Country experiences with the

Baby-friendly Hospital Initiative

Compendium of case studies from around the world

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World Health Organization

Compendium of case studies of the Baby-friendly Hospital Initiative

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Acknowledgements
Acknowledgements for the individual case studies can be found at the end of each case study.

The compilation of the case studies, oversight and editing were coordinated by Maaike Arts, UNICEF Nutrition Section, Programme Division. Support for the review of national data was provided by Chika Hayashi, Julia Krasevec and Vrinda R Mehra, UNICEF data and Analytics Section, Division of Data, Research and Policy. Inputs for the case study template and contacts for possible contributors were provided by Laurence Grummer-Strawn, Department for Nutrition for Health and Development, WHO, and the External Review Group for the Baby-friendly Hospital Initiative (BFHI).

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Design: Nona Reuter.

Special thanks to UNICEF's core donors, the Bill and Melinda Gates Foundation and the United States Fund for UNICEF which contributed to the production of this publication.

Notes on maps: These maps are stylized and not to scale and do not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Sudan and South Sudan has not yet been determined. The final status of the Abyei area has not yet been determined.

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Country experiences with the Baby-friendly Hospital Initiative

Compendium of case studies from around the world

Ten Steps to Successful Breastfeeding

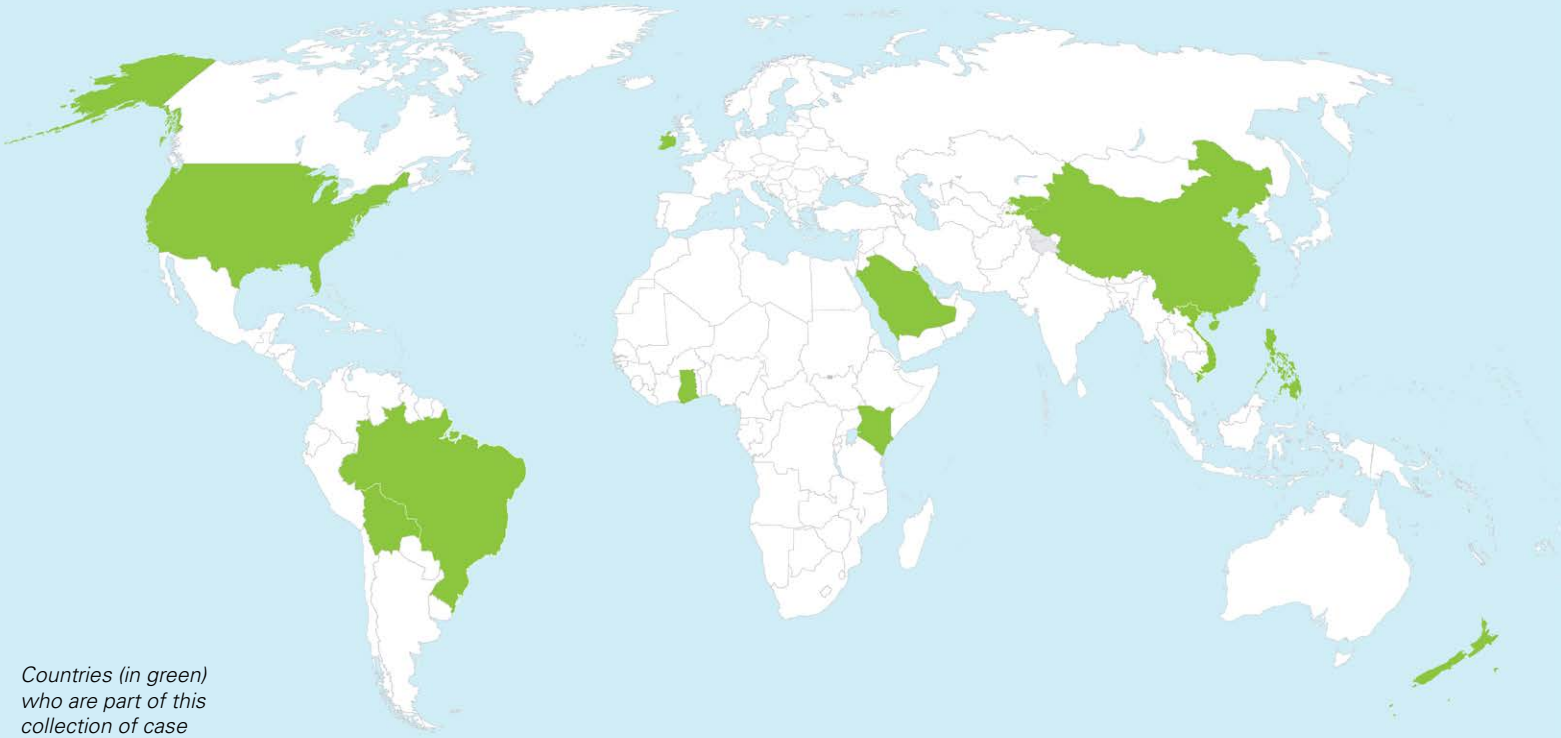
1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one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

Introduction

This set of case studies documents country experiences in implementing the Baby-friendly Hospital Initiative (BFHI) over the 25 years of its existence.

In 1991, WHO and UNICEF launched the BFHI, which is aimed at ensuring the protection, promotion and support for breastfeeding in maternity facilities. Hospitals or maternity facilities that comply with the Ten Steps to Successful Breastfeeding and with the relevant aspects of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions (the Code) are designated as baby-friendly.[1,2]

WHO and UNICEF revised the BFHI guidance package based on country experiences and published an updated BFHI package in 2009.[3] This package includes more emphasis on the International Code, a 20-hour training course on breastfeeding promotion and support for maternity staff and an orientation for decision makers. The updated guidance also includes recommendations for establishing mother-friendly interventions and baby-friendly communities, guidance on supporting mothers living with HIV, and more detailed guidance for monitoring and assessment. Recommendations for national coordination of the BFHI, including an overall national breastfeeding authority and a BFHI coordination group, and more detailed guidance for monitoring and assessment (external assessments recommended to be repeated every three to five years) are included in the guidance.



Countries (in green) who are part of this collection of case studies.

To achieve baby-friendly status, the global BFHI guidance recommends that facilities establish an in-house coordination group which coordinates and oversees the implementation of all Ten Steps, carries out a self-assessment and when the results are satisfactory, requests an external assessment. When the facility passes the external assessment, it can be designated as baby-friendly.

Evidence for the Ten Steps

WHO published a compendium of evidence for the Ten Steps in 1998, documenting literature showing how each step contributes to improved breastfeeding outcomes.[4] A randomized trial increased the rate of exclusive breastfeeding at three months of age to 43 per cent in hospitals that implemented the Ten Steps compared to only a 6 per cent rate in the hospitals that did not.[5] Several studies have confirmed the positive impact of the BFHI as a package on breastfeeding practices and child health. A systematic review of 58 studies from 19 countries published in 2016 concluded that when maternity facilities follow the Ten Steps, this leads to increased breastfeeding rates (any breastfeeding, early initiation immediately after birth, exclusive breastfeeding, and breastfeeding duration). The review found that the likelihood of improved breastfeeding rates is higher when mothers and newborns are exposed to more of the Ten Steps. Community support (Step 10) proved crucial to maintain the improved breastfeeding rates achieved in maternity facilities.[6]

Current status of the BFHI

The BFHI has been rolled out to almost all countries in the world. WHO estimates that in 2016, about 10 per cent of newborns are born in a facility that is designated as baby-friendly.[7]

Over the 25 years of its existence, the implementation of the BFHI has had its successes and challenges, the latter mostly related to scale-up, sustainability of country-level implementation and maintaining the quality of services.[8,9] In 2015, WHO and UNICEF embarked on a process of updating the BFHI guidance aimed at addressing

the challenges and providing recommendations to improve scalability and sustainability of the interventions. Simultaneously, WHO initiated a review of the scientific evidence for the Ten Steps.

To inform the drafting of updated guidance, case studies of BFHI implementation were sought from a broad range of countries. Thirteen countries submitted case studies: Bolivia, Brazil, China, Ghana, Ireland, Kenya, Kuwait, Kyrgyzstan, New Zealand, Philippines, Saudi Arabia, United States of America, and Viet Nam.

To facilitate the sharing of information, a UNICEF team edited the case studies into the summaries in this compendium. Several countries have published the extensive versions of their case studies elsewhere. Most case studies were presented, either orally or as a poster, at the BFHI Congress in October 2016.[10]

Summary of the BFHI country case studies

These case studies are testimony to the diversity in BFHI implementation. While several countries have been able to bring the BFHI to a national scale, in other countries the coverage has remained more confined. Coordination mechanisms and operational modalities also vary from country to country. The compendium is designed to reflect a range of country experiences. While it is difficult to generalize, some key commonalities can be extracted from the case studies.

The BFHI is often established and can flourish in countries with an enabling policy environment, most often when specific infant and young child feeding and newborn health policies, and sometimes broader development policies, are in place. Strong social mobilization for breastfeeding works in synergy with the BFHI to create a demand for breastfeeding support in maternity facilities and ensure sustainability of breastfeeding outcomes in communities.

The main funding sources reported were from governments, donor funding and fees from participating healthcare facilities. Different coordination mechanisms exist and are either led by a central government entity, decentralized governments or non-governmental organisations (NGO). The most common key actors involved in BFHI implementation at the national level are Ministries of Health, national or international NGOs, technical experts, UNICEF and WHO country offices.

Most countries have made adaptations to the Ten Steps to ensure alignment with national priorities. The most common adaptations are including mother-friendly interventions and compliance with the Code as an explicit additional step. Many countries adapted the implementation modality of the BFHI to their context, to ensure national relevance and sustainability. Examples include: involving communities or community-based organizations, embedding BFHI into broader Maternal and Child Health (MCH), Nutrition and Development interventions or policies, using a quality improvement approach, and incorporating breastfeeding and BFHI-related indicators in national health information systems.

The case studies show that designation and recognition as a baby-friendly facility is the main incentive for facilities. The external assessment is most often carried out by health professionals and sometimes other cadres, at the request of the national BFHI coordinator and after a training for external assessors. However, alternative ways of recognition are also used, such as the reimbursement of increased amounts for services provided in facilities certified as baby-friendly. In-service training is the main capacity building strategy for the BFHI; BFHI or breastfeeding support in pre-service training is rare or insufficient.

The main challenges described in the case studies include: lack of ownership by the government (vis-à-vis ownership by donors or NGOs), the voluntary nature of BFHI implementation as opposed to mandatory implementation, loss of momentum for the BFHI, lack of funding for the recurrent costs for training and (re-) assessments, staff rotation and a high workload for health facility staff.

The case studies describe several lessons learned: the policy environment is pivotal to initiate and

maintain success in breastfeeding outcomes from the BFHI interventions. 'Champions' can help accelerate implementation, mainstreaming of the BFHI into other interventions facilitates scale-up as well as acceptance by health facilities, community support and social mobilization are important, certificates for facilities certified as baby-friendly need expiry dates so that compliance with the Ten Steps needs to be re-evaluated regularly.

The case studies provide a broad range of recommendations for updating the global guidance. The following are some of the most frequently mentioned recommendations: Integrate the BFHI into national policies, programmes and protocols, invest in capacity building for health workers, for example via inclusion of lactation management and the BFHI in pre-service training, conduct ongoing monitoring of the quality of care and secure sustainable funding. Allowing flexibility in the guidance for adaptation to national realities was also deemed very important.

For more information on UNICEF and WHO's work on the Baby-friendly Hospital Initiative, and to download materials as they are updated, please refer to **http://www.unicef.org/nutrition/index_breastfeeding.html** and **http://www.who.int/topics/breastfeeding/en/**.

The individual case studies have been written by authors from each country, who are mentioned in the acknowledgements section of each case study. For harmonization purposes, all case studies are edited according to the *UNICEF Style Book*.[11]

Endnotes

1 World Health Organization, United Nations Children's Fund, *Protecting, promoting and supporting breastfeeding: the special role of maternity services,* Geneva, 1989.
2 World Health Organization, *International Code of Marketing of Breastmilk Substitutes,* Geneva, 1981.
3 World Health Organization, United Nations Children's Fund, *Baby-Friendly Hospital Initiative: revised, updated and expanded for integrated care,* Geneva, 2009.
4 World Health Organization, *Evidence for the Ten Steps to Successful Breastfeeding,* Geneva, 1998.
5 Kramer, Michael S., Beverly Chalmers, Ellen D. Hodnett et al., Promotion of Breastfeeding Intervention Trial (PROBIT), a randomized trial in the Republic of Belarus. *Journal of the American Medical Association* 285(4):413-420, 2001.
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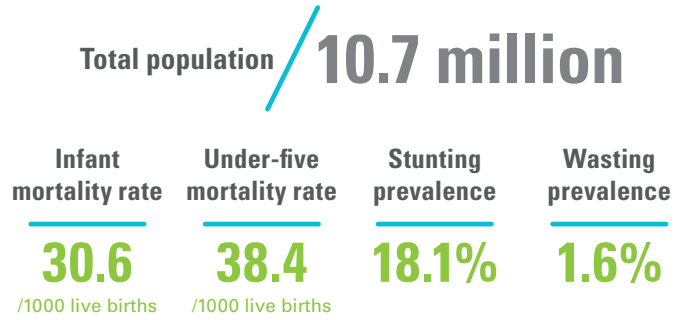
The Baby-friendly Hospital Initiative in Bolivia
Twenty-five years of history

Country and policy context

Bolivia's population is 10.7 million. There are just over 150,000 live births a year. Under-five and infant mortality are relatively low at 38.4 and 30.6 per 1,000 live births, respectively. Eighteen per cent of children under 5 years of age are stunted and only 1.6 per cent wasted. In 2016, there were 82 maternity facilities at the secondary and tertiary care level.

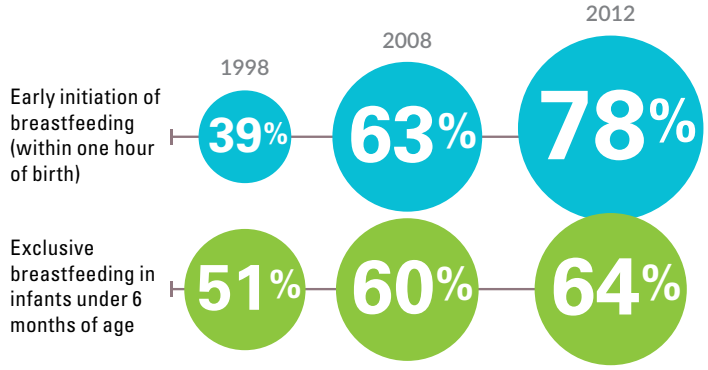
Data from the 2012 national Survey of the Assessment of Health and Nutrition indicate that 78 per cent of newborns were breastfed within the first hour after birth. In addition, 64 per cent were exclusively breastfed in the first six months of life in 2012, an increase from 51 per cent in 1998 *(see Figure 2)*.

Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on EESN 2012.

Figure 2: Key national breastfeeding indicators (1998, 2003 and 2012)



Source: Demographic and Health Survey 1998 and 2003; National Survey of the Assessment of Health and Nutrition 2012.

Indigenous Chipaya. Photo competition in breastfeeding, Ministry of Health. Photo credit: MoH Bolivia/2016/Vásquez.

Case study methodology

Research for the case study was conducted between July and August 2016. It included a review of national and international literature related to the Baby-friendly Hospital Initiative (BFHI) and data from the Ministry of Health (MOH). Qualitative interviews were conducted at the national, departmental and local level (in hospitals) with 20 key informants from the MOH, local level representatives and informants from academia.

Enabling environment

In 2007, as part of the new Health Policy *Family, Community and Intercultural Health* (SAFCI), the multi-sectoral Zero Undernutrition programme introduced a set of strategies to eradicate undernutrition in children under 5 years of age. In Bolivia, nutrition is considered a crucial first step for a child's well-being. The Integrated Management of Childhood Illness approach has also implemented a nutritional component. Other strategies implemented from the outset were the so-called Integrated Nutrition Units, which are teams of professionals tasked with leading nutrition-related actions at the municipal level. National policies and strategies enacted to support breastfeeding, including the BFHI, are summarized in Figure 3.

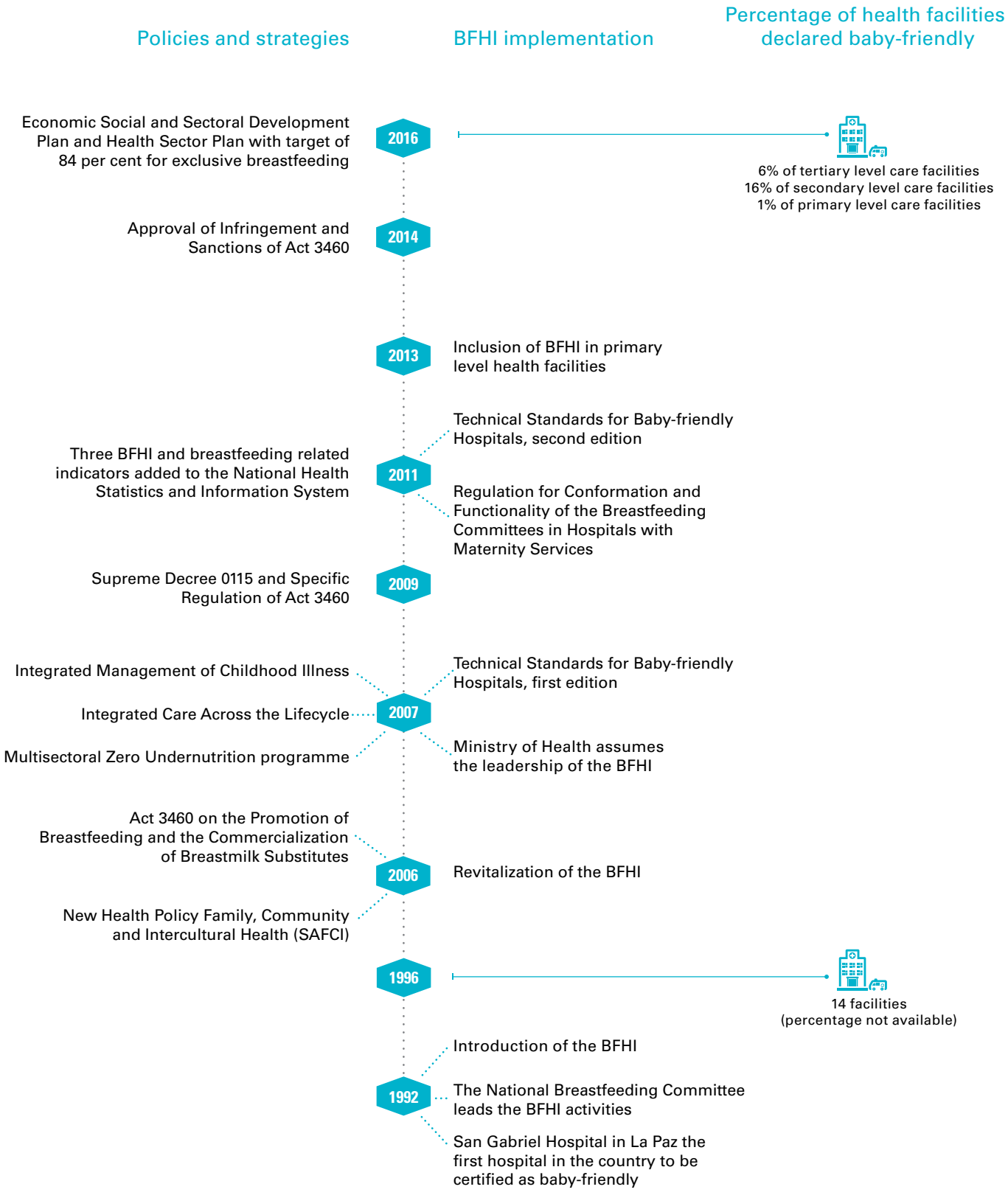


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

Overview of BFHI implementation

The BFHI was introduced in Bolivia in 1992. The initiative was led by the National Breastfeeding Committee, comprising representatives of the MOH and other institutions, including the Maternal and Child Directorate, Pan American Health Organization (PAHO), UNICEF and the Technical Breastfeeding Support Committee (COTALMA), a non-governmental organization which was already supporting breastfeeding in the country when the BFHI was launched. The National Breastfeeding Committee also included representatives from the Paediatric Association, Gynaecology-Obstetric Association and the School of Nutritionists and the NGO La Liga de La Leche. From the beginning, the committee had a set of unofficial regulations that constituted the legal and operational basis for its work.

UNICEF provided financial support, including for training of trainers and evaluators at the national level and the transfer of these to the nine departments and various local hospitals that were in the process of certification according to global BFHI criteria. By 1996, 14 hospitals were certified as baby-friendly. In the following period, the initiative entered a time of inactivity. Although there was demand for the certification, there was no strategy to ensure sustainability or continued compliance with standards.

Between 2006 and 2009, Bolivia underwent a period of political change that was highly favourable for the BFHI and propelled by the advocacy of the Minister for Health. In 2007, the State-sponsored Zero Undernutrition programme, which included actions to promote breastfeeding, was officially launched and the BFHI was reactivated under the leadership of the MOH. The Breastfeeding Area of the Nutrition Unit of the MoH was strengthened with the appointment of a staff member exclusively responsible for breastfeeding, for the promotion of the BFHI and other strategies to support breastfeeding. At the departmental level, the structure of the Departmental Health Services for the promotion of breastfeeding was also strengthened.

Since 2006, the criteria for baby-friendly certification in Bolivia require 90 per cent compliance with each of the Ten Steps to Successful Breastfeeding. This requirement is stricter than the global BFHI criteria, which require a compliance of 80 per cent. Also, the MOH decided to include the prohibition of the sale or distribution of breastmilk substitutes in hospitals as Step Eleven.

The regulations and norms previously developed were updated and formalized by the MOH, and a variety of official documents regarding the initiative were elaborated especially for the Bolivian context, including the Technical Standards of Baby-friendly Hospitals (first edition, 2007; second edition, 2011), and the Regulation for Conformation and Functionality of the Breastfeeding Committees in Hospitals with Maternity Services (2011).

Although the global BFHI package incorporated monitoring guidelines in 2006, monitoring and recertification were not incorporated in the package in Bolivia and therefore not practiced. In 2017, the MOH is adapting the BFHI guidelines on monitoring and evaluation to incorporate them in the national guidelines.

The Quality Unit of the Departmental Health Services (SEDES) of Cochabamba handles the BFHI certification process. Although certification is supervised by another unit within SEDES, the Unit of Food and Nutrition, the Quality Unit has incorporated the BFHI certification processes. This coordination structure is being promoted by the MOH for incorporation into the national norm.

Key achievements/results

To date, a total of 51 health facilities have been certified as baby-friendly. Of these, 37 were certified between 2013 and 2016 (2 are tertiary level facilities (6 per cent of facilities at this level), 14 are secondary level (16 per cent) and 21 are primary level facilities (1 per cent). None of the 51 facilities have been re-certified. An unofficial estimate is that 9 per cent of births in the public sector took place in health services certified as baby-friendly.

In 2011, the MOH introduced three new indicators in the National Health Statistics and Information System: exclusive breastfeeding; mother-infant skin-to-skin contact; and rooming-in for mothers and newborns.

Challenges

- Continuous turnover of hospital staff has made it challenging to sustain the BFHI.
- Act 3460 on the Promotion of Breastfeeding and Commercialization of Breastmilk Substitutes (BMS), it is not functional. Mechanisms for implementing Act 3460 are not yet in place. The MOH is developing simple operational tools for the local level.
- Continue law enforcement and control of the interests of the BMS industry.
- More can be done to adapt the BFHI to the health system.
- Identifying a sustainable support system for mothers after discharge is important. Many mothers give birth in hospitals but continued engagement with the health system is limited.

Lessons learned and recommendations

- Incorporating BFHI into the general certification of hospitals and health services and generating incentive mechanisms for staff to implement baby-friendly practices promotes the sustainability of the Initiative. Vertical management of various programmes, including the BFHI, may result in the duplication of efforts and can overburden health staff and increase costs. In the same vein, while actions oriented specifically to the mother have not been formally incorporated into BFHI in Bolivia, since 2001 obstetric and neonatal care practices, which are the basis of "humanized" delivery and can easily be linked up with the BFHI.
- Key staff can lead the implementation process, supported by the commitment of heads of health institutions to accelerate implementation. Health personnel (such as nutritionists, nurses, paediatricians, neonatologists and obstetricians) usually led the breastfeeding committees and BFHI actions in hospitals. However, positive results have been seen in hospitals where other professionals (such as physiotherapists) led the initiative. Establishing a technical team at the national level to lead breastfeeding related activities and drive the BFHI provided the ownership and vision to ensure its success.
- Support staff to gradually adapt to new processes and task shift where viable, especially tasks seen as challenging or problematic. For example, health staff initially opposed the skin-to-skin practice because it took more of their time to observe the mother and child. The task of observation was delegated to other staff such as the medical interns and gradually the observation time was increased from 15 minutes to half an hour. This enabled a new procedure to eventually become a routine practice.
- Seek alternative training for the BFHI throughout the health system. For example, including the BFHI and breastfeeding in the preservice curriculum, including in university education, could overcome the difficulties caused by rotation of health personnel, training new staff and associated costs. A virtual training course could also address the time and financial constraints. Hospitals would still be responsible for training staff, promoting appropriate practices, assessing staff knowledge and skills. Developing materials for new or temporary staff is also an option.
- Creating a favorable legal and normative framework with the political support of the State is essential to ensure the success of the BFHI. A legislative package must be well-adapted to the national and local context. Specifically, in Bolivia, authorization of the Law on the Promotion of Breastfeeding, including the Initiative was critical for effective implementation.
- The institutionalization of the BFHI was reinforced through adoption as public policy with the framework of the national decentralized system, with budgetary allocations in the Economic and Social Development National Plan, Health Sectoral Plan and Zero Undernutrition programme of the MOH.

Recommendations for global BFHI guidance

- Include sensitive indicators in the National Health System, for a better monitoring of the implementation of the initiative and its results.
- Seek more cost effective training alternatives for the BFHI throughout the health system, such as the use of interactive tools.
- The initiative should be included as part of the institutional accreditation system of health facilities, not as an isolated process.
- Simplify the steps and time frames for accreditation.

Acknowledgements

Authors and contributors: Alenkar Bento Seoane, consultant; Rimsky Chavez, UNICEF Bolivia; Karen F. Berrios and Yecid Humacayo, Ministry of Health, Bolivia and Yecid Humacayo, MOH Bolivia; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Mary Ann Perkins. Design: Nona Reuter.

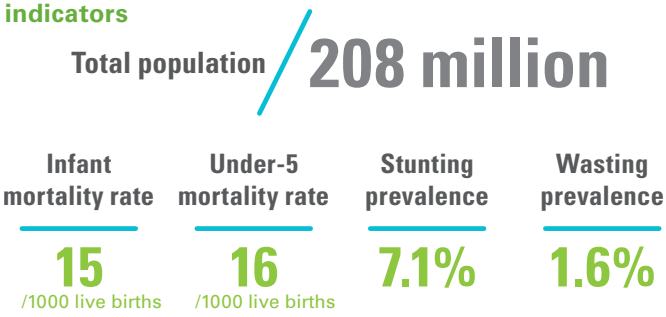
The Baby-friendly Hospital Initiative in Brazil

A quarter century of saving lives

Country and policy context

Over the last quarter century, the Federal Republic of Brazil (Brazil) has achieved a large reduction in under five and infant mortality rates, the latter falling from 51 deaths per 1,000 live births in 1990 to 15 deaths per 1,000 live births in 2015.

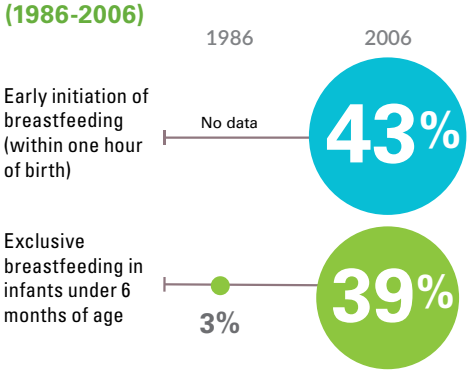
Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on PNDS 2006.

In 1988, the country established the Brazilian Health System, a dynamic and complex public health system based on the principle of health as a legal right and the duty of the State. Currently, there are over 5,300 total hospitals with birthing and delivery rooms, about half of which are public, 25 per cent philanthropic and 19 per cent private. Jointly, they delivered almost three million babies in 2014. More than half of all deliveries are caesarean sections.

Figure 2: Key national breastfeeding indicators (1986-2006)



Source: Demographic and Health Survey, 1986, 2006 (additional analysis by Pelotas University 2014).

A mother shares her bed with her baby in the maternity ward of the Pernambuco Mother and Child Hospital in Recife. ©UNICEF/UNI52326/ Sprague.

Breastfeeding has been identified as a key factor contributing to the reduction of infant mortality in Brazil.[2] National breastfeeding statistics have shown positive trends, with an increase in exclusive breastfeeding during the first six months from 3 per cent in 1986 to 41 per cent in 2008. The median breastfeeding duration increased as well, as seen by a 15 per cent increase in the national breastfeeding rate beyond 12 months *(see Figure 2)*.

Case study methodology

The authors reviewed and analyzed published articles and documents, including institutional documents from the Ministry of Health (MOH) and information available from the Centers of Reference for health professional training.

Enabling environment

Implementation of actions for breastfeeding protection, promotion and support in Brazil are ensured by various national policies and strategies *(see Figure 3)*.

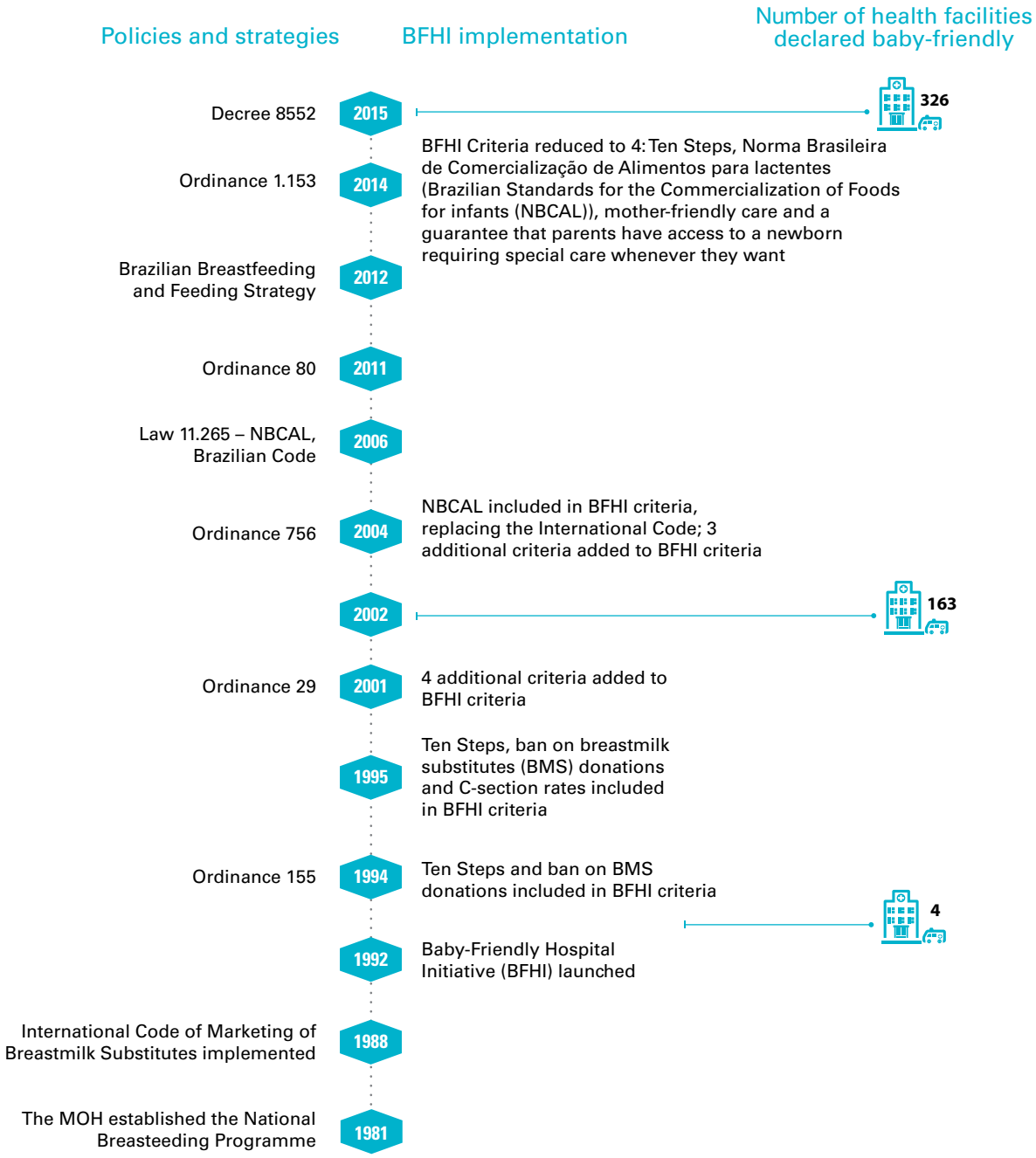


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

Overview of BFHI implementation

The MOH of Brazil established the National Breastfeeding Programme in 1981. The Baby-friendly Hospital Initiative (BFHI) was launched in 1992 and has been coordinated by the MOH and the National Breastfeeding Committee. In 1992 and 1993, the first four hospitals were accredited and two of these hospitals (in the Northeast and Southeast) became national centers for training of health professionals and BFHI assessors. These facilities were instrumental in expanding the number of trained health workers and accredited facilities.

In 1996, the MOH changed the BFHI accreditation process to include a focus on decreasing the caesarean section rate, and included five additional criteria. Due to the more stringent criteria, fewer hospitals applied for accreditation and there was a large decline in demand for accreditations.

After analyzing the challenges to BFHI accreditation, the MOH decided to make better use of the adapted WHO/UNICEF training courses for clinical management and the short course for sensitizing decision-makers and managers. Also included were a training course about the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions (the Code) and a module on monitoring BFHI post-training. The number of accredited hospitals peaked in 2003. However, the MOH included new national criteria again, resulting in a second decline in the demand for accreditations.

In 2009, Brazil started using the revised global BFHI modules without incorporating the HIV and mother-friendly criteria. All states were trained using these modules and the revised version of the Ten Steps and include the Code. In 2014, in anticipation of revitalizing the BFHI in Brazil, the MOH changed the accreditation law and the Brazilian criteria, softening them, and gradually invited more hospitals for accreditation.

In 2010, the MOH introduced a computerized monitoring tool for the BFHI accreditation process. This is a web-based system which enables hospitals and evaluators to register the pre-assessment, external evaluation, monitoring and annual external assessments. Hospitals can access their own data and results and assessors and states can access information about the hospitals. It also enables the MOH to track progress.

A key change to the BFHI in 2014 was the decision to integrate mother-friendly criteria and one additional criterion related to the improvement of neonatal care for at-risk infants. The changes regarding care for sick neonates allow caregivers or legal guardians to participate in care and stay with sick neonates at baby-friendly hospitals 24 hours per day.

Since 1994, BFHI-accredited hospitals receive financial incentives including higher reimbursements for best practices during delivery and birth: currently this is 8.5 per cent more per caesarean section and 17 per cent more per normal delivery. Non-accredited facilities receive reimbursements from the National Health System in the amount of $127 or $92 per caesarean section or normal delivery, respectively.

The estimated cost for a global assessment in Brazil is $750 per hospital, which is paid for by the federal government and covers travel costs and the expenditures for travel and the assessors. Over the years, BFHI has been funded by the government of Brazil, partially by the federal budget and partially by the state and municipality budgets. BFHI plaques are funded by the UNICEF Brazil office. The financial crisis has reduced federal and state funding available for BFHI accreditations. Although a total of 382 hospitals have ever been BFHI accredited, the number fluctuated greatly between 1992 and 2016.

Coordination of the BFHI in Brazil is carried out by the MOH's Department of Child Health and Breastfeeding and the Brazilian Breastfeeding Committee. The national committee includes representatives of different government ministries, civil society organizations such as the International Baby Food Action Network (IBFAN), mothers' groups, professional associations for Obstetrics and Gynecology (OBGYN), Pediatrics, Midwifery and Nutrition, assessors of main BFHI academic hospitals and the Brazilian Network of Human Milk Banks. Supporting actors include UNICEF and the Pan-American Health Organization (PAHO) Brazil.

The Santos Lactation Center (CLS) and Instituto de Medicina Integral Prof. Fernando Figueira (IMIP) trained health professionals, currently totaling almost 11,000, as well as assessors and decision makers, in other states, other Latin American countries and Portuguese-speaking African countries. These trainings were fundamental for the expansion of the BFHI.

Key achievements/results

Over the last 25 years, the number of new hospitals accredited annually has varied *(see Figure 3)*.

In 2014, around 674,000 deliveries (23 per cent of all deliveries) took place in the 326 accredited hospitals. Infants born in baby-friendly facilities in Brazil have a:

- Nine per cent higher chance to be breastfed in the first hour of life than newborns in a non-BFHI-certified hospital).
- Median duration of 60 days of exclusive breastfeeding (compared to 48 days when born in a non-BFHI hospital).[3]

In 2015, 98% of hospitals used the online computerized self-monitoring system. This system alerts hospitals when compliance with the national criteria decreases and helps create local improvement mechanisms.

Challenges

- Strengthen breastfeeding committees in the 26 states and the federal district as well as in hospitals, and the linkages between these committees.
- Coordination, external evaluation of the hospitals and transport are inherently more challenging and costly due to the sheer size of the country and the number of hospitals to be assessed and monitored.
- Accreditation of new hospitals depends on the availability of financial resources by the state and federal government.
- Coordination at the state and municipal level has been a challenge due to the lack of available assessors to perform the reassessments.

Lessons learned and recommendations

- Decentralization is key for strengthening the BFHI.
- Investing in distance learning for health professionals and BFHI assessors is useful for decentralization of the BFHI.
- Health managers and decision makers should be sensitized to the BFHI and the BFHI should be included on the agenda of Management Committees of Health Secretaries.
- More concise management courses have made participation of high-level officials viable.
- Rather than focusing on increasing BFHI facility coverage in Brazil, it is important to think about sustainability of the services.
- The National Health Agency, which is responsible for the private sector should require health insurance companies to include BFHI goals as quality criteria for private hospitals.
- University hospitals should be prioritized in order to educate health professionals through pre-service training, which is more cost effective than in-service training.

Recommendations for global BFHI guidance

- Rather than focus on increasing coverage in terms of the number of baby-friendly facilities globally, it is important to ensure sustainability of quality maternity and breastfeeding care.
- For stronger implementation at local levels, key decision makers should be sensitized to the BFHI and focus should be placed on capacity building and decentralization of national programmes.

Acknowledgements

Authors and contributors: Elsa Giugliani, Brazilian Pediatric Society; Keiko Teruya, Lactation Training Center in Santos, SP; Marina Rea International Baby Food Action Network (IBFAN); Sônia Venâncio, Instituto de Saúde São Paulo; Vilneide Braga Serva, IMIP, Recife; and all members of the Brazilian Breastfeeding Committee and employees of the Brazilian Ministry of Health and technical staff member of the Ministry of Health: Thereza de Lamare, Fernanda Monteiro, Neide Cruz and Renara Araujo; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Melissa Theurich; Design: Nona Reuter.

Endnotes

1 United Nations Inter-agency Group for Child Mortality Estimation (IGME) in 2015, accessed 29 December 2016.

2 Victora, C.G., et al., 'Maternal and child health in Brazil: progress and challenges', *Lancet*, vol. 377 no. 9780, May 2011, pp. 1863-76.

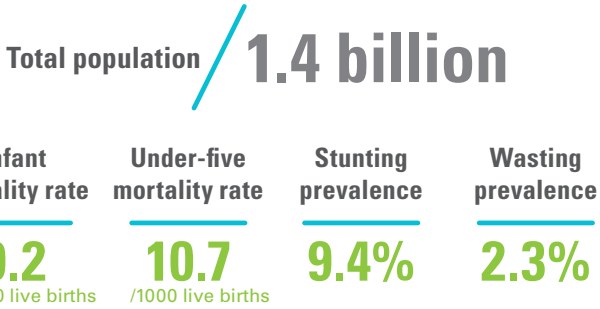
3 Venancio, S.I., Saldiva S.R., Escuder, M.M. and E.R. Giugliani, 'The Baby-Friendly Hospital Initiative shows positive effects on breastfeeding indicators in Brazil.' *Journal of Epidemiology and Community Health*, vol. 66, no. 10, October 2012, pp. 914–8.

The Baby-friendly Hospital Initiative in China
The road to universal baby-friendly hospitals

Country and policy context

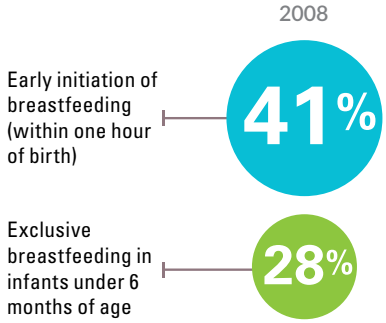
China is the most populous country in the world, and two-thirds of its population of about 1.4 billion people are women and children (more than 880 million people). Indicators of maternal and child health show improvements in recent years. China met many of the United Nations Millennium Development Goals ahead of schedule, having reduced the maternal mortality rate to 20.1 per 100,000 live births, infant mortality rate to 9.2 per 1,000, and the under-five mortality rate to 10.7 per 1,000 *(see Figure 1).*

Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on the Chinese Center for Disease Control and Prevention 2012.

Figure 2: Key national breastfeeding indicators (2008)



Source: National Health Services Survey (NHSS) 2008 (additional analysis), and UNICEF database.

Photo credit: UNICEF China.

There are more than 15 million births per year; virtually all (99.6 per cent) take place in a health care institution. The rate of early initiation of breastfeeding is 41 per cent and about 28 per cent of children under 6 months of age are exclusively breastfed *(see Figure 2).*

Case study methodology

A desk review of relevant documents was conducted as the basis for this case study. The desk review included government documents and reports of the BFHI re-assessment in 2014 and 2015.

Enabling environment

The Government of China puts high priority on maternal and child health and development. It began implementing the Baby-friendly Hospital Initiative (BFHI) in 1991. A series of legal measures have been enacted to protect maternal and child health, as outlined in Figure 3.

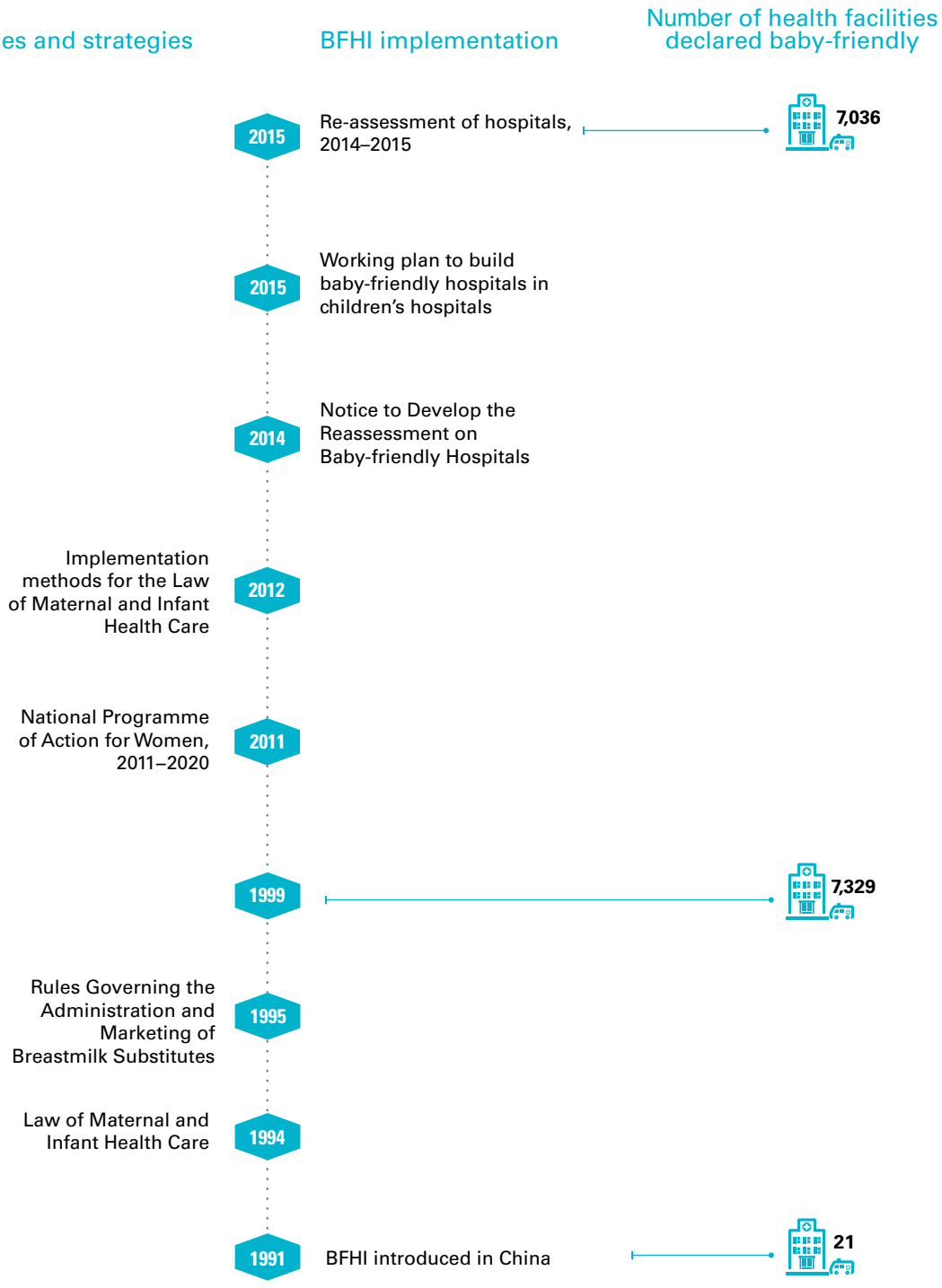


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

Overview of BFHI implementation

In 1991, the Ministry of Health (MOH) launched the BFHI in cooperation with the World Health Organization (WHO) and UNICEF. Under the leadership of the MOH, a National Technical Support Committee on Breastfeeding adapted the global Ten Steps to Successful Breastfeeding to the National Criteria for Baby-friendly Hospitals. The criteria were applied to assess health facilities nationally, with financial and technical support from local governments, WHO and UNICEF. In the next year, through the efforts of the MOH, the All China Women's Federation, the National Working Committee on Children, WHO, UNICEF and the United Nations Population Fund, the baby-friendly certification was given to 21 state-owned hospitals. By 1999, 7,329 facilities in China were assessed and recognized as baby friendly, estimated to be about one third of all the baby-friendly hospitals in the world at that time.

In the following years, the Government of China continued to strengthen the management of baby-friendly hospitals and put in place several other measures to protect, promote and support breastfeeding. The National Programme of Action for Children (2011–2020) included a target to raise the national rate of exclusive breastfeeding in children 0–5 months to 50 per cent by 2020.
The BFHI is linked with the routine management of hospitals such as the evaluation of obstetric techniques and emergency care and the transfer system for near-miss maternal and newborn cases. Key indicators such as caesarean section rate and breastfeeding coverage have been included in the annual management targets for hospitals and the quality performance evaluation of departments, and they are linked to the incentive mechanism of health workers, in order to motivate the health facilities and health workers to promote breastfeeding and natural delivery. Besides, the prices for obstetric and paediatric services have been reasonably raised to acknowledge the value of their technical services and motivate health workers to meet the demands of mothers and children through better service quality.

In June 2014, the National Health and Family Planning Commission (NHFPC) released a 'Notice to Develop the Re-assessment on Baby-friendly Hospitals'. This revised the original 1991 national BFHI criteria to include new mother-friendly measures. The revised criteria covered indicators related to successful breastfeeding, infant safety and a reduction in the prevalence of caesarean sections (in total, there are 10 primary indicators, 18 secondary indicators and 44 tertiary indicators).
A year later, the NHFPC released a 'Working plan to building baby-friendly hospitals in children's hospitals'. To be certified as baby friendly, pediatric hospitals need to comply with six commitments: 1) promote early initiation of breastfeeding and natural delivery; 2) refrain from the promotion of infant formula and related products; 3) communicate breastfeeding knowledge and skills through multiple channels; 4) implement 24-hour rooming in; 5) set up a breastfeeding hotline and counselling clinics; and 6) provide technical support in the community and timely support for breastfeeding after discharge.

The revision of BFHI criteria and re-assessment of BFHI was accompanied by four steps. First, between August and December 2014, the NHFPC held an orientation meeting and a national training of trainers for hospital managers and clinical staff (physicians). Second, in the first half of 2015, the NHFPC conducted unannounced spot checks in 20 baby-friendly hospitals across nine provinces to assess compliance with the criteria in the hospitals' daily work, after the revision. Findings were shared with local health authorities, and health facilities that were not in compliance with national criteria were instructed to improve their performance or lose their baby-friendly status.

Third, to provide ongoing support to mothers following delivery, the NHFPC developed a free breastfeeding hotline for the general public seeking advice on breastfeeding. The hotline staff received a two-day training course on breastfeeding counselling skills in August 2015. Fourth, the NHFPC produced a five-minute advocacy video broadcasted on television, subway trains and public buses to raise public awareness of BFHI and guide the public to look for baby-friendly practices.

The re-assessments were undertaken by provincial health authorities. The general public was invited to report any violation by health staff of the BFHI guidelines via a public health hotline.

Key achievements/results

By the end of 2015, there were 7,036 certified baby-friendly hospitals with maternity services in China. It was not possible to translate this number into a percentage of hospitals with maternity services in the country. One hundred hospitals were selected as 'outstanding' baby-friendly hospitals who play a pioneering role and show an even better performance than the other baby-friendly hospitals. In addition to promoting breastfeeding, baby-friendly hospitals are now also expected to enhance obstetric and paediatric services. Strong improvements on key indicators were recorded after the revision and re-assessments. For instance, at the national level, 66 per cent of births took place in baby-friendly hospitals, 92 per cent of the infants in these were exclusively breastfed during

the hospital stay, and the caesarean section rate was reduced to 35 per cent. The re-assessment raised people's awareness of breastfeeding again, and became the most effective channel to help the health system support breastfeeding.

Challenges

- As the unconditional second-child policy rolls out, health services will deal with a greater number of newborns and older pregnant women with heightened risks of obstetric complications. To cope with increased demand on the health care system, it is essential to improve the management of the BFHI and the capacity of hospitals to provide high quality maternal and newborn services.
- Because there is a large number of baby-friendly hospitals in China, monitoring and re-assessment are a challenge. Nevertheless, monitoring is the key to ensure the quality of care provided at baby-friendly hospitals. Health departments at all levels have a responsibility to conduct supervisory visits, and must increase their capacity for monitoring the BFHI.

Lessons learned and recommendations

- Decentralized management of the revision and re-assessments proved crucial for its implementation. Provinces have also developed workplans for regular follow up to the BFHI.
- Implementation of the BFHI in China was closely linked to strengthening the health system and facilities. This included efforts to improve hospital management, optimize service flow, establish an expert team to provide technical guidance, and strengthen routine and long-term supervision. Assessing and improving public satisfaction was also a critical element of the BFHI re-assessment programme.
- Linking the implementation of BFHI to staff and hospital performance evaluations has been an effective strategy. Key indicators such as the caesarean section rate and the prevalence of breastfeeding are included in the annual management targets for hospitals and the quality performance evaluations of departments. They are linked to the incentive mechanisms of health workers to motivate them as much as possible to promote breastfeeding and natural delivery.
- Innovative and personalized services are encouraged to meet the emerging and unique needs of mothers. For example, maternal and child hospitals used the Internet to improve service flow and provide health education and counselling. Health education facilities and health counselling are provided at the waiting area, fetal heart rate monitoring rooms and maternal schools. Also, more individualized and quality maternal and child care services are available through specialized clinics for second births, high-risk pregnancies clinic, high-risk children, breastfeeding counselling, etc.

Recommendations for global BFHI guidance

- Encourage more paediatric hospitals to apply for baby-friendly status, since sick children need breastfeeding even more.
- Baby-friendly hospitals need to provide services such as counselling and a hotline, and conduct mobilization on exclusive breastfeeding in the communities.

Acknowledgements
Authors and contributors: Cao Bin and Liu Wei, National Health and Family Planning Commission; Suying Chang and Robert Scherpbier, UNICEF; Xu Yiqun, National China Women and Children Center, China Centre for Disease Control and Prevention; Fan Chaoyang, Capital Institute of Pediatrics; Also acknowledged are: Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Mary Ann Perkins. Design: Nona Reuter.

The Baby-friendly Hospital Initiative in Ghana

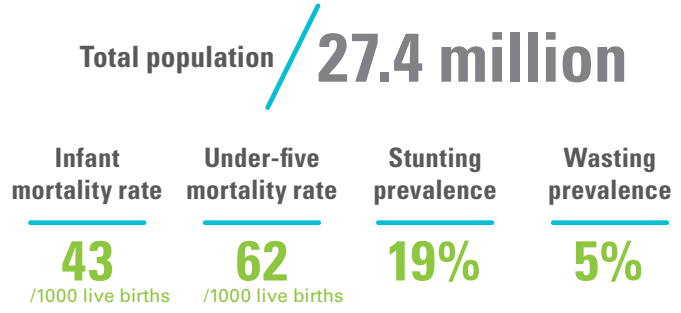
Promoting children's right to appropriate breastfeeding practices

Country and policy context

Ghana is among the few sub-Saharan countries that have attained the Millennium Development Goal targets on poverty and food security. In the last decade, key maternal and child health outcomes improved significantly *(see Figure 1)*.

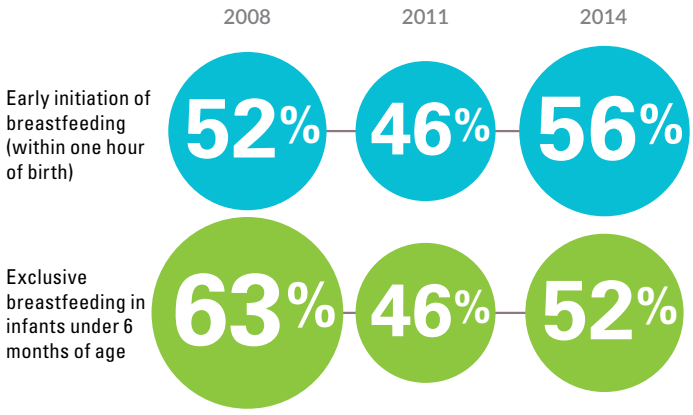
Currently, excluding Community-Based Health Planning and Services compounds, there are 1,527 health facilities providing maternity services throughout the country (data on private facilities are not available).

Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on DHS 2014.

Figure 2: Key national breastfeeding indicators



Source: Demographic and Health Surveys, 2008, 2011, 2014.

Mother and child in Volta Region. Photo credit: UNICEF Ghana.

Virtually all children (98 per cent) are breastfed (DHS, 2014). After increasing breastfeeding rates, a reduced investment in breastfeeding promotion and support caused early initiation and exclusive breastfeeding rates to decline as reflected in the 2008 data *(see Figure 2)*. Since 2011-2012, investments in a comprehensive infant and young child feeding (IYCF) support package to complement the BFHI increased, leading to a reversal of the downward trend.

Beginning in the early 1990s, Ghana demonstrated strong political will to promote, protect and support optimal breastfeeding. This is evidenced by the policy and strategy documents developed to guide programmes such as the Safe Motherhood Protocols, Newborn Care Guidelines, Infant and Young Child Feeding, and HIV response.

Case study methodology

This case study report is based on evidence gathered in June and July 2016 using three main approaches: desk review of relevant literature; interviews with key informants; and site visits to three facilities [two in Greater Accra (Maamobi Government Hospital, Korle-bu Teaching Hospital) and one in the Central region (Nyanyano Health Center)] to observe BFHI implementation.

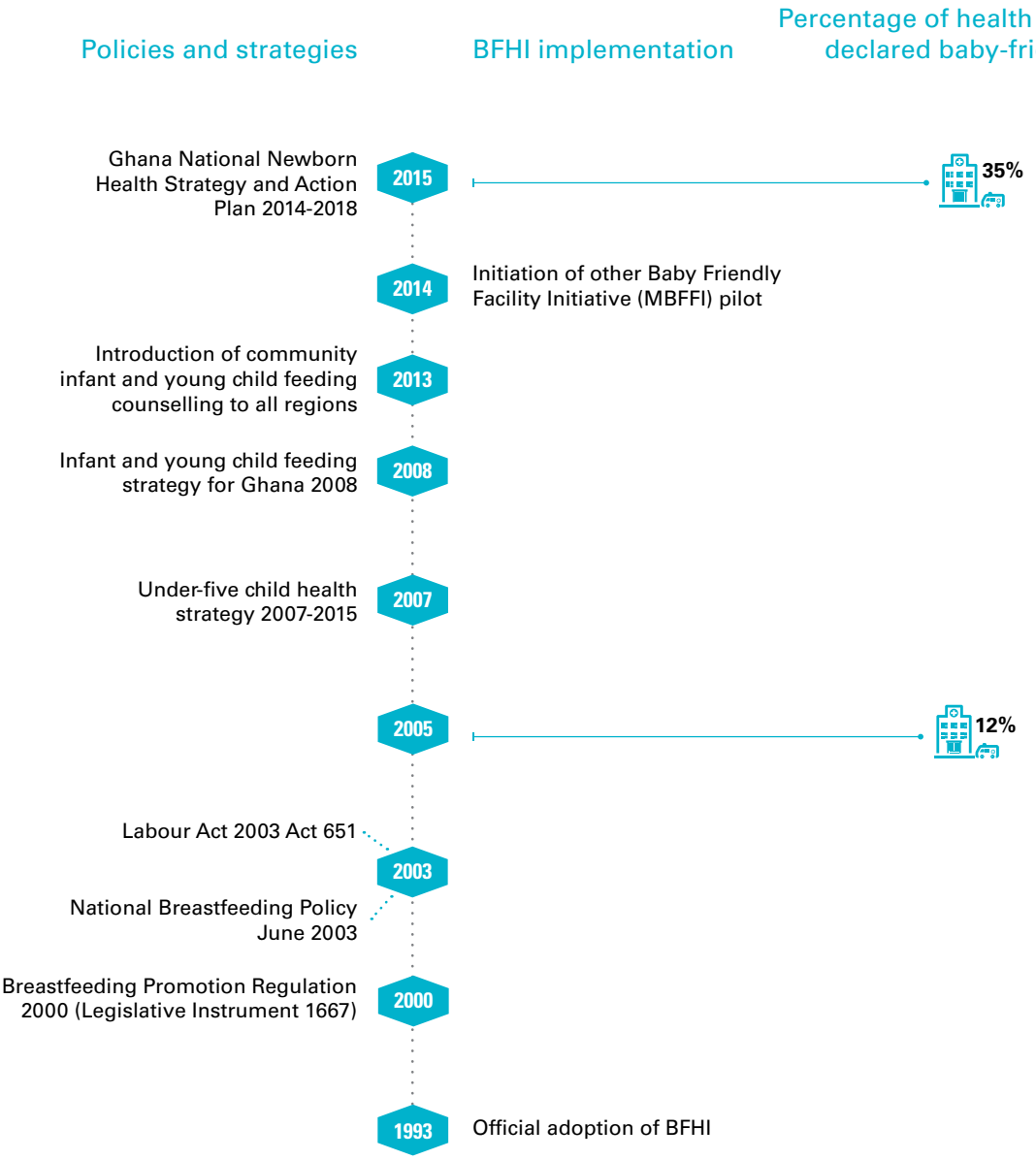


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

Enabling environment

Implementation of actions for breastfeeding protection, promotion and support in Ghana are supported by various national policies and strategies *(see Figure 3)*.

Overview of BFHI implementation

Since the 1980s, the Ghana Infant Nutrition Action Network, a civil society organization, has championed breastfeeding and played a key advocacy and watchdog role.

In 1991, UNICEF commissioned an assessment of breastfeeding practices in Ghana. Findings showed that although breastfeeding was universally practiced, rates of early initiation and exclusive breastfeeding for six months were low, while bottle feeding was common. In response, the National Breastfeeding Authority (NBA) was established to coordinate efforts to close the gaps in breastfeeding. It supported the development of the National Legislation to Promote Breastfeeding, advocated against violations of the Code of Marketing of Breastmilk Substitutes (BMS) and organized the World Breastfeeding Week celebration. These activities were implemented in collaboration with UNICEF, the World Health Organization (WHO), the Ghana Employers' Association, the Paediatric Society of Ghana, and the Ministry of Health (MOH).

In 1993, Ghana began implementing the BFHI with technical and financial support from UNICEF, in collaboration with the Ghana National Commission on Children. Led by the Reproductive and Child Health unit of the MOH this team was responsible for organizing training for national BFHI trainers and assessors. It also coordinated the preparation and assessment of facilities leading to designation, and routine monitoring and quality assurance; all in consultation with the NBA. Supervised by NBA, the MOH led the process of designating baby-friendly facilities. Each facility conducted an initial self-appraisal, followed by pre-assessment by the regional monitoring team, and finally the external assessment.

The lack of systematic re-assessment of facilities was a key weakness in implementation. In 2014, the designation process was decentralized to the regional level and required external assessments of facilities, carried out by trained regional assessors. To ensure the success of this approach, more regional master trainers (five per region) and assessors (four per region) were trained in 2015 for each of the 10 regions. Re-assessment exercises in 2015 showed that some facilities maintained the standards, but the performance of a few facilities had deteriorated and no longer qualified as baby-friendly.

In 2014, the MOH initiated, with support from the Bill and Melinda Gates Foundation and through UNICEF, a three-year pilot in the Upper East Region Mother Baby Friendly Facility Initiative (MBFFI) as part of National Newborn Strategy. The MBFFI supports the development of Every Mother Every Newborn quality standards for pregnancy and newborn care, and uses a quality improvement approach. The pilot will inform the scale-up of MBFHI across the health system in the country.

BFHI implementation has focused on public sector health facilities. To increase designation, the Ghana Health Service is currently collaborating with the NHIA to integrate BFHI into standards for credentialing facilities reimbursed by reimbursed by NHIA. The credentialing process will thus be based on assessment standards including components of the BFHI Ten Steps to Successful Breastfeeding.

Key achievements/results

Over the past 10 years, the number of maternity facilities designated as baby friendly has increased from 189 in 2005 to 538 in 2015 (out of 1,527 maternity facilities). However, there is wide regional variation in coverage. The Upper East Region has the highest proportion (74 per cent) of designated facilities and Greater Accra the lowest (17 per cent). Of these, an estimated 10 private facilities in the Ashanti Region have been designated baby friendly.[1]

Challenges

- Staff capacity: Most health facilities have no procedure to deal with staff turnover, transfer of roles and responsibilities. Although there are few champions for breastfeeding at the health facility level, standards are not maintained in their absence. Health staff who participate in training activities often fail to implement the cascade training needed to build the capacity of other staff. Health staff reported low motivation to take on BFHI actions in addition to their other duties.
- Complacency and limited funding: Reduced funding from UNICEF in the early part of 2000 following the initial successes in breastfeeding and BFHI implementation slowed down the momentum that was required to sustain BFHI implementation, thereby creating gaps. However, with funding support from Global Affairs Canada, UNICEF has supported the Ghana Health Service with funding and technical support to revitalize BFHI implementation through training of health staff on lactation management and code monitoring, as well as assessments of health facilities. However, implementation gaps still exist due to government's inability to provide sustainable funding over time.

- Vertical and centralized implementation: Efforts of Public Health Nurses to support breastfeeding mothers are often negated by paediatricians who recommend BMS when mothers complain of having too little milk.
- Centralized processes for implementation (training, assessment, monitoring) were slow and delayed scaling up, facility monitoring and quality improvement. Decentralized training has been implemented to resolve this challenge, but there is no evidence yet of its effectiveness.
- Viability of mother support groups: Although Ghana implemented a policy of community peer support, the strategy of forming entirely new caregiver groups proved unsustainable in the absence of financial incentives for attendance.

Lessons learned and recommendations

- Advocacy, champions and leaders: Identifying and training facility leaders stimulated facility-level leadership and support for BFHI. In some regions with high coverage, facility and district public health officials translated training into action. In the Eastern and Upper East Regions, some of these managers became breastfeeding champions and were instrumental in keeping breastfeeding high on the public health agenda, which contributed to high BFHI coverage rates.
- The World Breastfeeding Week was a useful platform to advocate for optimal breastfeeding to the public.
- Civil society groups were supportive of BFHI implementation and strengthening in specific regions.
- Community peer support: Existing groups organized around occupation, religion, ethnicity and others issues are already intrinsically motivated to meet and work together and can be leveraged to support breastfeeding. Forming totally new groups raises the issue of unsustainable and non-feasible financial incentives.

Recommendations for global BFHI guidance

- Improved child care practices relating to breastfeeding requires that each health professional should have skills to promote, support and protect breastfeeding.
- Adopt a long-term measure such as pre-service training to ensure health staff have adequate capacities in breastfeeding promotion, support and protection.
- Short-term health staff capacity building like in-house training sessions are less expensive and divert less staff time from clinical tasks. Training must include decision-makers and clinical and administrative staff for maximum effect. Decentralization of training and assessment can accelerate coverage and integration into existing programmes.
- Funding diversification and partnerships: BFHI can be resource intensive; plan for a diversified funding mechanism particularly direct support from the Government and the private sector. Fostering collaboration with the private sector is needed to protect, promote and support breastfeeding. This can be achieved through partnerships between the Government and key civil society organizations.
- To increase BFHI coverage, expanded access to other facilities where women give birth, especially in communities which lack hospitals and maternity facilities is required.
- Sustained monitoring and assessment: A broad-based sustainability plan for the BFHI programme should include robust monitoring and assessment. The outcomes of routine re-assessments, reported as part of an annual breastfeeding score card, may be presented at sub-national review to foster healthy competition and sustain high standards.
- Performance appraisal for directors of health services at sub-national levels should include indicators of BFHI coverage and quality to increase accountability.

Acknowledgements

Authors and contributors: Esi Amoaful, Isabella Sagoe-Moses, Gifty Margaret Donkor, Eunice Sackey, Christiana Annoh and Paapa Larbi Debrah, Ghana Health Service; Vivian Addo-Cobbiah, National Health Insurance Authority; Veronica Gomez, Ghana Infant Nutrition Action Network; Gabriel Ganyaglo Solace Goka, Korle-Bu Teaching Hospital; Gifty Tabi, Maamobi Government Hospital; Madam Adam, Nyanyano Health Center; the Head of Public Health, Korle-Bu Teaching Hospital, the Greater Accra Regional Director of Health Services; Central Regional Director of Health Services; Richmond Aryeetey, consultant; Ernestina Agyepong, Nutrition Association of Ghana; Lilian Selenje and Theodocia Ofosu-Appeah, UNICEF Ghana; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Mary Ann Perkins. Design: Nona Reuter.

Endnotes

1 Information provided on private facility designation is anecdotal (former national BFHI coordinator); records on this are not immediately available.

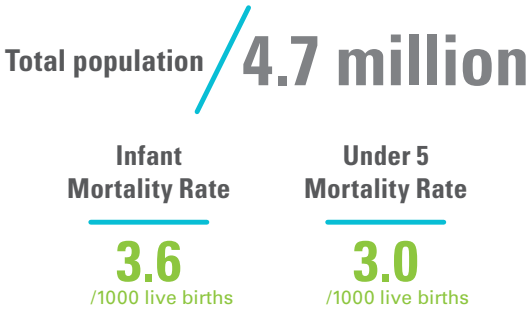
The Baby-friendly Hospital Initiative in Ireland
A health promotion and quality initiative

This is an edited summary prepared by UNICEF. The full report can be can be found on www.babyfriendly.ie

Country and policy context

The Republic of Ireland (Ireland) has 4.7 million inhabitants with about 66,000 infants born annually. The under-five mortality rate and infant mortality rate are 3.6 and 3.0 per 1,000 live births respectively (*see Figure 1*).

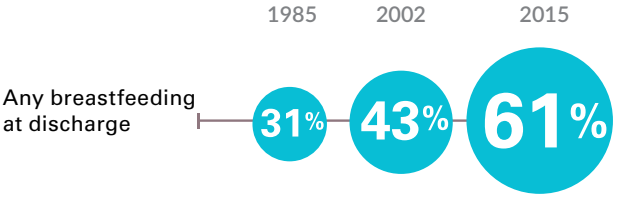
Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015

At present, maternity health care services are provided without charge in public hospitals and private hospitals do not offer maternity care. Home births are available free of charge if strict criteria are met and services are available. The rate of home births decreased from over 30 per cent in 1956 to less than one per cent in 2013. In 2015, 19 hospitals reported births in their facility.

Figure 2: Key national breastfeeding indicator (1985-2015)



Source: Adapted from the National Perinatal Reporting System, Economic and Social Research Institute (ESRI), Health Service Executive (HSE) National Pricing Office, Central Statistics Office, BFHI national coordinator.

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All pregnant women ordinarily resident in Ireland are entitled to free maternity care under the Maternity and Infant Care Scheme. This scheme provides an agreed programme of care provided by a family doctor of choice, under the direction of a hospital obstetrician with hospital midwives providing most of the care. Two post-natal visits to a family doctor are also covered under the scheme.

Case study methodology

Information for this case study was obtained from the records of the Baby-friendly Hospital Initiative (BFHI) national coordinator. Country overview information was provided from government websites or as specifically referenced. A draft case study was shared and discussed with members of the BFHI National Committee.

Enabling environment

At the end of the 1980's, Ireland adopted a voluntary Code which mirrored some parts of the International Code of Marketing of Breastmilk Substitutes (the Code). A code monitoring committee, comprised of representatives from the various manufacturers and distributors of infant formulae and a number of medical, nursing, midwifery and other interested professional bodies, monitored compliance with the voluntary Code. However, artificial feeding company representatives continued to frequently

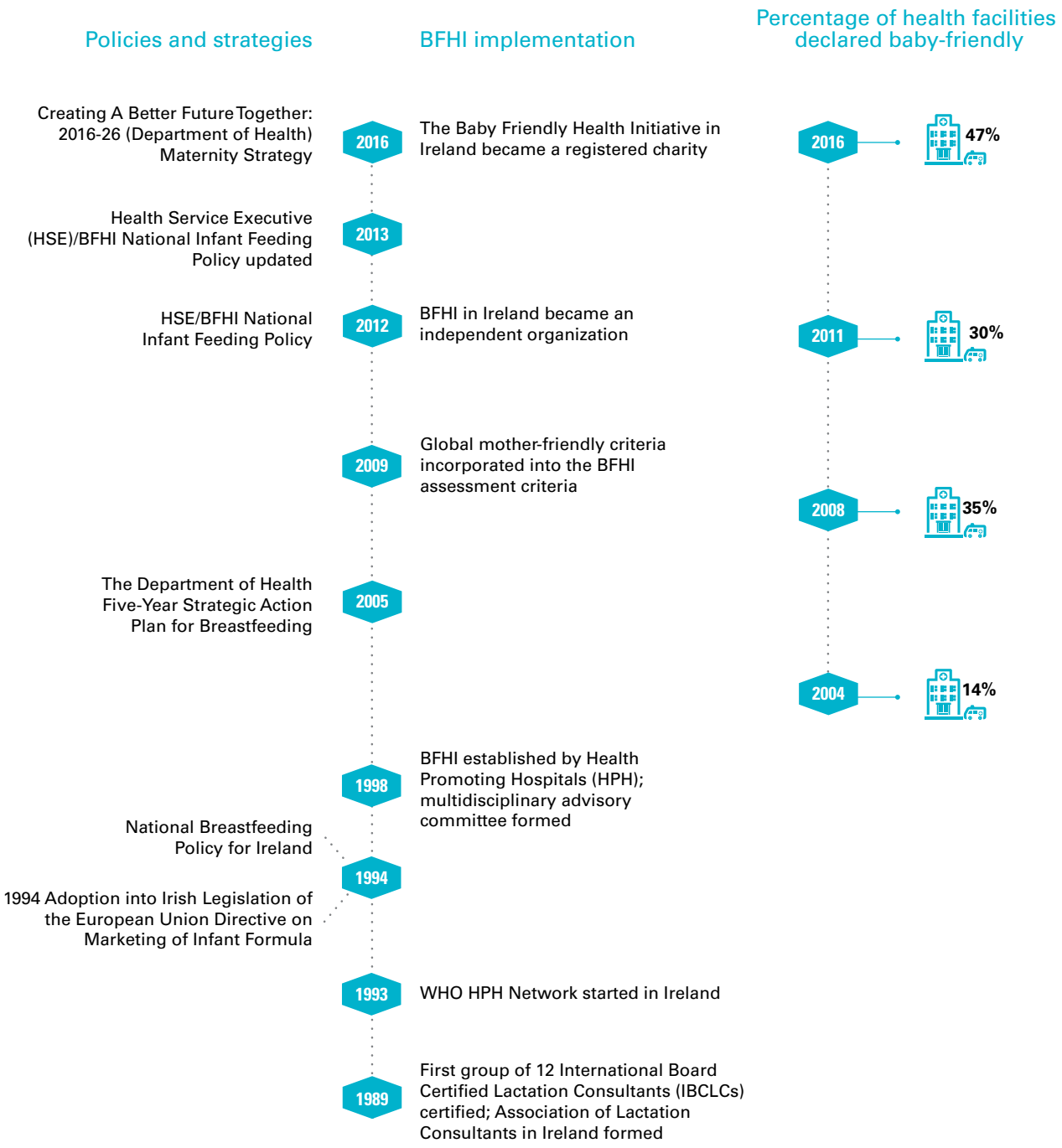


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

visit maternity facilities, providing information and gifts to health care providers. Following the 1986 World Health Assembly (WHA) resolution, provision of free artificial milk and supplies to hospitals ceased. Around the same time, the first group of International Board Certified Lactation Consultants (IBCLCs) in Ireland was certified.

In 1994, the Code was partially implemented into Irish legislation. The Department of Health (DoH) launched the National Breastfeeding Policy in 1994, developed by a multidisciplinary committee including volunteer mother to mother support group representatives. This policy endorsed the Innocenti Declaration and recommended the BFHI be established in Ireland.

In the early 2000's, legislation came into effect for paid lactation breaks until the baby was 26 weeks old. A national breastfeeding coordinator was appointed in 2001. The second national Breastfeeding (Ministerial) Committee formed in 2002 with a Five Year Strategic Action Plan for Breastfeeding developed and launched in 2005. This plan expected all maternity facilities to be working towards achieving baby friendly status. The first national Maternity Strategy was launched in early 2016 and included many references to participation in the BFHI as a best practice standard.

Overview of BFHI implementation

In the early-1960's, breastfeeding was the norm in Ireland. Some maternity hospitals recorded 90 per cent exclusive breastfeeding at discharge. At least one human milk bank operated at the time and rooming-in was usual practice. By the late 1960's, commercially prepared breastmilk substitutes were widely available and the human milk bank closed. Studies indicated breastfeeding rates of 10 per cent in some facilities.

In 1998, the BFHI started under the auspices of the Irish Health Promoting Hospitals Network (HPH). The BFHI advisory committee held its first meeting in June 1998 to discuss the BFHI process, including how to involve hospitals that were currently less interested in improving practices that support breastfeeding. The committee included representatives from the two national voluntary mother to mother support groups: La Leche League and Cuidiu-Irish Childbirth Trust; the Association of Lactation Consultants in Ireland and interested individuals from midwifery education, public health nursing, a paediatrician, IBCLCs from interested hospitals and two members of the HPH national committee.

In the spirit of a network supporting moving in a structured way towards a hospital as a health promoting setting, the BFHI advisory committee instigated a Membership Certificate instead of focusing on assessment. This certificate indicates that the hospital has carried out a self-appraisal and developed at least one structured Action Plan to address a gap, has a named contact person, and agrees to report on their action plan and breastfeeding rates annually to the national BFHI coordinator.

The first two hospitals were designated as baby-friendly in 2004. In 2009, BFHI Ireland integrated the global mother-friendly criteria into the assessment criteria. Efforts were made to blend baby-friendly practices into the national health quality improvement programmes.

In 2005, the Health Service was restructured and several agencies were merged into the Health Service Executive (HSE). As a result, the HPH network became inactive. These changes affected the effective functioning of the BFHI. In 2012, the BFHI in Ireland became an independent organization, funded through annual grant aid from the HSE. This meant that the former advisory committee to the BFHI coordinator needed to become a governance and management committee – and still on volunteer time. BFHI Ireland changed its name to Baby Friendly Health Initiative to allow for future expansion into community health. In 2016, the BFHI National Committee became a registered charitable organization which will allow other sources of funding to be explored as well as being seen as an established organisation. In 2013 and 2014, the BFHI applied for and received financial support from the HSE, however, grants awarded in 2015 and 2016 were insufficient which has restricted activity.

BFHI Ireland uses a model of peer national assessors instead of assessors external to the country, which minimizes costs and ensures that assessors have the contextual and cultural knowledge to support hospitals. Assessors undertake a structured training programme with self-study, observation and supervised practice. A BFHI National Award is given to facilities if the maternity unit fully meets BFHI criteria and adheres to the Code. Facilities are not required to have a rate of 75 per cent exclusive breastfeeding throughout the hospital stay. The Certificate of Commitment, provided to hospitals who had taken a few steps towards achieving baby-friendly status, is no longer being used. Hospitals acquired the certificate but did not take action to implement the remaining criteria and progress to external assessment.

Key achievements/results

The achievement with perhaps the most lasting effect was the development of a BFHI National Infant Feeding Policy adopted by the HSE, applicable to all maternity and neonatal units and which situated BFHI practices as the norm. The number of maternity units designated

as baby-friendly increased from 3 in 2004 to 9 in 2015 (out of 19, equalling 47 per cent). Of these 9 in 2015, 3 are newly designated and 6 re-assessed and re-designated. Ten additional facilities have a Membership Certificate. In 2015, 43 per cent of births took place in one of the nine Baby-friendly hospitals, from 14 percent in 2004.

Challenges

- The BFHI National Committee is an NGO and currently is only responsible for BFHI support, assessment and assisting with on-going monitoring in maternity hospitals/units. The BFHI is managed by a small group of volunteers and a part-time national coordinator. Ireland currently has no national infant and young child feeding strategy or coordination body for infants and young children nutrition which slows widespread protection for practices that support breastfeeding.
- National funding for the types of support the BFHI provides to hospitals is currently provided as a series of short-term grants that need to be re-negotiated annually which makes it difficult to plan a strategy.
- At the facility level, the BFHI competes with many other initiatives for funding, interest and time allocated by hospital managers.
- The BFHI does not have funding to produce their own materials or for a modern media presence to change the narrative on breastfeeding from a choice and benefit to the risks of not breastfeeding.
- At the facility level, inadequate human resources are a challenge to support breastfeeding mothers, attend staff trainings and undertake the on-going monitoring of BFHI practices.
- Marketing of breast milk substitutes is widespread in the media and to community health workers. Government subsidies and financial incentives to the breastmilk substitute industry and limited mechanisms to effectively monitor the Code impedes progress.

Lessons learned and recommendations

- Standards need to be maintained to protect babies and mothers, to value the hospitals that are keeping to standards and to support the importance of the designation. Ensure there is an agreed and written policy and process for hospitals not achieving or not maintaining the standards.
- There is a need for an agreed and written policy and process for hospitals not achieving or not maintaining the BFHI standards and to recognize hospitals that successfully maintain BFHI standards over time.
- Invest in planning and monitoring before the first assessments starts to balance feasibility, availability of assessors, and health facility time for completing documentation and to reduce costs.
- Remind those directing and funding maternal and infant services how the BFHI contributes to the holistic care of mothers and infants. This includes assisting the mother to be confident, skilled and comfortable nurturing her baby. BFHI is also a form of quality improvement, which goes beyond the provision of clinical care alone.
- To keep the BFHI functioning effectively, a sustainable funding mechanism is needed so that hospitals are continuously supported and the national committee can focus on issues other than acquisition.
- National policies and guidelines that include the BFHI as a national initiative rather than a hospital-level initiative should be developed. BFHI should be positioned broadly to complement other programmes and issues gaining attention.
- Highlight to hospital staff and managers how participation in BFHI contributes to continuing professional and personal development with transferable skills and is therefore a valuable use of their time.

Recommendations for global BFHI guidance

Consider fully incorporating baby-friendly practices into routine health worker training, standards of practice, policies and auditing, if feasible, and sustaining and expanding the BFHI as a standard for external monitoring and assessment of quality in maternal, neonatal and child health programmes.

Acknowledgements
This document was written by Genevieve Becker, with contributions from members of the National Committee of the BFHI in Ireland. Also acknowledged are: Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Melissa Theurich. Design: Nona Reuter.

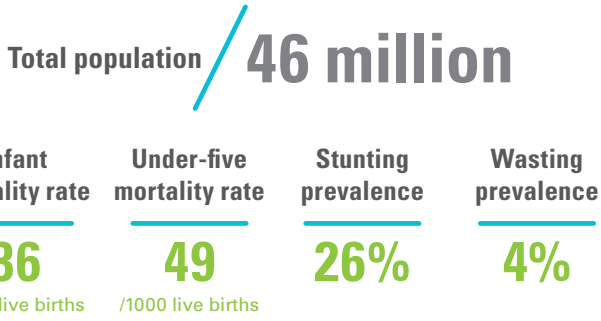
The Baby-friendly Hospital Initiative in Kenya

A Silver Jubilee—a reason to revitalize the BFHI

Country and policy context

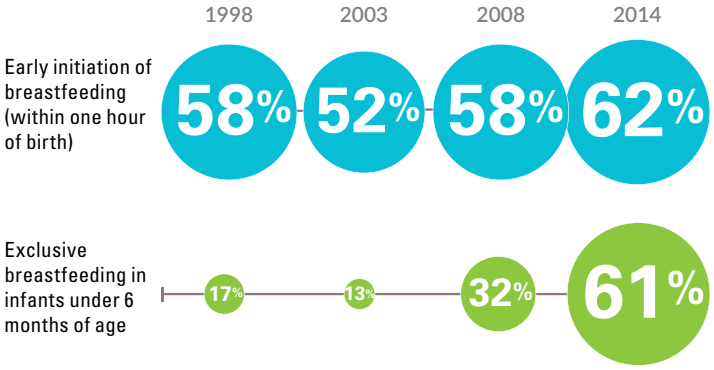
In recent years, evidence-based policies such as free maternity services have resulted in significant improvements to health outcomes in the country. The under-five mortality decreased from 115 per 1,000 live births in 2003 to 49 in 2015. The number of facilities offering maternity services increased from 350 in 1994 to 1,450 in 2010, and as a result, the number of hospital deliveries with a skilled birth attendant has also increased. In rural Kenya, two out of every five mothers (39 per cent) give birth at home.

Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on DHS 2014.

Figure 2: Key national breastfeeding indicators



Source: Kenya Demographic and Health Survey 2008, 2014..

The supervising nurse for the maternity ward shows a new mother the correct way to hold and breastfeed her baby. Garissa Provincial Hospital in Garissa, capital of North Eastern Province. Photo credit: © UNICEF/ UNI115671/Nesbitt.

Breastfeeding practices in Kenya have improved over the last 15 years; exclusive breastfeeding rates increased from 15 per cent in 1998 to 61 per cent in 2014. The rate of early initiation of breastfeeding showed less change however: from 58 per cent in 1998 to 62 per cent in 2014 (Kenya Demographic and Health Survey (KDHS) and *Figure 2*).

Case study methodology

The case study includes a review of relevant documents and write-ups from experts involved in BFHI implementation, as well as an external assessment undertaken in 61 maternity facilities in four provinces (Nyanza, Western, Rift Valley and Nairobi) in 2009. The assessment used the WHO and UNICEF tools and protocols, including key informant interviews, observations and the review of facility data.

Enabling environment

The constitution of Kenya (2010) states that every person has the right to be free from hunger and to have adequate food of acceptable quality and that every child has a right to basic nutrition, among other things.
Much progress has been made in the policy environment for nutrition and

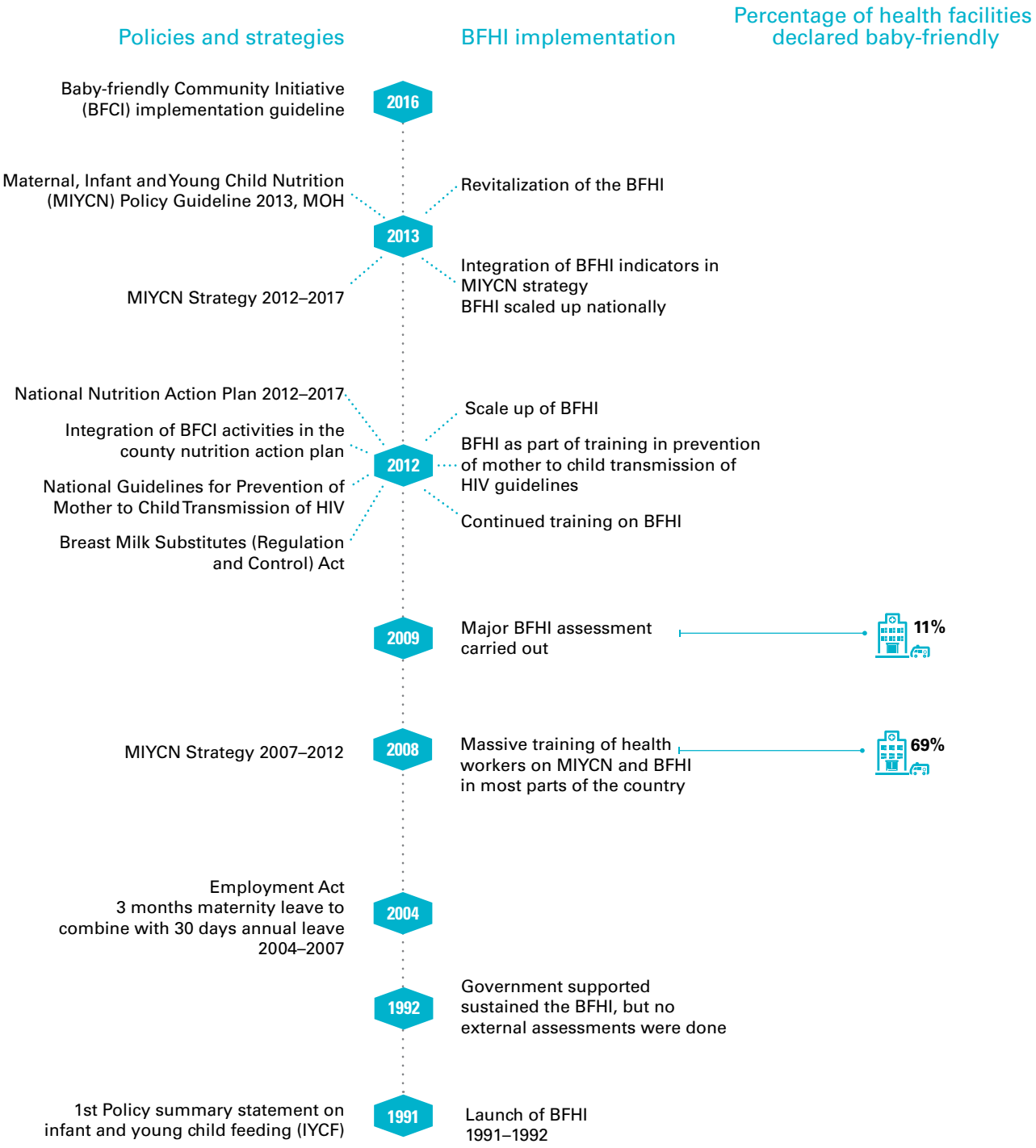


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

breastfeeding in Kenya in the last decade. In 2004/2007, the Government adopted the Employment Act granting three months maternity leave and two weeks paternity leave. In 2012, the Government passed the Breast Milk Substitutes (Regulation and Control) Act and in 2013 the Maternal, Infant and Young Child Nutrition (MIYCN) Policy Guideline and the related MIYCN Strategy 2012–2017. To complement the facility based work and ensure continued breastfeeding support, the country approved the Baby-friendly Community Initiative (BFCI) implementation guideline protocol in 2016 (for a full overview *see Figure 3*). From the 1990s to 2008, infant feeding options for women living with HIV in Kenya were based on individual counselling and assessment of the Acceptable, Feasible, Affordable, Safe and Sustainable (AFASS) criteria. This affected breastfeeding promotion as health workers were careful to allow mothers to choose replacement feeding. In 2010, Kenya adopted the updated WHO recommendations. The country decided to counsel mothers to opt for either breastfeeding plus anti-retro viral treatment or replacement feeding for those who could meet the AFASS (affordable, feasible, acceptable, sustainable and safe criteria). Currently, in accordance with WHO 2016 HIV and infant feeding guidelines all HIV positive mothers are counselled and supported to exclusively breastfeed with appropriate use of antiretroviral treatment.

Overview of BFHI implementation

Kenya launched the BFHI in 1991, and almost immediately thereafter two hospitals (Kenyatta National Hospital and Pumwani Maternity Hospital) were designated as baby friendly.
In 2009, an assessment was undertaken in 61 facilities. This process began with a training of 38 external assessors drawn from both government and non-government organizations on the self-assessment in preparation for the external assessment. The assessment was conducted in four provinces targeting nurses in charge of the maternity, clinical staff, non-clinical staff, as well as pregnant or postpartum mothers and mothers of babies in the special care unit.

Kenya adopted a new system of government that brought new coordination structures into the health sector. At the time of the BFHI assessment in 2009, the coalition government split the Ministry of Health into two ministries: the Ministry of Medical Services and Ministry of Public Health and Sanitation. Counties were created and new staff were deployed who had not been trained in BFHI. Frequent change of leadership in nutrition made it difficult to obtain data and reports. Most programmes were stalled during the handover process and higher priority was given to scaling up programmes in counties. The decline may also be attributed to resource limitations and the challenges in communicating the recommendations for infant feeding in the context of HIV/AIDS.

Key achievements/results

Through extensive training of health care providers coordinated by the nutrition division in the Ministry of Health (MOH) with support from UNICEF and WHO, a total of 242 (69%) of 350 hospitals were designated as baby friendly between 1994 and 2008. The proportion of baby-friendly facilities decreased to 11% in 2010. Of the 61 hospitals assessed in 2009, hospitals in the Rift Valley Province performed better on average with seven hospitals accredited as baby friendly. Only two hospitals were found to be violating the Code.

Rift Valley hospitals performed better than others due to the extensive support for implementation of BFHI following the post-election violence crisis in 2008. This support included a strong component of follow up after trainings on BFHI at individual facilities. Furthermore, managers participated in a one-day orientation meeting and were requested to support the hospital staff in implementing the initiative.
A BFHI coordination committee was formed led by the provincial nutrition officer, nursing officer in charge and clinical officer. The committee offered technical support to the districts and each hospital developed a workplan which was handed over to the province nutrition officer for follow up, supportive supervision and mentorship. The lessons from this assessment were applied to the revitalized BFHI programme.

In response to the findings of the assessment, the MOH has been working on revitalizing the BFHI since 2013 and has addressed some of these challenges using various avenues. The MIYCN Policy was translated into simplified language with pictorials for dissemination in health facilities. The University of Nairobi has integrated BFHI sessions in the post graduate peadiatrics curriculum. The MOH will strengthen the capacity of health workers in 10 of the 47 counties with UNICEF support. These counties will become centres of excellence in the BFHI; other counties can go for learning exchange. The MOH also works with UNICEF in 17 other counties to strengthen BFCI rollout. The Micronutrient Initiative and Maternal Child Survival Programme (MCSP/PATH) support BFCI rollout in another 16 and two non-arid and semi-arid lands (ASAL) counties respectively to strengthen linkages between facilities and communities.

Challenges

- Limited funding from the government for BFHI as resources were primarily allocated to address emergency issues. BFHI is a viewed as a preventive strategy and therefore received less attention and resources.
- Human resources shortages for health have limited the roll-out of BFHI. Kenya has seven nurses per 4,000 residents, half the number recommended by the World Bank. Other health workers usually lack training in BFHI practices and IYCF counselling.
- Linkages between health facilities and local community remain weak, despite efforts to institute BFCI. Although this link has been established through breastfeeding support groups, they are donor dependent.
- Inadequate training on BFHI for newly employed staff- the county government has employed new staff who requires training on BFHI.

Lessons learned and recommendations

- BFHI targets are achievable with adequate resources and consistent follow up and mentorship. Mentorship and supportive supervision are integral to the success and sustainability of BFHI, as demonstrated in the Rift Valley.
- The Government needs to commit resources for the sustainability and widespread promotion of BFHI. The cost of BFHI could be reduced by forming vibrant committees to conduct on-the-job training. Instead of using external trainers, the hospitals could designate in-house instructors with work plans and clear targets.
- Training must begin in pre-service training at universities and middle level colleges and be reinforced through continuous medical education.
- The BFHI trainings need to be revitalized and offered as an independent course separate from the integrated training course on IYCF counselling.
- Influential policy-makers must also receive training so they gain knowledge about the initiative and demonstrate their commitment to promoting and sustaining baby-friendly standards.
- Capacity building and coordination of BFHI activities from the national to the hospital level is key to the success of BFHI.
- Formation of BFHI coordination committees' at all levels of the health system with inclusive membership from all departments caring for infants like maternity, maternal child welfare clinic, paediatric ward, and newborn is critical from the national level to health facilities in the county.
- Capacity building of Ministry of Health staff to conduct external assessments ensures the sustainability of BFHI.
- Developing simplified messages with visual images for low-literacy audiences would help increase awareness of the policy among mothers and health workers. This would complement the efforts made to translate the policy into local languages.
- The community initiative (BFCI) is key to the implementation of Step Ten for the linkages with and continuity of care.

Recommendations for global BFHI guidance

Developing simplified messages and visual images for lay audiences to complement the operational guidance would help to make the policy more easily understood by mothers and community members.

Acknowledgements
Authors and contributors: Betty Samburu and Gladys Mugambi, Ministry of Health, Kenya; Grainne Moloney and Laura Kiige, UNICEF Kenya; Professor Rachel Musoke, University of Nairobi; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Mary Ann Perkins. Design: Nona Reuter.

The Baby-friendly Hospital Initiative in Kuwait

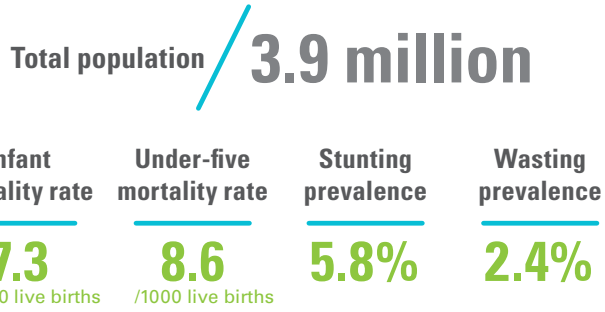
Supporting breastfeeding through in-service training and credentialing

Country and policy context

The population of Kuwait is 3.9 million of which non-Kuwaitis account for more than 69 per cent, while Kuwaitis make up 31 per cent of the population. The under-five mortality rate and infant mortality rate are both under 10 per 1,000 live births (see *Figure 1*).

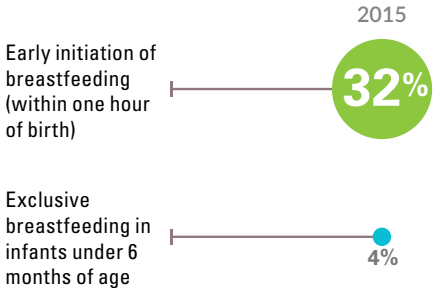
In Kuwait, all citizens have access to free medical care. The proportion of institutional deliveries is 98 per cent and almost all births are delivered by a skilled attendant. At present, there are four public health facilities and twelve private hospitals with maternity services distributed over six health regions. In 2014, there were just over 60,000 births, with half of births in public facilities and half in private facilities.

Figure 1: Key national health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on KNSS 2013-2014.

Figure 2: Key national breastfeeding indicators



Source: Kuwait National Surveillance System 2015.

Lactation Consultants of Adan Hospital Lactation Unit, Ms Shyla Sajumon & Ms Sindu Surendren, supporting a mother to breastfeed her newborn baby exclusively. Photo credit: Dr Azza Tolba.

In 2015, 89 per cent of all Kuwaiti infants were ever breastfed[1]. Due to differing lifestyles and promotion of infant formula, non-Kuwaiti mothers have higher breastfeeding initiation and continuation rates compared to Kuwaiti mothers. Breastfeeding is systematically included in the Kuwait National Surveillance System, which undertakes regular surveys. In the 2015, the survey questions for data collection on exclusive breastfeeding was aligned with the WHO definition. Therefore only this figure is shown and cannot be compared with earlier years *(see Figure 2).*

Case study methodology

This case study was undertaken using a multi-modal approach including literature review, interviews with key stakeholders, self-appraisal reports and visits to the two BFHI certified hospitals in Kuwait. The author collected a variety of policy, practice and observational data, and cross checked and verified data from multiple sources.

Enabling environment

To improve breastfeeding practices in Kuwait, various national policies and strategies to protect, promote and support breastfeeding have been

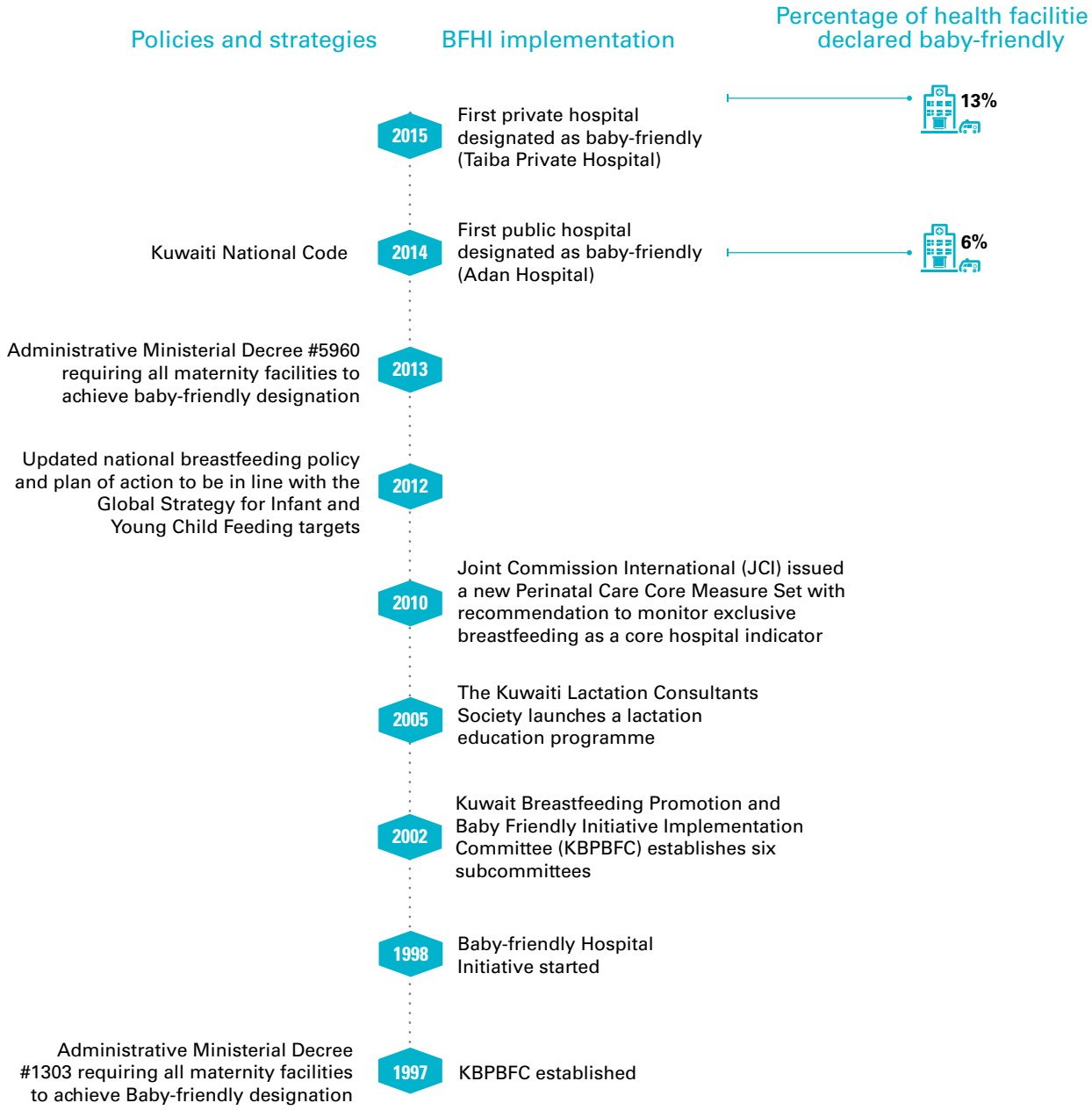


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

enacted *(see Figure 3).* In 1997, the MOH issued an administrative ministerial decree indicating that Kuwaiti maternity facilities are required to achieve baby-friendly designation. In 2013, a second ministerial decree was issued to include private facilities and to strengthen enforcement of the BFHI. In August 2014, Kuwait adopted a comprehensive National Code linked to Law #38 for 2002 on regulating advertising health related items, thereby fully implementing the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly Resolutions (the Code). This code includes enforcement mechanisms and sanctions but it has not yet been implemented.

Overview of BFHI implementation

In 1997, the Kuwait Breastfeeding Promotion and Baby Friendly Initiative Implementation Committee (KBPBFC), a multi-sectorial national breastfeeding committee, was established and led by a national breastfeeding coordinator. This committee provides information, support and assessments for hospitals with maternity facilities and primary health services to implement best practices in infant feeding.

From 1998 to 2004, breastfeeding promotion and BFHI in Kuwait was established. The BFHI began implementation in 1998 and in 2002 the KBPBFC established six subcommittees, representing each health region with a multidisciplinary team. The central committee remains in place with one member from each health region team. This decentralization, coupled with central level support, helped accelerate implementation.

In 2005, the Kuwait Lactation Consultants Society launched a lactation education programme and education on lactation management gradually expanded, despite that the International Board Certified Lactation Consultant (IBCLC) credential was not approved by the Kuwait Institute for Medical Specializations. After two neonatologists from Adan Public hospital achieved the IBCLC credential in 2010, a local lactation training programme for IBCLCs was launched in 2011. The training programme was originally for nurses but has since been expanded to include a wide range of health professionals all over the country.

Since 2011, community support has been an integral element of BFHI in Kuwait and the BirthKuwait group was established as a local non-profit community health network. The group is linked to hospitals and run by trained breastfeeding peer counselors to provide low-cost in-person and on-line breastfeeding support. It also helps build families' awareness about newborn health and nutrition management.

In Kuwait, the Ministry of Health (MOH) manages BFHI certification of individual hospitals, while a national breastfeeding coordinator and the KBPBFC are responsible for coordinating partners and activities. In 2012, Kuwait updated its national breastfeeding policy and plan of action to be in line with the Global Strategy for Infant and Young Child Feeding (GSIYCF) targets and endorsement of the Code is a prerequisite for BFHI designation.

The BFHI assessment is carried out using the updated WHO and UNICEF Global Hospital Assessment Criteria from 2009, adapted for Kuwait in 2010. The BFHI monitoring process includes quarterly and yearly reports, submitted to the KBPBFC higher committee in addition to the data from the Kuwait Nutrition Surveillance System annual reports.

In February 2014, the first public hospital was BFHI accredited and in June 2015, the first private hospital followed. The three remaining public hospitals are working toward BFHI accreditation. While some private hospitals have shown interest in supporting mothers to breastfeed, there has been little progress in achieving baby-friendly accreditation in more private hospitals. The Joint Commission International (JCI) is a non-profit organization that works to improve patient safety and quality of health care by offering advisory services and international accreditation to health care organizations and programs, globally. In 2010, the JCI issued a new Perinatal Care Core Measure Set that included a recommendation to monitor exclusive breastfeeding as a core hospital indicator. JCI has supported monitoring and data collection for the BFHI in Taiba private hospital.

Kuwait has adapted global WHO and UNICEF training packages and used a training of trainers' model to deliver the Decision Maker's Breastfeeding Course and the Breastfeeding Management in a baby-friendly Maternity Facility course. Thereafter, local training teams in all regions conducted several training courses focusing on frontline health staff at public hospitals.

The KBPBFC has strengthened the BFHI process, formed a local team of assessors with a designation system for continuing the reassessment and expanded the designation process. To accelerate these efforts, the government requested support from the Breastfeeding Education Support and Training Centre (BEST Services Centre) in Ireland. Consequently, seven local people were trained as local BFHI assessors in 2010.

The MOH is the main source of funding for BFHI and has allocated a budget to BFHI since 2006. The MOH pays an honorarium to BFHI assessors if they work overtime. Individual hospitals are not charged for BFHI assessments.

Key achievements/results

Two hospitals are BFHI accredited in Kuwait and have successfully sustained accreditation, however, a number of hospitals remain to be accredited. Twelve per cent of births in the country take place in these two hospitals. So far, hospital data from accredited facilities have shown progress in early breastfeeding initiation rates. Al-Adan Hospital, a BFHI accredited hospital showed an increase from 27 per cent early initiation in 1995 to 70 per cent in 2013. Taiba private hospital indicated a rapid increase over a one-year time span, from 50 percent in 2014 to 100 per cent in 2015.

Challenges

- Limited funding and government support for BFHI has hampered scale-up.
- Coordination between national and local authorities should be improved.
- Standards and guidelines about mother-friendly childbirth practices and maternity care are not yet developed, limiting the capacity to reinforce BFHI.
- Despite ministerial decrees to enforce the BFHI, many hospitals do not maintain training. Pre-service practical training of health professionals about breastfeeding and infant feeding issues has not been adequate enough to foster adoption of new practices.
- The BFHI in Kuwait is facing coverage challenges, mainly at the private sector level. Both public and private hospitals and community maternity support services need integration, expansion and strengthening.
- On-going monitoring is a challenge at all levels, including monitoring of the Code.

Lessons learned

- Hospital breastfeeding policies should be communicated to all staff and a team of health professionals should be responsible for implementation of the policy. Posting and publicizing written breastfeeding policies in all hospital labor rooms, postnatal wards, neonatology and out-patient clinics has been shown to be effective. Commitment from both management and frontline staff is necessary so that BFHI policy is reviewed, implemented and monitored effectively.
- Continued advocacy is required to change the behaviour of health staff and parents alike.
- Recognition and appraisal by direct managers has shown to be useful in Kuwait.
- On-going data collection, quality improvement and related activities are vital to ensuring that facilities maintain the high standards of care.

Recommendations for global BFHI guidance

- Ensure sustainability, hospitals should incorporate the BFHI indicators into their hospital quality accreditation systems and collaborate with hospital accreditation bodies. All BFHI quality criteria should be adopted, not only exclusive breastfeeding rates.
- WHO and UNICEF should recommend that member states mandate the implementation of BFHI in public and private hospitals.
- BFHI should be expanded to include neonatology units as well as the community health sector.

Acknowledgements

Authors and contributors: Mona Al Sumaie, Ministry of Health, Kuwait; Niran Alnaqeeb and Shylla Sajumon, Adan Hospital; Aisha John, Taiba Private Hospital; Monica Karen and Elaf Ashraf, Food and Nutrition Administration; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Melissa Theurich. Design: Nona Reuter.

Endnotes

1 Food and Nutrition Administration, Ministry of Health, Kuwait Nutrition Surveillance System Report 2015, Ministry of Health of Kuwait, Kuwait City, 2016.

The Baby-friendly Hospital Initiative in Kyrgyzstan

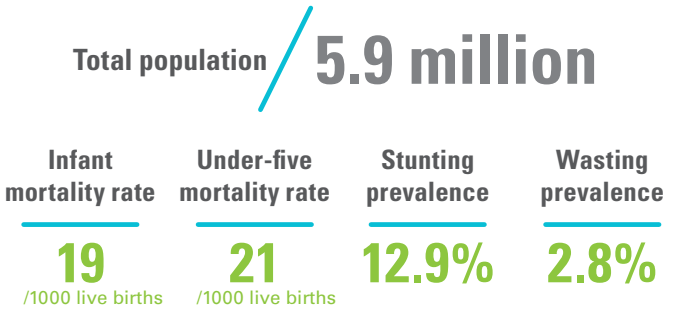
Sustainable breastfeeding outcomes through integration

Country and policy context

Virtually all births in Kyrgyzstan take place in health facilities under the supervision of a qualified midwife. Fifty facilities provide care around birth. The country had 158,756 births in 2014. Caesarean sections are uncommon, constituting 10 per cent of all births. Child mortality has been steadily declining from 65 deaths per 1,000 live births in 1990 to 21 deaths per 1,000 live births in 2015 *(see Figure 1).*

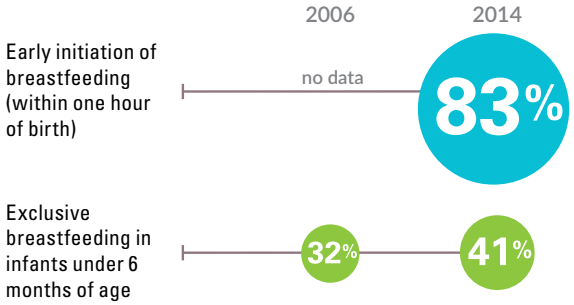
Breastfeeding is common in Kyrgyzstan, with over 80 per cent of newborns initiating breastfeeding within the first hour of life *(see Figure 2).*

Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on Multiple Indicator Cluster Survey (MICS) 2014.

Figure 2: Key national breastfeeding indicators (2006-2014)



Source: Multiple Indicator Cluster Survey (MICS) 2006 and 2014.

A mother with her 3 month old daughter in Osh Family Center, which implements BFHI at primary health care level. Photo credit: UNICEF Kyrgyzstan/Pirozzi.

The rate of exclusive breastfeeding increased from 32 per cent in 2006 to 41 per cent in 2014. Breastfeeding rates vary by region. While the proportion of breastfed infants increased over time, the proportion of breastfed children under two years decreased, due to a significant reduction in breastfeeding in the capital.

Case study methodology

Individuals from government, civil society organizations and the UN conducted a desk review of data from the Republican Medical Information Centre, MICS, DHS and BFHI reports between 2000 and 2015. The group also interviewed key stakeholders from the MOH, BFHI coordinators, USAID/ SPRING and the Civil Alliance for Improvement of Food Security and Nutrition and visited health facilities in Jalal-Abad and Naryn districts.

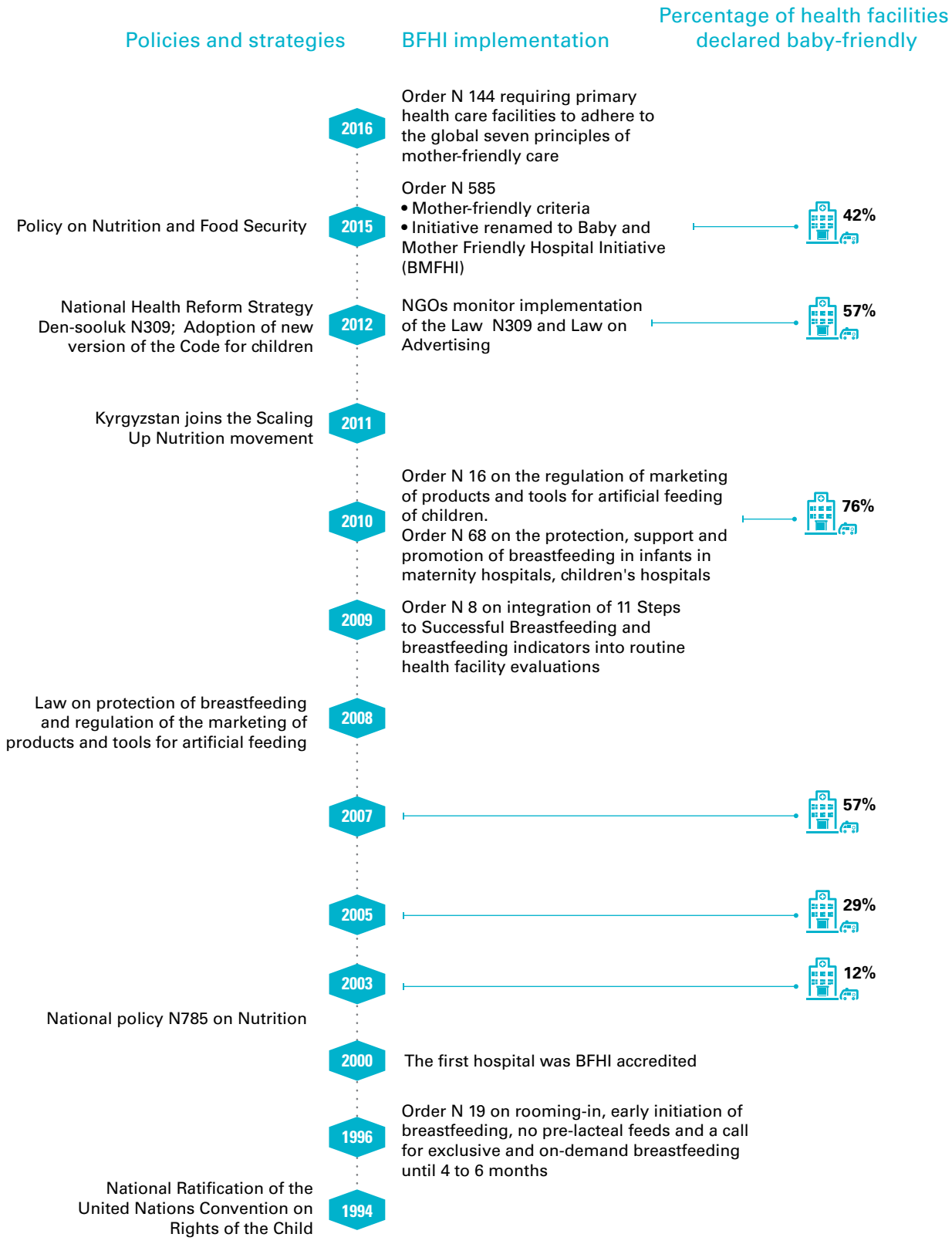


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

Enabling environment

Protection, promotion and support of breastfeeding in Kyrgyzstan is consistent with the Global Strategy on Infant and Young Child Feeding, the International Code of Marketing of Breastmilk Substitutes (the Code) and subsequent World Health Assembly Resolutions. Exclusive breastfeeding has been implemented in health facilities since 1996 following Order N 19 which called for rooming-in, early initiation of breastfeeding with an hour after birth, a ban on feeding the infants prior to lactation and a call to breastfeed exclusively and on demand until four to six months of age.

In 2008, Kyrgyzstan passed a law on the protection of breastfeeding and the regulation of the marketing of products and appliances for artificial feeding of children, which sparked the integration of an Eleventh Step in the BFHI. The following year, Order N 8 integrated the *Eleven Steps to Successful Breastfeeding* as well as adherence to indicators on the prevalence of exclusive breastfeeding (EBF) into routine evaluations of standard practices at health facilities.

To curb the drop in BFHI accredited facilities from 38 in 2011 to 21 in 2015, mostly due to insufficient funding for training and reassessments, the Ministry of Health (MOH) renewed Order N 144 in 2016 and now requires facilities to also adhere to the global seven principles of mother-friendly care. This order has given new life to trainings and has prompted regular meetings with civil society organizations to raise public awareness around breastfeeding.

Since 2011, when Kyrgyzstan became a member of the Scaling Up Nutrition (SUN) movement, the understanding of the importance of multisectoral support to the nutrition interventions has increased in general, and this has also benefitted the multi-sectoral support to breastfeeding. Expansion of the BFHI programme is included in the National Health Reform Strategy Den-sooluk (2012-2018) and the State Program on Nutrition and Food Security (2015-2017).

Overview of BFHI implementation

The MOH has implemented the Ten Steps in Kyrgyzstan since 2000 and the first hospital was BFHI accredited that year. For ten years, the BFHI was fully implemented and 39 maternity houses were certified by 2010.

Between 2010 and 2015, Kyrgyzstan expanded the BFHI to include health facilities providing primary care, children's hospitals and obstetric units and staff in all facilities were trained. Due to insufficient local administrative capacities and numerous new employees that required training, there was a drop in the number of certified facilities. By 2015, 21 of 50 total facilities were certified.

The MOH oversees the BFHI, and has established an expert council for coordination of the BFHI (with 17 members as of 2016). The expert council is headed by the Deputy Minister of Health and is comprised of a wide range of representatives including, but not limited to: chief MOH specialists, heads of paediatric departments of universities, specialists of the National Centre on Motherhood and Childhood Care, national Baby-friendly trainers, the Medical Accreditation Commission (MAC) and the Civil Alliance for Improved Nutrition and Food Security. This council coordinates certification healthcare facilities, monitors compliance to maternal protection laws, reviews breastfeeding promotional materials and approves training programmes. Along with expanding the BFHI to health facilities beyond hospitals, Kyrgyzstan included mother-friendly criteria in 2015, spurring the renaming to the Baby and Mother Friendly Hospital Initiative (BMFHI). An Eleventh Step was included in the assessment criteria to ensure that facilities abstain from accepting free or low-cost breastmilk substitutes (BMS) products or samples. If an infant is born through cesarean section under the general anesthesia, they are put on the partner's chest for two hours and then, unless there are contraindications from the mother or the child, placed on the mother's chest.

Since 2012, civil society organizations have monitored national laws protecting breastfeeding. Measures for repeated violations of the law include withdrawal of the baby-friendly certification. In 2014, violations were reported and results were shared with the MOH, local authorities, civil society organizations and the media, which stimulated awareness of the law. Amendments to the law are drafted and awaiting finalization.

Working committees of Health Organizations (HO) which consist of the heads of neonatal wards, chief nurses and deputy heads at the health facility and headed by a Regional Health Coordinator, coordinate BFHI assessments. An evaluation commission from the Expert Council performs the external assessment; the Expert Council votes on awarding BFHI status to health facilities. Results of the reports are shared by all relevant units of MOH and the Public Health Coordination Unit under the Vice Prime Minister's Office. Re-assessments are conducted every two to three years. Separate from the BFHI external evaluation, health facilities must undergo routine evaluation of standard practices every three years by the MAC. The MAC integrated the Eleven Steps

to Successful Breastfeeding as well as adherence to indicators on the prevalence of exclusive breastfeeding (EBF) at 6 and 12 months of age into its accreditation standards in 2009.

The BFHI in Kyrgyzstan received financial support for trainings, monitoring, assessment and re-assessment from UNICEF up to 2012. Since then, it has been partially supported by the National Den-sooluk Health Program for 2012-2016, and partially by development partners like WHO, UNFPA, UNICEF, World Bank, USAID, German Development Bank and SPRING. A pilot project commissioned by the World Bank aims to include assessment tools for including BFHI elements into the medical accreditation system (MAC) and to provide pre-service training for undergraduate and postgraduate health programmes.

Key achievements/results

The number of BFHI certified facilities has fluctuated over time from a peak of 65 in 2011 to 21 in 2015 *(see Figure 3).* This is primarily due to a decline in the number of re-certifying facilities due to funding and training constraints, which varies by region. In 2015, 21 of the 50 maternity facilities (42 per cent) in the country were certified as baby-friendly, compared to 39 in 2011 (78 per cent). Only 6 of the 21 facilities have been recertified. This translates into 43 per cent of births in the country, down from 65 per cent in 2011. The region of Batken has the highest percentage of certified facilities (5 out of 8, or 63 per cent, 3 of which have been recertified).

Inclusion of the expanded BFHI into the government programmes is a testament to the fact that the Kyrgyz Government recognized the importance of breastfeeding and is committed to it, which could contribute to improved scale up.

Challenges

- Limited financial support, lack of consistent coaching and capacity building, regular internal monitoring and external evaluations contributed to a decrease of BFHI certified facilities.
- Manufacturers and distributors of BMS continue to promote BMS at health facilities.
- National legislation on BMS in the context of HIV is lacking (the government recommends breastfeeding for women who adhere to antiretroviral treatment and provides BMS for women who do not).

Lessons learned and recommendations

- Multi-sectoral commitment, leadership and ownership by local authorities, civil society organizations and hospitals are key to BFHI's success.
- Technical and financial support from government, WHO, UNICEF, USAID/SPRING and other development partners have been crucial to sustaining the BFHI.
- Legal and regulatory support, including the ability to withdraw the baby-friendly title based on compliance with existing laws provides much needed leverage and increases adherence.
- Involvement of civil society organizations, most notably the medical accreditation system, and the Mandatory Health Insurance Fund in monitoring the Law on Protection of Breastfeeding and the Code and BFHI implementation ensures sustainability of the BFHI.
- Civil society organizations should be involved in raising public awareness of the benefits of breastfeeding and giving birth in BFHI accredited facilities.

Recommendations for global BFHI guidance

- BFHI global guidelines should describe specific measures to ensure sustainability in countries with limited resources.

Acknowledgements

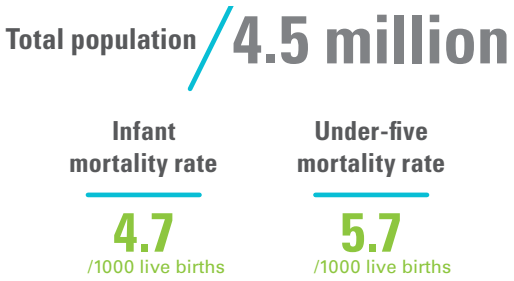
Authors and contributors: Jyldyz Artykbaeva, National MCH Centre; and Tursun Mamyrbaeva, Kyrgyz-Russian Slavonic University; Gulsara Kozhonazarova, Kyrgyz State Medical Academy; Kalida Amanova, Civil Alliance for Nutrition and Food Security; Damira Abakirova, UNICEF Kyrgyzstan; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Melissa Theurich. Design: Nona Reuter.

The Baby-friendly Hospital Initiative in New Zealand
Community involvement as a cornerstone

Country and policy context

According to the Ministry of Health (MOH), there were 61,038 births in New Zealand in 2014. Approximately 96.8 per cent of births took place in medical institutions, while 3.2 per cent took place at home. Almost all births (99.5 per cent) took place with skilled assistance. New Zealand has 73 maternity care facilities.

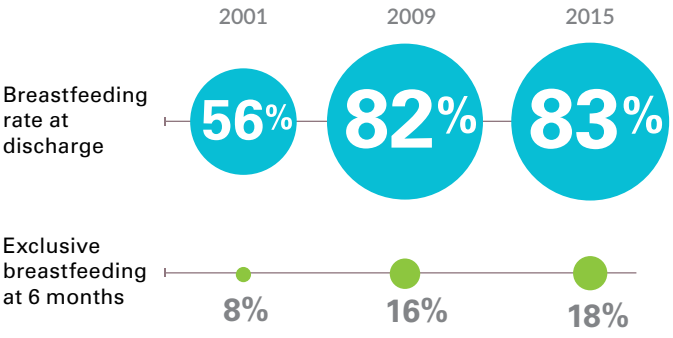
Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015.

Since 2001, exclusive breastfeeding rates at discharge increased from 56 per cent in 2001 to 83 per cent in 2015 and at 6 months from 8 per cent in 2001 to 18 per cent in 2015 *(see Figure 2)*.

Figure 2: Key national breastfeeding indicators (2001, 2009 and 2015)



Source: Data at discharge from New Zealand Breastfeeding Association (NZBA) Maternity assessments/reports (using previous years' data); Ministry of Health Well Child data collection.

Brothers visit mum in the maternity unit to meet their new baby sister. Photo credit: Robyn Greening.

Exclusive breastfeeding rates among Māori, New Zealand's indigenous people, post discharge are significantly lower than the population average at almost 10 per cent at the age of 6 months. Infant formula use is also much higher among Māori people.

Case study methodology

To prepare this case study, a comprehensive review of New Zealand literature and data was undertaken. It draws on information from the New Zealand Breastfeeding Alliance (NZBA), MOH publications and MOH publications and BFI assessment materials.

Enabling environment

Lead Maternity Carers (LMCs) are midwives, general practitioners or specialist obstetricians, who provide care throughout pregnancy and the postpartum period, including the management of labour and birth. The MOH pays for LMCs services with government funds.

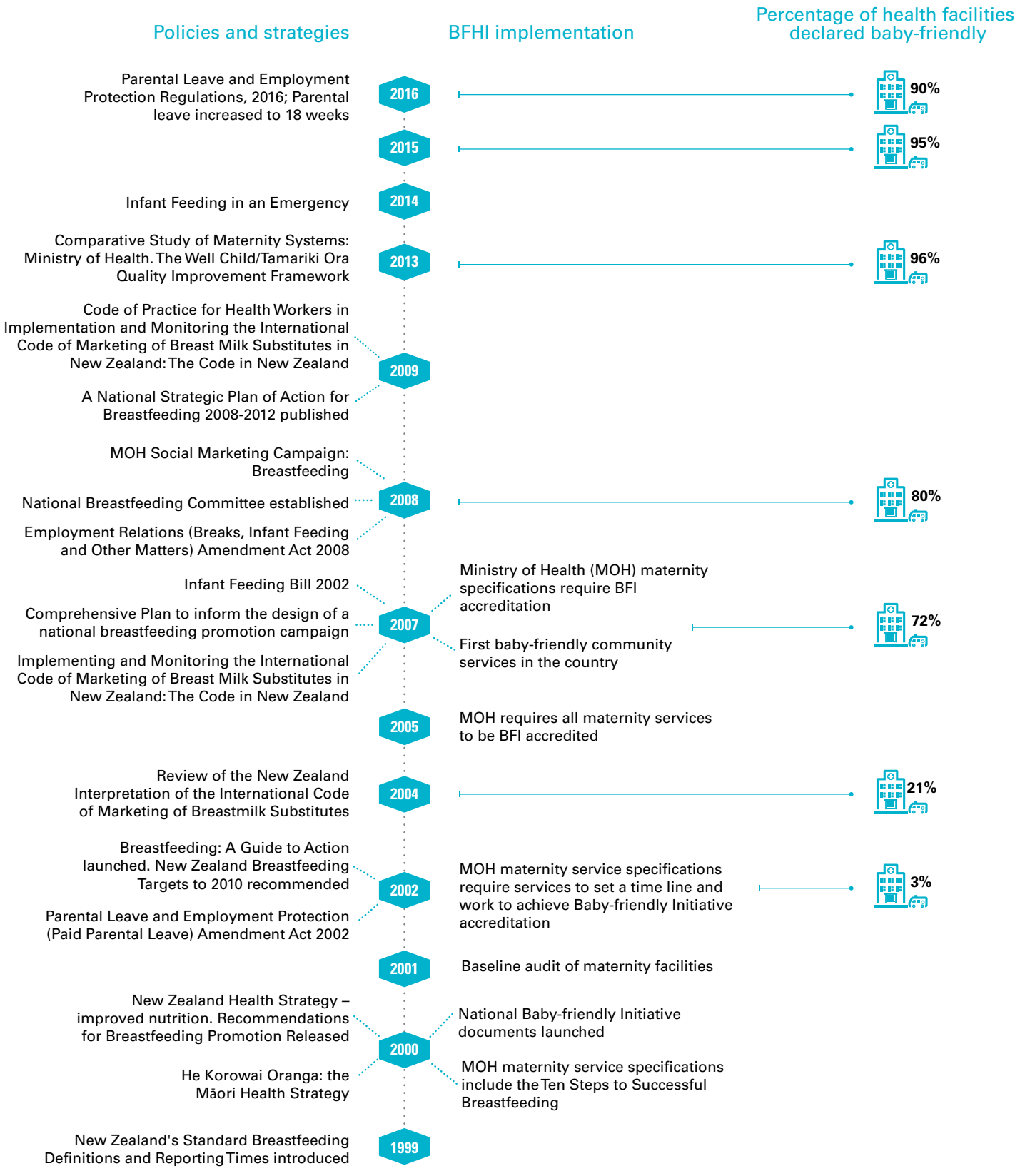


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

All LMCs are required, through their contract and their access agreement with the maternity facility, to support the implementation of the Baby-friendly Initiative (BFI) in New Zealand (the local name for the BFHI).

There are many community groups and organizations that support optimal breastfeeding in New Zealand. Major public policies and strategies are summarized in Figure 3.

Overview of BFHI implementation

In 1998, the New Zealand College of Midwives and key stakeholders formed the NZBA to lobby and improve support for breastfeeding in New Zealand. The NZBA is a coalition of 35 breastfeeding stakeholder organizations, including representatives from hospital maternity managers, midwives, Māori people, Pacific peoples, medical professionals, lactation consultants, dietitians, Plunket, Parents' Centre, La Leche League and a number of child focused non-governmental organizations (NGOs). The NZBA became an incorporated society in 1999 and gained a contract to establish the BFI in New Zealand.

The NZBA adapted the global BFHI guidelines to New Zealand's maternity and health system in consultation with Māori health professionals and consumers, Pacific peoples, health professionals, consumer groups and overseas experts and launched the BFI documents in August 2000. The documents have been updated four times since then, in 2004/5, 2008, 2011 and 2014.

In 2001, the NZBA undertook a baseline audit of 30 maternity facilities prior to accrediting any facility as 'baby friendly'. Findings indicated that of the 25 facilities that collected breastfeeding statistics, only seven achieved 75 per cent exclusive breastfeeding.

The BFHI guidelines for New Zealand have several unique features. The guidelines recognize the Treaty of Waitangi as the founding document of New Zealand and the special relationship with the *tangata whenua* (Māori, the indigenous people of the country). Assessment teams are managed by a lead assessor and supported by a Māori assessor who ensures assessments take into consideration socio-cultural factors and norms and provides recommendations and feedback to the NZBA. Consumers are entitled to informed consent and that is also integrated into the BFI assessments. Consumer participation occurs at all levels of BFHI implementation and includes development and review of BFI guidelines, and consumer membership on the NZBA Board and as BFI assessors.

Lastly, community consultations with local Māori groups, Māori Women's Welfare League, other health providers and groups such as La Leche League are required in the development of a maternity services' breastfeeding policy. As a result, community health needs in addition to breastfeeding can be identified and acted on. In this way, baby-friendly initiatives encompass and model a comprehensive health promotion approach.

Acquiring the baby-friendly designation in New Zealand starts with a self-appraisal conducted by the health facility, followed by an external evaluation. The assessment supports the International Code of Marketing of Breast Milk Substitutes, and the standard for rooming in is 100 per cent (instead of 80 per cent in the global criteria). Maternity facilities pay NZBA for assessments. The fee covers the cost of the assessment as NZBA is a non-profit organization. A pre-assessment visit is offered to new facilities or facilities with a new BFI coordinator free of charge.

In 2006, a National Breastfeeding Advisory Committee (NBAC) was established to advise the Director-General of Health and work with the MOH to develop a national plan for breastfeeding, set priorities for increasing breastfeeding rates, coordinate relevant sector activities and monitor and report on progress in implementing the national plan. The NBAC also advocates for the protection, promotion and support of breastfeeding. Its membership included representatives from the New Zealand College of Midwives, Te Puawaitanga Ki Otautahi Trust, primary care providers, health promotion advocates, hospital maternity services, La Leche League, NZBA and the MOH.

Key achievements/results

Government commitment to the BFI has enabled NZBA to achieve changes in day-to-day practice (such as rooming in, routine skin-to-skin contact) and high levels of accreditation. In 2016, 66 of 73 facilities (primary, secondary and tertiary level) were certified as baby-friendly, which equals 90 per cent of facilities, up from 3.4 per cent in 2002 and 87 per cent in 2009. Ninety per cent of births in the country take place in certified facilities. However, seven facilities have lost their accreditation.

Most notably, the average exclusive breastfeeding rate at discharge for all facilities has reached 83 per cent, well above the global requirement for BFHI accreditation (at least 75 per cent).

Challenges

- Assessments have shown challenges related to the Ten Steps, specifically staff education (Step Two), showing mothers how to hand express (in Step

Five), rooming in (Step Seven), having a policy (Step One) and/or low breastfeeding rates. Re-assessment data show that well over 50 per cent of medical institutions require follow-up work to meet the standards, and standards will slip if monitoring is weak.

- Maintaining adequate funding is a challenge. Reliance on one stream of funding makes NZBA vulnerable to political change. Difficult economic times have reduced the budgets for health services, which has implications for staff numbers, training and assessment fees. To reduce costs, some medical institutions are resisting ongoing maintenance of some BFHI standards, or not requesting re-accreditation.
- Limited authority of the NZBA inhibits accountability. The NZBA has no power to address non-compliance other than to report to the MOH for action.
- Variation in standards for compliance with the International Code of Marketing of Breastmilk Substitutes. This is a voluntary agreement in New Zealand, but the standards are higher under the BFI, which requires full compliance with the International Code and subsequent resolutions of the World Health Assembly. This leads to some confusion for medical institutions.
- Hospital managers are required to achieve BFI accreditation, but their support for BFI implementation is variable. Meanwhile, BFI Coordinators may not have enough time or resources to fulfil the requirements of the position, and the turnover of BFI Coordinators requires additional resources to train new staff for this role.

Lessons learned and recommendations

- Government commitment demonstrated by financial support and favourable policies makes the BFI achievable.
- A health promotion approach focuses on making a difference for the most disadvantaged populations, especially Māori people in New Zealand. An evidence-based assessment and audit conducted prior to implementation provides a baseline to benchmark the changes and measure the effectiveness of the BFHI. The BFI has clearly established, measurable quality standards to facilitate performance monitoring for providers. Reviewing facility staff practice in relation to the Ten Steps and gathering feedback from consumers/women within the assessment process is also a critical component of implementation.
- Maintain the momentum, advocacy and favourable enabling environment for the BFI through the enactment of the Innocenti Declaration strategies, namely the National Breastfeeding Committee and Strategy, Ten Steps and BFI, and protecting the breastfeeding rights of working women (paid parental leave and breastfeeding support in the workplace). Maintain the integrity of the programme by mandatory inclusion of the International Code of Marketing of Breastmilk Substitutes.
- Having a national breastfeeding committee or strategy would reinforce the importance of BFI at all levels of the health system.

Recommendations for global BFHI guidance

- Ensure the entity that manages the accreditation process is free from conflicts of interest and commercial influence. It should periodically review the accreditation requirements to ensure they are consistent with the latest guidance.
- Conduct a country baseline survey and preliminary assessments of a facility before awarding accreditation. This provides an invaluable benchmark to measure the impact of implementing the Ten Steps and BFHI.
- Identify high needs groups, such as ethnic communities, geographically or socio-economically disadvantaged people or those without breastfeeding support. Provide special attention to improving breastfeeding support, protection and promotion, through collaboration, consultation, empowerment and education. Reorient health services to meet community needs, involving consumers, and ongoing support for mothers (breastfeeding or formula feeding) beyond discharge.

Acknowledgements

Authors and contributors: Julie Stufkens and Wendy Scanlon, New Zealand Breastfeeding Alliance; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Mary Ann Perkins. Design: Nona Reuter.

The Baby-Friendly Hospital Initiative in the Philippines

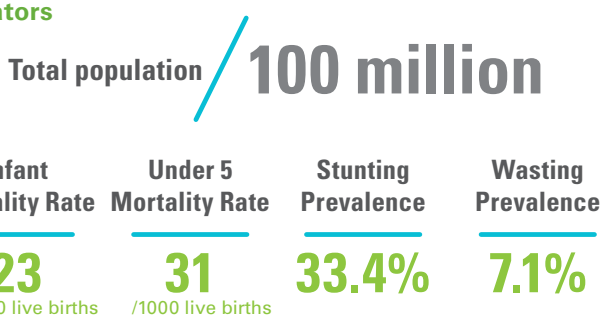
The first embrace of life

Country and policy context

The Republic of the Philippines (the Philippines) has a rapidly growing population of 100 million people. Infant and under five mortality rates and stunting prevalence are high but have been in steady decline over the last decade while the prevalence of wasting has remained relatively stable *(see Figure 1)*.

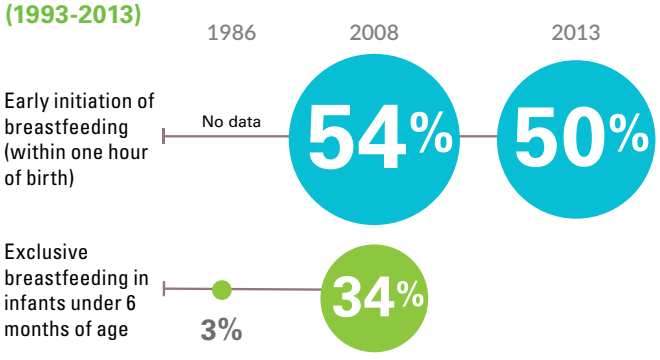
In 2014, there were 1.75 million registered live births. In 2013, approximately 61 per cent of infants were delivered in a health facility and 73 per cent were attended by a skilled-birth attendant. In all, there are 1,164 (407 government, 757 private) licensed hospitals offering maternity and newborn services, while non-hospital facilities number three to four thousand. Breastfeeding indicators have fluctuated over the last decade *(see Figure 2)*.

Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on the 2015 National Nutrition Survey, Food and Nutrition Research Institute.

Figure 2: Key national breastfeeding indicators (1993-2013)



Source: Philippines National Demographic and Health Surveys 1993-2013

A health worker helps a mother position her newborn infant to breastfeed, at the baby-friendly Jose Fabella Memorial Hospital, in Manila, the capital. ©UNICEF/UNI33326/Noorani.

Case study methodology

The authors conducted a desk review of existing national laws, policies, guidelines and protocols on maternal, newborn and child health services, and conducted retrospective analyses of the National Demographic and Health Surveys (NDHS) and National Nutrition Surveys (NNS). They also reviewed Department of Health (DOH) Regional Offices' administrative reports.

Enabling environment

In order to improve breastfeeding practices, various national policies and strategies protecting breastfeeding and recognizing the Baby-friendly Hospital Initiative (BFHI) have been enacted *(see Figure 3)*.

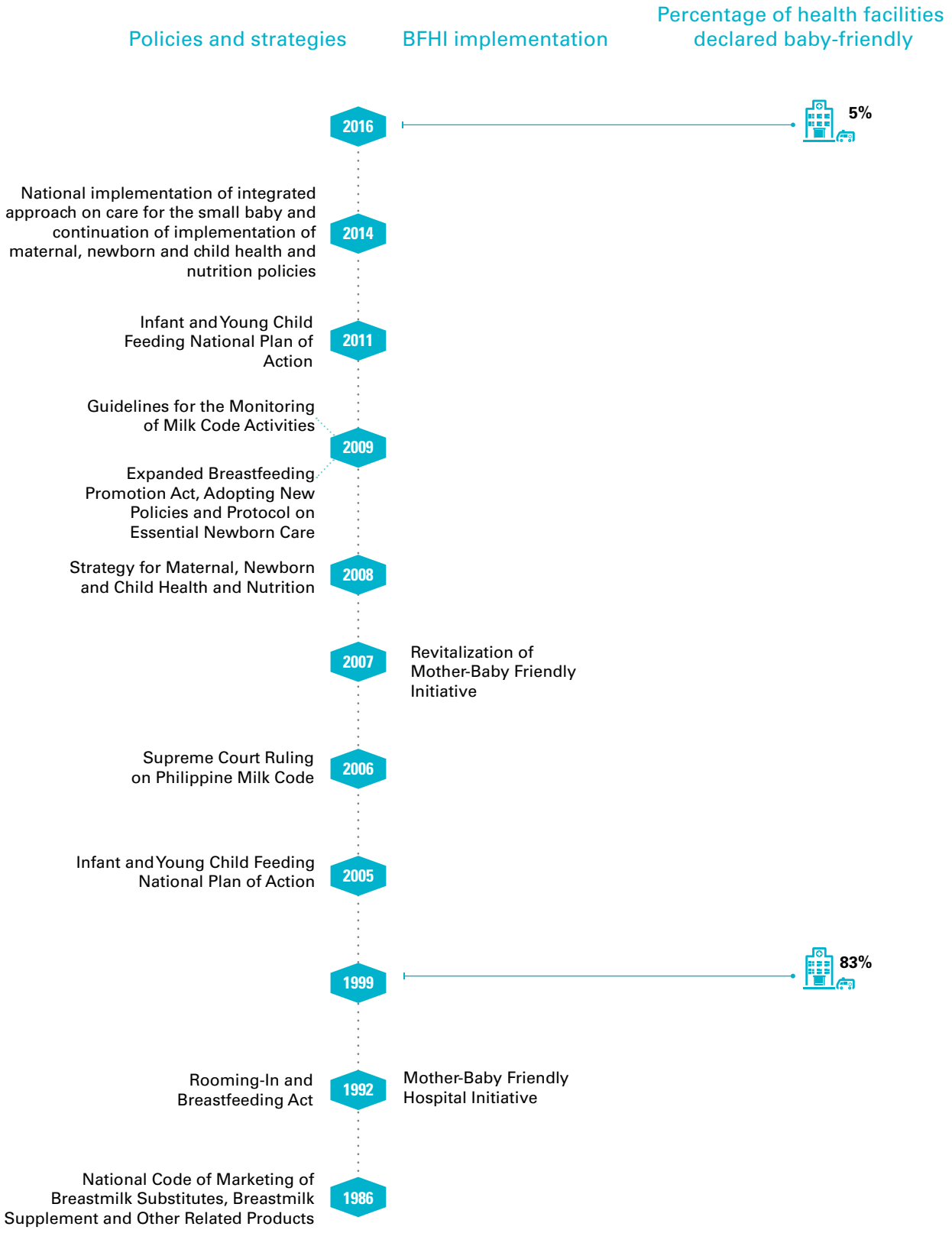


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

Source: Breastfeeding in the Philippines, A Critical Review, World Health Organization Western Pacific Region, 2013,Chaparro, C.; Oot, L.; and Sethuraman, K. 2014. Philippines Nutrition Profile. Washington, DC: FHI 360/FANTA

Overview of BFHI implementation

In the late 1940s, the Philippine health care system adopted international standards for birthing practices including sedation during labor, routine separation of mothers and infants, and the provision of commercial infant formula, including samples from companies.

The movement towards the Mother-Baby-Friendly Hospital Initiative (MBFHI) in the Philippines began around 1975 when a pediatrician began to study patterns of neonatal mortality and morbidity in one Philippine hospital. For the purpose of the study, the hospital discontinued the use of commercial infant formula and prohibit the distribution of free samples, while ensuring newborn infants were not systematically separated from their mothers. These changes resulted in a drop in the number of neonatal sepsis cases and increased the rate of exclusively breastfeeding. Results of the intervention were published internationally in 1982[1] and facilitated the formation of the global BFHI guidelines, demonstrating how in-country experiences can influence global policies.

Despite this evidence, many hospitals did not follow suit immediately. In 1986, the Executive Order No.51, *National Code of Marketing of Breastmilk Substitutes, Breastmilk Supplement and Other Related Products* was signed. Its signing was a landmark achievement for championing breastfeeding in the Philippines and has been instrumental in curbing the illicit marketing of milk formula in hospitals and to health professionals.

The DOH has developed health policies, standards, guidelines and protocols on maternal, newborn, child health and nutrition and oversees the implementation of the MBFHI, which is managed by the National IYCF Programme Manager. At sub-national level, MBFHI is implemented through the DOH Regional Offices. Each regional office assigns a coordinator for the IYCF programme, where MBFHI is an integral part. At the local level, programmes are implemented from the provincial level and reach the cities and municipalities.

Key drivers of the MBFHI include pediatric, obstetric, anesthesia, nursing and midwifery societies and organizations and academia. Policy statements from health professional organizations have been instrumental in obtaining support from members. The MBFHI in the Philippines incorporates both the global Ten Steps to Successful Breastfeeding and the global criteria for mother-friendly care that requires hospital policies to stipulate mother-friendly labour and birthing practices.

In 2008, an outbreak of neonatal sepsis in Manila in which 32 of 35 newborns died became a turning point for health reforms in newborn care practices. A large scale investigation found that newborn deaths were attributed to their separation from their mothers, and not receiving any colostrum.[2] The investigation resulted in the development of the *Clinical Practice Pocket Guide on Care for the Newborn in the First Week of Life.* In 2009, both the Administrative Order *Adopting New Policy and Guidelines on Essential Newborn Care (ENC)* and the *Expanded Breastfeeding Promotion Act* were enacted to amend and strengthen certain provisions of the *Rooming-In and Breastfeeding Act* of 1992. A key feature of this act is the requirement for all workplaces to establish lactation stations and provide lactation breaks for breastfeeding workers.

The DOH plans to integrate training on essential maternal and newborn care with lactation management in 2017. Currently, MBFHI accreditation is a pre-requisite for the Care for the Small Baby training which includes Kangaroo Mother Care (KMC). The MBFHI accreditation process in the Philippines follows the guidelines of the global BFHI where health facilities must pass an external assessment to receive a Certificate of Commitment (COC). After two years, a reassessment is conducted and if the facility has maintained the BFHI standards, they are accredited. Health facilities are reassessed every three years. While it doesn't currently exist, a quality improvement system must be put in place to sustain MBFHI accreditation and encompass other services.

DOH-Regional Offices monitor the MBFHI, however, assessment and accreditation responsibilities have had unstable shifts between various offices. At one point, MBFHI accreditation was linked with the Philippine Health Insurance Corporation (PhilHealth) so that no health facility could become licensed without MBFHI accreditation. A PhilHealth Circular was issued in 2005 providing timelines for hospitals, however, many hospitals did not comply.

In 1992, Republic Act 7600 or the *Rooming-In and Breastfeeding Act,* a landmark legislation which declared the adoption of rooming-in as a national policy to encourage, protect and support breastfeeding was passed. In addition, the Millennium Development Goals (MDGs) paved way for improvement of maternal and newborn survival in the Philippines. More recently, the Administrative Orders, *Implementing Health Reforms for Rapid Reduction of Maternal and Newborn* Mortality (2008) and *Adopting New Policy and Guideline on Essential Newborn Care* (ENC) (2009) have elevated the importance of the MBFHI.

The government of the Philippines and development partners issued the *Revitalization of the MBFHI* in 2007 which stipulated that all health facilities with maternity and newborn services must seek MBFHI accreditation.

Certification as MBFHI is now a requirement for hospital licensing, making the Philippines the first country in the Western Pacific Region to impose such a requirement.

At the national level, government appropriations for MBFHI are focused on capacity development activities, specifically for training of the DOH Regional Offices. The DOH, in partnership with Mother and Child Nurses Association of the Philippines (MCNAP), the Integrated Midwives Association of the Philippines (IMAP) and the Association of Philippine Schools of Midwifery (APSOM), conducts training of trainers for midwives and nurses in birthing facilities. This pool of trainers has been rolling out their training within their various associations. For pre-service trainings, the APSOM has conducted a skills training course for the curriculum integration for their member schools. A harmonized module on basic emergency obstetric and newborn care (BEmONC), including breastfeeding content has also been developed for pre-service and in-service training.

Funding for MBFHI assessments are integrated in the DOH Regional Offices' own budget. Select DOH hospitals receive specific budget allocations from the government for the delivery of training services on lactation management.

Key achievements/results

MBFHI in the Philippines reached a peak in the late nineteen nineties, when the DOH certified 1,427 or 83 per cent of targeted facilities. Currently, of 2,063 health facilities, 102 have active accreditation (5 per cent), while 61 hold a certificate of commitment. A total of 834 facilities, which represents 40 per cent of all facilities covered by the reports, never applied for accreditation.

Challenges

- Limited personnel for periodic monitoring and evaluation activities at national and regional offices and assessment of uncertified or currently certified health facilities.
- Turn-over of technical health staff due to mandatory retirements, transfer to other offices, and resignations.
- Competitive prioritization of other national health programmes by upper management in the DOH for implementation by staff trained on the MBFHI.
- Routine data collection of the number of health facilities certified and implementing MBFHI is not done regularly due to programme management shifts from one office to the other. This makes MBFHI assessments a challenge. This has been a lack of appropriate MBFHI guidelines for non-hospital-based facilities.
- Backing and financial support from local government and administrators to expand MBFHI.

Lessons learned and recommendations

- There is a need for a unified approach to integrate trainings and ensure that post-training and post-certification or accreditation activities sustain progress made and avoid duplication of efforts. MBFHI has overlaps with various national governmental health programmes like lactation management training, basic emergency obstetric and newborn care (BEmONC), essential intrapartum and newborn care (EINC), KMC and Care for the Small Baby. Participants come from the same departments or the same group of committee members.
- Rather than solely relying on external training courses for their health care staff and providers, the use of coaching, mentoring and supportive supervision methods can be a realistic and practical approach to reinforce skills and ensure continuity. Self-sufficiency for institutional capacity development requires a counterpart effort from the sending institution to sustain their investment.

Recommendations for global BFHI guidance

- Maintain the mother-newborn dyad as the focal point for the Ten Steps.
- A change in terminology to "Mother and Baby Friendly Facility Initiative" to be more inclusive and reflect both mothers and babies and to encompass all types of health facilities.
- Provide guidance for obtaining "buy-in" at decentralized levels of government.
- Give clear guidelines on monitoring of previously certified health facilities.
- Include a quality improvement system or mechanism to sustain post-training and post-certification activities.

Acknowledgements

Authors and contributors: Anthony P. Calibo and Ana Epefania Escober, Philippine Department of Health; Maria Evelyn Pionilla Carpio and Janice Datu Sanguyo, UNICEF Philippines; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Melissa Theurich. Design: Nona Reuter.

Endnotes

1 Clavano, N., 'Mode of Feeding and its Effect on Infant Mortality and Morbidity',*Journal of Tropical Pediatrics*, vol. 28, December 1982, pp.287-293.

2 Sobel, H., et al., 'Immediate newborn care practices delay thermoregulation and breastfeeding initiation', *Acta Paediatrica*, vol. 100, no. 8, August 2011, pp. 1127–1133.

The Baby-friendly Hospital Initiative in Saudi Arabia
Focus on the Ministry of National Guard

Country and policy context

Saudi Arabia has just over 30 million inhabitants, one third of whom are foreign nationals. Each year, about 600,000 babies are born in the country. The Ministry of Health (MOH) has the overall oversight over health facilities and is directly in charge of 1,030 primary health care (PHC) facilities and 415 maternity facilities, other ministries also provide health services. These include the Ministry of National Guard-Health Affairs (MNG-HA), which operates 20 PHC facilities and five maternities in five medical complexes called 'medical cities' (in Dammam, Ehssa, Jeddah, Madinah and Riyadh). The priority of MNG-HA is to serve the military population, but it also serves non-military patrons.

Figure 1: Key national child health and nutrition indicators

Total population 31.5 million

Infant mortality rate	Under-five mortality Rate	Stunting prevalence	Wasting prevalence
12.5 /1000 live births	14.5 /1000 live births	9.3%	11.8%

Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on Growth charts for Saudi children and adolescents, 2007 (data from 2004-5).

Information about breastfeeding practices in Saudi Arabia is available from several studies. The studies use different definitions of indicators. There appear to be large regional varieties in breastfeeding practices. Reported initiation are often above 90 per cent, but timely initiation (within one hour) was low in some studies. Exclusive breastfeeding rates varied from about 1 per cent to about 44 per cent (with varying definitions and study designs). The mean duration of breastfeeding has declined from 13.4 months in 1987 to 8.5 months in 2010.[1]

Breastfeeding counselling visit at a National Guard Maternity Clinic, Ministry of National Guard.

Case study methodology

The methodology included a review of documents and data collection through questionnaires and semi-structured discussions with stakeholders. The evaluation followed an audit checklist and action plan and assessed accredited baby-friendly facilities, including one certified hospital with maternity and birthing services and four PHC centres with maternity services without birthing services. The evaluators adapted the audit checklist based on the global BFHI criteria (revised 2009).

Enabling environment

Saudi Arabia has enacted various laws and policies to support women to breastfeed, including the implementation of the Baby-friendly Hospital Initiative (BFHI) and efforts to comply with the Ten Steps to Successful Breastfeeding (*see Figure 2*). National legislation allows 10 weeks of paid maternity leave for women working in the public sector and provides for worksite accommodation for breastfeeding and/or child care in the formal sector. Private sector employers are obligated to provide eight weeks of paid maternity leave and a one-hour break for lactation during working hours. Legislation prohibits employment discrimination and provides job protection for women workers during the breastfeeding period.

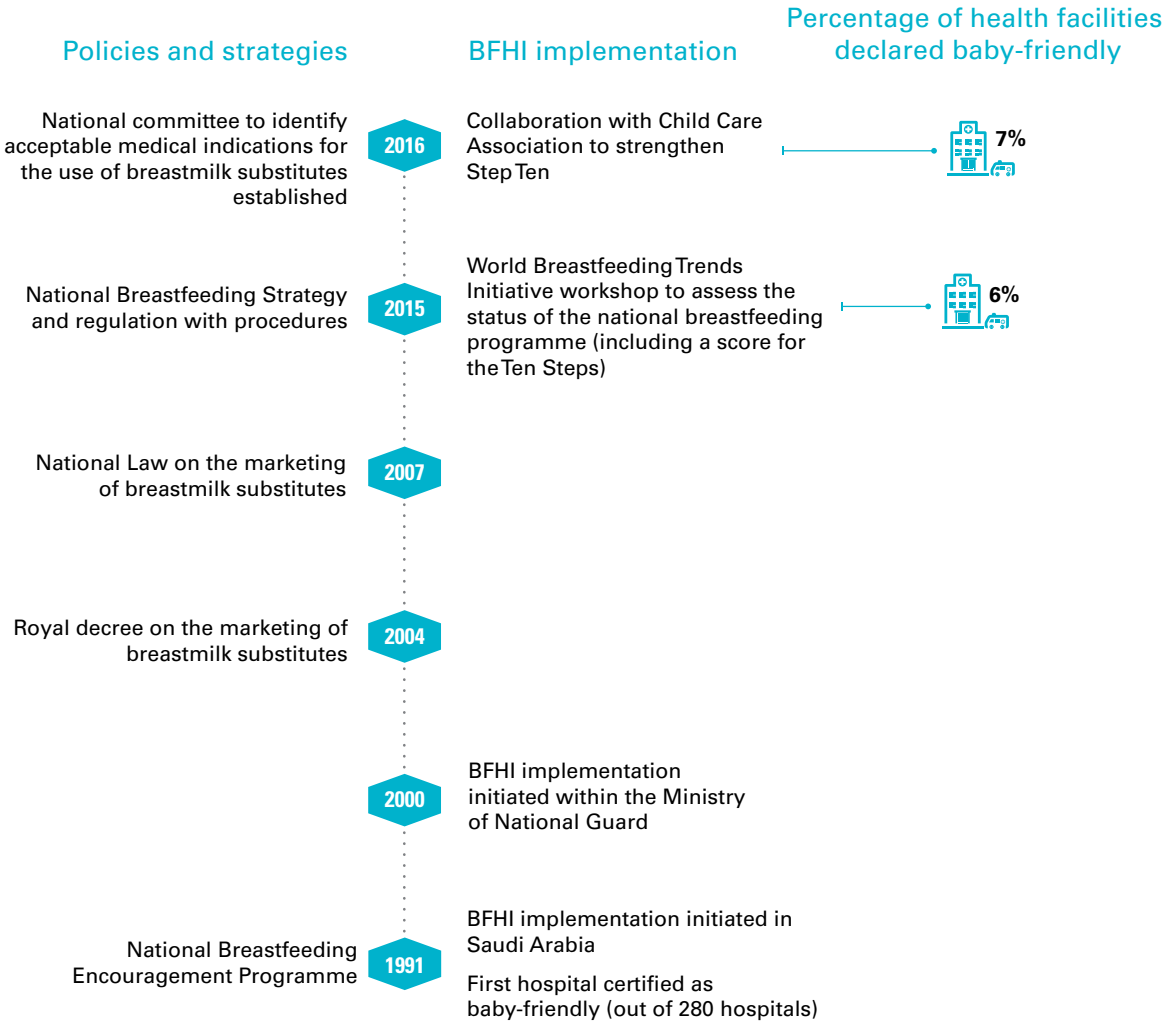


Figure 2: Timeline of key national policies and strategies supporting breastfeeding

Overview of BFHI implementation

In Saudi Arabia, the recommendation for the breastfeeding duration of two years is based firstly on the Holy Koran and supported by the recommendations of the WHO and UNICEF. In 1991, Saudi Arabia began implementing the BFHI and the Ten Steps in hospitals and eight of the steps in PHC centres (which lack delivery facilities). That same year, the MOH established the National Breastfeeding Encouragement Programme, coordinated by the Public Health Department and transferred to the Nutrition Department five years later. The MOH approves policies and strategies related to breastfeeding for the health of mothers and children.

The BFHI Coordination and Designation Group consist of members from different ministries who are responsible for designating baby-friendly facilities. Hospitals provide the funds for the assessment visits, including accommodation. Saudi Arabia uses the global BFHI criteria and the hospital self-appraisal tool as a precursor to the external assessment. If the assessment determines that the global BFHI criteria are fully met, the Minister for Health grants the facility the Baby-friendly Hospital Award which is valid for five years. The MOH also provides the funds for a celebration by the MOH National programme.

The MNG-HA began BFHI implementation in 2000. There is a fixed annual budget to support breastfeeding programmes. Local committees in each facility are all linked together and led by breastfeeding co-coordinators (neonatology consultants), who meet annually.

In 2004, a royal decree created regulations to control the marketing of breastmilk substitutes, and a national law was issued in 2007. In 2011, the National Code Committee was formed, along with the National Code Penalties Committee in 2012 to deal with violations. The Saudi Law Committee formulated an update to the law in 2015. The MOH approved the *National Breastfeeding Strategy and regulation with procedures* in 2015. A national committee was formed in 2016 to identify acceptable medical indications for the use of breastmilk substitutes.

Monitoring and re-assessment are scheduled without informing the facility of the date. Monitoring helps to ensure compliance with standards and involves: 1) annual reports of birth and feeding practices to the regional and national level; and 2) annual visits by regional coordinators and the assessment team to observe practices and to check with mothers and staff.

If baby-friendly facilities uphold the standards for five consecutive years after receiving the initial award, a full re-assessment is scheduled. Facilities that meet the global BFHI criteria at re-assessment retain their baby-friendly designation for an additional five years. If monitoring reveals poor compliance, the National Breastfeeding Encouragement Programme coordinators discuss the findings with the facility and develop performance improvement plans. If the facility does not improve, the baby-friendly award may be withdrawn.

Key achievements/results

In the last 20 years, 29 out of 415 hospitals (7 per cent) in 11 of the 22 regions in Saudi Arabia have been designated as baby-friendly. The designated hospitals include 27 governmental and two private facilities. Each year, 1,000 to 9,000 births took place in these hospitals, out of a total of about 569,000 births per year in the country. In addition, 33 out of 1,030 PHC centres with maternity services but without birthing facilities have been designated or re-assessed as baby-friendly in the last five years.

The assessment in the MNG-HA facilities showed that the BFHI was implemented as part of a wider programme of maternal, newborn and child health, and raised awareness of breastfeeding and supportive practices. The majority of the health workers were supportive of the BFHI programme. New staff received 30-minute orientations to the policy. Training is provided on-site (20 hours) for all staff working on maternity and child care and evaluators found a clear relationship between training staff and breastfeeding rates. Where training was effective, breastfeeding rates were higher.

Challenges

There are numerous human resource challenges to implementing the BFHI, including initial reluctance by many maternity services and health professionals to participate in the programme; high staff turnover at health facilities; limited staff qualified to provide counselling on breastfeeding and lactation management; resistance to releasing staff to attend courses; and limited available time as breastfeeding advocates are responsible for implementing the BFHI in addition to other daily duties.

Most facilities experienced difficulties in collecting data and calculating exclusive breastfeeding rates. This was partly because BFHI indicators are not integrated with the statistical database of the hospital or PHC centre.

There is little community support or private sector engagement to promote breastfeeding. Weak facility-community linkages contribute to limited awareness, education and counselling for breastfeeding and infant and young child feeding practices. In addition, marketing of breast-milk substitutes continues in unaccredited health facilities.

Lessons learned and recommendations

National level

- The promotion of BFHI practices within hospitals must be evidence based.
- It would be more effective to integrate BFHI practices into existing health care services and systems rather than implement it as a standalone project. Linkages with the relevant government ministry or agency need to be strengthened.
- Educational materials for health professionals and parents (on parenting, antenatal care and PHC centre follow up of infants) need to be standardized.
- Sufficient time and funding must be allocated for the coordination of BFHI-related activities such as assessment and monitoring, as well as health worker training is important. Establishing a centre of excellence for training (Lactation Excellence Centre) and providing e-learning courses can help to establish a pool of well-qualified staff to implement the BFHI.
- The absence of compulsory training for hospital and PHC centre staff weakens affects the outcome of BFHI implementation.
- Since breastfeeding counselling training is not included in staff competencies, BFHI requirements are underestimated.

Local level (MNG-HA)

- Strong steering committees can help health facilities implement changes in practices and policies to support breastfeeding. Engaging the facility leadership in the process facilitates cultural change around breastfeeding.
- E-learning and printed documentation on breastfeeding can be provided in health facility waiting areas to strengthen knowledge of mothers
- Establish a policy for visiting hours that allows babies to be with their mothers at all times (the current practice in Saudi Arabia is to separates babies from mothers during visiting hours).
- Ensure lactation consultants are available in maternity wards for all shifts (currently educators and lactation consultants work mainly during the day).

Recommendations for global BFHI guidance

- Release more information about the impact of implementing the Ten Steps for facilities, families and countries.
- Seek recognition for baby-friendly facilities from the World Health Assembly.
- Clearly describe the duties of baby-friendly hospitals.
- Include mandatory training of health staff in breastfeeding counselling within guidelines for promotion of baby-friendly practices.
- Include breastfeeding statistics in the key national statistics of each country.
- Encourage postgraduate studies in breastfeeding.
- Hold the WHO/UNICEF BFHI congress biannually.

Acknowledgements

Authors and contributors: Nora Al Kharji and Saeed ur Rahman, Ministry of National Guard-Health Affairs; Maryam Shanqiti, Ministry of Health, Saudi Arabia and Randa Sa'adeh, independent; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Mary Ann Perkins. Design: Nona Reuter. Also acknowledged, with appreciation, is Dr. Bandar Al Knawy, Ministry of National Guard, for granting ethical permission for the study.

Endnotes

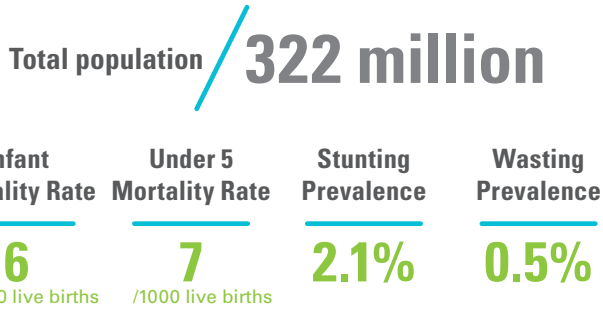
1 Al Junaid, D.A.M., C.W. Binns, and R.C. Giglia, 'Breastfeeding in Saudi Arabia: A review', *International Breastfeeding Journal,* vol. 9, no. 1, 14 January 2014.

Baby-friendly Hospital Initiative in the United States of America
Accelerating action for breastfeeding families

Country and policy context

In 2015, the United States of America (United States) had nearly four million live births.[1] The country has approximately 3,300 total maternity facilities,[2] where approximately 99 percent of infants are born.[3] Progress has been made in reducing infant and child mortality indicators *(see Figure 1)*.

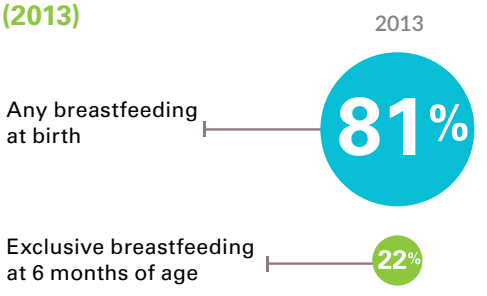
Figure 1: Key maternal, newborn and child health indicators in the United States



Sources: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on National Health and Nutrition Examination Survey Data 2011-12.

The United States Department of Health and Human Services (HHS) Office of Disease Prevention and Health Promotion manages the Healthy People initiative in which key national objectives are identified to monitor public health issues. Eight objectives are related to breastfeeding behaviors and different kinds of support for breastfeeding. The prevalence of infants breastfeeding at birth and exclusive breastfeeding at six months of age are two of the five Healthy People 2020 breastfeeding indicators *(see Figure 2)*.

Figure 2. Key national breastfeeding indicators (2013)



Sources: Centers for Disease Control and Prevention. Healthy People 2020 Objectives for the Nation; Centers for Disease Control and Prevention, National Immunization Survey Rates of Breastfeeding among Infants Born in 2013.

A mother and father interact with their baby in a maternity unit of a facility in the USA. Photo credit: United States Breastfeeding Committee.

Case study methodology

For this case study, data on live births, breastfeeding indicators, maternity facilities and related facility characteristics were provided by the HHS's Centers for Disease Control and Prevention (CDC) surveillance systems. Data and information on BFHI designations were provided by Baby-Friendly USA, Inc. Key achievements and results were summarized from literature reviews and interviews with key stakeholders.

Enabling environment

The policies and actions for the protection, promotion and support for breastfeeding in the United States are summarised in Figure 3.

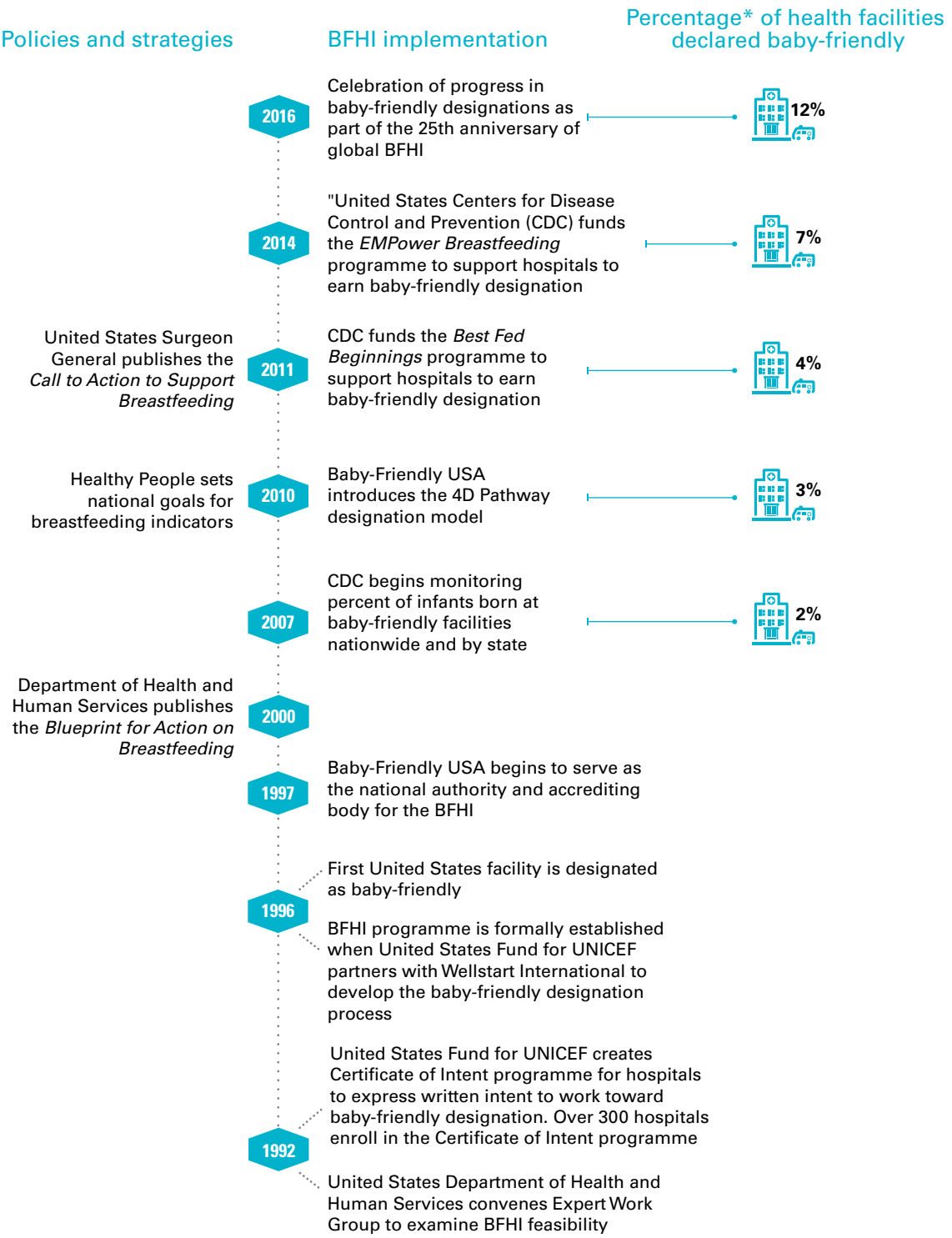


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

*Percentages are approximations and are not available prior to 2006. Data on percentage of facilities designated provided by Baby-Friendly USA.

Overview of BFHI implementation

In 1992, HHS convened an expert working group to consider how to implement a BFHI programme in the United States. This led to the development of facility eligibility criteria, development and testing of BFHI evaluation criteria, and establishment of a voluntary designation programme in 1994. The USA Committee for UNICEF (UNICEF USA) created the Certificate of Intent process for hospitals to express written intent to work toward baby-friendly designation.

In 1996, the BFHI programme was formally established when UNICEF USA partnered with Wellstart International to develop the Baby-Friendly designation process for the country.[4] In 1997, baby-friendly USA, Inc., a non-governmental, non-profit organization began serving as the national authority and accrediting body which was responsible for BFHI implementation. In 2000, the HHS published the *Blueprint for Action on Breastfeeding* which stated that hospitals and other maternity centers are encouraged to adopt the Ten Steps to Successful Breastfeeding as outlined by UNICEF, the WHO, the HHS Expert Work Group, and Baby-Friendly USA.[5]

In 2007, the CDC in consultation with Baby-Friendly USA and other national experts, began monitoring the public health impact of BFHI. In conjunction with Baby-Friendly USA, which maintains a publically available list of baby-friendly designated facilities, CDC reports the annual percentage of infants born at designated facilities. In 2010, HHS released Healthy People 2020 which set national goals for eight indicators related to breastfeeding behaviors and supports.

In 2011, the *Surgeon General's Call to Action to Support Breastfeeding* recommended acceleration of implementation of BFHI as a strategy to ensure that maternity care practices in health facilities are supportive of breastfeeding.[3] It was an important milestone in supporting the BFHI by drawing attention to the importance of and need for a society-wide approach to support breastfeeding families.

From 2011 through 2014, CDC funded the *Best Fed Beginnings* (BFB) programme, which used a collaborative quality improvement approach to support 89 hospitals to work toward baby-friendly designation. In 2014, CDC funded *EMPower Breastfeeding,* a three year hospital-based quality improvement programme to support 93 hospitals to earn baby-friendly designation, building on lessons learned in the course of the *BFB* programme.

Baby-Friendly USA, coordinates and conducts the activities necessary to confer the baby-friendly designation for USA birth facilities. Facilities earn the designation by completing the four phases of the *4D Pathway* (described below), implementing the Ten Steps to Successful Breastfeeding in a manner consistent with the *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*, and successful completion of an external evaluation. Although the United States has not implemented the International Code of Marketing of Breastmilk Substitutes in legislation, USA facilities must comply with this Code to earn baby-friendly designation.

Baby-Friendly USA launched the *4D Pathway* in 2010 to help hospitals implement the Ten Steps using a quality improvement approach. It is comprised of four phases.[6]

- *D1: Discovery:* a facility registers with Baby-Friendly USA and undertakes specific actions, including completing a self-appraisal tool.
- *D2: Development:* the facility establishes a multidisciplinary baby-friendly committee to develop a work plan to facilitate achieving designation, a comprehensive infant feeding policy, and plans for staff training, patient education, and data collection.
- *D3: Dissemination:* the facility carries out the staff training plan, rolls out practice improvements, and collects data to self-assess implementation of all Ten Steps.
- *D4: Designation:* the last phase, which includes the external assessment.

The external assessment is a two-stage process. The first is an on-site assessment conducted by a Baby-Friendly USA assessment team. The findings are compiled into a report, blinded (i.e., facility specific identifying information is removed), and sent to an External Review Board (ERB), which determines whether or not the facility has fully and appropriately implemented all requirements. If these have been met, the facility will officially be designated and granted the approval to use the baby-friendly certification mark. If not, there is a corrective action process to correct identified problems and a re-assessment can occur.

Health facilities pay fees directly to Baby-Friendly USA, and are also responsible for assessors' travel expenses. CDC provides financial support to state and local public health agencies and other organizations that work to increase the percentage of infants born at baby-friendly designated facilities.

Key achievements/results

In 1996, the first facility in the United States was designated baby-friendly. In 2011, at the time of the publication of the Surgeon General's *Call to Action to Support Breastfeeding,* approximately 5.3 per cent of infants were born at BFHI facilities and 127 hospitals were designated as baby-friendly. Since the release of *The Call to Action to Support Breastfeeding* and the implementation of

the *BFB* and *EMPower Breastfeeding* programmes, funded by the United States government, there has been an acceleration in the number of baby-friendly designated facilities and the percent of infants born at designated facilities. Nearly 6 per cent of infants are born at hospitals that took part in either the *BFB* or *EMPower Breastfeeding* programmes. As of December 2016, there are 400 baby-friendly maternity facilities (12 per cent of facilities), and nearly one in five infants are born at a baby-friendly facility.

In addition to progress in both the number of baby-friendly facilities and the per cent of infants born at these facilities, improvements are being made in maternity care practices that support breastfeeding in hospitals across the country. CDC has integrated indicators of the Ten Steps into a national surveillance system that assesses maternity care policies and practices that support breastfeeding. In 2007, CDC administered the first national Maternity Practices in Infant Nutrition and Care (mPINC) survey to all facilities that routinely provide maternity care services. Currently, mPINC is administered every two years. CDC provides facility-specific mPINC Benchmark Reports to assist facilities in identifying opportunities to improve maternity care practices that support breastfeeding.

Challenges

- Organizational infrastructure: The rapid acceleration in the number of hospitals working to achieve baby-friendly designation has placed significant demands on Baby-Friendly USA. It must keep pace with increasing numbers of facilities going through the designation process, conducting on-site assessments for designation and re-designation, and responding to needs for technical assistance from hospitals.
- Facility expectations: Several of the Ten Steps were identified as challenging to implement in the context: Step Two (staff training), Step Three (prenatal breastfeeding education), and Step Ten (after discharge support). A better understanding of the barriers to the BFHI in the United States is necessary to ensure sustainability. It is important to provide technical assistance to help facilities overcome barriers.

Lessons learned

- Collaboration across hospitals is helpful and well-received. Formalizing collaborative learning opportunities can enable facilities to share successful strategies to overcome barriers implementing challenging steps and earning baby-friendly designation.
- In the United States, the capacity of state and local public health agencies to help hospitals pursue baby-friendly designation varies widely. Providing individualized technical assistance to state and local public health agencies can address this.
- Data collection on process and outcome measures can help facilities determine fidelity and effectiveness of the implementation of the Ten Steps and can be used to improve quality. Standardized tools can help facilities collect these data.

Recommendations for global BFHI guidance

- A key consideration is to write the global operational guidance in broad language that allows individual countries to implement the guidance in the context of their resources, health care systems, and culture.

Acknowledgements

Authors and contributors: Trish MacEnroe, Baby-Friendly USA; Daurice Grossniklaus, Heather Hamner, Carol MacGowan, Cria Perrine and Katherine Shealy, Centers for Disease Control and Prevention; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Melissa Theurich. Design: Nona Reuter.

Endnotes

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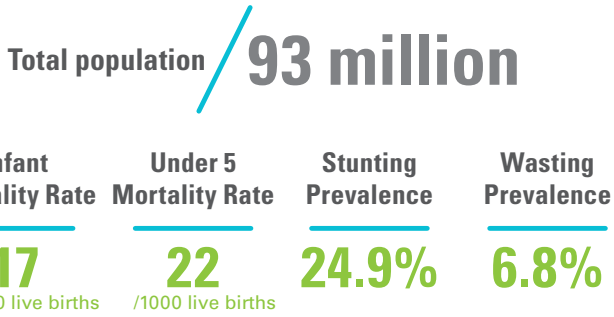
The Baby-friendly Hospital Initiative in Viet Nam
Enhancing healthcare quality criteria

Country and policy context

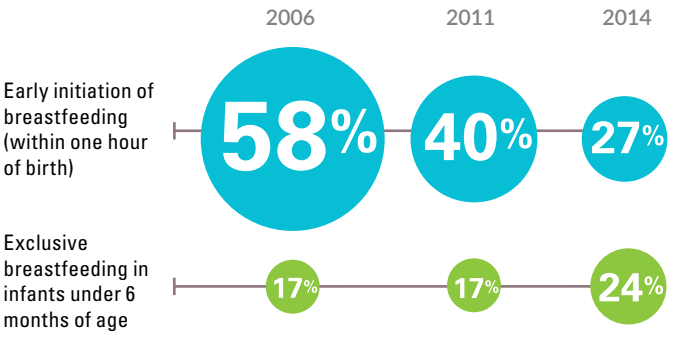
The Socialist Republic of Viet Nam (Viet Nam) is a lower middle income country. In 2014, 74 per cent of pregnant women had at least four antenatal visits. There are 1,147 public and 165 private hospitals and over 35,000 clinics in the country. Almost all mothers in Viet Nam (94 per cent) deliver their babies at a health facility. Infant morality and under-five mortality rates remain high despite almost all mothers (94 per cent) delivering at a health facility (*see Figure 1*). The proportion of births by caesarean section increased from 20 per cent in 2011 to 28 per cent in 2014. Breastfeeding is a very common practice in Viet Nam, however, early initiation and exclusive breastfeeding under six months remain low *(see Figure 2)*.

Figure 1: Key national child health and nutrition indicators



Source: United Nations Children's Fund (UNICEF), State of the World's Children Report 2016; Inter-agency Group for Child Mortality Estimation (IGME) 2015; Joint Malnutrition Estimates 2016, based on Nutrition surveillance profiles 2014

Figure 2: Key national breastfeeding indicators (2011-2014)



Source: Multiple Indicator Cluster Survey (MICS) 2006, 2011, 2014

UNICEF Viet Nam supports breastfeeding families after birth in the Binh Thanh Dong commune, An Giang Province, in the Mekong Delta region of southern Viet Nam. ©UNICEF/UNI180267/Viet Hung.

Case study methodology

This case study was conducted by UNICEF Viet Nam in collaboration with the Medical Service Administration (MSA) of the Ministry of Health (MOH) using a mixed methods approach including a literature review, hospital visits (eight hospitals in the cities of Danang and Ho Chi Minh City) and a review of MSA data from over 1,000 hospitals from 2013 to 2015.

Enabling environment

Historically, the lack of clear policies and guidelines protecting, promoting and supporting breastfeeding in Viet Nam were contributing factors that limited its practice. However, since 2012, the government strengthened several national policies to create a better enabling environment for breastfeeding (*see Figure 3*). On June 18th, 2012,

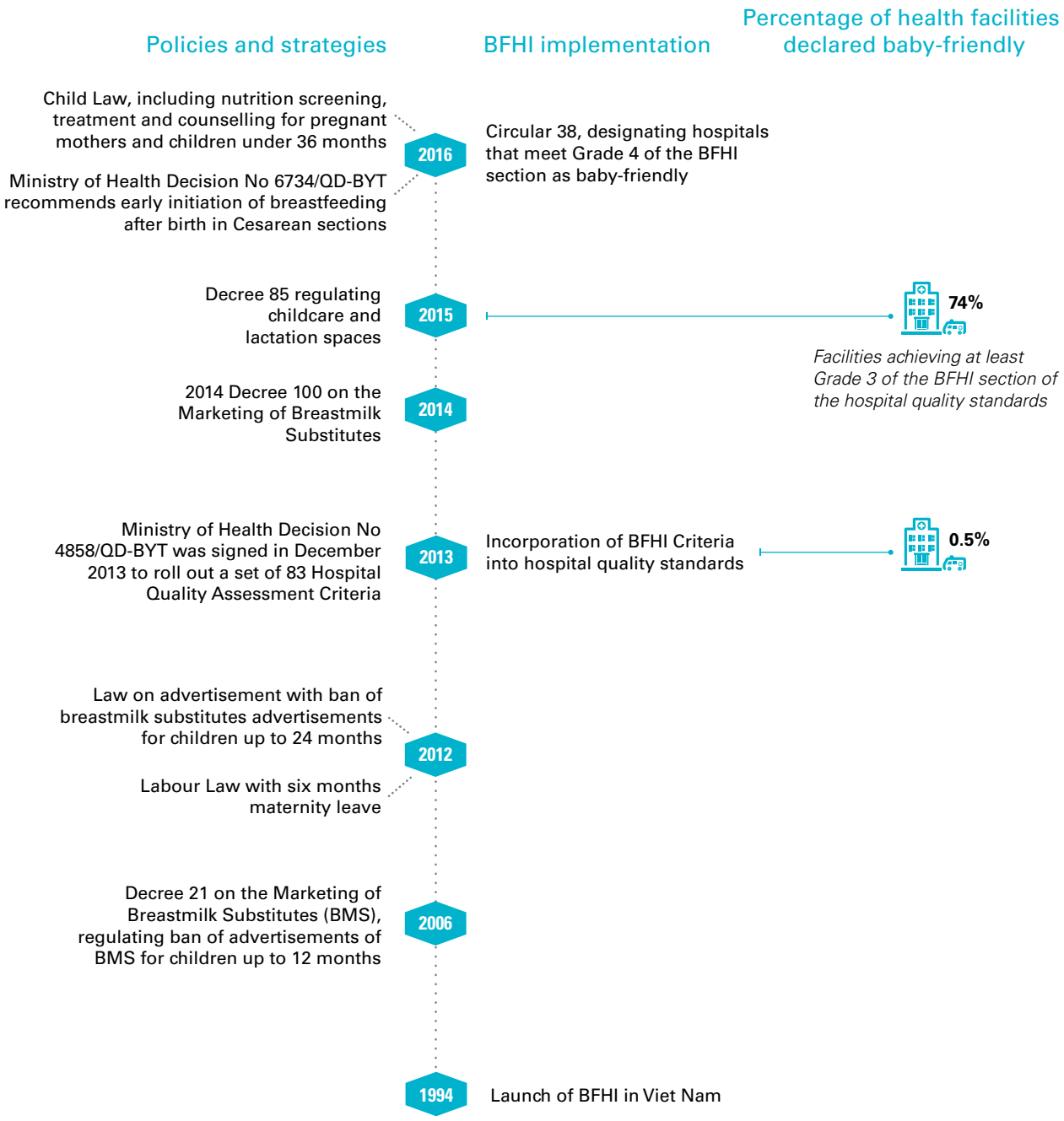


Figure 3: Timeline of key national policies and strategies supporting breastfeeding

Viet Nam's National Assembly made a landmark decision to extend paid maternity leave from four to six months—a bold departure from other maternity leave policies in Southeast Asia. Three days later, on June 21st, the National Assembly voted to expand the ban on advertising of breast milk substitutes (BMS) for infants from 6 months to 24 months, including feeding bottles and teats, as well as complementary foods for children under six months.

In 2013, the government of Viet Nam overhauled its hospital standards and national hospital quality assessment criteria to, among others, incorporate nine of the BFHI's Ten Steps (Step Ten on referral to mother support is not yet incorporated). These standards are mandatory for all hospitals providing maternal and child care at city, province and district level, including public and private hospitals.

In 2014, the government passed Decree 100, which regulates marketing of breastmilk substitutes (BMS) including a ban on advertising of BMS for children less than 24 months of age. This decree replaces many previous provisions of the earlier Decree and controls the supply of BMS at hospitals and in stores located nearby hospitals. It has also been integrated into the hospital quality criteria as the most critical indicator to assess hospital quality. If a hospital has violations of decree 100, the hospital gets a zero score for all BFHI criteria.

In 2015, the government passed another important decree mandating that all workplaces with a large number and/or proportion of female workers have childcare facilities and lactation spaces in their workplaces. In April 2016, the Child Law added an article supporting nutrition screening, treatment and counselling for pregnant mothers and children under 36 months. This provided the legal foundation and financial incentive for the provision for breastfeeding and nutrition support to mothers and children as these costs were eligible for reimbursement by the health insurance.

Overview of BFHI implementation

Since 1994, the MOH has promoted voluntary commitments to the BFHI criteria in all hospitals with external (UNICEF) support. However, most hospitals failed to commit to full implementation of the BFHI to avoid overburdening staff and losing donated commercial infant formula supplies. High caesarean section rates, limited breastfeeding support, limited skin-to-skin contact, early umbilical cord clamping, prolonged separation of mothers and infants after delivery and violations of the national milk code were commonplace in Vietnamese hospitals.

In 2013, the MOH integrated the BFHI into the health system through including BFHI criteria (with the exception of Step Ten on referral to support after discharge since mother support groups do not yet exist) into the national hospital quality criteria. These criteria include 84 indicators in five sections covering hospital management, administration, safety, service delivery and obstetric and gynecological practices. The criteria related to the BFHI are covered in Section E.1.4.

Hospital assessment criteria are close to international standards and based on a five-grade hierarchy, with Grade 1 being very poor and Grade 5 good quality. The aim is to have all hospitals in Viet Nam reaching at least Grade 3 which is considered acceptable. Hospitals are ranked by Grade and in 2016 the MOH issued Circular 38, regulating that hospitals meeting Grade 4 of the BFHI criteria are designated as baby-friendly. Hospital assessments are conducted in three phases annually: a self-assessment; an external assessment conducted to verify or adjust the self-assessment score; and a final three-day external assessment. External assessments are conducted by a team of six to seven members from the Quality Assessment Management team at the MOH. To verify the external assessment score, the MOH randomly inspects a select number of hospitals. If hospitals cannot meet Grade 3 in three years, they will not receive full reimbursement by government health insurance. In 2015, information about the quality of hospitals was published on the MOH website.

Integrating the BFHI into national hospital quality criteria sustainably linked it with the Vietnamese health system. This is a distinguishing feature of BFHI in the country. The impact on breastfeeding rates has not yet been fully assessed.

UNICEF and WHO supported the introduction of the BFHI in Viet Nam. Currently, virtually all costs are born by the MOH. The MSA of the MOH manages hospital assessments on quality criteria, while provincial departments of health conduct monitoring visits. UNICEF and WHO provide technical assistance, monitoring and selected trainings, and Alive & Thrive for breastfeeding support in communities. New IYCF and clinical nutrition standards have stimulated capacity building and pre-service training of health professionals. For example, Hanoi Medical University has established a new department and developed a curriculum for nutritionists.

Key achievements/results

Since its conception in 1994, only 0.5 per cent of central, provincial and district level hospitals had been certified as baby-friendly by 2013 (57 out of 12,146 hospitals).[1]

With the incorporation of criteria into the hospital quality standards, progress is measured in a different way. Although the goal of having all hospitals with a score of Grade 3 within three years has not been achieved, data from the national database indicate that the national average grade is currently 3.3 for public and private facilities alike, compared to 2.7 in 2013. In 2015, a total of 297 of the total 402 obstetric hospitals (74 per cent) achieved scores of Grade 3 or higher for the BFHI criteria (178 reached Grade 3, 78 Grade 4 and 41 Grade 5). As the hospital quality criteria become more widely known and accepted, compliance increases, as does the number of hospitals publishing their results.

Eight hospitals assessed in 2016 as part of this case study showed improvements in implementation of the BFHI criteria, with the hospitals in both cities achieving Grade 3, the minimum acceptable standard. Qualitative interviews with hospital leaders, staff and patients in Da Nang and Ho Chi Minh City showed marked improvements in breastfeeding indicators. In the Danang OBGYN Pediatrics Hospital, the rate of early initiation of breastfeeding increased from 27 per cent in August 2014 to 78 per cent a year later, and for the hospitals in Ho Chi Minh City, this rate increased from 32 per cent in 2010 to 59 per cent in 2015.

In November 2016, the MOH approved updates guidelines for postpartum care in case of cesarean sections, which include skin-to-skin contact and early initiation of breastfeeding.

Challenges

- In-service training is currently only provided to midwives and nursing staff on maternity wards but it should be provided to surgical staff and other staff involved in prenatal, delivery and postpartum care.
- Step Ten is not included in the BFHI in Viet Nam. There is a lack of coordination between hospitals and communities to facilitate continued support for breastfeeding.
- Provision of breastfeeding education to pregnant women starting in antenatal care by hospital staff.

Lessons learned and recommendations

- Including breastfeeding indicators in the hospital quality criteria and mandatory enforcement has strengthened hospital commitment to BFHI and as a result, marked improvement in the quality of care (including counselling during antenatal care (ANC), delivery and after delivery, support with correct positioning and continued BF) provided in hospitals has been observed in Viet Nam.
- Linking Early and Essential Newborn Care (EENC) including breastfeeding counseling and support and other quality of care criteria during hospital assessments can contribute to improved practices and compliance with BFHI criteria. Furthermore, providing a financial incentive linking hospital quality to health insurance reimbursement may also improve results. This may generate demand and increase the number of hospitals in applying BHFI criteria.
- National dissemination and training workshops on Decree 100 on the marketing of breastmilk substitutes that promote and support breastfeeding were held, but dissemination at local levels would reinforce compliance. Similarly, provincial departments should strengthen their monitoring systems to identify violations of Decree 100 and improve compliance at all hospitals. Moreover, dissemination and training workshops should be organized not only for health inspectors, but also for health staff working in obstetric and pediatrics hospitals.
- BFHI criteria should be upheld for cesarean sections, especially in contexts such as Viet Nam where the cesarean section rate is very high.

Recommendations for global BFHI guidance

- Commitment from government leaders at national and local levels is needed to fully implement BFHI at scale. Small scale, donor-dependent BFHI programmes are not sustainable.
- Integrating BFHI into the health system coupled with regular monitoring is the most sustainable and effective way to support compliance among maternity services.

Acknowledgements

Authors and contributors: Aisling Nora Daly, Do Thi Thu Thuy and Do Hong Phuong, UNICEF; Mr. Duong Huy Luong, Medical Service Administration of the Ministry of Health; Jessica Rodrigues and Maaike Arts, UNICEF New York. Editing: Melissa Theurich. Design: Nona Reuter.

Endnotes

1 WHO 2013 Internal Report (no details available)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World Health
Organization