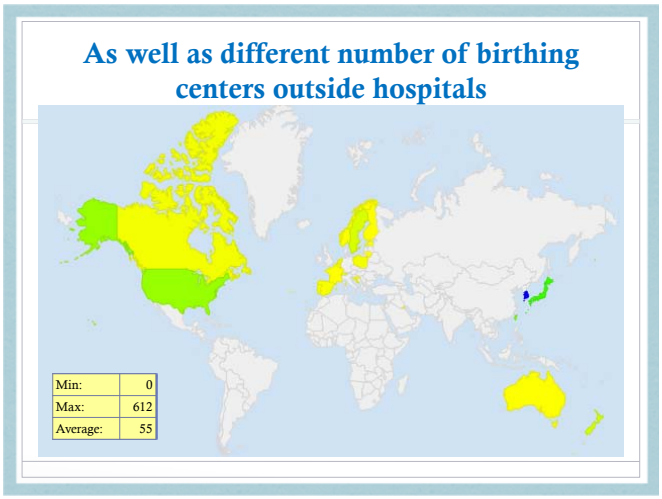






Number (#) Maternities in Hospitals 2018

Country	# Maternities	Countries	# Maternities
Australia	293	Malta	3
Belgium	97	Netherlands	88
Canada	380	New Zealand	24
Croatia	32	Norway	40
Estonia	15	Poland	388
Finland	26	Portugal	40
France	517	South Korea	616
Germany	700	Russia	3000
Hong Kong	19	Singapore	10
Ireland	19	Spain	453
Italy	561	Switzerland	90
Japan	2311	Taiwan	167
Kuwait	15	Ukraine	1166
Lithuania	28	Un. Kingdom	220
Luxembourg	4	United States	3100

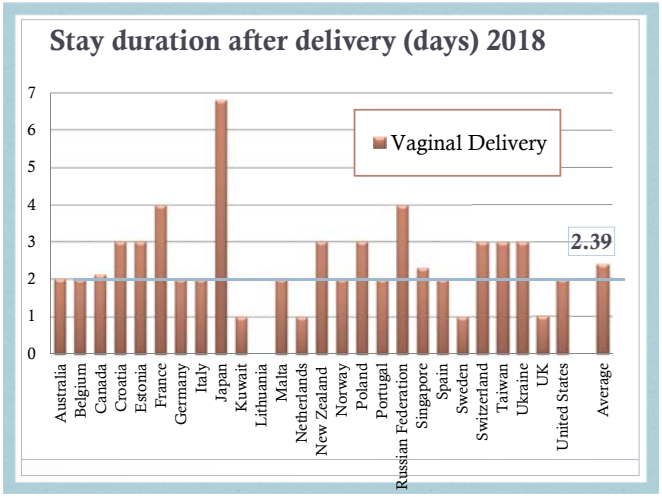


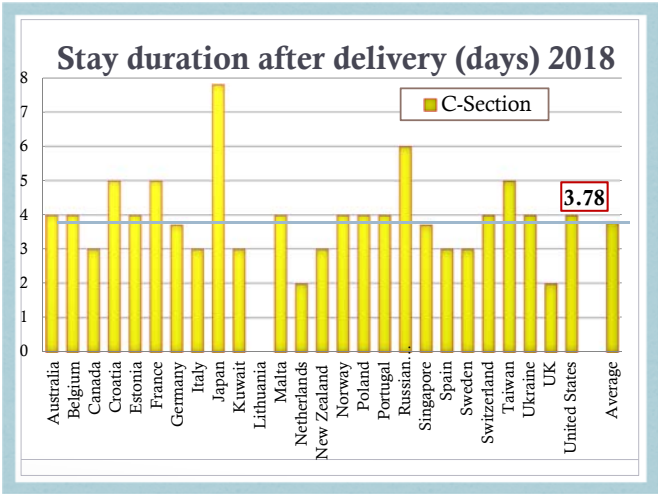
Number of birthing centres (non hospital related)

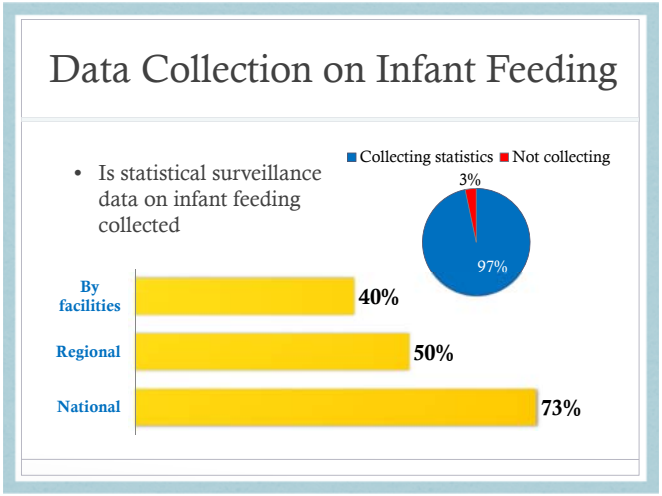
Countries	2018	Countries	2018
Australia	3	Netherlands	11
Belgium	2	New Zealand	50
Canada	14	Norway	5
Croatia	2	Poland	11
Estonia	0	Portugal	0
Finland	0	South Korea	612
France	0	Singapore	0
Germany		Spain	10
Hong Kong	0	Sweden	46
Japan	240	Switzerland	35
Kuwait	0	Taiwan	155
Lithuania	0	United States	125
Luxembourg	0		

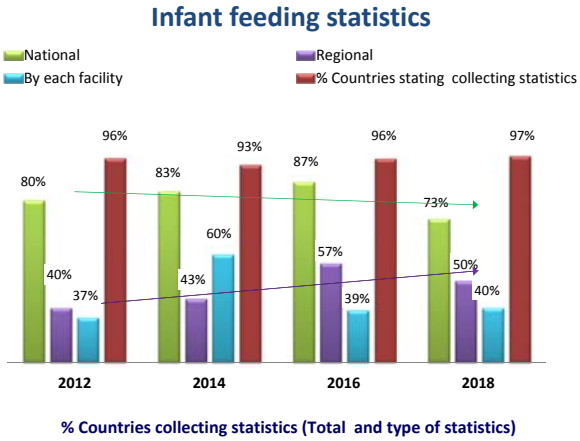
The number of hospitals and BC is decreasing!

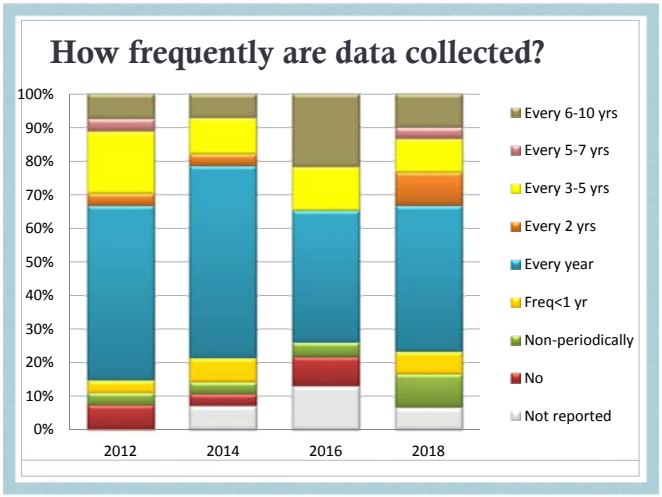
	Maternities		Birthing centers	
	2016	2018	2016	2018
Average	583	481	45	55
Min	4	3	0	0
Max	3,125	3,100	250	612
% Countries without BC			38%	36%

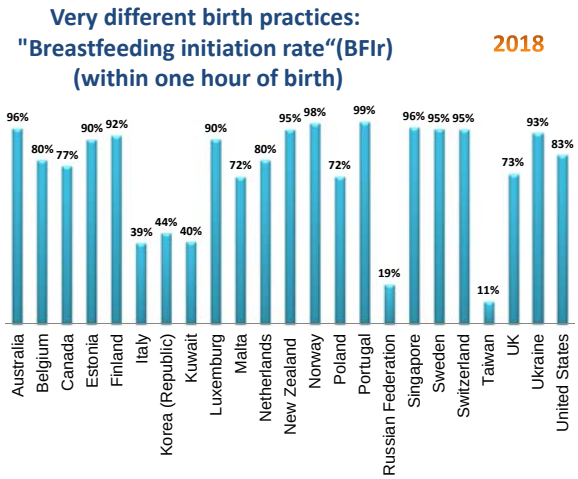

Stay duration after delivery (days) 2018
Vaginal Delivery
2.39
Australia
Belgium
Canada
Croatia
Estonia
France
Germany
Italy
Japan
Kuwait
Lithuania
Malta
Netherlands
New Zealand
Norway
Poland
Portugal
Russian Federation
Singapore
Spain
Sweden
Switzerland
Taiwan
Ukraine
UK
United States
Average


Stay duration after delivery (days) 2018
C-Section
3.78
Australia
Belgium
Canada
Croatia
Estonia
France
Germany
Italy
Japan
Kuwait
Lithuania
Malta
Netherlands
New Zealand
Norway
Poland
Portugal
Russian...
Singapore
Spain
Sweden
Switzerland
Taiwan
Ukraine
UK
United States
Average

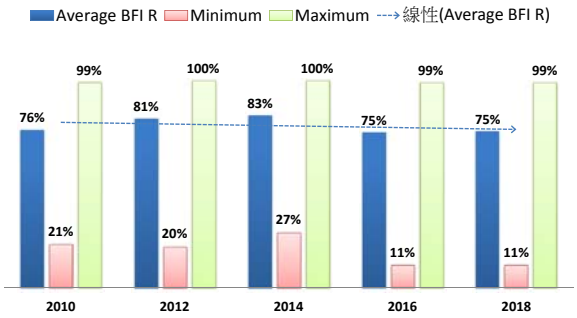

Data Collection on Infant Feeding
Is statistical surveillance data on infant feeding collected
Collecting statistics
Not collecting
3%
97%
By facilities
40%
Regional
50%
National
73%


Infant feeding statistics
National
Regional
By each facility
% Countries stating collecting statistics
80%
40%
37%
96%
83%
43%
60%
93%
87%
57%
39%
96%
73%
50%
40%
97%
2012
2014
2016
2018
% Countries collecting statistics (Total and type of statistics)

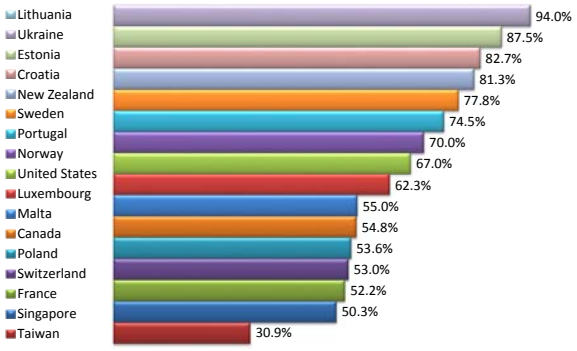

How frequently are data collected?
Every 6-10 yrs
Every 5-7 yrs
Every 3-5 yrs
Every 2 yrs
Every year
Freq<1 yr
Non-periodically
No
Not reported
2012
2014
2016
2018


Very different birth practices:
"Breastfeeding initiation rate"(BFIr)
(within one hour of birth)
2018
Australia
Belgium
Canada
Estonia
Finland
Italy
Korea (Republic)
Kuwait
Luxemburg
Malta
Netherlands
New Zealand
Norway
Poland
Portugal
Russian Federation
Singapore
Sweden
Switzerland
Taiwan
UK
Ukraine
United States

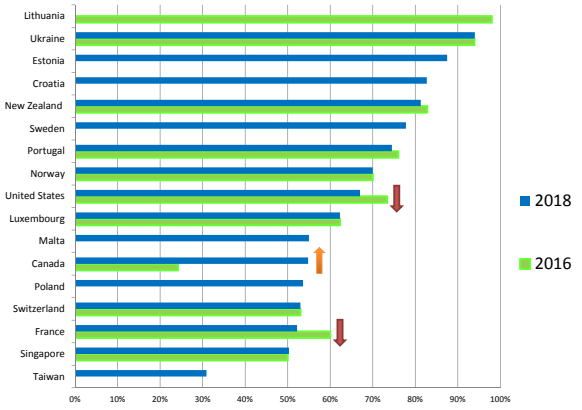
Decreasing tendency? BFIr 2010-2018



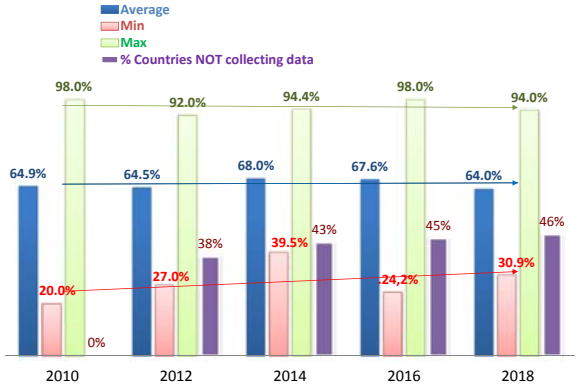
Very different EBFr from Birth to Discharge-2018



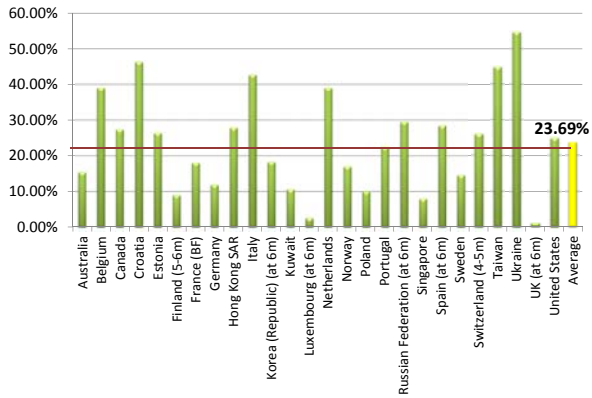
EBF Rate from Birth to Discharge 2016-2018



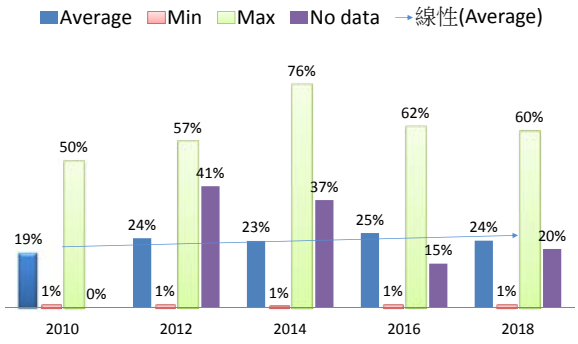
EBF from birth to discharge. Rate (%)



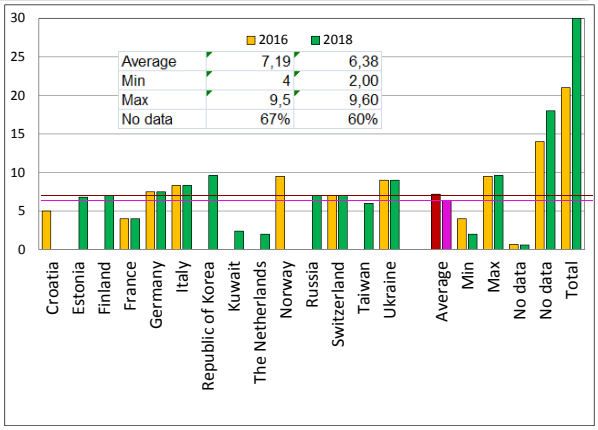
EBF from birth to 6 months & at 6m (2018)



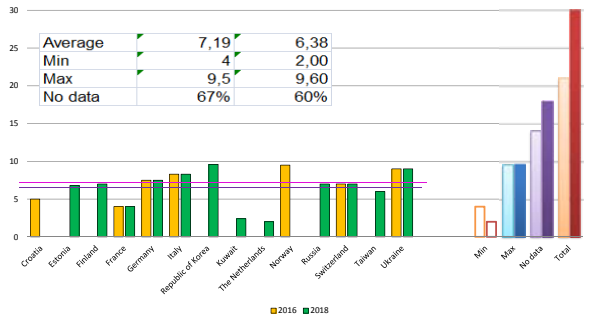
EBF from birth to 6 months & at 6m



BF Mean duration (months)



BF Mean duration (months)



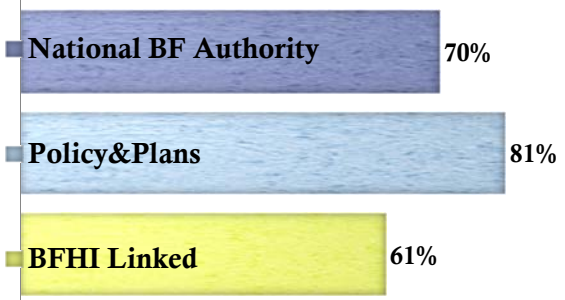
There is great diversity of indicators among countries

% Countries collecting each indicator

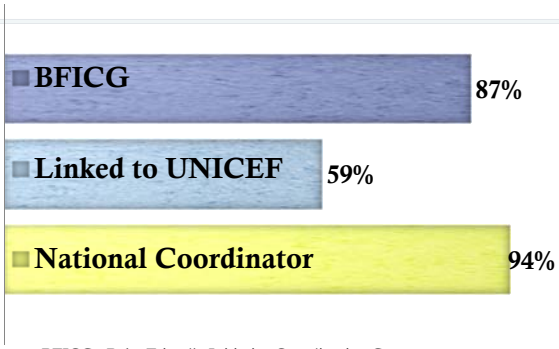
BF < 1 hr	77%
EBF to discharge	54%
EBF 0-6 m & "at 6 mo"	87%
BF median duration	40%
Other stats	77%

Is it time to find unified practicable BF indicators?

Most Countries have National Infant & young child Feeding Authority

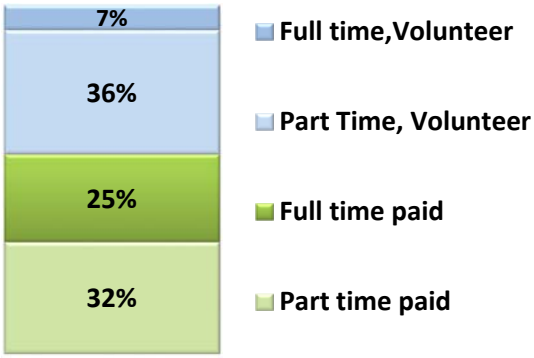


BFHI in our countries

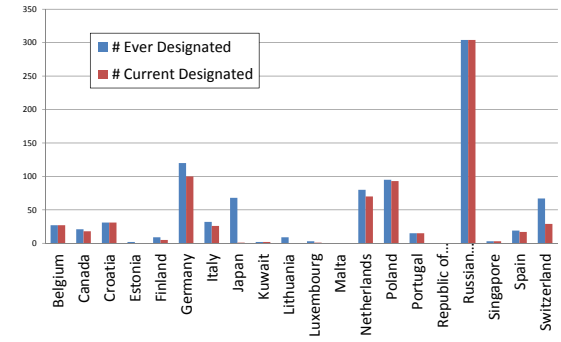


BFICG: Baby Friendly Initiative Coordinating Group

National Coordinator

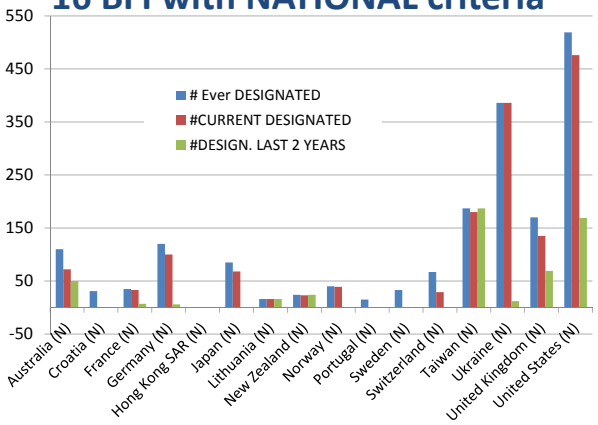


20 BFI with GLOBAL Criteria

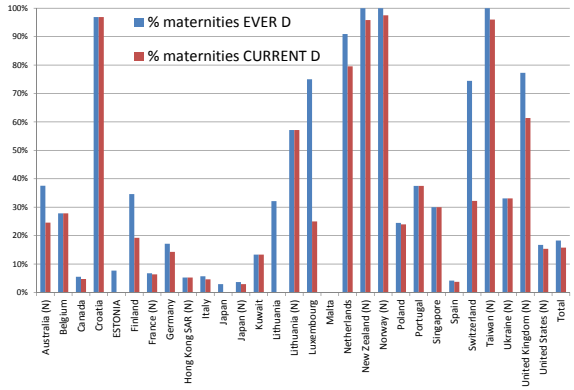


Some countries declare both systems

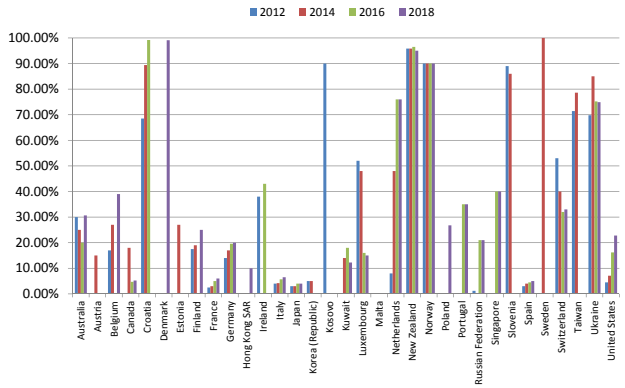
16 BFI with NATIONAL criteria



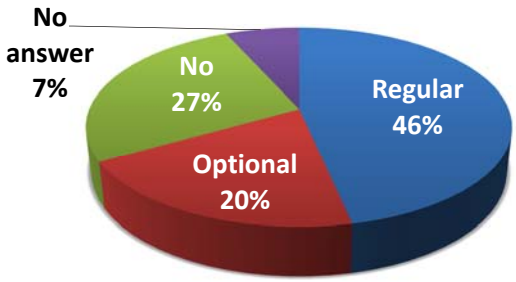
% Ever and Current Designated Maternities



Percentage of births in BFHs



Do you include Mother-Friendly Criteria?



	Ever	Current	Last 2 years
Total GLOBAL Criteria	907	742	64
Total National Criteria	1839	1558	544
Total Designations	2513	2171	600
% Designations Global Criteria	36%	34%	11%
% Designations National Criteria	73%	72%	91%

If National Criteria: different from the Global Criteria?

Less

- HIV & Mother Friendly not included
- No observations of birthing space
- No minimum BF rates, No 75% BF rates,
- Disclosure but not Fully compliance with the Code
- Using BFHI First Guidelines
- Less training: 8 hours; 3 hrs. for MD
- Allowed delayed S2S contact (not immediate)
- Only 10% rates rooming-in

If National Criteria: different from the Global Criteria?

More

- Details about complementary food
- More mother's BF Ed:
  - care of the nipple from pregnancy,
  - nurture mothers' childcare ability,
- Mandatory Support for mothers after discharge
- Mandatory BF assessments
- Provision specialist care for some cases
- Strengthened Code standards

Funding Sources

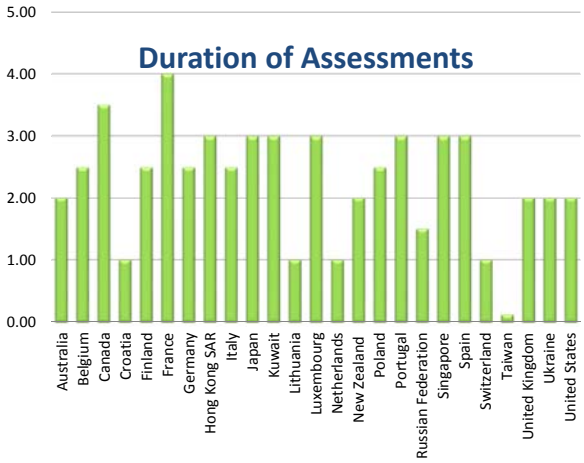
	For the activities of the National BFHI Committee	For the National Coordinator
Service Fees	10	9
Mixed	8	
MOHTotal	7	6
Membership/Hosp Fees	5	4
MOH Part	4	3
Conferences, Books	3	2
None	3	7
UNICEF Part	2	1
UNICEF Total	2	2

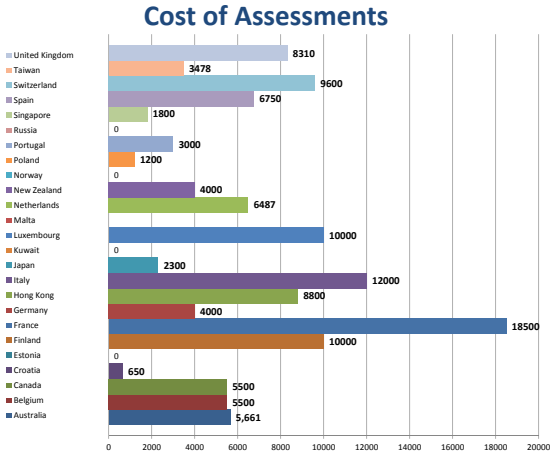
Strengths and opportunities

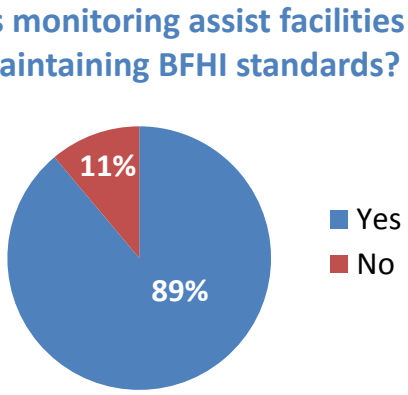
Barriers and Obstacles

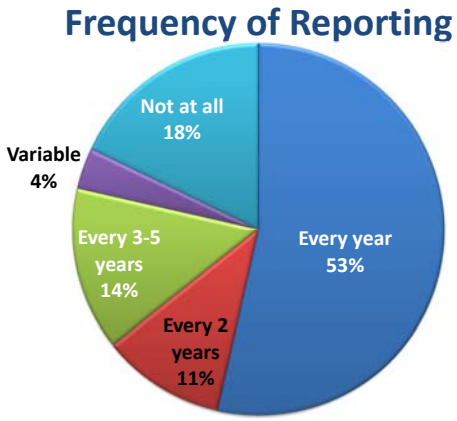
Succesful Strategies

Main activities and Plans





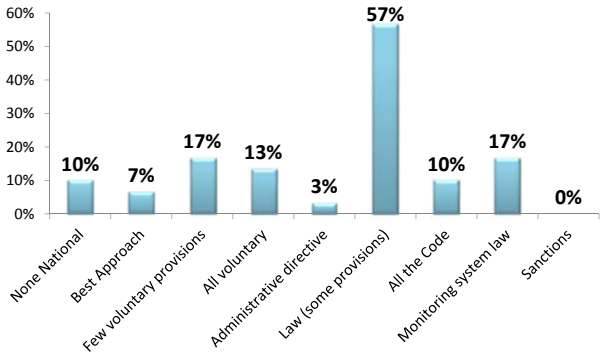




Expansion

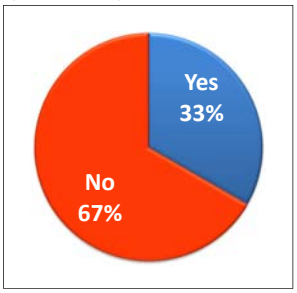
	Community Health S	Pediatric Units	Neonatal	Universities	Workplaces	M2M support Groups	antenatal clinics
Yes	7	3	5	2	8	2	2
No	12	18	9	12	12	19	12
Under Development	5	3	7	2	4	2	2
# Facilities Designed	445	499	115				

Situation of the Code at National Level

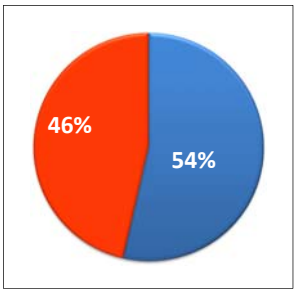


Formula companies

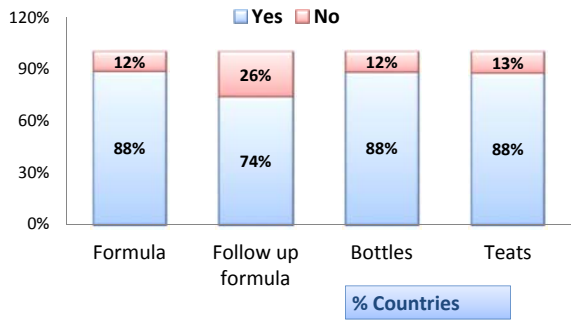
Do they fund maternity/health services in your country?



Do they provide free or subsidised infant formula, sponsorship, or gifts to services ?



Standards included in the BFHI Assessments: Regarding the Code, are these included?



Code compliance

Do you review companies' representatives access to	
Pregnant mothers	93%

For Accreditation, are Gifts given by Formula companies to…				
	Facility	Professionals	Researchers	Mothers
Not allowed	86%	90%	54%	97%
Not assessed	14%	10%	43%	3%

Thank You!

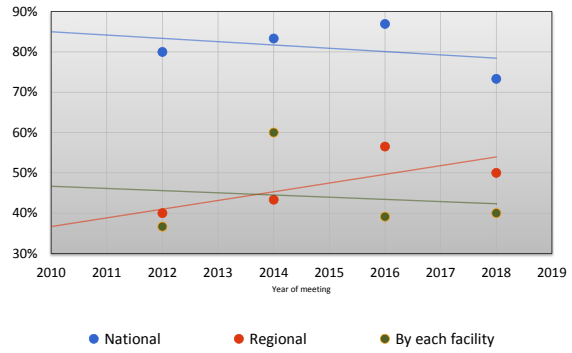
Thank You!

Thank You!

Thank You!

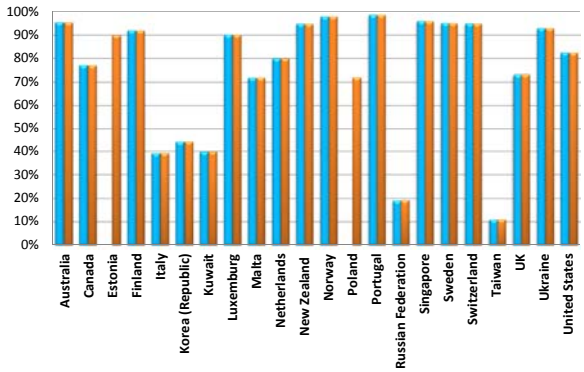
Infant feeding statistics

Tendency for each type of statistics



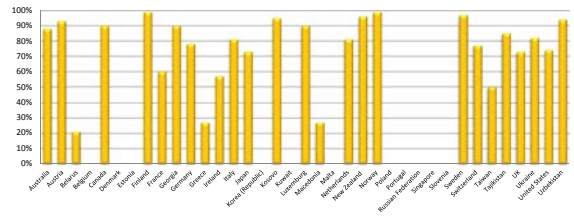
"Breastfeeding initiation rate" (within one hour of birth)

2016-2018



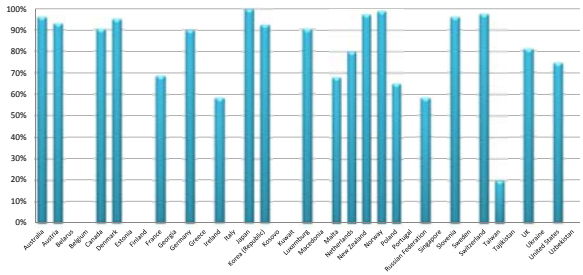
"Breastfeeding initiation rate" (within one hour of birth)

2010



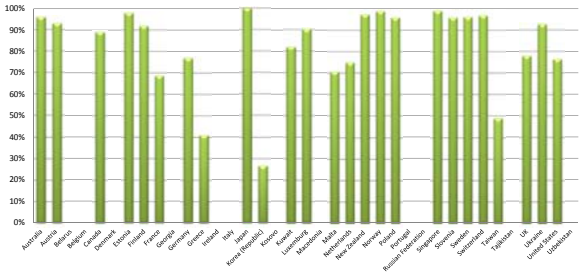
"Breastfeeding initiation rate" (within one hour of birth)

2012



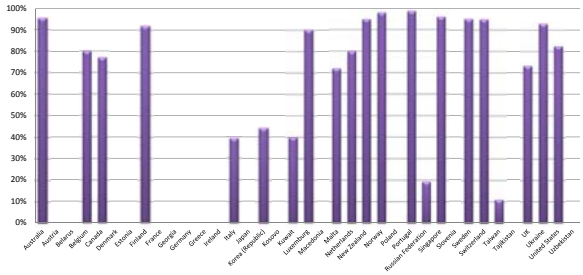
"Breastfeeding initiation rate" (within one hour of birth)

2014

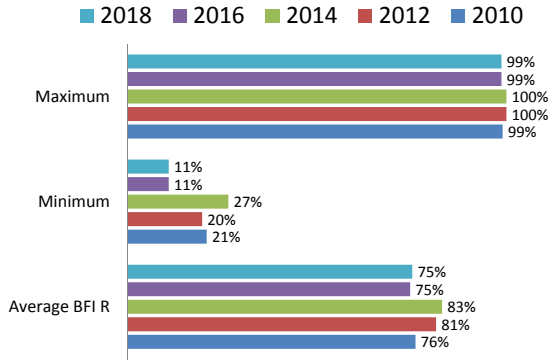


2016

"Breastfeeding initiation rate" (within one hour of birth)



Breastfeeding initiation Rate



2018 BFHI Network Countries' reports

- **Does the Country Collect BF Data periodically?**

	Total countries' reports	% Countries reporting statistics collected	National	Regional	By each facility
2012	30	96%	80%	40%	37%
2014	30	93%	83%	43%	60%
2016	23	96%	87%	57%	39%
2018	30	97%	73%	50%	40%

Client portal Baby-Friendly Netherlands

Serge Halewijn

5th June 2018

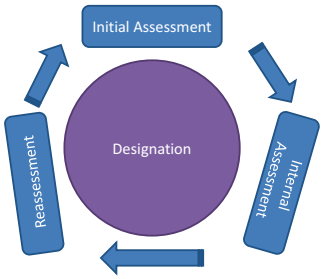
TRIQS

- Branches
  - Business Services
  - Government
  - Education
  - Healthcare (Home care, Maternity Care,..)
- TRIQS Research
  - Customer Satisfaction survey
  - Employee satisfaction survey
  - EUROQOL
  - REPROQ
- Software Development
  - Assessments on location (Kapablo.nl)
  - Dynaview.nl
  - Matriqs.nl
  - Baby Friendly Nederland 'Client portal'

Client Portal

From dispersed papers and Excel sheets to one single central system which monitors the whole Assessment cycle

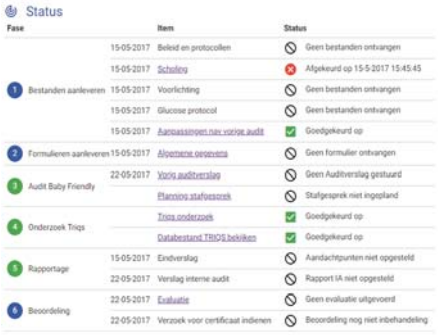
Assessment cycle



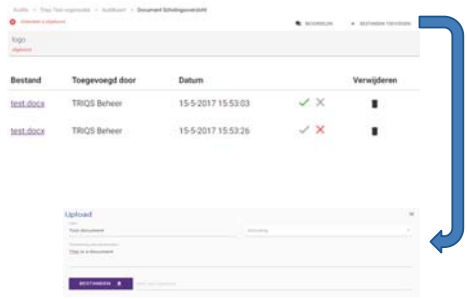
Walkthrough Client portal

- Assessment Card
- Document uploading and checking
- Starting a questionnaire
- Reporting
- GDPR implementation

Assessment card



Document uploading and checking



Starting Online survey or Interview

- Interview -> Start from assessment card
- Online survey -> Upload e-mails and start immediately. Automatically fail-safe on e-mail validity and duplicity. Excel document is automatically anonymised

Questionnaire

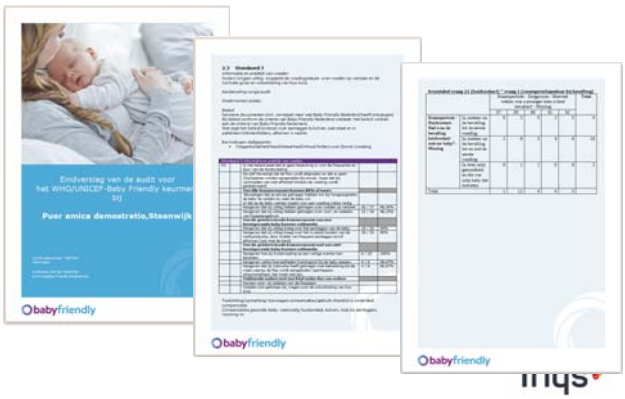
Features

- Support for Multi-lingual questionnaires
- Routing based on answers of respondent
- Responsive design

Reporting

- Collected data is analysed automatically by running SPSS syntax
- Output from SPSS is mail merged automatically in an editable MS Word document
- Reports are executed real-time on demand and can be executed multiple times
- The report with is delivered by e-mail to the logged in user.

Reporting output

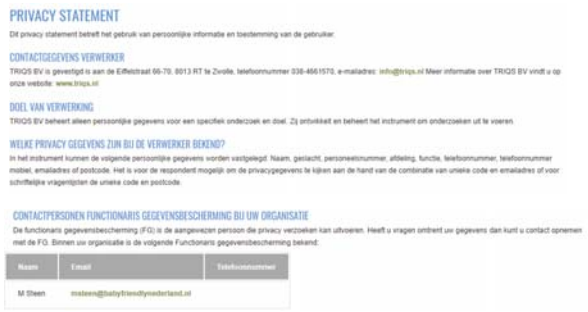


GDPR implementation

25th May 2018 GDPR Imposed

- European Law and Territory
- Processors agreement
- Right to be forgotten
- Privacy statement in questionnaire
- Right to be informed

Privacy statement GDPR compliant


PRIVACY STATEMENT

Dit privacy statement betreft het gebruik van persoonlijke informatie en toestemming van de gebruiker.

CONTACTGEGEVENS VERWERKER

TRIQS BV is gevestigd is aan de Eiffelstraat 66-70, 8013 RT te Zwolle, telefoonnummer 038-4561570, e-mailadres: info@triqs.nl Meer informatie over TRIQS BV vindt u op onze website: www.triqs.nl

DOEL VAN VERWERKING

TRIQS BV beheert alleen persoonlijke gegevens voor een specifiek onderzoek en doel. Zij ontwikkelt en beheert het instrument om onderzoeken uit te voeren.

WELKE PRIVACY GEGEVENS ZIJN BIJ DE VERWERKER BEKEND?

In het instrument kunnen de volgende persoonlijke gegevens worden vastgelegd: Naam, geslacht, personeelsnummer, afdeling, functie, telefoonnummer, telefoonnummer mobiel, emailadres of postcode. Het is voor de respondent mogelijk om de privacygegevens te kijken aan de hand van de combinatie van unieke code en emailadres of voor schriftelijke vragenlijsten de unieke code en postcode.

CONTACTPERSONEN FUNCTIONARIS GEGEVENSBESCHERMING BIJ UW ORGANISATIE

De functionaris gegevensbescherming (FG) is de aangewezen persoon die privacy verzoeken kan uitvoeren. Heeft u vragen omtrent uw gegevens dan kunt u contact opnemen met de FG. Binnen uw organisatie is de volgende Functionaris gegevensbescherming bekend:

Naam	Email	Telefoonnummer
M Steen	msteen@babyfriendlynederland.nl	

Triqs

Right to be informed


MIJN GEGEVENS

RECHT VAN INZAGE

De pagina maakt het mogelijk om uw gegevens die bij TRIQS BV bekend zijn en gekennerd zijn als persoonsgegevens op te halen.

UITNODIGING GEKREGEN VIA DE E-MAIL?

Door uw persoonlijke code en het e-mail adres dat bij ons bekend is hieronder in te vullen kunt u uw gegevens bekijken.

UITNODIGING GEKREGEN VIA DE POST?

Door uw persoonlijke code en postcode dat bij ons bekend is hieronder in te vullen kunt u uw gegevens bekijken.

BEVEILIGING

Als extra beveiligsmaatregel zijn uw gegevens voorzien van zogenaamde sterretjes (*). De gegevens zijn voor u herleidbaar, maar niet voor derden. TRIQS BV of opdrachtgever verstrekt NOOIT elektronisch een link naar uw profiel. U heeft maximaal drie foutieve pogingen om uw gegevens te kunnen bekijken. Daarna wordt uw account afgesloten en de beheerder ingelicht. Mocht u vragen hebben over de inhoud van de gegevens neem dan contact op met de functionaris gegevensbescherming (FG) van de organisatie. Deze zal gelijkend worden „indien de FG bekend, is na het inloggen op 'Mijn gegevens'.

Uw code: Vul hier uw code in.

Uw emailadres of postcode: uw e-mail adres of postcode

Mijn gegevens ophalen

Triqs

Client portal Key benefits

Online questionnaire
- Large sample
- Based on customer experiences (no knowledge test)
- Ability to coach better on quality improvement

Interview
- Start questionnaire in assessment module of the client portal

Client portal
- Clients are owner of their assessment process
- Document flow and assessments are transparant for client
- Communication platform for auditors with their clients
- Time efficient platform
- Created Task are assignable to auditors
- Data collection is the start of benchmarking

Triqs

Are there any questions?

Triqs

Swiss TPH
Swiss Tropical and Public Health Institute
Schweizerisches Tropen- und Public Health-Institut
Institut Tropical et de Santé Publique Suisse
Associated Institute of the University of Basel

Anna Späth, BFHI Monitoring Switzerland

Monitoring - from theory to practice. Ideas for an approach with an open-source software

Anna Späth, Swiss TPH, Unit Society Gender and Health

BFHI Monitoring

- ✓**Facility-based monitoring of the key clinical practices**
- ✓**Recommended indicators for facility-based assessment**
- ✓**Indicators for national and subnational monitoring**

Source: WHO/UNICEF 2018, Appendix: Indicators for monitoring, Protecting, promoting and supporting BREASTFEEDING IN FACILITIES providing maternity and newborn services: the revised Baby-friendly Hospital Initiative, The Revised Baby-friendly Hospital intitaive 2018

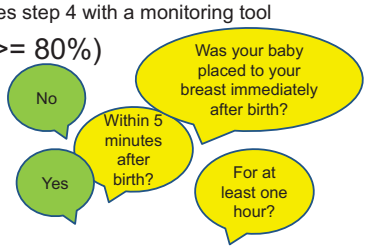
BFHI Monitoring

Table 1. Recommended indicators for facility-based monitoring of the key clinical practices for the protection, promotion and support of breastfeeding

Key clinical practice	Proposed indicator definition	Target	Primary source	Additional sources
Step 3: Discuss the importance and management of breastfeeding with pregnant women and their families.	The percentage of mothers of preterm and term infants who received prenatal care at the facility who received prenatal counselling on breastfeeding	≥80%	Interviews with mothers of preterm and term infants	Clinical records
Step 4: Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.	The percentage of mothers of term infants whose babies were placed in skin-to-skin contact with them immediately or within 5 minutes after birth and that this contact that lasted 1 hour or more	≥80%	Interviews of mothers of term infants	Clinical records
	SENTINEL INDICATOR: The percentage of term infants who were put to the breast within 1 hour after birth	≥80%	Clinical records	Interviews with mothers of term infants

Monitoring Step 4

I. Identify mothers of term infants
II. Get the information
   a) Ask the mother whether she experienced step 4
   b) Extract this information out of clinical records
   c) Hospital staff assesses step 4 with a monitoring tool
III. Calculate (goal >= 80%)
IV. Report
V. Rate



ODK

Open Data Kit (ODK)
https://opendatakit.org/

Open source software, community based
Large user community, active developer community (including Swiss TPH)

ODK

- Build a data collection form or survey
- Collect the data on a mobile device and send it to a server; and
- Aggregate the collected data on a server and extract it in useful formats.

Build a data collection with ODK

✓Based on xls forms

Build a data collection with ODK

✓Contains all relevant elements to build a questionnaire (type of data, label, name)
✓Easy to label in several languages
✓Multiple choices are defined in the choice worksheet
✓Constraints, design e.t.c are defined in the settings worksheet

Get the information

Calculate, Report and Rate

Extract your data to calculate, then report and rate (ODK1.x)

Based on ODK several projects developed tools that go beyond collecting data (ODK 2.0)

ODK 2.0 modular framework

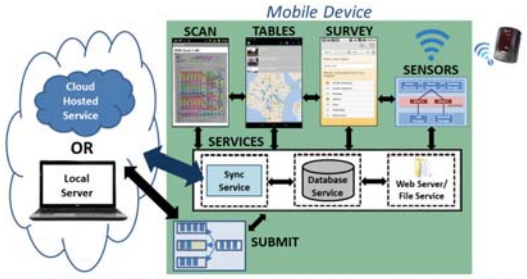


Figure 1: ODK 2.0 modular framework's five mobile tools are used in concert to create customizable *mobile data management* applications. The five ODK mobile 'apps' that comprise the framework are *Services*, *Survey*, *Tables*, *Scan*, *Sensors*, and *Submit*.

Brunette W.: Open Data Kit 2.0. A Services-Based Application Framework for Disconnected Data Management. MobySys.17 June 10-23, 2017, Niagara Falls, NY. http://delivery.acm.org/10.1145/3090000/3081365/p440-brunette.pdf?ip=131.152.32.193&id=3081365&acc=OA&key=FC66C24E42F07228%2EF51B18EF81371F95%2E4D4702B0C3E38B35%2EBBCD68C0FAC0CC7C&__acm__=1527597204_e2a1cfca233fb8c245ac3209610cb370

The ODK Ecosystem

https://enketo.org/

Open source software developed as a follow-up to a 2009 Masters Dissertation at the University of Liverpool on the 'Applicability of Offline-capable Web Technologies for Information Management in Humanitarian Aid'.

The ODK Ecosystem

http://help.kobotoolbox.org/

KoBoToolbox is an open source suite of tools for field data collection.

The ODK Ecosystem

- ✓**Facility-based monitoring of the key clinical practices**
- ✓**Recommended indicators for facility-based assessment**
- ✓**Indicators for national and subnational monitoring**

Source: WHO/UNICEF 2018, Appendix: Indicators for monitoring, Protecting, promoting and supporting BREASTFEEDING IN FACILITIES providing maternity and newborn services: the revised Baby-friendly Hospital Initiative, The Revised Baby-friendly Hospital intitaive 2018

THANK YOU FOR YOUR ATTENTION

Special thank to:

UNICEF Switzerland

Aurelio di Pasquale, Sonja Merten, Gian-francesco Ferrari and Li Zemp from Swiss TPH

Baby-friendly Hospital Initiative

National Leadership and Coordination

World Health Organization unicef

Outline of the presentation

- BFHI national authority collaboration with governments
- Technical assistance
- Incentivizing participation of maternity facilities

National leadership and coordination

Necessary to ensure access to timely and evidence-based care and services appropriate to the needs of mothers and newborns

Transforming the quality of services to protect, promote and support breastfeeding in all facilities requires a health-systems approach

1. service delivery
2. health workforce
3. health information systems
4. access to essential medicines
5. financing, and
6. leadership/governance

National breastfeeding coordination body

National BFHI program primary objectives:

- scale-up to 100% coverage of the program
- sustain recommended practices over time

Responsibilities of a national BFHI programme

National breastfeeding coordination body

- Multi-sectoral
- Led by government, existing professional organization, or NGO
- Oversees all key responsibilities of the national BFHI
- Govt. leadership important - Accountability

BFHI national authority collaboration with governments

BFHI should not be:

- a vertical or stand-alone intervention (silo approach)
- separated from other maternal and child health and nutrition interventions

Ten Steps should be integrated into relevant national policy documents and professional standards of care

- Program/body function to be added to existing governmental department or existing professional organization or NGO
- If outside government, ensure functional government oversight – performance benchmarks / time frames / sanctions (?)

BFHI national authority collaboration with governments

Challenges to achieving 100% coverage and sustainability need to be addressed, e.g.:

- Ownership (government vs NGOs vs external donors)
- Voluntary nature of BFHI in many countries
- Political, financial and institutional sustainability
- Recurrent costs

  – What needs to be done ensure sustainable government commitment to BFHI as an integral element of efforts to ensure high quality maternal and newborn care?

  – How to move from government commitment to government obligations? What are entry points? Code/other laws? Human rights frameworks? Accountability needs to be enhanced

Technical assistance to facilities

Scale up application of the Ten Steps to all facilities

- Exchange of experiences within groups of facilities
- Start with teaching hospitals/larger hospitals
- Establish role models within regions
- Training-of-trainers
- Provide technical assistance where needed

Incentives and sanctions

Develop incentives for compliance and/or sanctions for non-compliance with the Ten Steps

- Performance-based financing
- Inclusion in performance contracts
- Public recognition of excellence/ award/designation
- Public reporting of quality indicators and outcomes

Incentives and sanctions

Performance-based financing

- Lower payment rates to those facilities not in compliance or higher rates for those performing well
- Case studies show effectiveness

But ….

- Requires strong external monitoring system
- Can be costly if schema is to pay “extra” for meeting the standards

Incentives and sanctions

Inclusion in performance contracts

- performance contracts for managers and/or staff of public services that include specific goals to be met
- indicators related to protection, promotion and support of breastfeeding in facilities providing maternity and newborn services to be included in performance contracts

Incentives and sanctions

Mandatory standards for all facilities ?

- Strongest incentive
- Benefits all families

But …

- may need to limit the number or rigor of standards
- Requires strong external monitoring system
- Application of sanctions may be challenging

Incentives and sanctions

Public recognition of excellence: award/designation

- Traditional focus in BFHI on this incentive
- Meeting the standards would improve the image of the facility (publicly and professionally)
- May drive more patients to the facility
- Compliance must be monitored externally

NOTE: This is an option for countries, but not key focus of BFHI

Designation – food for thought

- Is it a sufficiently strong incentive for quality improvement?
  - dependent on advocacy and publicity
  - can be short-lived
  - depends on competition
- Is external monitoring as effective as internal monitoring?
- How cost effective is operating a designation programme?

But … continue designation process where it is working and sustainable

Thank you

World Health Organization unicef

Baby-friendly Hospital Initiative

The International Code of Marketing of Breast-milk Substitutes

World Health Organization unicef

Outline of the presentation

- Code integration in BFHI and other global standards
- Key challenges with Code adherence in facilities
- Practical steps forward

Code integration in BFHI and other global standards

BFHI Step 1a:

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

Step 1a - Global Standards:

- All infant formula, feeding bottles and teats used in the facility have been purchased through normal procurement channels and not received through free or subsidized supplies
- The facility has no display of products covered under the Code or items with logos of companies that produce breast-milk substitutes, feeding bottles and teats, or names of products covered under the Code
- The facility has a policy that describes how it abides by the Code, including procurement of breastmilk substitutes, not accepting support or gifts from producers or distributors of products covered by the Code and not giving samples of breast-milk substitutes, feeding bottles or teats to mothers
- At least 80% of health professionals who provide antenatal, delivery and/or newborn care can explain at least two elements of the Code

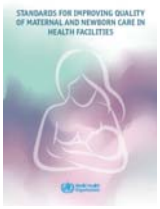
Step 1b:

Have a written infant feeding policy that is routinely communicated to staff and parents.

Global Standard:

The health facility has a written infant feeding policy that addresses the implementation of all eight key clinical practices of the Ten Steps, Code implementation, and regular competency assessment.

Supported by integration of the Code in other Global MNCH Standards:



Standard 1:

Every woman and newborn receives routine, evidence-based care and management of complications during labour, childbirth and the early postnatal period, according to WHO guidelines.

Quality statement 1.9:

No woman or newborn is subjected to unnecessary or harmful practices during labour, childbirth and the early postnatal period

Rationale: Unnecessary and harmful practices can lead to complications and harm and their newborns. They should be avoided and replaced with evidence-based health practices .....

Supported by integration of the Code in other Global MNCH Standards:

…. includes advertising and promotion of breastfeeding substitutes and bottle-feeding!

Input measurements:

1. The health facility does not display infant formula or bottles and teats, including on posters or placards
2. The health facility does not give newborns food or drink other than breast milk, unless medically indicated, and does not give pacifiers (also called "dummies" or "soothers") to breastfeeding babies
3. Health care staff in the facility receive in-service training and regular refresher sessions on harmful practices and unnecessary interventions at least once every 12 months
4. The health facility does not promote infant formula on the wards, and samples are not distributed to mothers or staff

Supported by integration of the Code in other Global MNCH Standards:

Quality statement 1.6: All infants and young children are assessed for growth, breastfeeding and nutrition, and their carers receive appropriate support and counselling, according to WHO guidelines.

1. The health facility has a written, up-to-date policy for exclusive breastfeeding and appropriate feeding, according to WHO guidelines
2. The health facility maintains a baby-friendly status that supports breastfeeding according to WHO guidelines
3. The health facility fully complies with the International Code of marketing of breast-milk substitutes and has systems in place to monitor compliance with the Code

STANDARD 1

EVIDENCE-BASED PRACTICES AND MANAGEMENT OF ILLNESS

Standard 1: Every child receives evidence-based care and management of illness according to WHO guidelines.

Supported by integration of the Code in other Global MNCH Standards:

Quality statement 5.5: All children have access to safe, adequate nutrition that is appropriate for both their age and their health condition during their care in a facility.

The health facility has an up-to-date, written policy on breastfeeding that adheres to the International Code of Marketing of Breast-milk Substitutes and is routinely communicated to all health care staff.

STANDARD 5

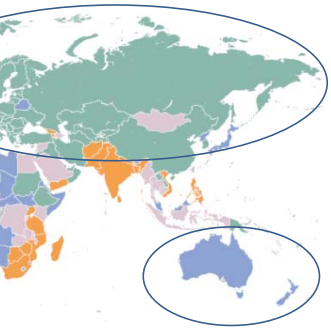
RESPECT, PROTECTION AND FULFILMENT OF CHILDREN'S RIGHTS

Standard 5. Every child's rights are respected, protected and fulfilled at all times during care, without discrimination.

Key challenges with Code adherence in facilities

Legal Status of the Code in countries

136 out of 194 countries report having legal measures in place related to the Code



Full provisions in law
Many provisions in law
Few provisions in law
No legal measures

TABLE 1. LEGAL STATUS OF THE *INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES* (4) IN WORLD HEALTH ORGANIZATION REGIONS IN 2018

Law categories	WHO Region						
	African	The Americas	Eastern Mediterranean	European	South-East Asia	Western Pacific	Total
Full provisions in law	12	6	6	3	5	3	35
Many provisions in law	12	5	4	4	3	3	31
Few provisions in law	6	9	7	43	—	5	70
No legal measures	17	15	4	3	3	16	58
Total	47	35	21	53	11	27	194

31 EU and EEA countries limited by EU regulation no. 609/2013, but another 12 EURO countries have weak laws also

Provisions within legal measures		Region, percentage					
	Global (*n* = 134)	African (*n* = 30)	The Americas (*n* = 19)	Eastern Mediterranean (*n* = 17)	European (*n* = 50)	South-East Asia (*n* = 8)	Western Pacific (*n* = 10)
Prohibition of promotion to health workers/facilities							
Provision of free/low-cost supplies	43	63	42	76	14	75	40
Materials and gifts	48	83	58	59	14	88	40

The reality for most if not all countries in the room:
…. weak or no legislation on the Code

Where to go from here?

For EU/EEA countries: identify existing laws/regulations which may facilitate facility level monitoring of BMS promotion ….. National Constitutions and the right to health and health care, and the right to food ….. a long shot! For non-EU/EAA countries ….. legislate!

How about international human rights obligations and monitoring?

BFHI Monitoring under the **UN Convention on the Rights of the Child** (CRC)

Art. 4:
States Parties shall undertake all appropriate legislative, administrative, and other measures […] States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation

Article 24:
States Parties shall appropriate measures to:
[…] combat disease and malnutrition through the provision of adequate nutritious foods
[…] ensure appropriate pre-natal and post-natal health care for mothers
[…] ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding …

How about international human rights obligations and monitoring?

BFHI Monitoring under the **UN Convention on the Rights of the Child** (CRC)

Pre-sessional working group:

- October 2018 – Norway
- February 2019 – Japan
- June 2019 – Belgium, Italy

Session:

January 2019 – Spain
May 2019 – Norway
September 2019 – Japan
January 2020 – Belgium, Italy

Submission dates under the CRC reporting process

		Due date	Submitted date
Andorra	CRC/C/AND/3-5	31 Jan 2018	
Austria	CRC/AUT/5-6	04 Mar 2018	04 Apr 2018
Azerbaijan		11 Mar 2018	
Cyprus		08 Mar 2018	
Czech Republic		30 Jun 2018	
Iceland		26 May 2018	
Slovenia		24 Jun 2018	
Ukraine		26 Sep 2018	
Uzbekistan	CRC/C/UZB/5	28 Jan 2018	

Key challenges with Code adherence in facilities

Code knowledge and monitoring capacity among health care providers

- What is the Code about?
- How does it affect my work?
- What are my responsibilities or obligations?
- How do I obtain more information about the Code's relevance?

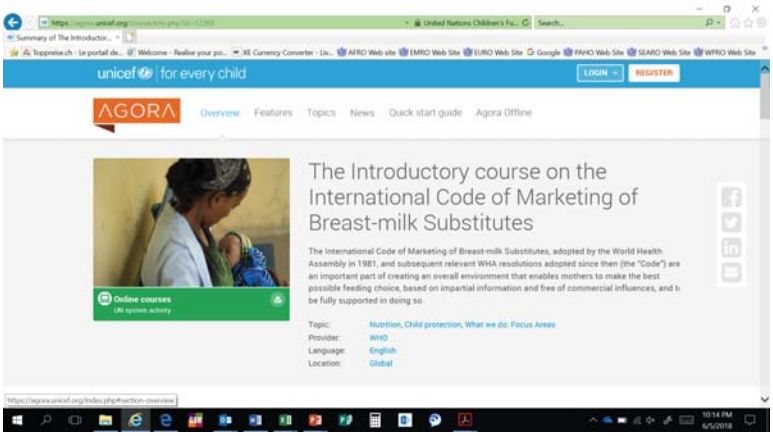
Basic information available: FAQ, Code Essentials (IBFAN), WHO/UNICEF e-learning course

But systematic integration of Code matters needed in training (pre-service/in-service training)

Key challenges with Code adherence in facilities

Code knowledge and monitoring capacity among health care providers – where to go from here

Encourage colleagues to take the e-learning course on the Code!



Key challenges with Code adherence in facilities

Code knowledge and monitoring capacity among health care providers

Expand the WHO FAQ – send in your questions!

Key challenges with Code adherence in facilities

Expand the WHO FAQ – send in your questions!

- Would WHO consider having a statement like "There should be no cross-promotion to promote breast-milk substitutes indirectly via the promotion of any other product" in one of its Code related documents?
- How does WHO view claims in trademarks and brand names?
- Does WHO/BFHI has any requirements on research on formula milk in BFHs with such research often funded by formula companies?
- Is it possible to fully implement "the Code" when at the same time you must follow the EU Regulations for infant formula and follow on formula?
- Is it allowed for a hospital or other healthcare facility to inform mothers about bottle feeding through a leaflet on their website?
- Is it allowed for formula companies to raise a fund for supporting education of healthcare workers on infant feeding?
  - If so: what would be the regulations on brands and logos on materials/websites claiming that the fund was facilitated by the industry?

Key challenges with Code adherence in facilities

Code knowledge and monitoring capacity among health care providers

- Explore existing health care or quality improvement monitoring processes – and how Code adherence monitoring fits in

Thank you

World Health Organization unicef

INITIATIVE HÔPITAL AMI DES BÉBÉS

The BFHI-Neo program FRANCE

Wednesday, June 6th

AMI DES BÉBÉS

517 maternity units
349 neo units
767 000 births/year

AMI DES BÉBÉS

Baby friendly facilities in France:

50 000 birth/year (6 %)

33 Baby Friendly Hospitals

December 2017

AMI DES BÉBÉS

33 Baby Friendly hospitals
16 with neo units
12 Baby Friendly designated neo units

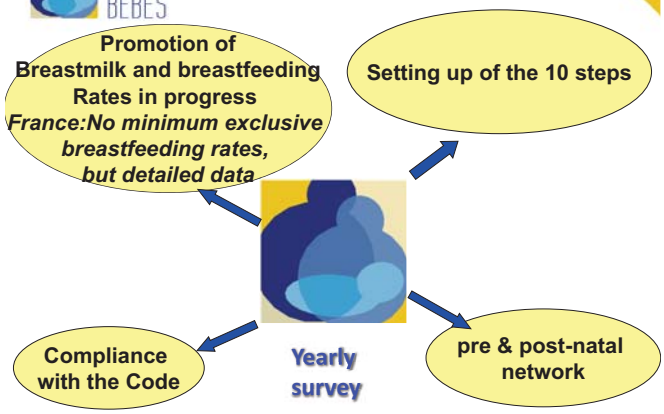
AMI DES BÉBÉS

History:

- **2008 – first Neo unit assessed**
- **2011 – "Neo BFHI program" +including 3 guiding principles (In France also required for maternities)**

AMI DES BÉBÉS

Like in maternity facilities:



« Skin to skin » early, often and long

Encourage breastfeeding

Parents principal caregivers

Assessment *Designation* *Survey*

International NEO BFHI SURVEY - France

27 neonatal units

Results (median scores)

- **Baby Friendly neo units: 93**
- **Neo units in BF process: 75**
- **Units not BF: 69**

Thank You!

NEO-BFHI PROGRAM IN CROATIA

Anita Pavicic Bosnjak

10th BFHI Network Meeting
5-7 June 2018, Steenwijk-de Bult, the Netherlands

CROATIA

- Population: 4.2 million
- 38 000 births per year
- Rate of preterm birth: 6%
- Rate of VLBW infants: 0.9%
- Rate of C-section: 21%
- 31 public maternity hospitals + 1 private maternity hospital
- One year of paid maternity leave

Source: *Croatian National Institute of Public Health 2017*

Levels of neonatal care

32 hospitals

21 Level 1 (basic care)

11 NICUs in maternity hospitals
Level 2 (n=6)
Level 3 (n=5)

70% of all live births/year

77% of all liveborn premature infants

2 NICUs in non-delivery hospitals
Level 3

200 premature infants' admissions/year

BFHI program in Croatia 2007 – 2018

- 31 out of 32 maternity hospitals are designated as "Baby – Friendly" providing Baby-Friendly care to 99.2% of newborns
- **11/13 NICUs are situated in BFHs**

Neo-BFHI Program

- Launched: 2013 by MoH and UNICEF Croatia
- All 13 Croatian NICUs joined the program
- No designated NICUs
- No external assessment

Nordic and Quebec Working Group, 2015

BF training for NICU staff

- 20-h course held in March 2015 covered 3 principles and 10 steps of the Neo-BFHI, 100 participants
- All course lectures were recorded and are available to all NICU staff in Croatia as audio-visual material for self-learning
- 2015: five regional workshops on cup feeding and kangaroo care

UH Sveti Duh Zagreb

UHC Split

UHC Zagreb

Equipment for bf support

- Phase 1 (2015) – all NICUs equipped with necessary equipment thanks to the funds from UNICEF (60000 USD)
- Phase 2 (2018) – 2nd UNICEF donation will be provided to all NICUs

Bf in Croatian NICUs: results of two national surveys

Croatian Society of Perinatal Medicine and UNICEF Croatia

	2012 All NICUs	2015 All NICUs
Exclusive BM feeding at discharge	64%	62%
Cup or syringe feeding as preferred methods of supplementation during bf transition	58%	77%
Daily STS contact of 2 - 4 h	33%	60%

No use of donor human milk, no human milk banks

Facilitators to implement Neo-BFHI

- **Dedicated staff**
- **All public maternity hospitals are designated as BFHs**
- **11/13 NICUs are situated in BFHs**
- Neo-BFHI program is a part of the **National Program for Breastfeeding Protection and Promotion in the Republic of Croatia**
- **Strong recognition and support of the BFHI and Neo-BFHI by the government**
- **MoH - UNICEF Croatia partnership**

Challenges

- Conducting external assessment and designation of NICUs
- Integrating BFHI and Neo-BFHI criteria into the National Accreditation System for Hospitals
- Establishing the first Croatian milk bank

More than 2,000 people took part in the Milky Way humanitarian run organized by UNICEF to raise funds for the first Croatian human milk bank

附錄七、肌膚接觸時安全議題簡報

Picture from Dumas, Gatineau, with permission

ENSURING SKIN-TO-SKIN SAFETY AT VAGINAL AND CAESAREAN BIRTH FOR ALL INFANTS

LOUISE DUMAS, RN., MSN, PhD

De Bult, Netherlands, June 2018

BABY-FRIENDLY HOSPITAL INITIATIVE: STEP 4

1. Facilitate immediate and uninterrupted skin-to-skin contact after birth (vaginal or caesarean)

2. Support mothers to initiate breastfeeding as soon as possible after birth

For **all** infants including preterm and sick infants as long as they are stable

(WHO-UNICEF, 2018)

Picture from Dumas, Lachenaie, Quebec, with permission

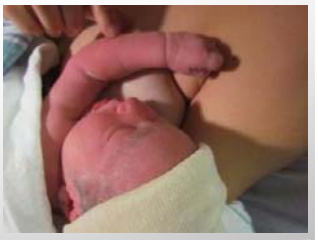
Picture from Miramichi hospital, New-Brunswick, with permission

SKIN-TO-SKIN ENSURES THE BEST TRANSITION FOR BOTH MOTHER AND BABY

CLEAR EVIDENCE

1. Physiological benefits for mother and baby
2. Benefits with breastfeeding
3. Psychosocial benefits for mother and baby

AS LONG AS IT IS DONE PROPERLY



Picture from Dumas, Lachenaie, Québec, with permission

HERE WE ARE DISCUSSING SKIN-TO-SKIN AT BIRTH SO, IMPORTANT DISTINCTION

Kangaroo care

Extended skin-to-skin contact (aim = 24h/24)

between a *mom (or dad or family)*

and her/his *premature* baby

Picture from Dumas & Lemire, KI-Solna, Stockholm, Sweden, with permission

Picture from Dumas, Gatineau,with permission

Skin-to-skin contact

Immediate and uninterrupted skin-to-skin

at birth, for *at least an hour*

between *mother* and *term* infant

WHAT SKIN-TO-SKIN MEANS IS THAT

"We should respect baby and mother instinctive behavioral and endocrine interaction sequence at birth." (Widström, 1988 & 2011)

Picture from Miramichi hospital, New-Brunswick, with permission to Dumas

SKIN-TO-SKIN AT VAGINAL BIRTH: HOW TO

- Nude newborn's abdomen *directly* on mother's nude chest, *without drying*
- Skin-to-skin is *immediate* (directly from the mother)
- Newborn is completely nude (no diaper, no ID, ...)
- Baby is extended as much as possible, so as much ski contact as possible (oxytocin)
- Baby is dried, especially back and head
- Newborn is *then* covered with a *dry* blanket

Picture from Dumas, VBAC, Gatineau, with permission

Dumas, 2014, revised 2016; Widström et al., 2011

SKIN-TO-SKIN AT CAESAREAN SECTION: HOW TO

- Nude newborn's abdomen *directly* on mother's nude chest, *without drying*
- Skin-to-skin is *immediate* (directly from the mother; or dried while cord is pulsating)
- Newborn is completely nude (no diaper, ...)
- Baby is extended as much as possible, so as much skin contact as possible (oxytocin)
- Baby is dried, especially back and head
- Newborn is *then* covered with a dry blanket

Picture from Dumas, Miramichi hospital, New-Brunswick, with permission

Picture from Dumas, St-Mary's hospital, Montréal, Québec, with permission

Dumas, 2014, revised 2016

YES BABIES HAVE DIED WHILE SKIN-TO-SKIN DURING THE FIRST 2 HOURS

Reports from:

Andres et al., 2011, France; Becher et al., 2012, UK and Ireland; Dageville et al., 2008, France; Espagne et al., 2004, France; Gatti et al., 2004, France; Gnigler et al., 2013, Austria ; Gnigler et al., 2013, literature review ; Gomez et al., 2011, Spain; Pejovic & Herlenius, 2013, Stockholm; Peters et al., 2009, Scotland; Poets et al., 2011, Germany; Poets et al., 2012, Germany

Picture from Dumas, Miramichi hospital, New Brunswick, Canada, with permission

But, yes, babies have died while swaddled/bundled at birth but we almost don't hear about those deaths

FOR SKIN-TO-SKIN, FACTS ARE THAT

ALL authors arrive at same conclusions:

1. Most mothers were primipara, so not experienced
2. Most babies were placed prone on their mothers
3. Mothers were lying flat on their back
4. Many babies were in an asphyxiating position
5. Mothers were left unattended
6. Most events happened during the night shift, less observation

Picture by Dumas, Lachenaie, Québec, with permission

SO WE NEED TO MAKE SURE SKIN-TO-SKIN IS PRACTICED SAFELY

- Practice safe skin-to-skin. How-to and important notes

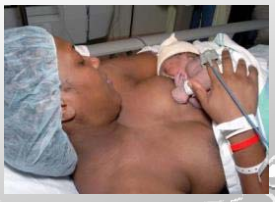
Dumas & Widström, 2014, revised 2016 — Adobe Acrobat Document

- Safety items at caesarean section

Dumas, 2014, revised 2016 — Adobe Acrobat Document

I have those pdf here: USB key and with poster

Picture from Moncton, New Brunswick,with permission to Dumas



Picture from Dumas, after caesarean section in post-partum ward, Gatineau, Québec, with permission

SAFETY ISSUES, SKIN-TO-SKIN AT VAGINAL BIRTH

- Inform parents on safe skin-to-skin practice, *especially fathers/partners*
- Prepare mother's gown so to remove it completely at the time of birth
- Place baby on the mother's skin *immediately* at birth, *without drying*
- Dry the baby's *back and head* thoroughly.
- *Expand baby's body* as much as possible on mother's chest to avoid pressure on the thorax, for better breathing and to ↑ oxytocin level
- *Make sure baby's nose and mouth are free to secure free airways. Baby should always be free to lift head.* So do not touch baby's head.
- Remove all wet blankets. Cover baby with one dry blanket. *Avoid overheating*

Dumas & Widström, 2015, revised 2016

SAFETY ISSUES, SKIN-TO-SKIN AT CAESAREAN SECTION

- Inform parents of the safe practice of skin-to-skin, *especially fathers/partners*
- Prepare mother's gown so to remove it completely at the time of birth
- Place baby on the mother's skin *immediately* at birth, *without drying*
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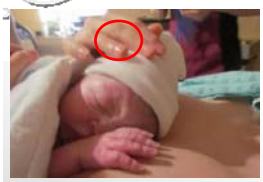
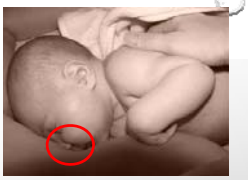
- *Expand baby's body* as much as possible on mother's chest to avoid pressure on thorax, for better breathing and to ↑ oxytocin level
- *Make sure the baby's nose and mouth are free to secure free airways. Baby should always be free to lift head.* So do not touch baby's head.
- Remove all wet blankets. Cover baby with one dry blanket. *Avoid overheating*
- *Ask father/partner to firmly hold his baby's bottom or thigh, directly on his skin, in case baby slips*

Dumas & Widström, 2015, revised 2016

DON'T



Pictures by Dumas, Gatineau, Québec, with permission



Picture from St.Marys hospital, Montréal, Québec, with permission

Picture from Dumas, Hôpital George Dumont, Moncton, New Brunswick, with permission

UNOBSTRUSIVE, CLOSE OBSERVATION OF THE BABY *WITHOUT LIFTING BLANKET*

- **By parents:** they need to be informed of what to observe and what is normal

AND

- **By either health professional present** at birth but responsibility and accountability have to be assigned *to one person*

- **What to observe**: skin coloration, adequate respiration, can move head and neck freely, general body tone, responsiveness to parents' stimulation

Picture by Dumas, post-cesaerean section, Gatineau, Québec, with permission

SAFETY ELEMENTS: PARENTS NEED TO UNDERSTAND BENEFITS AND RISKS

Clear explanations

- What we know is best and safest for baby and mother

- Importance of immediate and uninterrupted skin-to-skin

Adobe Acrobat Document

Dumas, 2014, revised 2016

I have this pdf here:USB key and with poster

Poster in birthing rooms: Hôpital Ste-Justine, Montréal, Québec & Hôpital Montfort, Ottawa, Ontario

ALSO IMPORTANT

The 2hrs separation at birth followed by rooming-in does NOT compensate for lack of immediate skin-to-skin at birth

SENSITIVE PERIOD **

Not enough evidence

to demonstrate critical period

Picture from Dumas, Gatineau, Québec, with permission

BABY-FRIENDLY HOSPITAL INITIATIVE: STEP 7

Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day

(WHO-UNICEF, 2018)

Picture from Dumas, after caesarean section in post-partum ward, Gatineau, Québec, with permission

YES BABIES HAVE DIED WHILE SKIN-TO-SKIN OR BREASTFEEDING IN MATERNITY WARDS OR AT HOME

Fleming, 2012, UK; Herlenius & Kuhn, 2013, literature review + Stockholm; Pejovic & Herlenius, 2013, Stockholm; Peters et al., 2009, Scotland

And, yes, babies have died while swaddled/bundled in the maternity ward

Herlenius & Kuhn, 2013, Stockholm; Krouse et al., USA; Pease et al., 2016; Pejovic & Herlenius, 2013, Stockholm; Peters et al., 2009, Scotland; Poets et al., 2011, Germany; Thach, 2014, USA

Picture from Dumas, Hôpital George Dumont, Moncton, NewBrunswick, Canada, with permission

YES BABIES HAVE DIED WHILE BEING SWADDLED

Known risks of swaddling/tight bundling (Dumas, 2016):

- Babies cannot express their needs with body movements (arousal is a survival skill)
- Babies can oversleep which is abnormal in the first days, weeks (sleeping/waking patters is a survival skill)
- Replaces skin-to-skin so lack of its benefits for mother and baby
- Replaces breastfeeding so detrimental to lactation and exclusivity
- More frequent respiratory difficulties, less lung expansion
- Linked to hip displasia, forced internal rotation
- Doesn't prevent SIDS

Adobe Acrobat Document

I have this pdf here:USB key and with poster

SAFETY ASPECTS OF SKIN-TO-SKIN IN MATERNITY WARDS OR AT HOME

Known risks at hospital or at home: Parents need to be informed

- **Sleeping or resting surface** : soft mattress; water bed; sofa or resting chair unless full awake
- **Parent's position** when the baby is placed skin-to-skin or on parent's chest (parent flat on her/his back; should be 30-45 degrees)
- **Soft bedding around baby** : pillows; bumper pads
- **Bedrails or bed placed by a wall**
- **The parent :** obesity; mother's large breasts; smoking even if not in the presence of the baby; medication or drug use; very tired parent risking lack of vigilance

UNOBSTRUSIVE, CLOSE OBSERVATION OF THE BABY

- **By parents:** they need to be informed what to observe and what is normal AND one parent is awake for close observation

AND

- **By nurse or midwife** in charge of the family

- **What to observe**: skin coloration, we can see nose and mouth, adequate respiration, can move head and neck freely, general body tone, responsiveness to parents' stimulation

Picture by Dumas, Gatineau, Québec, with permission

SKIN-TO-SKIN *AFTER* BIRTH

Known benefits:

- ✓ increased oxytocin (mom) and in so, promotes breastfeeding
- ✓ shortened time to solve major breastfeeding difficulties
- ✓ increased maternal or paternal bonding (oxytocin)
- ✓ demonstrated analgesia during painful procedures (baby): skin-to-skin, breastfeeding, breastmilk, skin-to-skin and breastfeeding
- ✓ decreases mother's postpartum depressive symptoms & stress (up to 3 months)
- ✓ colonizes baby with family bacteria
- ✓ decolonization of Methicillin-Oxacillin-Resistant Staphylococcus (MRSA), in *preterm* babies

Picture by Dumas, Hôpital de Trois-Rivières, Québec, with permission from Linda Lemire

AND WE CAN ENCOURAGE SAFE SKIN-TO-SKIN AND ROOMING-IN AT THE HOSPITAL AND AT HOME

From Vilja Design, Québec, Canada www.vilja-design.com

From Joeyband: www.sleepbelt.net/

AND WE CAN ENCOURAGE SAFE SKIN-TO-SKIN AND ROOMING-IN AT THE HOSPITAL AND AT HOME

FREE POSTERS FOR PARENTS- www.vilja-design.com

Picture by Dumas, Moncton, New-Brunswick, with permission

QUESTIONS?? COMMENTS??

To reach me

Louise Dumas, RN, MSN, PhD

louise.dumas@uqo.ca

Greater citizen, Gatineau city
Carreer Merit Award, Quebec Professional Order of Nurses
Florence award-international influence , Quebec Professional Order of Nurses
Honorary professor-researcher, associated with the Department of Nursing Sciences
Université du Québec en Outaouais (Western Quebec, Canada)
Honorary guest researcher, Department for Women and Child Health
Karolinska Institutet, Stockholm, Sweden
Associate professor-researcher, University of Moncton, New Brunswick, Canada
Lead-assessor Baby-Friendly Initiatives, Breastfeeding Committee for Canada
Representative of the BCC at the International BFHI Network for industrialized countries, WHO/UNICEF

Sustaining the BFHI

World Health Organization unicef

Responsibilities of a national BFHI programme

7. National monitoring

Monitor implementation of the initiative

1. **Monitoring of activities and practices**

See Appendix 1, Table 3:

a) Global Nutrition Monitoring Framework (WHA 2015):
   - Prevalence of exclusive breastfeeding in infants < 6 months
   - Percentage of births in Baby friendly facilities

b) Clinical practice indicators (household surveys; or: HMIS, exit interviews, facility surveys)

c) BFHI Programmatic output indicators

Reporting to: WHO, Committee on the Right to Food/Committee on Economic, Social and Cultural Rights, Committee on the Rights of the Child, Scaling Up Nutrition (SUN) movement

7. National monitoring

Monitor implementation of the initiative

Further to options for monitoring of clinical practices and BFHI programme:

- Facilities reporting into online system
- National survey of facilities
- Incorporation in national surveys

8. Communications & advocacy

Advocate for the BFHI to relevant audiences

Identify key audiences for sustained implementation of the BFHI, including:

- Facility leaders
- Health professionals and associations
- Legislators
- Funders
- Pregnant women, community members

8. Communications & advocacy – cont'd

Advocate for the BFHI to relevant audiences

In a communications plan identify:

1) Key audiences
2) Existing knowledge and attitudes
3) Messages to be developed/adapted
4) Key communication channels for each target audience

9. Financing

Ensure the ongoing funding of the initiative

Funding:

- Government budget should be primary resource
- External donors, foundations, NGOs on temporary basis
- Facility fees can be considered
- No conflict of interest

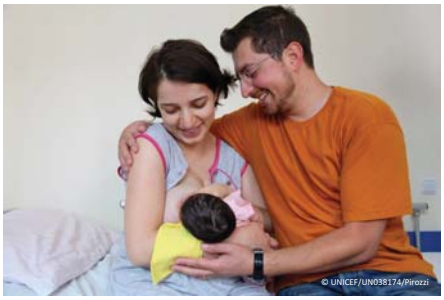
Budgeting:

- Plan and budget BFHI activities in a way that is sustainable
- Mainstream activities where possible

Thank you

World Health Organization unicef

Transition planning to the BFHI Guidance 2018



World Health Organization unicef

Transition planning – 1
Well-functioning BFHI

1. Develop a plan to incorporate the updated Ten Steps into the national BFHI standards
2. Integrate the Ten Steps into national policies, quality improvement and maternal and child health programmes
3. Develop a transition plan, including time for facilities to adhere to new standards
4. The BFHI coordination body needs to:
   - Revise public materials on the Ten Steps
   - Revise training courses and materials
   - Develop or update materials to assist facilities with internal monitoring
   - Revise external assessment standards

Transition planning – 2
No active or successful BFHI

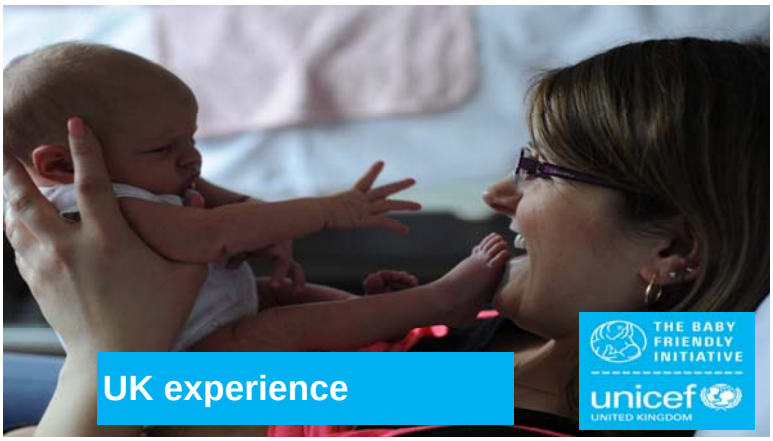
1. Develop a plan to incorporate the updated Ten Steps into the national BFHI standards
2. Integrate the Ten Steps into national policies, quality improvement and maternal and child health programmes
3. Use a quality improvement approach
4. Ensure supportive policy environment
5. Establish solid monitoring and accountability mechanisms
6. Inform certified facilities of the changes

Transition planning
WHO and UNICEF

1. Requesting countries to document their experiences with the implementation of the 2018 Guidance
2. "First Wave" countries to start implementing new guidance and document experiences.
   - Committed to the BFHI
   - BFHI dormant or being revitalised
   - Major changes being planned
3. "Second Wave" countries:
   - BFHI implemented in large number of facilities, vertical approach
   - BFHI standards not incorporated into national policies and standards
   - Funding not sustainable
4. "Third Wave" countries:
   - BFHI implemented at slow pace, in vertical manner
   - BFHI standards not incorporated into national policies and standards
   - Funding not sustainable

Thank you

World Health Organization unicef

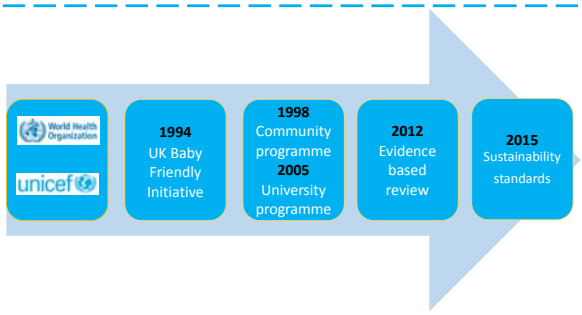


The Baby Friendly Initiative

Promoting health and wellbeing for all babies

Upholding the CRC

The Baby Friendly Initiative



Maternity standards

- Pregnant women are prepared
- Closeness and feeding straight after birth
- Breastfeeding off to a good start
- Informed decisions re other food for babies
- Close and loving relationships

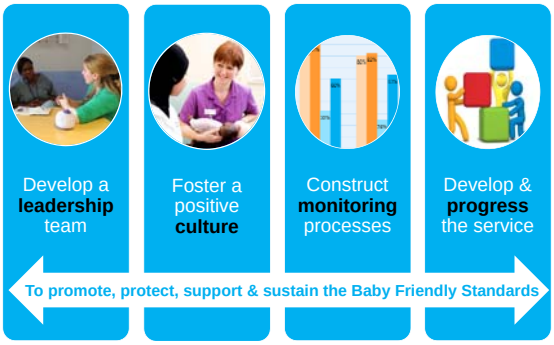
Transition process

2012 – launch new standards – conference, website, National Infant Feeding Network meeting
2012- develop new materials- assessment tools, including piloting, audit tools, training slides
2013-further discussion at conference etc – learning from pilot process
2014 Launch new assessments.

Transition

- Year 1 - NO expectation about new standards – feedback given
- Year 2 - 50% requirement for staff knowledge, 30% for mother outcomes
- Year 3 - 80% requirement for staff knowledge, 50% for mother outcomes
- Year 4 - 80% for all

Achieving Sustainability



Achieving Sustainability
Leadership

- Named Baby Friendly lead with sufficient hours/ability
- Baby Friendly Guardian
- Leadership structures robust
- Managers educated

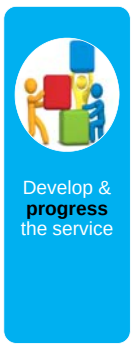
Achieving Sustainability
Culture

- Ongoing staff learning
- Mechanisms support a positive culture
- Positive feedback from staff, managers and mothers

Achieving Sustainability
Monitoring

- Robust monitoring and data collection
- Evidence of analysis and action planning
- Effective internal and external reporting

Achieving Sustainability
Progression



Service demonstrates:

- Innovation and change
- Improvement in outcomes
- Integrated working