EVALUATION OF THE BABY-FRIENDLY HOSPITAL INITIATIVE IN SERBIA FOR THE PERIOD 1995-2008

Final Report of Consultants

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October 2009
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Executive summary

Background

The Baby-Friendly Hospital Initiative (BFHI) is a global initiative of the World Health Organisation and UNICEF that was launched in 1991. The Initiative aims to give every baby the best start in life by creating a health care environment that supports breastfeeding and appropriate health care practices as the norm. This Initiative began in the then FR of Yugoslavia in 1994.

A formative evaluation was carried out by external evaluations between the end of August and early October 2009. This aimed to review the Baby Friendly Hospital Initiative in Serbia 1995-2008 towards assisting the Special Working Group for Baby Friendly Hospital Initiative Plus to make recommendations for the future course of BFHI. The Terms of Reference for this evaluation were agreed by the Special Working Group.

Activities related to the BFHI in Serbia were very broad and had spanned many years including a period of political and social change. Responsibility for the implementation, monitoring and funding of BFHI activities had moved over time, which limited the data available to answer some of the questions within a business model of effectiveness and efficiency. The design was primarily exploratory focusing on what was the current situation, how past activities had influenced the present, and lessons for the future.

The stakeholders in the BFHI include the:

- service users: the current pregnant women, new mothers and their infants, and potential parents;
- service providers: the midwives, nurses, doctors and other staff, their managers, and those who provide staff training and public awareness activities;
- service funders: taxpayers, the ministry of health, budget holders and, in the past, UNICEF.

Methodology

Data was collected from a variety of sources to ensure its accuracy, validity and reliability, and that all affected people/stakeholders are considered. Instruments used for data collection at the facilities were based on the assessment and monitoring instruments of the global UNICEF/WHO Baby Friendly Hospital Initiative (revised 2006-8), adapted to the needs of the evaluation and the time available.

Documents and reports related to the establishment and implementation of the BFHI and associated activities, health indicator data, and other materials were acquired and reviewed. Five hospitals with maternity services and four associated primary health care facilities were visited taking into account geographic location and population served, their relevant documents reviewed and observations of practice carried out. Individual interviews were conducted with 17 managers of these facilities, 32 members of the staff of the facilities, plus discussions with 11 groups of staff. Individual interviews were conducted with 42 pregnant women and 71 postnatal women using the services in these facilities. Ten organisations including parent groups, NGOs and governmental organisations participated in interviews.
The choice of facilities and sampling of respondents attempted to ensure equal representation of population groups. The evaluation aimed to be conducted in a manner that was respectful and confidentiality for the people participating in interviews. Interview data was collected without individually identifiable information as far as possible and stored safely by the evaluators, then handed over to UNICEF to be securely kept until the evaluation report is accepted and then destroyed.

Overview of findings

There were eight objectives of the evaluation provided to the evaluators in the Terms of Reference. The findings and specific recommendations for each objective are reported followed by a general recommendations section. An overview is presented here.

The BFHI is relevant to the needs of mothers, infants and the health service in Serbia, fits with national priorities and is generally acceptable. The BFHI was implemented as part of a wider programme of maternal and infant activity and raised awareness of breastfeeding and supportive practices. For the evaluation, it was not possible to separate out the specific BFHI activities from this broader programme. There are misperceptions of what is the BFHI by many mothers, staff and managers as well as the wider community. The Initiative had many activities and was moderately effective until about 2003 when support was reduced and activity curtailed. Low level activity continues in some areas due to the commitment of individuals. While some of the practices remain in place in some hospitals, the overall “Initiative” with its assessment and monitoring of standards has not been sustained. The WHO/UNICEF global BFHI was updated in 2006-8 and the updated standards and supporting materials are not part of the BFHI in Serbia at present.

Conclusion

The evaluation of the Baby Friendly Hospital Initiative (BFHI) in Serbia was carried out in accordance with the Terms of Reference.

Though there are difficulties due to the economic situation, this is also a time of opportunities for actions related to the BFHI in Serbia as improvements are made to health services. The evaluators recommend revitalisation of the BFHI starting with an effective and sustainable system of coordination of the Initiative that would raise awareness of the BFHI and work to link it with routine training of health workers as well as with other health service quality programmes. A health service model is also recommended that places the baby and mother needs at the centre of a supportive environment, including protection from marketing of breast milk substitutes.

The Special Working Group and others will need to develop a plan of action with realistic goals and measurable objectives and a suitable time frame. Bearing in mind economic realities, the evaluation report provides detailed recommendations and a suggested plan for action.
1. Introduction

The Baby-Friendly Hospital Initiative (BFHI) is a global initiative of the World Health Organisation and UNICEF that was launched in 1991. The Initiative aims to give every baby the best start in life by creating a health care environment that supports breastfeeding and appropriate health care practices as the norm. This Initiative began in the then FR of Yugoslavia in 1994.

This is the report of a formative evaluation to review the Baby Friendly Hospital Initiative (BFHI) in Serbia 1995-2008 towards assisting the Special Working Group for Baby Friendly Hospital Initiative Plus to make recommendations for the future course of BFHI. The Terms of Reference for this evaluation were agreed by the Special Working Group.

The evaluation commenced with a desk review of documents at the end of August 2009. Visits to maternity facilities, interviews with service provider and service users, key informant discussion, and presentation of the preliminary report, were undertaken during September 22nd – 30th in Serbia.

The primary audience for this evaluation report are the Special Working Group, the broad group of partners in the programme including government services, UNICEF, other NGOs, professional and parent associations.

The evaluation team consisted of Dr Genevieve Becker and Dr Elizabeta Zisovska, with Maja Medic assisting with translation. The biographic information for the evaluators is contained in Appendix B.

The evaluation team acknowledges the support of Dr Aleksandra Jovic and her colleagues in the UNICEF Office, Dr Djurdja Kisin, Institute of Public Health of Serbia, Centre for Health Promotion, the members of the Special Working Group, and the many mothers and facility staff members who assisted with this evaluation.

2. Programme profile

Baby-Friendly Hospital Initiative (BFHI): a global initiative

Breastfeeding is important. Worldwide, about 5500 children die every day because of poor infant feeding practices. In addition, many children suffer long-term effects from poor infant feeding practices including impaired development, malnutrition, and increased infectious and chronic illness. Rising rates of obesity in children are also linked with lack of breastfeeding. Improved infant and young child feeding is relevant in all parts of the world.

Women who do not breastfeed are more likely to develop anaemia, obesity and heart disease, become pregnant again soon, develop breast cancer, and to have hip fractures in later life. There are other costs too. If a baby is not breastfed there is replacement milk to buy, to prepare and equipment to keep clean, thus using money and time. A baby who is not breastfed may be ill more often with medical costs and loss of work time for the parent, as well as a source of worry.
Breastfeeding is also an investment in the future. A country needs healthy children as future workers. Breastfeeding is environmentally sustainable too.

The Baby-Friendly Hospital Initiative (BFHI) is a global initiative of the World Health Organization and UNICEF that was launched in 1991. The Initiative aims to give every baby the best start in life by creating a health care environment that supports breastfeeding and appropriate health care practices as the norm. It does this by implementing the Ten Steps to Successful Breastfeeding and working to end the marketing and distribution of free and low-cost supplies of breast milk substitutes through the health services. The BFHI provides a framework for enabling mothers to acquire the skills they need to breastfeed exclusively for six months and continue breastfeeding with the addition complementary foods for 2 years and beyond.

The Initiative includes a global assessment and accreditation scheme that recognises the achievements of health facilities whose practices support breastfeeding and encourages health facilities with less than optimal practices to improve. By the end of 2008 more than 20,000 health facilities worldwide had been officially designated as meeting the criteria to be a Baby-friendly hospital. A hospital is required to meet the criteria at the assessment in order to be awarded or designated as Baby-friendly. It is not enough that the hospital are working hard or getting nearer to meeting the criteria, or has a plan to meet them. At the external assessment visit the practices must be seen and the assessors must be clear that the mothers are being supported. Hospitals are required to participate in on-going monitoring and reassessment to retain their designation.

The BFHI is not a short term project with the only aim to pass the assessment or to increase breastfeeding rates. It is a package of health care practices that are research-based best practice. All maternity services should be working towards implementing and maintaining these practices as routine care even if there was no external assessment.

The BFHI fits with related strategies and programmes such as the WHO/UNICEF Global Strategy on Infant and Young Child Feeding (2002) and UN Millennium Development Goals.

BFHI is implemented in various ways in different countries:
- as part of government programmes in the Ministry of Health or other agencies;
- by NGOs such as UNICEF or others, in association with government;
- through professional associations, for example, the midwives or paediatric association;
- in conjunction with other programmes such as health promotion or quality of health care;
- by private companies under contract to an organisation or government ministry.

BFHI is a global programme. However each country decides how it is best to implement the programme in that country.
Baby-Friendly Hospital Initiative (BFHI) in Serbia

Background

A report to the Yugoslav Breastfeeding Protection and Support Committee from Prof Yungve Hofander and Charlotte Hilarvk (Uppsala, Sweden) in 1994, described practices that were incompatible with the Baby Friendly Hospital Initiative practices, including use of breast milk substitutes, that contributed to low exclusive breastfeeding rates and a fall-off in the incidence of any breastfeeding in the early months. There was reluctance from health workers to change these practices, with underlying poor knowledge related to breastfeeding. There was an environment that contributed to a high mortality rate for infants and young children, as well as limitation to the care received by pregnant women and new mothers.

The Baby-Friendly Hospital Initiative was launched in the Republic of Serbia in 1995 to address this situation. General programme goals were set and evaluation indicators listed.

Purpose of the programme

The purpose of the programme was to “protect children’s physical and mental health and improve the nutritional status of infants and young children”. Objectives of the programme differ slightly across reports from various sources, however they were basically to improve health worker knowledge, skills and practices; improve pregnant women/mothers knowledge, skills and practices; provide a supportive health service environment including no marketing of breast-milk substitutes through the health services; support, protect and promote exclusive breastfeeding in emergencies; and for maternity wards to become certified as meeting the Baby-Friendly criteria.

The Annual Report on joint activities of partners and UNICEF in 2003 listed the programme specific objectives as:
- to have 80% of maternity wards become “baby-friendly”,
- to increase the exclusive breastfeeding rate at the end of the sixth month of infants to 40%,
- to decrease the rate of illnesses and deaths due to diseases immediately connected with feeding,
- to strengthen friendly relationship of health professionals and families,
- to include community into the support program.

2 Kisin D, Institut of Public Health of Serbia, “Dr Milan Jovanović Batut” Belgrade
### Table 1: Baseline data and indicators

<table>
<thead>
<tr>
<th>From birth facilities</th>
<th>Inception 1994</th>
<th>Interim 1997</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding initiation</td>
<td>Not stated</td>
<td>Not stated</td>
<td>16.9%</td>
</tr>
<tr>
<td>Exclusive breastfeeding on discharge</td>
<td>85%</td>
<td>89.9%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>16.9%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Non-Exclusive breastfeeding on discharge</td>
<td>-</td>
<td>95-100%</td>
<td></td>
</tr>
<tr>
<td>Full formula feeding from birth</td>
<td>Not stated</td>
<td>Not stated</td>
<td></td>
</tr>
<tr>
<td>From Primary Health Care centre</td>
<td>Rates increased in 3 areas reported on</td>
<td>Rates increased in 3 areas reported on</td>
<td></td>
</tr>
<tr>
<td>(against the total number of live births in the region covered by the PHC)</td>
<td>Rates increased in 3 areas reported on</td>
<td>Rates increased in 3 areas reported on</td>
<td></td>
</tr>
<tr>
<td>Exclusive breastfeeding at 4 months</td>
<td>30% - 46%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>(unclear if exclusive)</td>
<td>3% (1996)</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Exclusive breastfeeding at 6 months</td>
<td>6%</td>
<td>11% (2000)</td>
<td>15%</td>
</tr>
<tr>
<td>Any breastfeeding at 6 months</td>
<td>20%</td>
<td>38.7%</td>
<td></td>
</tr>
<tr>
<td>From on-going monitoring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of facilities carrying out programme activities</td>
<td>4</td>
<td>50</td>
<td>54% - 55%</td>
</tr>
<tr>
<td>Number of facilities distributing or otherwise marketing breast milk substitutes</td>
<td>-</td>
<td>None of the participating hospitals</td>
<td></td>
</tr>
<tr>
<td>Number of facilities certified as meeting and maintaining Baby-Friendly criteria</td>
<td>Certification not yet in place</td>
<td>14*</td>
<td>49</td>
</tr>
<tr>
<td>% of births taking place in facilities certified as meeting and maintaining Baby-Friendly criteria</td>
<td>Certification not yet in place</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>% of pregnant women / mothers receiving information on importance of breastfeeding and of BFHI practices</td>
<td>60% of PHC provide classes for parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From central sources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of maternity facilities</td>
<td>80</td>
<td>58</td>
<td></td>
</tr>
</tbody>
</table>

*Includes 4 in Montenegro, 5 in Vojvodina, 5 in central Serbia.

4 Terms of Reference Evaluation of the Baby-Friendly Hospital Initiative in Serbia for the Period 1995-2008
5 Multiple Indicator Cluster Survey, 2005, UNICEF
Coordination and Partners
UNICEF served as a catalyst for the initiative, and a broad range of partners were involved initially and over the following years. The Federal Committee for Mother and Child Healthcare and Family Planning, September 1994 defined activities for health centres (services for women and children healthcare and polyvalent visiting-nurse service) and hospitals of all levels (maternity units and children’s units within hospitals where sick children are treated). At that time, the main responsible entity and coordinator was the Federal Institute of Public Health of FR Yugoslavia. In the period 1994-2004, it was the Federal Public Health Institute (FR Yugoslavia for Serbia and Montenegro), and since 2004 it has been the Institute for Public Health of Serbia Batut. A “Special Working Group for Preparing Methodology for Institutionalisation and Activity Plan of the Program Baby Friendly Plus” was formed by Ministry of Health of the Republic of Serbia in August 2009.

Since 2005 the BFHI in Serbia no longer receives UNICEF’s direct support, and other funding sources have also become limited. A shift in Ministry of Health focus moved BFHI to a lower priority and has also affected BFHI funding. These changes have increased the challenges for implementing BFHI in Serbia.

Activities
There was a combined program for Promotion, Support and Protection of Breastfeeding and the Baby Friendly Hospital Initiative, and specific BFHI activities cannot be separated out. This programme was an official compulsory programme in all healthcare institutions in Serbia dealing with mother and child healthcare from 1995.

The main activities over the years included training of health workers through preparation of materials and regional workshops lasting between one-day and one week, establishment of classes for pregnant parents in health care centres and maternity hospitals, visits to hospitals to monitor standards, to formally assess practices and certification of some hospitals. Monitoring of Marketing of Breast-milk Substitutes and distribution of free and low-cost infant formula in health institutions and the community was also carried out.

Wider promotional activities included the provision of printed materials for parents, activities to mark World Breastfeeding Week including literary and art competitions for schools, events for mothers, events for health professionals, and public media activities. The evaluators were provided with information on the activities related to BFHI as an annex to the Terms of Reference for the evaluation (Appendix E).

3. Evaluation profile

Purpose of Evaluation
This was a formative evaluation to review the Baby Friendly Hospital Initiative (BFHI) in Serbia 1995-2008 towards assisting the Special Working Group for Baby Friendly Hospital Initiative Plus to make recommendations for the future course of BFHI.
Objectives
The Terms of Reference (TOR) outlined objectives for the scope and focus of the evaluation (Appendix A) which broadly included:
- Effectiveness (the extent to which objectives are met)
- Efficiency (relative balance of costs to benefits)
- Appropriateness (relevance to need)
- Acceptability (sensitivity and flexibility)
- Equity (equal provision for equal need across all relevant groups)
- Identify approaches, strategies and practices which worked, and did not work, highlighting lessons learnt and good practices
- Make recommendations that will focus future BFHI activities in Serbia towards achieving sustainable outcomes.

Evaluation design
Activities related to the BFHI in Serbia were very broad and had spanned many years including a period of political and social change. Responsibility for the implementation, monitoring and funding of BFHI activities had moved over time, which limited the data available to answer some of the questions within a business model of effectiveness and efficiency. Therefore a more community development approach was used that looked at the inputs, processes, outputs and outcome as experienced by those involved. The design was primarily exploratory focusing on what was the current situation, how past activities had influenced the present, and lessons for the future.

Information from documents, questionnaires and semi-structured discussions with stakeholders were used in an iterative process to build a picture of the situation.

The evaluation design and methodology was presented and discussed with the Special Working Group at the start of the in-country stage of the evaluation.

Evaluation methodology
Evaluation methodology was guided by the Norms and Standards of the United Nations Evaluation Group. The BFHI is a multiple component intervention formed of activities within a wider environment with social, economic and health related aspects. Therefore the evaluation was multi-stage composed of several smaller self-contained studies supported by both quantitative and qualitative data. An attempt was made to substantiated key findings through triangulation.

Data sources
Data was collected from a variety of sources to ensure its accuracy, validity and reliability, and that all affected people/stakeholders are considered. The processes of identifying and reviewing documents began with the awarding of the contract and continue during the visit and in preparation of this report.

Information on the current situation was obtained through interviews with pregnant women, new mothers, staff working in the maternity services, and key informant interviews including both service users and programme administrators.
Table 2: Data sources and methods

<table>
<thead>
<tr>
<th>Purpose/Source</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiences and views of service users (pregnant women and mothers of young infants).</td>
<td>structured individual interview instruments</td>
</tr>
<tr>
<td>Knowledge, practices and views of service providers (staff providing care for pregnant women, young infants and their mothers)</td>
<td>structured individual interviews instruments</td>
</tr>
<tr>
<td>Information on practices in health care facilities providing care for pregnant women, young infants and their mothers</td>
<td>structured observation instruments</td>
</tr>
<tr>
<td>Key informants/stakeholders</td>
<td>semi-structured interview instruments</td>
</tr>
<tr>
<td>Data from records and reports</td>
<td>structured documentary review instruments</td>
</tr>
</tbody>
</table>

Instruments

Instruments used for data collection at the facilities were based on the assessment and monitoring instruments of the global UNICEF/WHO Baby Friendly Hospital Initiative (revised 2006-8), adapted to the needs of the evaluation and the time available. These instruments are restricted to assessment teams and are thus not attached to this report.

- Clinical staff interview
- Facility management interview
- Pregnant woman interview
- Mother of healthy infant interview
- Mother of infant with health concerns interview
- Observation protocol – facility

Instruments based on the Global BFHI were developed to acquire additional information from respondents using a qualitative format (Appendix C). However, these instruments were only used as a general guide during the interviews as many of the respondents did not have information or experience to answer the questions.

The evaluation framework is presented in Appendix A that indicates the sources and methods used to examine the questions set in the Terms of Reference.

Stakeholder participation

The stakeholders in the BFHI include the:

- service users: the current pregnant women, new mothers and their infants, and potential parents;
- service providers: the midwives, nurses, doctors and other staff, their managers, and those who provide staff training and public awareness activities;
- service funders: taxpayers, the ministry of health, budget holders and, in the past, UNICEF.

This evaluation sought to obtain the views of a sample of all these stakeholders (except for the infants) through direct interviews and through documents (including web sites) produced by these stakeholders.
Samples

**Literature and document review**

A variety of documents, records and reports was provided by UNICEF, the Institute of Public Health of Serbia and other sources. A web search was undertaken to obtain background information and reports of indicators including Millennium Development Goals, Convention on the Rights of the Child, WHO Making Pregnancy Safer Country Profile, MICS, TransMONEE database, and national web sites for parents as well as government services. Further documents were requested as needed to provide specific information and to provide background to inform the interviews and report.

**Facilities assessment**

A list of 64 birth facilities provided by the Institute of Public Health of Serbia was reviewed by the evaluators and facilities to visit selected, taking into account previous designation as a baby-friendly hospital, geographic location, number of births, level of care provided and population served. Size of facility (number of people to interview) and travel time considerations resulted in five facilities being listed for visits. Primary health care services linked to these five facilities were then chosen based on times of clinic/service to fit with times evaluators were visiting that area, number of pregnant women/mothers/infants served, and staff numbers (Table 3). The two chosen birth facilities in Belgrade served women linked with numerous PHC both in Belgrade and outside it. One large Belgrade PHC was visited as a sample of city services.

The TOR had stated 6 facilities to be visited, however within the time available it is not possible to visit 6 birth facilities plus their linked PHC services. Visiting PHC facilities in addition to the five hospitals was thought to provide a good range of data sources.

In each of the nine facility visited, written documents were reviewed that included relevant policies and guidelines, staff training curricula and materials, antenatal and postnatal information for women, data on birth and breastfeeding rates. Each evaluator independently carried out a structured observation in the facility noting any advertising for formula and associated products, supports for breastfeeding, and in the hospitals, practices such as rooming-in, use of supplements and feeding bottles, and other aspects within the global BFHI criteria. These visits were carried out in the period September 23rd – 25th and 28th – 29th, 2009 (Appendix D).

**Mother and staff interviews**

**Targets**

Based on the number of service users of each facility, a target sample size was decided for pregnant women of at least28 gestational weeks (as the revised assessment tool recommends) \( n=35 \) and mothers of infants in the first 28 days \( n=70 \), and for staff providing care for pregnant women, young infants and their mothers \( n=37 \) (Table 3). Respondents were randomly chosen by the evaluators from those using and those providing services on the day of the visit, ensuring that population groups (ethnicity, age, parity, education) were represented as far as possible. Respondent staff were chosen to ensure work areas (labour and birth, postnatal, neonatal, etc) and disciplines (nurse, midwife, paediatrician, obstetrician, etc) were represented.
Achieved

The number of interviews achieved with pregnant women and mothers were slightly above target. Staff individual interviews were slightly below target as in some facilities there was longer waiting time before staff were free to be interviewed and the longer time these interviews needed via a translator. Overall, there were 145 individual interviews conducted by the two evaluators in the nine facilities visited. (Table 3)

Table 3: Sample of facilities and for individual interviews

<table>
<thead>
<tr>
<th>Facility</th>
<th>Level</th>
<th>BFH</th>
<th>Births 2008</th>
<th>Interview staff target/achieved</th>
<th>Interview pregnant women target/achieved</th>
<th>Interview mothers target/achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valjevo PHC</td>
<td>3/3</td>
<td>no</td>
<td>3/3</td>
<td>5/4</td>
<td>3/3</td>
<td>5/5</td>
</tr>
<tr>
<td>General Hospital Valjevo</td>
<td>2nd</td>
<td>no</td>
<td>1390</td>
<td>5/4</td>
<td>3/3</td>
<td>5/5</td>
</tr>
<tr>
<td>Kraljevo PHC</td>
<td>3/3</td>
<td>no</td>
<td>3/3</td>
<td>5/3</td>
<td>3/3</td>
<td>5/5</td>
</tr>
<tr>
<td>General Hospital Kraljevo</td>
<td>2nd</td>
<td>no</td>
<td>1573</td>
<td>5/3</td>
<td>3/3</td>
<td>5/5</td>
</tr>
<tr>
<td>Novi Sad PHC</td>
<td>3/3</td>
<td>yes</td>
<td>3/3</td>
<td>5/5</td>
<td>5/5</td>
<td>10/10</td>
</tr>
<tr>
<td>Clinic for O&amp;Gyn Novi Sad</td>
<td>3rd</td>
<td>yes</td>
<td>6372</td>
<td>5/5</td>
<td>5/5</td>
<td>10/10</td>
</tr>
<tr>
<td>Clinic Gynaecology and Obstetrics “Narodni Front”</td>
<td>3rd</td>
<td>yes</td>
<td>7391</td>
<td>5/3</td>
<td>5/10</td>
<td>10/10</td>
</tr>
<tr>
<td>Clinical Center of Serbia, Institute for Gynaecology and Obstetrics</td>
<td>3rd</td>
<td>no</td>
<td>6899</td>
<td>5/5</td>
<td>5/5</td>
<td>10/10</td>
</tr>
<tr>
<td>Belgrade PHC</td>
<td>3/3</td>
<td>no</td>
<td>3/3</td>
<td>5/5</td>
<td>5/5</td>
<td>10/10</td>
</tr>
<tr>
<td>Totals – target/achieved</td>
<td>37/32</td>
<td>35/42</td>
<td>70/71</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BFH: accredited in the past as meeting the criteria for a Baby Friendly Hospital.

Key informants

Key informant interviews were conducted to obtain qualitative information on the evaluation issues. Respondents were asked questions about the historical performance of BFHI to address the program’s relevance, responsiveness, and the sustainability of results, and forward–looking questions to use in developing the recommendations. All questions were designed to be open–ended in order to gather perceptions, observations, options and knowledge of respondents. The first interviews served as pre–tests and the guides were adjusted as required.

A list of key informants, including government, NGOs and parent organisations was provided by UNICEF and interview times arranged for these informants. Interviews with eight organisations were originally planned, however during the time in Serbia further organisations were added for a total of ten organisations (Table 4). Individual or 3-4 people in a small group discussion were utilised in preference to larger focus groups due to language and confidentiality issues.
Interviews were also conducted with the head of maternity service and other senior manager(s) in the nine facilities to gain their perspective on BFHI participation. Scheduling of site visits did not allow for return visits if specific informants were not available. If the designated person was not available another suitable person in the organisation was interviewed.

In some facilities, when respondents were available and willing, a senior staff group discussion was conducted in addition to individual interviews. Over 77 people participated in these key informant interviews / discussions. (Table 5) Some senior managers had both an individual interview and participated in a group discussion.

**Table 4: Organisation interviews**

<table>
<thead>
<tr>
<th>Person</th>
<th>Organisation</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Branka Stamenković</td>
<td>Majka Hrabrost &quot;Mother Courage&quot;</td>
<td>Civic initiative, NGO</td>
</tr>
<tr>
<td>Dragana Soćanin</td>
<td>Association Roditelj</td>
<td>Association of parents</td>
</tr>
<tr>
<td>Dr Djurdja Kisin</td>
<td>Institute of Public Health of Serbia, Centre for Health Promotion</td>
<td>Government</td>
</tr>
<tr>
<td>Dr Ljiljana Radovic</td>
<td>Centre for Children Care (CCHC) / IBFAN</td>
<td>Civic initiative, NGO</td>
</tr>
<tr>
<td>Dr Ljiljana Abramović - Savić</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vladimir Ješić, journalist and colleagues</td>
<td>BEBAC</td>
<td>Web portal with parenting information (NGO)</td>
</tr>
<tr>
<td>Andjelka Kotevic</td>
<td>Patronage Service, Institute of Public Health of Belgrade</td>
<td>Government</td>
</tr>
<tr>
<td>Dr. Elizabet Paunovic , assistant minister for international cooperation</td>
<td>Ministry of Health</td>
<td>Government</td>
</tr>
<tr>
<td>Dr Ivana Misic, assistant minister for the organization of the health care system</td>
<td>UNICEF</td>
<td>UN agency</td>
</tr>
<tr>
<td>Dr Aleksandra Jovic, Programme Specialist, ECD</td>
<td>WHO</td>
<td>UN agency</td>
</tr>
<tr>
<td>Dr Melita Vujanovic, Deputy Head</td>
<td>Roma Mediators</td>
<td>Government</td>
</tr>
<tr>
<td>Lepa Nedeljkovic, Elizabeta Mitrovic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 5: Key informant interviews**

<table>
<thead>
<tr>
<th>Source</th>
<th>Number of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group discussions in the facilities visited (11 groups)</td>
<td>60</td>
</tr>
<tr>
<td>Managers in the 9 health facilities (PHC &amp; hospital) individual interviews</td>
<td>17</td>
</tr>
<tr>
<td>Government, NGO, and other organisations</td>
<td>17</td>
</tr>
</tbody>
</table>
Ethical considerations
The choice of facilities and sampling of respondents attempted to ensure equal representation of population groups.

The evaluation aimed to be conducted in a manner that was respectful and confidentiality for the people participating in interviews. The purpose of the interview was explained; that identifying information is not reported was highlighted, and verbal consent was obtained before interviewing. Respondents could decline to be interviewed.

Interview data was collected without individually identifiable information as far as possible. However, since the sample site is listed and the sample size is small, it may be possible to deduce who the respondent is likely to be if the interview instruments are examined. Therefore, individual data was carefully stored by evaluators during the evaluation and handed over to UNICEF on completion of the evaluation. It is recommended that this individual data is securely kept until the evaluation report is accepted and that it is then destroyed. No individual’s data was retained by the evaluators.

Feedback of evaluation report (or a summary) to the facilities involved and to parent organisations will be the responsibility of UNICEF/ Special Working Group.

Analysis
All questionnaires and interview forms were reviewed to establish key points to inform the evaluation report. Statistical reports for each of the BFHI criteria (Ten Steps) for each hospital visited were not prepared as intended because an overview of the data provided the impression that most of the practices were well below the standards expected by the WHO/UNICEF global criteria, and analysis time could be better used.

The data obtained from records and reports was extensive, though much as historical data, and not relevant to the key focus of this evaluation. It was not possible to perform comparative analysis using before and after data due to lack of comparable data over the many years of the programme.

The Evaluation Team used the documentary and interview data gathered to construct a report focusing on the areas as requested in the TOR adding additional information that they considered useful for review and planning for the future. The Evaluation Team held a consultation session with the Special Working Group to refine the preliminary findings and development of conclusions and recommendations.

Challenges and limitations of methodology
When examining outcomes in a broad and changing national setting it can be methodologically difficult to attribute results to a specific programme. The evaluation includes reference to other factors influencing results as appropriate.

When undertaking a country level review where there have been many different types of investments in a wide range of areas over a long period of time, determining efficiency would be extremely difficult with the time allocated (if not impossible), and with questionable results. The evaluation did not directly assess issues of cost effectiveness.

Where the programme had not set specific targets at the initiation stage, it was difficult to measure if these were reached. The evaluation assumed targets based on international programme targets and experience from other countries when there are not national targets.
4. Evaluation findings and recommendations by TOR objectives

Overview
There were eight objectives of the evaluation provided to the evaluators in the Terms of Reference. The findings and specific recommendations for each objective are reported followed by a general recommendations section.

In reading this report it should be noted that the global BFHI is quite different to the current implementation and perception of BFHI in Serbia; assessment and comparison is to the global BFHI.

Items for the document review were predominately for the period until 2005 and many of the indicators in this period were for the Federal Republic of Yugoslavia-Serbia and Montenegro. Because of organizational and political changes the last data are from Serbia separately, e.g. MICS 2005, as could be seen from Table 1. Therefore, we consider it inappropriate to compare these sets of indicators, and no clear conclusion about progress in breastfeeding indicators can be made.

According to the data acquired and reviewed, these conclusions could be drawn:

Objective 1: To assess BFHI relevance
Key findings:
- The Baby Friendly Hospital Initiative (BFHI) is very relevant to the overall health in the country (protection of health and prevention of diseases). In the past and currently it is linked to several other project and programme activities both within the Ministry of Health and the UNICEF Office in Belgrade, and included in the Early Childhood Development Programme.
- The “National Program of Healthcare of Women, Children and Young People in the Republic of Serbia” and the “Decree on National Program of Healthcare of Women, Children and Young People in the Republic of Serbia” adopted by the Government of the Republic of Serbia in April 2009 recognizes BFHI as a valuable initiative. It covers several activities within the implementation of the UNICEF/WHO Strategy of “Ten steps to successful breastfeeding” such as information to the pregnant, future parents about the feeding practices, care, and protection of the physical and mental health of the women and her child. The existing concept of BFHI is one of the priority actions in the building of the new, updated concept of healthcare in accordance with international best evidence-based practices. The implementation of the BFHI in all health institutions dealing with pregnant women, birth and infants, thus enabling the preterm and the at-risk newborns to have equal standards as the term newborns have is recognized as specific goal within these programmes.
- The criteria and standards within the global WHO/UNICEF BFHI are relevant to the needs of the mothers, babies, families, health system and the community in Serbia. Parent groups have highlighted unmet needs of mothers/families related to hospital maternity practices and widespread implementation of the full BFHI would assist in meeting some of these needs and requests.
- According to the interviews and discussions conducted in maternity hospitals/units and Primary Health Care (PHC) with pregnant women, mothers
of infants, and staff, there is widespread misconception of the meaning and scope of the BFHI. It is perceived primarily as 24-hour “rooming in”, or something related to promoting breastfeeding in general. Approximately half of the women answered that they would prefer a non-BFH (Baby-friendly Hospital) for giving birth (21 out of 42 pregnant women and 30 out of 65 postnatal). However this was linked with a perception that BFHI meant that they would be left to care for their baby on their own with little assistance from the staff, and in an environment with unsupportive birth practices that left them very tired and limited breastfeeding education for mothers.

- Some mothers and some staff were not aware of the reasons for the practices of the BFHI, or benefits to baby and mother; only that the practices should be done.
- Many staff members thought extensive structural changes were required to implement baby-friendly practices, such as providing facilities in each room for bathing babies, and focused on these perceived barriers rather than addressing easy to implement practices.
- Nearly one-third of women replied that they would expect higher levels of cleanliness, food, attention and similar services, in a hospital that was “Baby-friendly”. This may indicate a perception that the BFHI is a much broader quality improvement programme.
- The global BFHI is not designed to specifically address rights issues such as children with disabilities and institutionalisation of infants. However BFHI practices can assist maternal-child bonding and this contributes to a reduction in abandonment.

**Key recommendations:**

- Increase public promotion and awareness of the BFHI (the complete Initiative not only parts of it) in the wider community/ media.
- Avoid using the term “Baby Friendly Care” to signify that mothers and babies are together in hospital. Rooming-in is only one aspect of the BFHI criteria and standards.
- Enrich the existing web sites of the Ministry of Health, Institutes of Public Health and professional organizations (perinatal, obstetric, neonatal, paediatric, nursing, midwifery), as well as those of parent organisations, with information related to the importance of breastfeeding and the purpose and practices of the BFHI.
- Improve promotion of all practices of the BFHI within the hospitals (whether previously accredited as a Baby-friendly hospital or not) including the reasons for these practices.

**Objective 2: To assess BFHI effectiveness**

BFHI as an Initiative has the main aims to improve the quality of maternal, neonatal and child health care and to stop the marketing of breast milk substitutes, within the health service

**Key findings:**

- Since the Initiative was launched, it has made great difference in the approach towards the maternal and child health care, it has contributed to the increased breastfeeding rate, acted as a catalyst for staff training, and helped to improve the content and consistency of recommendations to the mothers and families.
The certification and reassessment process in that time (approximately 1994-2003) was conducted according to the original Global criteria of UNICEF and WHO. Ongoing contact and several monitoring visits were conducted to get the hospitals ready for the final external assessment.

An achievement was the transfer in 2005 of most of the items of the World Health Assembly International Code for Marketing of Breast-milk Substitutes into three laws:
- RULES ON LABELLING PACKED PRODUCTS INTENDED FOR FEEDING INFANTS AND YOUNG CHILDREN (Official Gazette of Serbia and Montenegro, number 4/2005, January 28, 2005),
- CONSUMER PROTECTION LAW (Official Gazette of the Republic of Serbia no. 79/2005, September 16, 2005)
- ADVERTISING LAW (Official Gazette of the Republic of Serbia no. 79/2005, September 16, 2005)

Unfortunately, in visits to some of the hospitals, both BFH and non-BFH, some violations of the Code/law were apparent (intentionally or unintentionally). Though a NGO had conducted monitoring in the past, they were not doing ongoing monitoring as they rely on volunteer workers and funding donations. An official government system for monitoring and enforcing the code/law was not in place according to key informants interviewed.

The tenth step (establishing mother support groups) was implemented and was spread all over the country, but these groups appeared not to be active any more. There appears to be a recent increase in parent-to-parent support provided by phone and web forums with enthusiastic leaders. It was not possible to evaluate the extent of usage or influence of these groups.

The PHC patronage service is very strong throughout the country and provides support to the mothers and families. The good practices of Parenting schools and Antenatal classes are contributing greatly to the successful breastfeeding. Aside from classes, there appeared to be low levels of attention to discussing breastfeeding supportive practices during pregnancy care, both in PHC and in hospitalised pregnant women.

Posters and information leaflets were provided for mothers and training materials for staff education. These achievements that took place could not happen without financial support in the period 1994-2003 from the UNICEF Office.

The visits and interviews of the current evaluation showed many of the BFHI criteria were not being met and indications that these gaps were not being addressed due to lack of funding and no allocated time for national coordination.

As far as could be established, the National Breastfeeding Committee was no longer active after the mid-1990s.

As time passed the majority of the managers of services were changed and some of the new managers were not familiar with the Initiative. This contributed to the decline in prominence and activity in some areas.

Key recommendations:
- Include the Ten Steps to Successful Breastfeeding (on which BFHI is based) as standards of routine perinatal practices that should be implemented in each maternity unit or maternity hospital.
• Provide means of collaboration with the relevant structures to update the curricula for undergraduate and postgraduate medical studies and nursing curricula to these practices and standards as routine practices.
• Involve professional associations (perinatal, obstetric, neonatal, paediatric, nursing, midwifery) in developing and implementing evidence based care for pregnant women, infants and their mothers.
• Hold workshops for managers/decision makers in the Maternity services about the concept of BFHI and their role in supporting it.
• Re-establish regular hospital/PHC level training and continuing education in baby-friendly practices ensuring that it reflects accurate and up-to-date information and skills.
• Increase availability of theory and practice sessions on skills for health worker-patient communication linked with a wider communication improvement programme.
• Standardise the content of all materials for parents, staff manuals and guidelines (for Parenting schools, Antenatal classes, counselling of the pregnant women during her antenatal visits, PHC follow up of the infants, patronage service) between all health professionals and within the country, in order to assist consistent information regarding care and feeding practices.
• Examine the use of web based methods for providing information both for parents and for health workers.
• Strengthen the capacities for improving the antenatal visits to routinely provide consistent supportive information, and discussion of this information, to all women (as distinct from relying on attendance at extra classes). Record these discussions in the women's antenatal record of care.
• Examine the linking or inclusion of BFHI assessments with the recently developed system of national accreditation of both hospitals and PHC.
• Include the breastfeeding and BFHI promotion in the antenatal care services, and postnatal care of infants, as routine practice and assessed within the accreditation of the Primary Health Care.
• Link with the relevant government ministry or agency to ensure monitoring and enforcement occurs of the Code for marketing of breast milk substitutes and that violations within health services and the wider community are addressed to thus protect breastfeeding.
• Encourage the development of voluntary parent-to-parent support networks to promote and support breastfeeding and supportive practices.

Objective 3: To assess BFHI sustainability

Key findings:
• The model of the BFHI in Serbia does not appear to have been sustained for long after UNICEF support was reduced since 2003. Currently there is little activity and a low profile. This appears to be primarily due to lack of funds both for national coordination and local implementation.
• Though actions can be taken locally, there needs to be a central plan to ensure consistency of information, economies of scale (production of materials), standards of assessment, as well as awareness of the BFHI at all levels.
General perception from interviews was that the BFHI was seen as an outside programme. There was low understanding among health workers and mothers of what the Initiative entailed.

BFHI global design can facilitate local take-up; however it was not clear if the BFHI in Serbia had a design or implementation plan in the last 5 years.

There are opportunities for expansion, though they are unlikely to be sustainable if the current model is continued. Primary Health Care centres, health worker education and training, quality and accreditation programmes all can link with the BFHI.

**Key recommendations:**

- Develop a new model that integrates the BFHI practices into existing health care services and systems rather than as a stand-alone project.
- Allocate on-going time and funding to coordination of BFHI activities as a distinct post or as protected time in an existing post.
- Allocate on-going funding to carry out BFHI related activities such as assessment and monitoring, as well as health worker training in supportive practices.
- Increase awareness of the importance of breastfeeding, and of the components and practices of the BFHI:
  - to policy and decision makers
  - to health workers and those who educate them,
  - to parents,
  - to wider community.

**Objective 4: To assess the BFHI’s impact**

The purpose of the BFHI programme in Serbia was to “protect children’s physical and mental health and improve the nutritional status of infants and young children.”

Objectives of the programme differ slightly across reports from various sources, however they were basically to improve health worker knowledge, skills and practices; improve pregnant women/mothers knowledge, skills and practices; provide a supportive health service environment including no marketing of breast-milk substitutes through the health services; support, protect and promote exclusive breastfeeding in emergencies; and for maternity wards to become accredited as meeting the Baby-Friendly criteria.

The goals stated in 2003 were: to have 80% of maternity wards accredited as “baby-friendly”, to increase the exclusive breastfeeding rate at the end of the sixth month of infants to 40%; to decrease the rate of illnesses and deaths due to diseases related to feeding practices; to strengthen friendly relationship of health professionals and families, and to include community into the support program.

**Key findings:**

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A report in 2005\(^9\) state that 84% of maternity facilities (49 facilities) were certified as Baby-friendly according to WHO/UNICEF global criteria, indicating the goal at that time had been achieved. However, Baby-friendly awards expire. It is at least 5 years since any formal assessments/reassessments were carried out and thus numbers of Baby-friendly awarded hospitals reflect the situation in the past rather than the present. The practices observed and information from interviews gave the impression that at least some of the hospitals certified in the past would not currently meet the standards.

Awareness of participation and achievement in BFHI was varied. Frequently both managers and staff were inaccurate in their response regarding if their facility had a Baby-friendly award at all, what is award was (e.g. paper certificate, plaque), and if awarded, where the award was displayed or kept.

The data about rates of exclusive breastfeeding did not facilitate comparison between the past and the present rates to judge if goals had been reached. In some hospitals the required data could not be provided because of irregular recording in patient files. According to the data provided by some of the facilities visited during the evaluation, the exclusive breastfeeding rate is tending to decline. The main factors in this decline relate to overuse of formula supplements. Reasons for this over use include: recommended by paediatricians without clear medical indications, routine supplement use to facilitate hospital systems such as separation of mother and baby, and mothers' supplementing by their own decision. There appeared to be a lack of awareness of the disadvantages and risks of formula use among both mothers and staff.

The second BFHI criteria (to have over 80% trained staff) is unlikely to be in place currently as there was no evidence of any training of the staff working in maternity hospitals/units since 2003. During the years there were many changes in managerial teams and working staff within the hospitals/units further contributing to the need to update staff knowledge and skills.

As there were many events and organisational changes in Serbia since 1994 combined with the systems of data collection, it was not possible to evaluate if the BFHI had a specific impact on morbidity and mortality rates across this time. It would be difficult in any setting to show a causal link between implementing the practices of the Baby Friendly Hospital Initiative and a decrease the rate of illnesses and deaths later due to diseases related to feeding practices.

Specific community supports for breastfeeding families appeared to be good where they were in place, though they were not available in all areas. Different supports may be appropriate in rural and in urban areas, and within different socio-economic groups. A formal process of assessing PHC facilities using set criteria did not appear to be in place. Note that the global BFHI applies to hospital services and there are no global BFI criteria or assessment forms for community health services.

Although there was not an objective to assess the implementation of the mother friendly criteria (an aspect of the 2006-2008 global BFHI revision, Appendix F) in the maternity hospitals/units, there was an impression that these criteria are not respected and applied. Mothers complain of poor communication with health workers, lack of attention, lack of respect, and less time spent with them than needed.

Key recommendations:

- Raise awareness of the acceptable medical indications for breast milk supplementation / no breastfeeding, develop skills of health workers to cope with situations without providing a formula feed as the solution for lack of staff knowledge or time, and review hospital systems of care to avoid reliance on formula feeds for breastfeeding babies.
- Include the desired indicators within the regular recorded data in the files of pregnant, mothers and babies in order to have good quality data, and to create a national database about the indicators related to feeding practices, and to health and illness. The new Law on records and statistical surveys in the area of health that should be drafted in the next period may provide an effective way of integration of these indicators in order to monitor the progress and changes of the health indicators and making them comparable with other countries.
- Educate mothers and staff and implement mother-friendly criteria in Maternity hospitals/Units.
- Consider if is more feasible to strengthen the capacities of existing patronage service and standardize their manuals for care rather than revitalize the mother to mother support groups that may not be appropriate in some areas.
- Develop a sustainable system of coordinating the BFHI assessment and reassessment of hospitals first rather than further stretching the present low level of coordination available in order to develop a PHC assessment process. As there is currently no global WHO/UNICEF assessment process for PHC, networking with other BFHI programmes in Europe would provide information on their activities towards developing assessment tools and processes that might be useful in Serbia.
- Increase the perception that the owner of the BFHI is the country by itself, as a part of the standard, routine perinatal care, and UNICEF should be considered only as a partner who will provide technical support and facilitator/link for some related activities.

Objective 5: To assess BFHI efficiency

Key findings:

- If was not possible in this evaluation to review UNICEF use of funds due to limitations of time and data. Evaluation of UNICEF use of funds over the period 1993 to 2009 would be very extensive work.
- From brief review of documents provided by UNICEF it did not appear possible to disaggregate the expenditure on the BFHI as distinct from other activities related to breastfeeding and maternal and child care.
- No cost benefit analysis reports were available to evaluators for comparison of the current situation with those 19 years ago.

Key recommendations:

- Some costs of the BFHI are possible to list as distinct line items in a budget, for example printed materials, training courses, assessment visits and other tasks. However outcomes such as differences in infant health may be difficult to attribute directly to a specific activity and to the funds used.
Objective 6: To assess the BFHI coordination

There were many changes in coordination of the Program for Breastfeeding, or BFHI, in the last few years. The shift of all coordinating activities from the State secretariat for health protection of mothers and children to the Institute for Public Health—Batut had great impact on the overall coordination of the BFHI. Unintentionally, almost in the same period, the financial support from UNICEF Office ceased for BFHI. Together these changes left the Initiative with little coordination and funding.

Key findings:
- The overall impression and interview based conclusion was that currently there is no monitoring of the standards in BFHI, no coordinated activities to improve the breastfeeding related practices within the Maternity hospitals/units, no funding to support training activities, few information materials for mothers, with hospitals left to themselves to work on their own if they so wish.
- The current situation is very prone to violations of the Code of Marketing and for facilities to receive donations and gifts from the companies that market and distribute breast milk substitutes and related products.

Key recommendations:
- The BFHI should not be a viewed as a separate, independent activity, but should be integrated as a routine activity of normal practice of the maternity services.
- There should be a national BFHI coordinator whose responsibilities include:
  1. Raising and maintaining awareness of the breastfeeding supportive hospital practices, and the role of BFHI assessment in assisting implementation and sustaining of these practices.
  2. Coordinating BFHI related training and education for health workers to ensure consistency of content, quality delivery of training, and measurable outcomes, as well as linking with academic institutions to work towards undergraduate/pre-service curricula and education of health workers consistent with BFHI practices.
  3. Assisting the facility level team or focal person to enable them to perform internal monitoring of BFHI related standards towards maintenance of the standards for (re)accreditation of the hospital/unit.
  4. Coordinating the team of assessors to develop their skills and activities in performing to a high standard in (re)assessments.
  5. Linking with those providing breastfeeding promotion and parenting materials for mothers and wider community to ensure they reflect baby-friendly practices.
  6. Linking with those developing and assessing accreditation standards to ensure consistency and reduce duplication of assessments.
  7. Linking with those responsible for the Code of Marketing law to ensure there are no violations in Baby-friendly hospitals.
  8. Networking with BFHI coordinators in other countries to develop ideas, share information and mutually support BFHI on a global basis.
- The main recommendation should be repeated: to make BFHI practices an integral part of the routine good perinatal practice (antenatal, intrapartum, postnatal), infant and child care.
Objective 7: To assess the application of a BFHI human rights-based approach

The BFHI can further the realisation of the right to the highest attainable standard of health through support for breastfeeding for all infants, young children and their mothers without discrimination. Mothers (and families) are active in providing care for their unborn child, their infant and older. The BFHI can assist in recognising mothers and families in this key role and empowering them, rather than considering mothers and infants as passive recipients of services. Mothers, though users of the health services, are generally not ill and can participate as stakeholders in planning, delivery and monitoring partnerships to further the objectives of the BFHI and thus contribute to its sustainability. All people are entitled to respect.¹⁰

Key findings:

- There was no indication of participation of mothers/parents in past design and implementation of activities. Recent involvement of parent NGOs in BFHI Working Group is an achievement.
- Frequently services are "done to" mothers and babies, rather than in conjunction with them. Basic respect for mothers and babies was low in many hospitals visited. For example, inviting the evaluator to be present for an intimate examination during labour (where there were already approximately eight people present) without consulting the mother or with no regard for the mother’s privacy, and babies separated from their mothers and fed to a schedule with fluids other than human milk. Respect appeared better in hospitals with past Baby-friendly assessment and in PHC centres.
- Mother satisfaction surveys from Batut and from two parent web sites indicate room for improvement. Parent NGOs are very willing to discuss changes needed.
- There is a national project to improve health worker communication skills and this could be encouraged in connection with BFHI activities.
- There was no indication that ethnic group related to care received, and no indication of ethic discrimination. However in some hospitals, companion during labour, access to visitors and standard of room and sanitary facilities, depended on willingness to pay.
- Visiting rules varied from mother (without baby present) allowed to meet visitors in an open public foyer (often with mother standing), through close family allowed to visit at bedside (with baby there), to pleasant outdoor balcony sitting area for mother and visitors (in private apartment section). The risk of infection from visitors was generally given as the reason for visiting restrictions, though the variety of practices observed made it questionable if there was any evidence for this infection risk.
- Health status was seen at times to be a barrier to Baby-friendly practices. Mothers with c-section were generally separated from their infants for 48 hours and infants fed formula during this time. Despite questioning the medical evidence base for this separation (and thus formula use) was not clear and it appeared to be primarily for the ease of staff in caring for these mothers. In one hospital it was admirable to see that both mothers and fathers were encouraged

to frequently spend time with their infant in neonatal ICU and to touch their infant; unfortunately in other hospitals there was low contact between mother/parents and their baby needing special care.

- The father or other companion to provide support during labour and birth was available in some of the hospitals only. However, there were usually conditions attached such as father required to attend parent classes (in one hospital these classes were no longer available but attendance at them was still a requirement), nose and throat swabs taken within the 5-7 days before birth (difficult unless birth was a scheduled induction or c-section, and these tests have to be paid for), as well as official charges made by the hospital for presence of companion. Even when allowed, few mothers appeared to be accompanied. There may be low understanding of why a companion would be helpful to the woman in labour.

**Key recommendations:**

- Place mother (parents) and baby at the centre of the system and relate practices to their needs.
- Balance needs of the mother (parents) and baby and needs of the service.
- Examine restrictive practices for evidence based justification and removed if there is no justification for them.
- Allow close family visiting and contact with their baby in an environment where the mother can sit and the temperature is suitable.
- Encourage companion (of mother's choice, not necessarily baby's father) during labour and birth to provide support for mother.
- Encourage walking, comfortable positions for labour and birth, light foods and fluid, to reduce the stress of labour and birth so that mother is less tired and feels more able to care for her baby after birth.
- Examine extending the BFHI to specialist hospitals caring for infants so that these support mother and baby contact, and exclusive and sustained breastfeeding.
- Continue to include parent-led non-commercial NGOs in activities to design and monitor services

**Objective 8: To assess the application of result-based BFHI management**

**Key findings:**

- Results-based management did not appear to have been used
- A structured management approach was not evident.
- The objectives set in 1995 at the launch of the BFHI in Serbia were unspecific and thus difficult to measure. Objectives set in 2003 were more specific, such as to have 80% of maternity wards assessed as Baby-friendly, though this may not have been realistic. Other objectives were less measurable, such as to "strengthen friendly relationships of health professionals and families".
- Measurement points for outcomes were not apparent nor a system of measurement. Indicators of breastfeeding sometimes were exclusive breastfeeding and sometimes partial breastfeeding, making comparisons difficult. Official health service performance indicators do not appear to include
exclusive breastfeeding rates. BFHI coordination does not appear to have a way of collecting data except for those hospitals assessed/monitored in the past.

- From the information obtained it was not possible to ascertain if data was linked to decision-making.

**Key recommendations:**
- Develop Action Plans that include SMART objectives.
- Focus on improving outcomes that will provide improved care or health not only measuring inputs or achievement of tasks.

**Good practices**
The majority of the health workers interviewed were supportive of the BFHI and wanted to improve care for baby and mother. The evaluators noticed a number of good practices that should be retained and built on. These include:

- The strong interest and commitment of individuals to work to implement best practices for infants and their mothers/families. These individuals should be recognised for their on-going efforts and supported in continuing. In addition, enthusiastic people in each facility should be sought out to serve as motivators of others.
- Particularly supportive practices in some facilities, such as a welcoming environment for family visits and encouraging parent contact with infants in the neonatal unit, which could be highlighted as examples for other facilities.
- Media and community activities over the years, such as marking Breastfeeding Week, that serve to raise awareness of the importance of breastfeeding and practices to support it. These activities should continue within an overall plan for promotion and support of breastfeeding and the BFHI.
- Involvement of parent groups in the Special Working Group and recognition of the value and energy of these groups in furthering BFHI related activities.
- Legislative support for protection from marketing of breast milk substitutes and related product.
- Classes for preparation for birth and parenting that were focused on the needs of the mothers/families and conducted using good adult education principles.
- Patronage and other postnatal community services provided in the mother’s home and targeted to her individual needs. Activities to provide accurate and consistent information from the nurses should be continued.

**Any unintended results attributable to the programme**
The BFHI is very broadly interpreted in Serbia with somewhat unspecific targets. It was difficult for the evaluators to determine what “the programme” was and what the expected results were. It was slightly surprising to find the high expectation that BFHI participation would require changes to the building to improve facilities for washing infants in their mother’s rooms; however this appeared to be an intended result of the programme in Serbia.
5. **Constraints and limitations of the evaluation**

All facilities and organisations chosen cooperated with the evaluation and respondents were helpful with their comments.

The changes over the fourteen years limited the availability of records; however the evaluators thought it unlikely that more extensive historical data would result in a different view of the current state of the BFHI.

All evaluations are done within time and funding constraints. More time and a larger team to visit more facilities would have given a broader view of the situation. Some facilities that were not visited may have had excellent practices in place and be carrying out their own internal monitoring to ensure these practices were sustained. Alternatively, some unvisited facilities might have even less supportive practices. The evaluators consider that the sample visited provides sufficient indications that the BFHI in Serbia needs revitalisation and effective on-going coordination.

6. **Conclusions**

The evaluation of the Baby Friendly Hospital Initiative (BFHI) in Serbia was carried out in accordance with the TOR presented to the evaluators.

The inception report outlining the evaluation methodology was presented, discussed and approved by the Special Working Group.

Documents and reports related to the establishment and implementation of the BFHI and associated activities, health indicator data, and other materials were acquired and reviewed. Five hospitals with maternity services and four associated primary health care facilities were visited taking into account geographic location and population served, their relevant documents reviewed and observations of practice carried out. Individual interviews were conducted with 17 managers of these facilities, 32 members of the staff of the facilities, plus discussions with 11 groups of staff. Individual interviews were conducted with 42 pregnant women and 71 postnatal women using the services in these facilities. Ten organisations including parent groups, NGOs and governmental organisations participated in interviews.

An interim evaluation report (draft findings, conclusions and recommendations), was presented and discussed with the Special Working Group and the draft findings were accepted. The final evaluation report (this document) was submitted to the Special Working Group.

The BFHI is relevant to the needs of mothers, infants and the health service in Serbia, fits with national priorities and is generally acceptable. The BFHI was implemented as part of a wider programme of maternal and infant activity and raised awareness of breastfeeding and supportive practices. However, there are misperceptions of what is the BFHI by many mothers, staff and managers as well as the wider community. The Initiative was moderately effective until about 2003 when support was reduced and activity curtailed, though low level activity continued in some areas due to the commitment of individuals. While some of the practices remain in place in some hospitals, the overall “Initiative” with its assessment and monitoring of standards has
not been sustained. The WHO/UNICEF global BFHI was updated in 2006-8 and the updated standards and supporting materials are not part of the BFHI in Serbia.

The evaluators recommend revitalisation of the BFHI starting with an effective and sustainable system of coordination of the Initiative that would raise awareness of the BFHI and work to link it with routine training of health workers as well as with other health service quality programmes. A health service model is also recommended that places the baby and mother needs at the centre of a supportive environment, including protection from marketing of breast milk substitutes. The evaluation report provides detailed recommendations and a suggested plan for action.

7. **Overall Recommendations**

**Opportunities**

Though there are difficulties due to the economic situation, this is also a time of opportunities for actions related to the BFHI in Serbia.

- The Global revision of BFHI that was undertaken in 2006-8 revised the criteria to address many of the issues highlighted by parent groups. These include mother-friendly birth practices assisting both baby and mother to be better ready for immediate skin to skin contact and early initiation of breastfeeding, renewed attention to marketing practices related to breast milk substitutes, attention to the needs of babies and mothers when not breastfeeding, and improving links to community support services. New staff training and parent information materials are available to support this revision (free downloads from WHO & UNICEF web sites). There is an opportunity to position a revitalised BFHI in Serbia as a part of this global revision.

- The BFHI can link easily into the national accreditation and quality programme for health services that is being developed. Breastfeeding and practices that support it is the topic of the BFHI, however the process is one of implementing, assessing and monitoring best practice, which is a quality activity. BFHI has an evidence base for practices, measureable criteria and a long-standing internationally recognised structured assessment process that can serve as an excellent example for accreditation and quality programmes.

- The Expert Commission for Health Care of Women and Children (2009) can serve to emphaise the importance of health facilities putting in place practices that support breastfeeding for health gains for women and children.

- Professional associations related to perinatal care are being strengthened. These associations can assist in raising awareness of the BFHI, develop supportive protocols for care, provide training in best practice, and be involved in BFHI related committees and working groups.

- The WHO assisted project to develop a nurse training strategy provides an opportunity to ensure that all levels of nurses have a basic awareness of the value of breastfeeding, and as relevant, have the knowledge and skills to implement best practices in supporting breastfeeding.

- Current projects to improve health worker communication skills and practices can be linked to communication related to all aspects of maternity care.

- Activities that are strengthening healthcare information systems provide an opportunity to obtain data on practices such as antenatal education and discussions, early contact and initiation of breastfeeding, exclusive breastfeeding
and rates of supplementation, as well as to effectively monitor breastfeeding rates during the child’s first year.

- Increasing internet use provides a low cost method of disseminating information to parents, health workers and the wider community. Opportunities exist to raise awareness and change attitudes through campaigns to the general public including schoolchildren, through to providing resources for parents to distance learning for health workers.

**Overall recommendations**

There are many recommendations presented with the findings for each objective of the evaluation (Section 5). Those recommendations are brought together in these overall recommendations from the evaluators to:

- Place the baby and mother/parents at center of supportive healthcare environment and the reason for the service to exist, not merely as objects of the health care process.
- Raise awareness of what are the practices and assessment process of the BFHI and why it is of value in Serbia.
- Update and disseminate the updated information for parents and health workers related to breastfeeding and supportive practices.
- Include up-to-date evidence based knowledge and skills related to breastfeeding and supportive practices, as the routine practice, in the pre-service training and continuing education of health workers through inclusion across the curriculum and in training materials. Ensure they know why the practices are important and can discuss this with parents, not only that the practices should occur.
- Link the BFHI to accreditation, quality assurance, health promotion and other health strategies to provide integrated processes rather than BFHI as an independent special project.
- Remember that breastfeeding is not a medical or clinical problem to be treated but a normal health practice to be supported.
- Enforce the protection of consumers as well as health workers from marketing practices that may undermine breastfeeding and optimal health for infants and their mothers. There is limited benefit in promoting breastfeeding if there is no protection from the much stronger promotion of breast milk substitutes.
- Provide funding and thus time for the effective and sustainable coordination of the BFHI and related activities.
- Recognise, reinforce and build on existing activities that are working well
- Seek out key enthusiastic people in each health facility, institution for educating health workers, professional associations and community groups, support them in activities and assist them in developing skills to motivate and leaders those around them
- Provide protective budgets for BFHI activities at individual facility and regional level as well as nationally.

**Suggestions towards a plan of action**

The Special Working Group and others will need to develop a plan of action with realistic goals and measureable objectives and a suitable time frame. Bearing in mind economic realities, the evaluators would like to suggest possible stages for the Special Working Group to consider. It is assumed that there is a coordinator in place with time allocated to BFHI activities. The cost of this person’s salary, office facilities, and
networking with BFHI coordinators in other countries to become and remain up-to-date themselves is not listed for each stage and this cost would obviously need to be provided for in order for effective coordination to occur. Each stage would continue at a maintenance level after the initial higher level of action.

1. **Raise awareness of BFHI among decision makers, educators, health workers, parents, wider community.** Existing Ministry of Health, Bantu or similar web site could serve as a repository of up-to-date information on the BFHI and supportive practices. Other web sites could then link to this central source. This information exists in English and some in Macedonian. The costs would be for some translation and adding the material to the existing web site. First half of year 1.

2. **Update training at pre-service and in-service levels reinforcing baby-friendly practices as normal, evidence based care.** The content exists for this and can be downloaded (and linked to) from WHO/UNICEF and other non-commercial web sites (Bibliography). By reinforcing local and regional trainers as well as those in academia, short update training sessions could be held at low cost. Costs would relate to translation, updating local trainers, some printing costs and holding training sessions for existing staff. Second half of year 1 perhaps on a regionally phased basis.

3. **Ensure consistency in parent information materials with that for health workers.** Similar to previous stage, the material exists. Costs related to translation and limited printing, using web sites for dissemination where feasible and including selected materials in existing information packs for parents. First half of year 2, perhaps on a regionally phased basis.

4. **Implement revised practices in maternity units where updating has taken place and motivated staff are leading activities.** Costs relate to BFHI coordinator visiting hospitals (if needed) to support implementation and assist in addressing barriers to implementing practices. First half of year 2, perhaps on a regionally phased basis.

5. **Prepare for assessments including localisation of assessment tools and process and preparation of an assessment schedule.** Examine linking with other accreditation/quality processes for initial assessment (possibly) and on-going monitoring (likely). The costs would include training of the assessment team members on the revised tools (it is assumed that their own knowledge and skill has been updated during stage 2 and 4). Second half of year 2.

6. **Start to carry out assessments on a gradual and sustainable level.** The costs would include time and travel of the assessment team and facility level time costs to prepare their documentation for the assessment and participate in the assessment, as well as costs of awards for successful facilities. First half of year 3, perhaps on a regionally phased basis.

7. **On-going monitoring and re-assessment process developed based on global tools and process, and linking with other national quality monitoring processes.** Development would be done within coordinator’s overall BFHI work. Costs for monitoring are at local facility level and are staff time related. Reassessment costs are similar to initial assessment costs. Development process would start first half of year 3. Monitoring and reassessment is on-going.

8. **Begin to examine methods of assessment and accreditation in community health services.** Second half of year 3.
Existing Baby-friendly Hospitals

The Special Working Group would need early on to decide how to address the past certification of facilities as Baby Friendly Hospitals. If the programme is marketed as the “new, revised and updated BFHI”, hospitals could be asked now to remove their award if on public display, and to reapply in due course for the new award. Activity reports would not refer to designated or accredited hospitals until they meet the assessment standards of the revised criteria. It would be confusing to be raising awareness of baby-friendly practices (Stage 1) whilst hospitals without these practices in place were referred to as accredited Baby-friendly hospitals. In addition management and staff interest in updating their knowledge and practices might be low if they thought they were already accredited as having good practices.

8. Lessons learned

• The Baby Friendly Hospital Initiative was instigated as one aspect of a broad programme of breastfeeding promotion within mother and child health care and did not have measurable specific objectives or plans of its own. The practices of the BFHI were not integrated into pre-service education of health workers or routine maternity care processes. This combination of lack of identity and isolation from routine care made it difficult to sustain over the years, and particularly when funding support from UNICEF reduced.
• Particularly in more recent years, most of the coordination of the Initiative was left to a small group of people who frequently did this work in their own time and in addition to their regular employment. Lack of support for this work, for example by paid work time allocated to it, resulted in lack of recognition for the value of the BFHI and lack of awareness of its activities.
• Political and social changes in the country resulted in changes in the responsibility and funding for BFHI. A specific handover plan to increase national ownership, establish coordination, and assume funding responsibility when UNICEF reduced support might have assisted in maintaining the assessment and monitoring activities of the BFHI.


9. Appendices

Appendix A: Terms of Reference and Evaluation Framework

<table>
<thead>
<tr>
<th>Question as per TOR</th>
<th>Source</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1 is to assess BFHI relevance in Serbia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what extent does the BFHI take into account specific country needs?</td>
<td>UNICEF &amp; stakeholders, reports</td>
<td>Review, interview</td>
</tr>
<tr>
<td>How the project relates to other UNICEF supported initiatives?</td>
<td>UNICEF &amp; stakeholders, reports rec’d</td>
<td>Review, interview</td>
</tr>
<tr>
<td>What is the relationship with UNICEF’s changing programme strategy?</td>
<td>UNICEF</td>
<td>Review, interview</td>
</tr>
<tr>
<td>To what extent and in what ways does the BFHI respond to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demand and needs of mothers and families?</td>
<td>Parent organisations, mothers</td>
<td>Stakeholder &amp; individual mother interview</td>
</tr>
<tr>
<td>Demand and needs of Mother and Child service providers?</td>
<td>Service providers - individual and organisation</td>
<td>Stakeholder &amp; individual service provider interviews</td>
</tr>
<tr>
<td>Whether a Baby Friendly approach is able to pick up and address important right issues such as children with disabilities and institutionalization of children?</td>
<td>UNICEF &amp; stakeholders</td>
<td>Review, interview</td>
</tr>
<tr>
<td><strong>Objective 2 is to assess BFHI effectiveness in Serbia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what extent did BFHI manage to increase the quality of services at delivery?</td>
<td>Documents</td>
<td>Review, comparison</td>
</tr>
<tr>
<td>Do certified BFHI apply all the steps to successful breastfeeding? What steps are applied, and what steps are not applied, and why? What are the missing components that will make a big difference? Is BFHI being used to its full potential?</td>
<td>Past BFHI assessment reports</td>
<td>Interviews mothers &amp; staff, past assessment teams</td>
</tr>
<tr>
<td>Has the practice of distributing free and low-cost supplies of breast-milk substitutes to maternity wards and hospitals ended? If not, why not?</td>
<td>Facility visits, IBFAN, MOH CRC report</td>
<td>Interviews mothers &amp; staff, IBFAN &amp; MOH</td>
</tr>
<tr>
<td>How widespread are mother support groups and how involved are they in the BFHI?</td>
<td>Parent organisations,</td>
<td>Stakeholder &amp; individual</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td>Question</td>
<td>Data Sources</td>
<td>Method</td>
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<tr>
<td>To what extent was the certification process interactive, transparent and a learning opportunity? What worked well, what didn’t? How important were follow-up visits and re-assessment in maintaining the agreed standards? If standards were dropped, what were the main reasons for it?</td>
<td>mothers, documents</td>
<td>Review, interview</td>
</tr>
<tr>
<td>What are the links between BFHI and primary health care centres (specifically, ante-natal and home-visiting services)? What links are functional, and what links are not?</td>
<td>Facility visits, Interviews mothers &amp; staff</td>
<td>Review, interview</td>
</tr>
<tr>
<td>What were the ways and approaches by which primary health centres’ services (specifically, ante-natal, post-natal and patronage) that preceded or followed BFHI services contributed to positive or negative outcomes of the BFHI? What was their role in preparing/supporting mothers to continue with breastfeeding once they leave maternity wards? What are the areas for improvement?</td>
<td>Facility visits, MOH, documents</td>
<td>Review, Staff &amp; stakeholder interviews</td>
</tr>
<tr>
<td>What was the main source of info for the general population on the BFHI and breastfeeding? What were the most relevant and most appreciated sources of info? What are the most useful communication channels? How much BFHI promotional and educational material is needed for both mothers (parents) and professionals? What impact has it had on increasing the breastfeeding rate?</td>
<td>Parent organisations, mothers, visits, MOH/IPH, documents, observation</td>
<td>Review, interview, observe</td>
</tr>
<tr>
<td>How critical was the role of the National Breastfeeding Committee and UNICEF in the design and implementation of the BFHI?</td>
<td>UNICEF &amp; Committee</td>
<td>Interview</td>
</tr>
<tr>
<td>What should be and what is UNICEF’s expected role in future BFHI implementation from the partners’ point of view?</td>
<td>Stakeholders / partners, UNICEF</td>
<td>Interview</td>
</tr>
<tr>
<td>What is the role of national legislation in the BFHI? What are the legislative gaps? How to overcome them?</td>
<td>MOH, IPH, IBFAN</td>
<td>Interview, document review</td>
</tr>
<tr>
<td>How much are MICS findings (and other research) used for policy development? What type of data is needed to better influence policy decisions, and how frequently is it required?</td>
<td>MICS data.</td>
<td>Review, interview</td>
</tr>
<tr>
<td>How is the BFHI perceived relative to maternity wards that are not applying the BFHI? Do mothers prefer to deliver in BF or in other maternity wards? Why?</td>
<td>Parent organisations, mothers, visits, MOH/IPH, documents, observation</td>
<td>Review, interview</td>
</tr>
</tbody>
</table>
What is the contribution of the BFHI to national capacity-building efforts among health professionals, policy makers and civil society and/or the private sector? To what extent did BFHI training sessions contribute to increasing knowledge and health workers’ practices in promoting and supporting breastfeeding? What kind of training would they recommend? What is the BFHI’s role in capacity-building of UNICEF staff?

### Objective 3 is to assess BFHI sustainability in Serbia

The evaluation should explore options for institutional sustainability and possible opportunities for expansion of the BFHI. The key questions are:

<table>
<thead>
<tr>
<th>Question</th>
<th>Source</th>
<th>Method</th>
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<tbody>
<tr>
<td>How sustainable was the BFHI after UNICEF suspended direct support?</td>
<td>UNICEF, MOH, documents</td>
<td>Review, interviews</td>
</tr>
<tr>
<td>To what extent should the BFHI be considered a “global public good” owned by the claimants and local community?</td>
<td>stakeholders, including NGOs</td>
<td>stakeholder opinion</td>
</tr>
<tr>
<td>What are the options to ensure BFHI sustainability in its current form?</td>
<td>Documents, stakeholders</td>
<td>Review, interviews</td>
</tr>
<tr>
<td>What are the sustainability issues related to a centralised vs. decentralised management plan and technical support?</td>
<td>Documents, stakeholders</td>
<td>Review, interviews</td>
</tr>
<tr>
<td>To what extent has BFHI design and implementation allowed good take-up by local partners?</td>
<td>Documents, stakeholders</td>
<td>Review, interviews</td>
</tr>
<tr>
<td>What are other types of health care services (e.g. outreach, paediatric) that must be taken into account when assessing BFHI sustainability?</td>
<td>Documents, stakeholders</td>
<td>Review, interviews</td>
</tr>
</tbody>
</table>

### Objective 4 is to assess the BFHI’s impact in Serbia

<table>
<thead>
<tr>
<th>Question</th>
<th>Source</th>
<th>Method</th>
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<tbody>
<tr>
<td>Has national ownership of the BFHI increased?</td>
<td>Past &amp; current documents/resea rch, stakeholders</td>
<td>Comparison</td>
</tr>
<tr>
<td>To what extent and in what ways is the BFHI used by claimants whose voices are rarely heard?</td>
<td></td>
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<tr>
<td>To what extent can an increase in the exclusive breastfeeding rate contribute to the BFHI?</td>
<td></td>
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<tr>
<td>Finally, to what extent the BFHI contribute to changes in the life of children (emotional, reducing morbidity, reducing mortality)?</td>
<td>Past &amp; current documents/resea rch, stakeholders</td>
<td>Comparison</td>
</tr>
</tbody>
</table>

### Objective 5 is to assess BFHI efficiency in Serbia (if possible)

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<th>Question</th>
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<tr>
<td>Question</td>
<td>Source</td>
<td>Methodology</td>
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</tr>
<tr>
<td>To what extent were UNICEF funds used in an economical manner?</td>
<td>Accounts from past</td>
<td>Document review</td>
</tr>
<tr>
<td>Should the invested funds have been allocated differently (e.g. more in capacity-building than in advocacy…)?</td>
<td>How are the funds used now, and can they be used differently?</td>
<td>Accounts from present</td>
</tr>
<tr>
<td>Referring to the cost benefit analysis done in 1995, whether we can draw any comparison? Is it viable?</td>
<td>Referring to the cost benefit analysis done in 1995, whether we can draw any comparison? Is it viable?</td>
<td>Past and recent cost-benefit analysis</td>
</tr>
</tbody>
</table>

**Objective 6 is to assess BFHI coordination in Serbia**

**What were the coordination mechanisms? Were they appropriate? What is the coordinating mechanism now? Is it functional? How to improve it?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents, stakeholders</td>
<td>Read, interviews</td>
</tr>
</tbody>
</table>

**Objective 7 is to assess the application of a BFHI human rights-based approach in Serbia**

**Was the whole system mother and baby-centred? Did mothers participate in project design and implementation? What were the mechanisms for mothers to influence policy and decision-making, and to shape the services to their needs?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders including NGOs, initial and interim reports</td>
<td>Read, interviews</td>
</tr>
</tbody>
</table>

**What is the relationship between service providers and mothers as claimants of rights? Do service providers take into account local knowledge, beliefs, and cultural differences when performing delivery? Are the root causes of these problems identified and challenges identified? Did they address them? How? What were the results?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent organisations, individual mothers &amp; staff, past &amp; recent research</td>
<td>Interviews mothers &amp; staff</td>
</tr>
</tbody>
</table>

**Are families allowed to visit mothers? If not, why not? Is it possible for fathers and other family members to attend the delivery? If not, why not, what are the main constraints?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>facility visits, Parent organisations</td>
<td>Interviews and observation</td>
</tr>
</tbody>
</table>

**To what extent has the BFHI contributed to fair access to basic services of a high quality?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>documents, Parent organisations</td>
<td>Read, interviews</td>
</tr>
</tbody>
</table>

**In accordance with the best human rights programming practices, were marginalised mothers empowered to exercise their rights through the BFHI? How accessible is the BFHI to different population groups? To what extent has the BFHI made it possible to satisfy the rights of the most marginalised population groups?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>documents, Parent organisations, UNICEF, MOH</td>
<td>Review, interviews</td>
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</table>

**To what extent were services providers giving information and acting in line with the best interest and rights of a child in the cases of children with disability (right to grow up in a family environment vs. residential institution)?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF &amp; stakeholders, documents</td>
<td>Review, interviews</td>
</tr>
<tr>
<td>Question</td>
<td>Source</td>
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</tr>
<tr>
<td>To what extent has the BFHI contributed to cross-cutting issues?</td>
<td>UNICEF &amp; stakeholders, documents</td>
</tr>
<tr>
<td>To what extent was the BFHI available / applied to all children regardless of ethnic, social and health status e.g. Roma, children at risk and/or with disabilities?</td>
<td>documents, Parent organisations, UNICEF, MOH</td>
</tr>
<tr>
<td><strong>Objective 8 is to assess the application of result-based BFHI management in Serbia</strong></td>
<td></td>
</tr>
<tr>
<td>To what extent was the result-based approach used in BFHI management?</td>
<td>UNICEF &amp; stakeholders, documents</td>
</tr>
<tr>
<td>Were the objectives SMART?</td>
<td>UNICEF &amp; stakeholders, documents</td>
</tr>
<tr>
<td>How often were outcome and outputs measured? Were the indicators used sufficiently specific? Did the BFHI have a way of measuring the indicators? Are they different from internationally accepted indicators? Is data sufficiently disaggregated to identify excluded groups? To what extent data were used in decision-making, e.g. adjusting the planned results, shifting the focus, etc?</td>
<td>UNICEF &amp; stakeholders, documents</td>
</tr>
</tbody>
</table>
Appendix B: Biographical information of the evaluators

Genevieve Becker, PhD, IBCLC. Independent consultant on maternal and infant care and nutrition, with particular focus on health worker training and assessment. Based in Galway, Ireland

Specific activities within BFHI and breastfeeding
- Owner, BEST Services, providing breastfeeding education support and training services nationally and internationally since 1992
- National Coordinator of BFHI in Ireland and assessor trainer/leader since 1998
- International network of National BFHI Coordinators facilitator
- Cochrane Review author, Methods of Milk Expression
- Doctoral research on methods of assessment of health worker performance in assisting mothers to learn skills related to breastfeeding
- Member of the National Breastfeeding Strategic Implementation Committee, Ireland

Dr Elizabeta Zisovska, PhD, Asst Professor of Pediatrics, Senior lecturer, coworker, Chief of the Department of Neonatology, Gynecology & Obstetric Clinic, Skopje, Republic of Macedonia.

Specific activities within BFHI and breastfeeding
- Certified Assessor for external assessment of BFHI in Budapest 1995
- National Breastfeeding Coordinator since 2001
- Educator for the Lactation Course within the BFHI
- Regular attendance on the biennale for the National Breastfeeding Coordinators and member of the Organizing Committee for the last one (Geneva 2008)
- Coordinator and lecturer within the regular workshops with the Coordinative hospital teams for implementation of BFHI
- Member of the team for the Revision of the new tool for assessment/reassessment, UNICEF/WHO 2006
- Contributor to the Publication “Acceptable medical reasons for use of breast milk substitutes” WHO 2008
Appendix C: Guidance framework for additional interviews

*Key Informants/Stakeholders interview and manager in facility*

1. What does the term BFHI mean to you? (scope, inputs/outcomes)
   How would you explain it to a parent, health worker, hospital manager?
   Do you see it as a special project or programme? Or a permanent change of practices?
   Once off or need for re-assessment?

2. What might be the benefits of participating in the BFHI to a hospital, a health service (government), community/country (children in general and specific groups - disability, marginalised)?
   And the disadvantages / negatives?
   (cost, time, staffing, equipment, building, staff / mothers wishes)

3. Does participating in BFHI help or hinder health worker/ health service in providing care to mother & child?
   Has the existence of BFHI in Serbia / or in an individual hospital increased the quality of maternity services (including delivery)?

4. How does BFHI function in changing knowledge-attitudes-practices, preparing hospitals for assessment, assessment, on-going monitoring?

5. Are there any circumstances when BFHI might not be suitable for a hospital?

6. Why might a mother choose to attend / not attend a hospital that is certified BFHI (assuming certified hospital was available in area)?

7. How does BFHI fit with other programmes that you are aware of/ participate in??

8. Could you describe the current organisation of BFHI at a national level? (responsibility, goals)
   Have changes in the organisation of BFHI over the years been positive or negative?
   What should be and what is UNICEF’s (and other partners) expected role in future BFHI implementation from the partners’ point of view?
   What might assist BFHI to continue in the future?

9. If a programme for improving the health and well-being of children was being developed now, what would you put as key goals for it?

*Additional for manager in facility only*

If your facility has participated in a formal assessment or re-assessment process:
   To what extent was the certification process interactive, transparent and a learning opportunity? What worked well, what didn’t? How important were follow-up visits and re-assessment in maintaining the agreed standards? If standards dropped, what were the main reasons for it?

What were the ways and approaches by which primary health centres’ services (specifically, ante-natal, post-natal and patronage) that preceded or followed BFHI
services contributed to positive or negative outcomes of the BFHI? What was their role in preparing/supporting mothers to continue with breastfeeding once they leave maternity wards? What are the areas for improvement? or

What were the ways and approaches by which maternity hospital services that preceded or followed PHC breastfeeding services contributed to positive or negative outcomes for mothers and infants? What was their role in preparing/supporting mothers to continue with breastfeeding once they leave maternity wards? What are the areas for improvement?

Questions for pregnant women and postnatal mothers additional to global BFHI assessment tools
What does the term BFHI mean to you? (scope, inputs/outcomes)
Would you prefer to attend a hospital that was certified as Baby-friendly or not? Can you explain why you would prefer this?
What practices would you expect to find in a Baby-friendly hospital?
Where do you hear about breastfeeding -BFHI - practices? Which sources were most useful to you?
Will/Was your husband or other family member allowed to be with you during the labour and birth?
Are/were you allowed to have visitors while in hospital?

Questions for facility staff members additional to global BFHI assessment tools
What does the term BFHI mean to you? (scope, inputs/outcomes)
  Do you see it as a special project or programme? Or a permanent change of practices?
  Once off or need for re-assessment?
What might be the benefits of participating to a health worker, hospital, a health service (government), an individual mother or infant?
And the disadvantages / negatives?
  (cost, time, staff levels, equipment, building, staff / mothers wishes, choosing to birth there)
Does participating in BFHI help or hinder health worker/ health service in providing care to mother & child?
Are there any circumstances when BHI might not be suitable for a hospital?
Has your knowledge and practice changed as a result of BFHI activities? (how)
Has the BFHI changed the perception of breastfeeding? Of marketing of breast milk substitutes, bottle and soothers?
If your facility has participated in a formal assessment or re-assessment process:
  To what extent was the certification process interactive, transparent and a learning opportunity? What worked well, what didn’t? How important were follow-up visits and re-assessment in maintaining the agreed standards? If standards dropped, what were the main reasons for it?
If a programme for improving the health and well-being of children was being developed now, what would you put as key goals for it?
Appendix D: Timetable of visits and interviews

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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| September 2009 Tues 22 | Special Working Group meeting  
 Key Informant Interviews:  
 Dr. Elizabeth Paunovic, Ministry of Health  
 Dr Gjurgja Kisin, Institute of Public Health of Serbia  
 Branka Stamenkovic, Majka Hrabrost  
 Andjelka Stojkovic, Head of patronage service for Belgrade  
 Dragana Soćanin, Roditelj |
| Wed 23     | Valjevo PHC  
 Valjevo General hospital maternity unit |
| Thurs 24   | Kraljevo PHC  
 Kraljevo General hospital maternity unit |
| Fri 25     | Novi Sad PHC  
 Novi Sad Hospital  
 Key Informant Interviews: Vladimir Jesic and colleagues, BEBAC |
| Mon 28     | Belgrade “Narodni front” maternity hospital  
 Belgrade hospital O&Gyn Clinical center of Serbia |
| Tue 29     | Belgrade PHC  
 Key Informant Interviews: Dr Ivana Misić, MoH  
 IBFAN/ Centre for Children Care |
| Wed 30     | Key Informant Interviews: Roma Mediators  
 Dr Melita Vujanovic, WHO  
 Present draft findings to Special Working Group |
Appendix E: BFHI Activities\textsuperscript{11}

- Development, publishing and dissemination of BF promotional and educational material.

Using WHO/UNICEF documents and publications (e.g. BF Policy Documents, Modular Course, Lactation Management Course…) as reference material, production of copious educational/promotional material, targeting mothers and health service providers. Manual on Breastfeeding Management, Manual on BF in Emergencies, Facts for Life in local language, Posters: “10 Steps to Successful Breastfeeding”, Annual UNICEF/WABA poster… are just some examples of the material that was disseminated to each health institution in the country. To parents: posters and leaflets on the main challenges and solutions related to breastfeeding, recommended Young Child Feeding Practices and Growth Monitoring, as well as other material was distributed in health counselling services.

- Training of health workers, media, parents.

The Serbian Mother and Child Health Care Institute, the Serbian Public Health Institute and the Belgrade Public Health Institute were the main partners in developing and delivering the training. The main workshops conducted included:

- \textit{Lactation Management Course}, a three-day Training of Trainers workshop attended by 200 doctors and 500 nurses. Trained health care professionals were later used as resource personnel and breastfeeding promoters/educators at regional and local level.

- \textit{18-Hour Course}, a three-day workshop for health employees working in maternity wards, aimed at acquiring and harmonising knowledge on breastfeeding among health workers. Over 4,000 health professionals in all were trained.

- \textit{Breastfeeding Management, modular course}, a one-day workshop for health managers and employees working in mother and child health care services, where international and national legislation related to breastfeeding was presented, organisational issues at different levels of health care were discussed. Close to 200 health professionals in all were trained.

- \textit{Facts for Life}, a five-day workshop for home-visiting nurses with one of the modules on breastfeeding. 1,600 (all) home-visiting nurses and 900 paediatric nurses were trained. Note: workshop evaluation and follow-up visits showed that the breastfeeding module had been the most useful and applicable of all modules, and that participants’ knowledge on the subject increased on average by 50-60%.

- \textit{Integrated Maternal and Child Health Management}, a five-day workshop for doctors working in primary health care services for children, with one of the modules on breastfeeding. 1,600 doctors (70% of all doctors working in the modules primary mother and child health care service at the time) were trained. Note: workshop evaluation and follow-up visits showed that participants’ knowledge on breastfeeding increased by 25% on average.

In total, over 6,000 health workers working in maternity units and primary health care centres for mother and child were trained to promote and support breastfeeding (some of them participated at several different training sessions).

- \textit{Certifying BFHI maternity wards}.

\textsuperscript{11} As provided by the Steering Committee in the Terms of Reference for this evaluation.
Following standard UNICEF/WHO methodology, the national BF team worked on making maternity wards Baby-Friendly. The work consisted of a series of meetings, hospital staff training sessions, follow-up visits, provision of technical assistance... until the Maternity Ward (Hospital) met the criteria to become Baby-Friendly and ready for assessment. An independent team assessed and certified the hospitals as Baby-Friendly. In order to maintain a satisfactory level of performance and compliance with the “10 steps policy” (see Annex 1), follow-up visits were conducted to certified BF hospitals at least once every three months. The follow-up visits were organised following standard methodology (meeting with management, meeting with staff, focus group discussions with mothers and their families, in-depth interviews and filling in questionnaires on performance and satisfaction with services provided). In total, over 500 monitoring visits were conducted.

- **BFHI re-assessment.**

Following standard methodology, an independent team (trained at an international workshop) of “external” assessors conducted re-assessment visits to hospitals certified as Baby-Friendly. In total, 40 reassessment visits were conducted, evaluating whether the hospitals met Global Criteria for the “10 steps”.

- **BF in primary health care centres.**

The programme included a special focus on support to breastfeeding activities in primary health centres. The main activities included: workshops with health staff on breastfeeding issues, supporting counselling services with equipment, educational and promotional material, establishment of a School for Parents...

- **BF promotion among the general population** was organised through a series of activities:
  - Counselling services in health centres (one-to-one discussions with mothers and family members on breastfeeding)
  - Dissemination of promotional material (posters, leaflets, calendars, booklets)
  - Articles in national and local newspapers on the benefits of breastfeeding, possible problems and how to overcome them...
  - Promotion in schools, where an annual competition for the best drawing and best poem promoting breastfeeding among school-aged children was organised. The entries (over 25,000 children’s drawings and 3,000 poems) were then exhibited at local and national exhibitions and conferences.
  - Promotion in artistic colonies, where children and artists produce and exhibit creative materials on the topic of breastfeeding.
  - Press conferences (a number of conferences promoting breastfeeding were organised throughout the country).
  - Annual conference on breastfeeding. An annual conference on breastfeeding is held every October. During the year, more than 4,000 health professionals, media representatives, mothers and children, attended those conferences. The focus varied following global recommendations and topics, and using the latest UNICEF/WHO material.
  - Promotion of proper nutrition. In October, public health workers traditionally hold a series of activities to promote proper nutrition, with the focus on young child feeding.
  - Support to parent/mother associations, through meetings, workshops, networking and distribution of promotional material.
• Support to the establishment of local multi-sectoral teams at local level, which promote and support breastfeeding through local plans of action, promotional activities, breastfeeding campaigns, with more than 10,000 participants.

• “Phone Counselling” project, established in the capital city, Belgrade, with the aim of providing counselling services to families with newborn babies. Initially the service was established to promote and support proper young child feeding practices. Due to parental needs and requirements, the service extended to other issues relevant to child health, nutrition and development. The service is very popular, having received almost one million inquiries…

• Support to the National BF Committee.
The National Breastfeeding Committee, established by the Ministry of Health (Federal and later Republic Ministry), played a crucial role in BF implementation. The Committee is multi-sectoral, with representatives from the health sector (mainly), education, private sector, NGOs, parents and media. The main ToR of the BF Committee was to draft an annual work plan and monitor implementation, communication with the main stakeholders at home and abroad, drafting of policy documents, establishment of communication with other ministries and partners, cooperation with the NGO sector and other organisations… The team consisted of public health experts, neonatologists, obstetricians and others. Team members were trained abroad in order to support knowledge management at home.

• Provision of medical equipment and consumables.
At the peak of the humanitarian crisis in Serbia (mid-90s), UNICEF was operating under emergency conditions. At a time of war, sanctions and an economic crisis, hospitals, and particularly maternity wards, suffered greatly. At the time, a big component of UNICEF’s support was supply. At the time UNICEF invested in provision of basic equipment (cots, mattresses, scales, tables, bed linen…), consumables, essential drugs, hygiene kits, heating fuel. In the period 2000-2005, for which we have kept electronic records, supply amounted to $1.44mn. This type of support was essential in order to maintain the most basic level of services - for example, at times when the heating was switched off.

• Support to national legislation to promote BF.
With UNICEF support a team of national experts, trained at a regional workshop on Code implementation, drafted a Code.

• BF research.
Breastfeeding was the subject of several national and many local studies. A breastfeeding module was conducted as part of MICS I, II and III (1996, 2000, and 2005), which was the only source of national representative data on young child feeding in the country. An opinion poll on breastfeeding was conducted in 2000. A Cost-Benefit Analysis of Breastfeeding was conducted in 1995.

• Breastfeeding in emergencies.
In times of emergency, with UNICEF support, mobile teams were set up, in charge of rapid assessment and establishment of local breastfeeding counselling services, monitoring emergency supply, etc.

• “Ancillary activities”.
The whole initiative triggered a series of local initiatives, like local donor mobilisation, media promotion, the creation of local clubs supporting breastfeeding…
Appendix F:

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 half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they need to be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in – allowing 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 upon discharge from hospital or clinic.

Revision 2006-2009

The Baby-friendly Hospital Initiative is a global effort to implement practices that protect, promote and support breastfeeding. It began in 1991 in response to the Innocenti Declaration. As a result of the renewed call for BFHI in the Global Strategy for Infant and Young Child Feeding, the challenges posed by the HIV pandemic, and the experiences of countries, combined with the interest and strong request for updating the BFHI package, UNICEF, in close coordination with WHO, undertook the revision of the materials in 2004-2005. The final version was completed in late 2008. The global BFHI materials were revised, updated and expanded for integrated care. The materials:

- Reflect new research and experience
- Reinforce the International Code of Marketing of Breast-milk Substitutes
- Support mothers who are not breastfeeding
- Support mother-friendly care during labour and birth
- Provide modules on HIV and infant feeding
- Give more guidance for monitoring and reassessment

The revised materials can be accessed on the UNICEF Internet at http://www.unicef.org/nutrition/index_24850.html, or the WHO Internet at www.who.int/nutrition


10. Bibliography

Documents reviewed as part of the evaluation


5. Institut za zastitu zdravlja Srbije, “Dr Milan Jovanovic Batut”, Beograd. Program Promocije, Podrske i Zastite dojenja i BFHI. Izvestaj za 2003 godinu


7. Izvestaj o radu za Ministarstvo zdravlja Republike Srbije za 2005 godine, Centar za unapregjenje zdravlja,

8. IZVEŠTAJ o realizaciji Programa Promocije zdravlja stanovnistva Republike Srbije u 2004 godini


12. OPINION POLL on breastfeeding report (2000)


14. Program proposal for protecting and supporting breastfeeding, as part of a Global Yugoslav programme - the first national BF program (1994)

15. PROJEKAT "Promocija Nacionalnog plana akcije za decu i pokretanje Inicijative za izradu lokalnih planova akcije za decu, 2004


17. Survey on client satisfaction with services provided –Institute of Public Health of Serbia, 2009

18. Trip reports – Monitoring of the Program for evaluation of the Promotion of the Breastfeeding


22. UNICEF Report: 14-ECD (Early Childhood Development) Summary matrix, Key results 2002-2004

23. web site http://www.majkahrabrost.com

Sources of information on the BFHI and supportive practices

World Health Organization, Geneva
Department of Child and Adolescent Health (CAH)

UNICEF/WHO Baby Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care (revised 2009)
Including BFHI Section 3: Breastfeeding Promotion and Support in a Baby-friendly Hospital, a 20-hour course for maternity staff

WHO, Infant and young child feeding: Model Chapter for textbooks for medical students and allied health professionals (2009)
Acceptable medical reasons for use of breast-milk substitutes (2009)
Evidence on the long-term effects of breastfeeding, Systematic reviews and meta-analysis (2007)

Infant and Young Child Feeding Counselling :An Integrated Course (2006)
The international code of marketing of breast-milk substitutes (2006) Frequently asked questions

Department of Reproductive Health and Research (RHR),
www.who.int/reproductive-health/pages_resources/listing_maternal_newborn.en.html

BFHI in other countries: the global criteria are applied similar in all countries however the process may vary in different countries.

BFHI in Ireland www.ihph.ie/babyfriendlyinitiative/ BFHI Link newsletter contains parent handouts as well as staff information. See Links for listing of web sites for BFHI in other countries

BFH UK www.babyfriendlyinitiative.org.uk

Academy for Breastfeeding Medicine, International: worldwide organization of physicians dedicated to the promotion, protection and support of breastfeeding and human lactation. Protocols available, some in multiple languages: http://www.bfmed.org
Emergency Nutrition Network (ENN): aims to improve the effectiveness of emergency food and nutrition interventions. Breastfeeding training packs downloadable from web site http://www.ennonline.net/

IBFAN: the International Baby-Food Action Network - consists of public interest groups working around the world to reduce infant and young child morbidity and mortality. IBFAN aims to improve the health and well being of babies and young children, their mothers and their families through the protection, promotion and support of breastfeeding and optimal infant feeding practices. http://www.ibfan.org/

World Alliance for Breastfeeding Action (WABA) http://www.waba.org.my/ Advocacy materials

International Lactation Consultant Association (ILCA), http://www.ilca.org

La Leche League International (LLLI), http://www.lalecheleague.org/ Mother-to-Mother international breastfeeding support organisation. Parent and Professional information on web site and links to materials in numerous languages.

Kangaroo Mother Care This web site has downloadable resources on the research supporting Kangaroo Mother Care and experiences of implementing this practice. http://www.kangaroomothercare.com

Breast Crawl video. Every newborn, when placed on the mother's abdomen, soon after birth, has the ability to find its mother's breast all on its own and to decide when to take the first breastfeed. This is called the 'Breast Crawl'. Download ‘Dossier’ for everything in one file. http://breastcrawl.org/index.html


11. Statement of agreement from evaluation team members

The evaluators state their agreement with the contents of this report and present this report to the Special Working Group.

Names: Dr Genevieve Becker & Dr Elizabeta Zisovska

Date: October 30, 2009