Baby Friendly Hospital Initiative
Hong Kong Association

愛嬰醫院香港協會

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Baby Friendly Newsletters 愛嬰通訊 (12.2021)

The Baby Friendly e-Newsletters feature various kinds of breastfeeding and related information, as well as sharing of cases and practical experiences, suitable for consumption by new parents, health professionals and individuals interested in breastfeeding.

香港愛嬰醫院的電子通訊提供各式各樣的母乳餵哺及其他有關知識、案例和實踐經驗分享等，適合新手父母、專業人士以及對母乳餵哺有興趣的朋友閱讀。

Breastfeeding – We Care
母乳餵哺 人人樂道

Infant and Young Child Feeding and Nutrition in Perspective
透視嬰幼兒餵哺與營養

嬰幼餵哺檔案
Infant and Toddler Feeding Case Files

愛嬰情報
Baby Friendly Watch

This issue of the Baby Friendly Newsletters has received additional funding from the Equal Opportunities Commission, allowing it to be distributed more widely.
今期「愛嬰通訊」獲平等機會委員會的額外資助，得以更廣泛派發。

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Content 目錄

About us:

In 1992, the Hong Kong Committee for UNICEF formed the Baby Friendly Hospital Initiative Committee in order to promote and support breastfeeding in Hong Kong. The Baby Friendly Hospital Initiative Hong Kong Association was subsequently established in 1994, aiming to promote breastfeeding and protect infant health. We are committed to creating a health care and societal environment that enables parents and other caregivers to make informed decisions about optimal infant feeding and carry them through.

1992年聯合國兒童基金香港委員會成立推動愛嬰醫院委員會，舉辦各項活動推廣及支持母乳餵養。委員會於1994年正式註冊為一間旨在提倡母乳餵養及保護嬰兒健康的志願機構，名為愛嬰醫院香港協會。我們致力建設一個醫療及社會環境，讓母親及嬰兒照顧者作出知情選擇，以最佳方法餵養嬰兒。

推動母乳餵哺 企業應升級家庭友善政策

作者：聯合國兒童基金香港委員會 (UNICEF HK)

法定產假在去年12月已經正式由10周延長至14周，對初生嬰兒和父母來說自然是一大喜訊。這亦對寶寶的健康成長有更正面的影響 —— 因為媽媽可以更容易在家餵哺母乳了。


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母乳餵哺是成就子女健康成長的第一步。母乳能減低嬰兒死亡、發病及營養不良的比率，長遠來說，更可以減低公共醫療開支。餵哺母乳亦可增加母親與孩子的親密感覺，建立良好的親子關係，助母親減低產後焦慮。聯合國兒童基金會（UNICEF）和世界衛生組織建議媽媽在產後一小時內開始餵哺母乳，並在最初6個月以全母乳餵哺。然而，香港衛生署兩年一度的母乳餵哺調查顯示，2020年出生的嬰兒中，6個月大時的全母乳餵哺率僅得 22.2%，遠低於國際水平的 40%[1]。愛嬰醫院香港協會 2020 年的問卷調查亦指出，產婦離院時的母乳餵哺率在過去兩年約 87%，不過，全母乳餵哺率僅 20%[2]。香港的母乳餵哺，仍然有改善空間。**要推動母乳餵哺，給予兒童最好的早期發展，企業同樣可以出一分力。**

> ***母乳餵哺是成就寶寶健康成長的重要一步，***
> ***要鼓勵媽媽們堅持餵哺母乳，企業的支援十分重要。***

企業應照顧雙職家庭育兒需要


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根據母乳餵哺調查，本地出生的嬰兒只有約 1/4 能以全母乳餵哺至 6 個月大。究其原因，主要是由於在職媽媽結束產假之後，在工作及餵哺之間難以取得平衡，令放棄餵哺母乳的機會增加。 UNICEF 的報告指出，在職媽媽的育兒假期若增加 4 周，能令她們堅持餵哺母乳多兩個月。相關法例去年在香港能有所推進，增加了 4 周產假，對本地媽媽來說實在是提供了莫大的支持。

然而，除了提供假期給在職媽媽，更多的支援亦是必須的。對於新手媽媽來說，母乳餵哺可能是一大育兒難關，餵哺過程中受盡各種痛楚，「滴滴皆辛苦」。因此，爸爸作為親密的「隊友」，提供的支援非常重要。讓職場爸爸放侍產假，可以分擔照顧初生子女的工作；丈夫支持妻子哺乳，有助減低產婦患上產後抑鬱的風險，更可增加家庭和諧。可惜，現時香港法例下，男士只獲五天法定侍產假。

UNICEF 建議企業訂立最少六個月的有薪產假和四星期的有薪男士侍產假，以確保雙職父母都能有充裕時間照料新生兒。

改善工作環境 增加對在職媽媽的支援

產假後重返工作崗位的在職媽媽，要同時兼顧工作和餵哺，令餵哺之路更加艱辛。哺乳期的女性工作繁忙，如果公司再欠缺相關支援，工作間缺乏育嬰室等私密空間，甚或直接或間接歧視，在職媽媽只好東躲西藏，於洗手間或其他欠衞生且缺乏私隱的空間集乳，均會影響她們對母乳餵哺的決心。

有見及此，UNICEF HK 自 2015 年起聯同食物及衞生局和衞生署推動「Say Yes To Breastfeeding」運動[3]，旨在提升公眾和企業對母乳餵哺的認識，呼籲企業提供相關支援。企業要支持母乳餵哺，可參考以下3大方向：

1. **時間上的支持**

提供授乳時段，基於《國際勞工公約》的原則，授乳時段應計算入工作時間之內，並需支付薪酬。以每天工作 8 小時計算，僱主應給予僱員兩節，每節約 30 分鐘或合共 1 小時的授乳時段。而僱主也不應要求僱員加時工作，以彌補因擠乳所佔的工作時間，或要求僱員提供任何有關其授乳情況的證明，才許可授乳時段。

2. **空間上的支援**

建議僱主為在職媽媽提供私人空間，設立授乳室或靈活運用現有的資源，短暫借用現有房間，如會議室、多功能房或更衣室等。若空間有限，可在安靜的角落加設屏風或簾子，以便在職媽媽作臨時擠乳之用。

3. **建立友善空間**

企業應支持母乳媽媽並提供一個友善的空間，消除對授乳僱員的歧視。同時，管理人員、授乳僱員及其他僱員應多溝通；並培訓員工對懷孕及在公共場所餵哺母乳持開放態度。此外，訂立一份適用於機構或企業的「母乳餵哺友善工作間」書面政策，有助僱主和僱員間的溝通及統一在工作間推行的措施。

推動家庭友善措施 提升員工歸屬感

不少企業在考慮實施家庭友善措施時，最大的顧慮為成本增加。事實上，在香港這個具競爭性的勞工市場，薪金並不是唯一指標。福利及家庭友善措施作為挽留人才的一大策略，長遠來說，有利企業發展。

近年，愈來愈多企業積極推動家庭友善措施，如增加對哺乳媽媽的支援。**參加「Say Yes To Breastfeeding」行動，為僱員設立「母乳餵哺友善工作間」的企業達 139 間，合共提供 952 個工作間**。僱員生育後有更優質的休息時間，精神及心理狀況較佳，工作效率亦有所提升。同時，工作間設母乳餵哺相關配套，女性僱員會更投入工作。現時，不少私人機構都設有比法例規定更長的產假及侍產假。由此可見，實施家庭友善措施漸趨普遍，有利企業長遠發展。

香港不少家庭為雙職家庭，因此，推動母乳餵哺，除了雙職父母的努力外，企業對員工的支援亦非常關鍵。法定產假延長至 14周，只是邁向家庭友善的第一步；企業何不更進一步，將公司打造成家庭友善工作間，讓僱員可以安心照顧嬰兒之餘，亦能做好準備，迎接重返工作崗位的挑戰？讓我們攜手推動家庭友善政策和措施，讓整個社會藉新生命的到來更添活力。

參考資料：

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   https://www.fhs.gov.hk/tc_chi/reports/files/BF_survey_2021.pdf

2. 愛嬰醫院香港協會 - 母乳餵哺周年問卷調查
   https://www.babyfriendly.org.hk/wp content/uploads/2020/08/2020 WBW-Annual-Survey_C_Final.pdf

3. 聯合國兒童基香港委員會 - 共建「母乳餵哺友善社區」
   https://www.unicef.org.hk/unicef-hk-joins-hands-with-different-sectors-to-build-breastfeeding-firendly-community-hotel-industry-joins-say-yes-to-breastfeeding-for-the-first-time-nearly-180-premises-and-653-workplaces-pledge to/

Say Yes to Breastfeeding Website

Instagram: UNICEF HK

Facebook: UNICEF HK

作者在本文章表達的見解，未必代表愛嬰醫院香港協會的意見或立場。

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母乳媽媽上班出差泵奶攻略

作者簡介：
曾珮瑜女士：自然育兒網絡創辦人之一、衞生署「母愛蜜語」朋輩支援計劃項目經理
黃章翹女士：曾任無線新聞部首席編輯，其後轉到政府資訊科技總監辦公室，主管香港政府一站通的內容編輯，女兒出生後，當了八年全職媽媽，以母乳餵哺女兒至兩歲。

經過多年來政府積極的推廣，以及醫院、母嬰健康院和社區在措施和支援上的改進，近十年的出院時母乳餵哺率已從1992年的19%大幅上升至2019年的87.5%。可是持續餵哺至6個月的媽媽卻只有26%.....其中，媽媽因需要上班而放棄母乳餵哺，或因工作期間未能安排集乳以致奶量大跌而被逼停止餵哺的媽媽為數不少。

究竟上班的母乳媽媽們面對什麼挑戰呢？

而重返職場後仍然持續餵哺的媽媽又有什麼秘訣呢？

上班母乳媽媽們的挑戰包括：

1.集乳時間

現時香港未有法例訂明母乳媽媽可以享有集乳時間，公司是否讓員工享有集乳時間屬自願。有僱主擔心其他同事的意見或因需要調動同事於母乳媽媽集乳時替代她的工作崗位而感到為難。也有媽媽表示雖然公司的政策容許母乳媽媽有集乳時間，但所屬部門的上司或同事卻不配合，讓她們感到失望。

媽媽的秘訣：

- 懷孕或產假期間與公司和上司溝通，讓公司、上司和同事有較長的時間去商量、安排及做好心理準備
- 與上司及同事解釋需要定時集乳的原因及母乳餵哺的好處，爭取他們的支持，例如：
  -長時間乳脹會引致乳腺炎，媽媽便需要請病假
  -母乳中的抗體能保護嬰兒，減少媽媽因為子女生病而需要請假的機會
- 如公司堅決拒絕提供集乳時間，媽媽可使用非正式工作的時間集乳，例如
  -媽媽的上班時間是上午9時至下午5時
  -媽媽可以安排其中兩次泵奶於上午8時45分及下午5時開始
  -加上午飯時間，媽媽可以在不使用上班時間的情況下集乳3次

2.集乳空間

近年不少大型企業都開始設立集乳室，讓員工可以在上班時間有固定地方去集乳，但對於較小型的公司，則未必可以額外安排房間供媽媽集乳。也有公司因為房間全以玻璃設計、可使用的空間由多個部門共同使用、或多位哺乳媽媽同時需要使用房間等原因，讓公司不知道應該如何解決。

媽媽的秘訣：

- 坐在工作位置，圍上哺乳巾或穿著外套遮蓋身體集乳
- 於座位的圍板上加上掛勾等工具，於集乳時掛上布巾遮掩，外面掛上「泵奶中」等字句讓同事知道
- 以大的布巾加上吸盤或其他工具，遮掩透明的房間外牆或門
- 需要使用房間集乳的媽媽們互相溝通，安排輪流使用房間
- 多位母乳媽媽同時共用房間集乳
- 到公司附近的商場的哺乳室集乳

3.儲存母乳的設備

母乳的儲存有一定的指引，部分媽媽會因為公司未有雪櫃或公司雪櫃的衞生情況不佳等原因而感到惆悵。

媽媽的秘訣：

- 使用有效時間較長的保溫袋及冰種代替雪櫃儲存母乳（部分冰袋加上冰種可以維持10 至12小時）
- 如公司的雪櫃衞生不理想但溫度正常，媽媽可以將盛了母乳的奶瓶或儲奶袋放在保鮮盒或保鮮袋內，再放進雪櫃
- 在環境許可的情況下，媽媽可考慮購買小型雪櫃放在自己的工作枱下，用以儲存母乳

***注意：部分小型雪櫃的溫度會較高，未能達到儲存母乳的要求，媽媽購買前要留意*

4.同事及家人的態度

在獲得公司政策（集乳時間）及設施（集乳間）的支援下，部分母乳媽媽仍然感到其他壓力，主要是來自同事或家人的態度或說話。同事或家人們未必明白母乳餵哺的好處，或會認為媽媽「在上班時集乳是不需要的，改餵配方奶就可以了」。有些習慣了親餵的寶寶於媽媽上班期間會拒絕以奶瓶進食，使照顧者擔心影響嬰兒健康而要求媽媽停止餵哺母乳。

媽媽的秘訣：

- 盡量與同事及家人解釋選擇持續餵哺的原因
- 安排集乳時間盡量不影響其他同事的工作
- 復工前2至3星期左右，開始讓家人或其他照顧者（工人姐姐等）餵哺及照顧寶寶，讓彼此有較多時間適應及摸索對方
- 媽媽可以留下一件曾經穿著的衣服給家人，在餵哺寶寶時把它放在寶寶旁邊，讓寶寶能聞到媽媽熟悉的氣味，對餵哺過程或會有幫助

今年（2021）6月，政府修訂了《性別歧視條例》，把母乳媽媽加入為受保障的對象。在條例下，母乳媽媽無論在工作、公眾地方及校園等環境下均受到條例的保障，避免她們受到歧視或騷擾（詳細見參考資料2）。這次修例對維護母乳餵哺是一個很重要的里程碑。

母乳媽媽們大多十分瞭解母乳對寶寶的好處，而且親餵的親密關係讓媽媽不輕易放棄餵哺母乳，不少媽媽即使遇到不同的難題，仍然選擇持續餵哺。以下，我們分享兩位媽媽的故事，讓大家瞭解更多。

為母則強，見招拆招

Pauline是兩個女兒的媽媽，餵哺大女兒時因工作需要時常到訪港九新界不同的商場，因為每個商場的配套及設備不同，為了節省時間及有較大的彈性，她選擇了可以使用電池（不需要插電源）及能長時間使用的電泵，這個「拍檔」對於她的母乳路非常重要！

另一方面，由於她沒有固定工作地點，上班加上交通時間超過12小時，為了確保母乳的質量，一個能長時間維持溫度的冰袋也是不能缺少的！

上班集乳的過程困難重重，商場的育嬰室不足而且經常都有人使用，部分育嬰室的環境及清潔程度也不太好。遇到有其他媽媽正在育嬰室泵奶，如果對方願意，大家就一起共用育嬰室泵奶。有時Pauline會爭取時間，按著工作行程隨處泵奶。除了商場中的育嬰室，開放式辦公室、會議室、員工休息室、午膳的餐廳及交通工具都是她泵奶的地方。同事們起初會感到驚訝，後來就習慣了，更有男同事代太太向她請教哺乳的問題呢！

上班泵奶除了泵奶器、時間、地方，如何清潔泵奶器的配件也是一個難題……有時工作地點連飲用水機都沒有的話，她更需要以保溫壺帶備熱水進行清潔，或者另外再多帶一份配件，所以每天上班需要的裝備非常多，而且缺一不可。

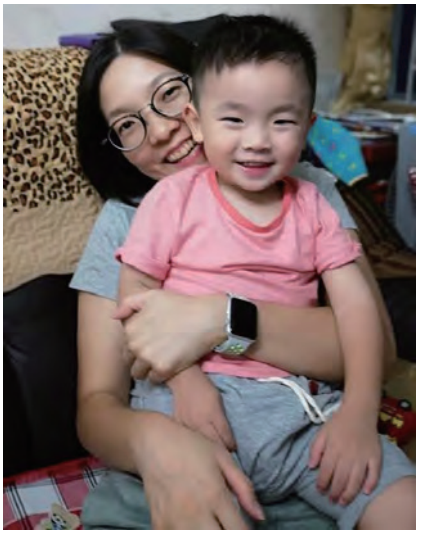
每天帶著一大堆裝備四處泵奶本來已經很辛苦，但Pauline覺得更難受的是旁人的說話及不理解。Pauline的上司曾經要求她於午膳的泵奶時間去會見客人，泵少了一次奶令她乳腺發炎了.....又有一次，一位同事拿著Pauline的奶泵笑著說：「嚇，泵咗半個鐘先得咁少？我一啖都唔夠喎！」

上班泵奶的過程雖然辛苦，但Pauline覺得生產的陣痛都能夠「捱過」，對比之下泵奶已經算是輕鬆了，而且自己修身較快，BB又較健康，確是值得的。

上班擠奶小貼士：

- 選擇合適自己的泵奶器
- 學習手擠奶，以備不時之需
- 與家人、公司、同事盡早溝通，商量復工後的安排
- 在公司準備數個儲奶袋，萬一儲奶容器出了問題，可使用後備的
- 預先準備一些寶寶的照片或影片，特別是寶寶肚餓或親餵時的樣子，有助刺激媽媽的噴奶反射
- 定時集乳，避免乳腺阻塞
- 放鬆心情、定時飲食、爭取時間休息

突如其來的出差安排



媽媽Carmen從事傳媒工作，誕下兒子逸喬後決心以母乳餵哺，希望給BB最好的營養。可惜母乳之路不易走，因為奶量不足加上工作時間長，她一直都以母乳和配方奶混合餵哺（以泵奶為主，輔以配方奶），下班回家便親餵，與BB共渡溫馨的時光。

兒子10個月大時，Carmen突然需要往北京進行三天的採訪工作，讓她感到不知所措，面對眼前必須出發的旅程，媽媽只好見步行步。

Carmen早前已經儲存了一些冰奶，而且兒子已經開始吃固體食物，所以在出發前她不需要為出差額外儲存母乳。由於航程只需數小時，Carmen選擇在出發前先泵奶一次，在航機上不泵奶，以避免需要安排儲存及運送母乳等，也同時可以增加「存貨」。從香港家中出發至目的地酒店的路程也不算短，Carmen擔心長時間沒有泵奶會使奶量下降，所以到達目的地的酒店後，她馬上到房間泵奶。

Carmen提醒大家，到達酒店後要檢查雪櫃的溫度，因為部分酒店房間內的雪櫃溫度不夠低，未能符合儲存母乳的標準。也有些酒店的雪櫃空間較小，未必足夠儲存數天的母乳。如果媽媽遇到這些情況，可以與酒店商討其他儲存方法，例如把母乳儲存在酒店其他的雪櫃。由於這次出差只是3天，而且家中已經有足夠儲備，Carmen選擇了把母乳棄掉，但期間維持定時泵奶及適當的飲食，以保持奶量，回港後可以持續餵哺。

出差小貼士：

- 如需在航機上泵奶，媽媽可於出發前向航空公司查詢有關儲奶的安排。有些航空公司可以協助儲存母乳在航機的雪櫃內，部分則沒有相關的服務
- 有關運送母乳，媽媽可於出發前向航空公司查詢出境及入境地區是否對母乳運送有特別的限制或要求。部分航空公司要求母乳需要存倉，媽媽便需預備運送的包裝及保溫設備（例如發泡膠箱、保溫袋、乾冰、冰種等）
- 預備足夠的保溫設備，確保母乳於運送過程能維持在指定的溫度
- 預備密封的膠盒，如果母乳需要儲存於酒店房間外的雪櫃時，可以將母乳放於盒中以防污染
- 泵奶時可以觀看寶寶的影片或與寶寶視像通話，有助刺激噴奶反射，以增加排奶效果
- 帶備清潔及消毒泵奶工具的設備和器皿
- 定時泵奶、進食
- 學習手擠奶，以備不時之需

其他實用資料：

衞生署 - 全方位認識泵奶器
https://www.fhs.gov.hk/tc_chi/health_info/child/30073.html

衞生署 - 僱主指引（實施「母乳餵哺友善工作間」）
https://www.fhs.gov.hk/tc_chi/breastfeeding/30031.html

衞生署 -僱員指引（母乳餵哺與工作相容）
https://www.fhs.gov.hk/tc_chi/breastfeeding/20038.html

衞生署 - 設有育嬰間的政府物業
https://www.fhs.gov.hk/tc_chi/breastfeeding/babycare_facilities_list.html

母乳GPS - 搜索全港育嬰室的流動應用程式

Mac APP store：https://apps.apple.com/hk/app/母乳gps/id1532240757

Google play： https://play.google.com/store/apps/details?id=hk.hku.nursing.bfgps

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   https://www.fhs.gov.hk/tc_chi/archive/files/reports/BF_survey_2019.pdf
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   https://www.eoc.org.hk/EOC/Upload/UserFiles/File/enews/news254c.htm

作者在本文章表達的見解，未必代表愛嬰醫院香港協會的意見或立場。

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Infant & Young Child Feeding n Nutrition in Perspective
透視嬰幼兒餵哺與營養
Baby Friendly Hospital Initiative Hong Kong Association
Jan 2021

Breastfeeding and Mental Wellbeing during the Early Postnatal Period

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Given the well-documented benefits of breastfeeding on short- and long-term health, the majority of mothers nowadays intend to breastfeed their babies.[1] Nevertheless, there has been concern over the negative impact of breastfeeding on perinatal mental health in recent years. While breastfeeding difficulty may be a postnatal stressor, the latest evidence regarding its relationship with postnatal depression remains equivocal. This article aims to provide a brief summary of the latest research on the relationship between breastfeeding and postnatal mood problems and offer tips to healthcare professionals in supporting breastfeeding mothers presenting with mood problems.

Relationship between Breastfeeding and Postnatal Mood Problems

It has been suggested that breastfeeding reduces stress and the risk of depression through the hormone oxytocin, which enhances maternal bonding and modulates the hypothalamic-pituitary-adrenal axis.[2] Yet, it is challenging to expound the relationship between breastfeeding and postnatal depression.

The Agency for Healthcare Research and Quality (AHRQ) of the USA conducted its second review on Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries in 2018.[3] The review on breastfeeding and postnatal depression included a systematic review of 48 cohort studies published in 2015 and 14 more recent cohort studies. The AHRQ review concluded an unclear association, in terms of both the magnitude and direction of effect,

between breastfeeding and postnatal depression. It commented that the studies were heterogeneous in design and results were inconsistent.

Notwithstanding the above, the systematic review[4] included in the AHRQ review reported an association between breastfeeding and postnatal depression in most of the studies. In several longitudinal studies, breastfeeding difficulties predicted postnatal depression and vice versa. It also reported that antenatal depression and postnatal depression were associated with early cessation of breastfeeding. The latter might have mediated the association between antenatal and postnatal depression. Thus, the authors suggested a need to identify and support women with depressive symptoms in pregnancy or breastfeeding problems in early postnatal period to improve breastfeeding outcomes and maternal mood.

Psychological Features of Breastfeeding Mothers with Mood Problems

It is not uncommon for healthcare professionals to come across mothers with mood issues while providing breastfeeding support. Emerging evidence suggests that supporting mothers through their breastfeeding difficulties is beneficial to the mental health of the mothers as well as health of their children.[5] Meanwhile, working with mothers with postnatal mood issues may pose additional challenges which can probably be addressed with a better understanding of their clinical presentations.

i) Repetitive Thinking Pattern

Ruminations and worries are very common in individuals with depression and anxiety.[6,7] Mothers with depressive mood may repetitively and passively focus on negative thoughts and experiences, such as the discrepancy between expectations and realities of motherhood[8], inadequacies as a mother, worries of inappropriate baby care, etc.

ii) Cognitive Biases and Difficulties

Research also shows that individuals with depressive mood tend to display cognitive biases to negative cues, e.g., having difficulties shifting attention away from negative scenes, tendency to appraise things negatively, enhanced recall of negative events, etc.[9]

As over-focusing on the negative aspects of one's experiences likely hinders effective problem solving and sensitivity to the cues and needs of infants, mothers with mood issues are found to show reduced nurturing mother-infant interactions such as skin to skin contact (Bigelow et al., 2012, as cited in Brown et al., 2015).[10]

Apart from the abovementioned characteristics, these mothers may also experience ambivalence towards issues such as giving up breastfeeding, seeking professional help for their mood problems, etc. They thus may appear to be more resistant to health advices. To provide effective professional support to mothers with such struggles and possible mental characteristics, paying particular attention to the way we make conversations is essential.

What Healthcare Professionals Can Do

i) Communicate with empathy

Understanding and accepting the tendency for these mothers to ruminate and cope with their problems ineffectively could prepare us to listen to their difficulties non-judgmentally. They may appear non-attentive or even resistant to health advices due to their decreased ability to avoid unwanted thoughts and emotions. For example, mothers may want to keep on breastfeeding but seem overly anxious to continue after experiencing breast pain in the early days. Instead of directly challenging their beliefs or behaviours, try to **validate their emotions** and **solicit more details of their concerns** empathically, e.g., we may say, "On the one hand, you worry about experiencing the pain again; on the other hand, you really want to continue breastfeeding. Breastfeeding the baby seems very important to you. Can you share a bit more with me?" (「你一方面擔心會再痛；另一方面你又好想繼續餵。餵母乳對你嚟講似乎好重要，可唔可以講多啲畀我聽？」) We can then **affirm their efforts and normalise their struggles** by saying "You are really tough to have kept trying to breastfeed! It is quite natural to worry that the pain may return. Mothers who have breast pain get similar worries as you do." (「你繼續嘗試餵母乳真係好唔簡單！擔心啲痛會持續其實都係人之常情，其他試過乳頭疼痛嘅媽媽都有類似嘅擔心。」) Then **ask for permission to offer information or suggestions** that may address their concerns, e.g., we may ask, "Would you like to know more about using different breastfeeding positions and ways to manage the sore nipples?" (「你想唔想知多啲其他餵哺姿勢同埋處理乳頭疼痛嘅方法？」)

ii) Empower and Focus on the Positives

As one core feature of individuals with mood problems is their bias towards the negatives and tendency to overlook the positives, we may have to listen carefully to their narratives and look for positive aspects of their encounters. We **can then gently reflect and affirm these positive experiences**. For example, we may say, "Although breastfeeding is not easy, you have put in every effort in the past weeks." (「雖然餵母乳並唔容易，但你喺呢幾個星期已經好努力咁嘗試。」) Besides, by listening actively and reflecting accurately on **what the mothers value**, the conversation may shift to positive aspects of breastfeeding or parenting as perceived by the mothers themselves, in turn empowering them to meet their goals, e.g., we may remark, "You feel great when you see him feeding well." (「見到BB食得

好，你就覺得一切都好值得。」). As we build on this conversation and work out the actions that the mother may take to achieve what they value, we can instill a sense of hope, e.g., we may comment, "Even though you are having such a hard time, you will keep trying in order to offer the best to your baby" (「即使你好辛苦，你都會繼續嘗試，想將最好嘅畀BB。」)

iii) Expand Perspectives

In view of their cognitive inflexibility, our goal in working with these mothers is to facilitate them to **expand their perspectives**. For example, instead of arguing with a worrisome mother whether she could exclusively breastfeed her infant, acknowledge this is a common concern among most mothers, gently explore with her whether she could try out some of our suggestions, and broaden her perspective to see that even if she could not breastfeed exclusively, her attempts have already attested to her love and commitment towards caring for her baby. After all, breastfeeding is but "one of the best" she could offer to her baby.

Apart from addressing breastfeeding issues, facilitate the mothers to **understand the significance of responsive parenting** in nurturing healthy development of the baby. As mothers with mood issues tend to miss or misinterpret babies' cues, with their permission, coach and encourage them to respond contingently and interact more frequently with their baby. This would facilitate mother-infant bonding which, in turn, enhance their health and well-being. For example, we may say, "Responding to the baby's needs is not easy, would it be helpful if I share a bit more about this with you? (「唔少新手媽媽同你一樣，覺得要回應BB嘅需要好唔容易，如果我同你分享多啲呢方面嘅資訊，唔知可唔可以呢？」)

iv) Support Autonomy in Decision-Making

In cases where the mother expresses preference for other modes of feeding, we may facilitate her to **make an informed choice** on an agreeable infant feeding plan. Be aware that some ambivalent mothers may appear to be relying on us to make such decisions for them. However, when we try to give them any advices, they may opt for the opposite. **Reflecting their ambivalence** instead of giving advices or **asking for permission before giving advices** will help empower mothers and preserve their autonomy. In the decision-making process, offering information and emotional support in the context of a partnership is therapeutic.

Coping with Challenges of Working with Mothers with Mood Problems

It could be frustrating working with depressed or anxious mothers who seem preoccupied with their problems. Avoid attributing it negatively to the mothers' motivation to change or our abilities to influence them. Seek peer support and employ healthy self-care practices after encounters that are more emotionally draining.

Despite the aforementioned challenges, any support healthcare professionals may render mothers in their breastfeeding journey could be invaluable to help them overcome difficulties in breastfeeding or cope with parenting and mental health issues. While we do not invalidate the mother's attempt to provide her baby with "the best" she could offer, healthcare professionals could help her recognise that breastfeeding is only a means to an end, which is the attainment of health. After all, **"good enough" is enough**.

Being Aware of Postnatal Mood Problems

It is reported that up to 80% of postnatal women experience postnatal blues (or "baby blues").[11] Such emotional disturbance usually subsides within a few days. If the distress persists or exacerbates, it may signal the onset of postnatal depression, a common mental illness estimated to affect 13% to 19% of postnatal women.[11] When postnatal depression is suspected, we should encourage mothers and significant others to seek help from the Maternal and Child Health Centre, family doctor, clinical psychologist or psychiatrist.

Key Messages:

- Latest research findings conclude that the association between breastfeeding and postnatal depression remains unclear, yet some evidence suggests their relationship may be bidirectional; identifying and supporting women with depressive symptoms in pregnancy or breastfeeding problems in early postnatal period is conducive to improving breastfeeding outcomes and maternal mood.
  根據最新的研究結果，母乳餵哺與產後抑鬱之間的關係尚不明確，但兩者或互相影響；及早識別和支援在妊娠期有抑鬱症狀或在產後早期有母乳餵哺問題的婦女，有助促進母乳餵哺和產婦情緒健康。
- Associated with their postnatal mood issues, mothers tend to over-focus on the negatives, may appear non-attentive or even resistant to health advices, and struggle to attune to their babies.
  有產後情緒問題的媽媽傾向聚焦於負面事物和經歷，可能會顯得不專心，甚至會對健康建議顯得抗拒，也難於敏銳地回應孩子。
- When supporting mothers with mood issues to breastfeed, healthcare professionals should pay attention to the above features and communicate with them more tactfully.
  為有情緒問題的媽媽提供母乳餵哺支援時，醫護人員應留意她們上述特質並有技巧地與她們溝通。

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Breastfeeding and Gut Health: from Prematurity to Adulthood

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文章內容摘錄中文版本
母乳餵哺與腸道健康：從早產嬰兒到成人

Introduction

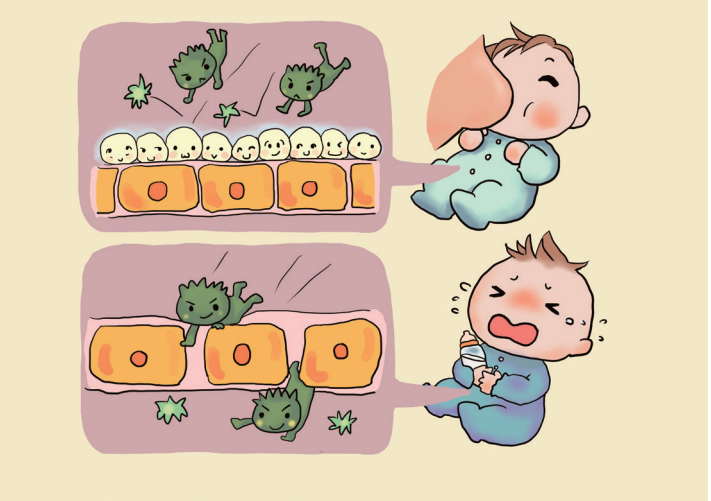
Breastmilk is the best nutrition for infants. It has a myriad of health benefits for the infant and mother. There is an abundance of unique components in breastmilk which have tremendous beneficial effects for the growing infant. The gastrointestinal tract is one of the most important immune organs in the human body as 70% of the immune cells are located there. Breastmilk does not only affect the microbiota of the gut, but also the immune system and gut health, both in the short and the longer terms. In this article, we review the health benefits of breastmilk on the gut, from prematurity to adulthood.

Necrotising Enterocolitis (NEC)

NEC is a severe inflammation of the gastrointestinal tract and the commonest gastrointestinal emergency in prematurity, affecting about 7% of premature babies. Patients can have multi-organ involvement which ends up with significant morbidity and mortality such as prolonged hospital stay, intestinal failure, short gut syndrome, etc. Breastmilk feeding, with its immunomodulating factors including human milk oligosaccharides, lactoferrin, antimicrobial peptides, and soluble IgA, is the only proven nutritional strategy that contributes to a decreased risk of NEC. The protective effect of breastmilk is also dose dependent, with a higher intake of breastmilk leading to higher protection against developing NEC[1]. In a meta-analysis, for preterm and low birth weight infants whose mothers do not produce enough breastmilk, donor breastmilk feeding also decreases the risk of NEC. Formula

feeding increased the risk of necrotising enterocolitis by almost 2 folds (risk ratio (RR) 1.87, 95% confidence interval (CI) 1.23 – 2.85)[2]. In sum, breastmilk should be used to feed premature babies whenever possible, as it provides the optimal nutrition and lowers the risk of NEC.

Gastroenteritis and Diarrhoea



Gastroenteritis and diarrhoea are common among children. Globally, between 3 and 5 billion children per year suffer from acute gastroenteritis, resulting in 1.3 million deaths because of its complications, especially in children younger than 2 years of age in developing countries. In Hong Kong, gastroenteritis and diarrhoeal illness are rare causes of mortality, but account for significant economic burdens and societal losses. Rotavirus infection was associated with 3.4% (1 in 30) of hospital admissions in children under 5 years of age in Hong Kong[3]. Breastmilk protects against diarrhoea by coating the intestinal lining and killing pathogens that can cause infections. The risk of diarrhoea in infants under 6 months is lower in those who are breastfed (pooled relative risk (RR) 0.37, 95% CI 0.27 – 0.50)[4]. The estimated relative risk of hospitalisation for diarrhoea illness is elevated among infants not breastfeeding compared to those with any breastfeeding[5]. Not breastfeeding also results in an excess risk of diarrhoea mortality (RR 2.18, 95% CI 1.14-4.16) compared to breastfeeding, in children 6 to 23 months of age[5].

Celiac Disease

Celiac disease is an immune-mediated inflammatory disease of the small intestine caused by sensitivity to dietary gluten and related proteins in genetically predisposed individuals. It affects 0.5 – 1% of the European and Northern American populations. However, it is not common in Chinese, especially those in the southern part of China. There is evidence suggesting that never versus ever being fed human milk is associated with a higher risk of celiac disease[6]. This protective effect of breastfeeding in Celiac disease is hypothesised to have been mediated through different mechanisms[7], namely, (1) the presence of gluten-specific IgA antibodies and immune system modulators in breastmilk may influence gluten tolerance induction; (2) breast-fed children are more likely to ingest less amount of gluten; (3) breastfeeding may delay infants' encounter with cow's milk protein; and (4) human breastmilk

modulates infants' microbiome composition which has protective effects. However, the relationships between shorter versus longer durations of any breastmilk feeding, shorter versus longer durations of exclusive breastmilk feeding, feeding a lower versus higher intensity, proportion, or amount of breastmilk to mixed-fed infants and celiac disease outcomes are not well established.

Inflammatory Bowel Disease (IBD)

IBD is a disease of chronic inflammation of the gastrointestinal tract. It can be classified as Crohn's disease (CD) and ulcerative colitis (UC). The incidence of IBD has increased dramatically over the past few decades. In Hong Kong, there is a 30-fold increase in the age-adjusted incidence of IBD from 0.10 (95% CI 0.06 – 0.16) per 100,000 in 1985 to 3.12 (95% CI 2.88 – 3.38) per 100,000 in 2014. The overall crude prevalence of IBD was 45.81 per 100,000 (95% CI 44.04 – 47.58) in 2015[8]. IBD has a significant impact on the quality of life of the patients and poses an economic burden to the health care system. About 15.3% of CD and 1.6% of UC patients require expensive anti-tumour necrosis factor treatment. In addition, the 5-year actuarial bowel resection rates for patients with CD and UC are 25.7% and 2.1 % respectively. Moreover, IBD is also a risk factor for developing colorectal cancers, which cause significant mortality. Environmental factors play significant roles in the development of IBD. Having been breastfed for more than 12 months decreases the odds for CD (adjusted Odds Ratio (aOR) 0.10, 95% CI 0.04 – 0.30) and UC (aOR 0.16, 95% CI 0.08 – 0.31) in Asia[9]. In a meta-analysis comprising 7536 patients with CD, 7353 with UC and 330 222 controls[10], ever-breastfeeding is associated with a lower risk of CD (OR 0.71, 95% CI 0.59 – 0.85) and UC (OR 0.78, 95% CI 0.67 – 0.91). The association between breastfeeding and risks of IBD is dose dependent. The risk further decreases when breastfeeding for at least 12 months is compared to that for 3 to 6 months. This protective effect is observed in all ethnic groups, and the magnitude of protection is significantly greater among Asians (OR 0.31, 95% CI 0.20 – 0.48).

There are several mechanisms involved in the protective effects of breastfeeding on the risk of developing CD or UC. First, non-breastfed infants have an abundance of peptostreptococci in the gastrointestinal tract, such as Clostridium difficile, which predisposes to immune-mediated diseases. Second, breastfeeding protects against childhood infections, which in turn, decrease antibiotic exposure. Both childhood infections and antibiotics exposure increase the risk of IBD. Third, components of breastmilk, such as the epidermal growth factor, insulin-like growth factor, leptin and adiponectin, modulate inflammatory response and reduce the risk of immune-mediated diseases.

Conclusions

Breastfeeding is the optimum mode of feeding for the newborn and confers immense health benefits to the developing infant. Its positive health impacts are not limited to the gastrointestinal system but a range of organs, systems and functions, e.g., better neuro-behavioural outcomes, protective effects in respiratory infection, otitis media, urinary infection and sepsis, as well as the sudden infant death syndrome. In addition to macro and micronutrients and bioactive compounds, now we also understand that breastmilk contains a plethora of bacterial species with its own unique microbiome, which plays a vital role in inoculating the infant gut with favourable bacteria after birth. With further research, we will certainly learn more about the implications on the development of the immature immune system, and its impact on the health of the individual, from infancy to adulthood.

Key Messages:

1. The unique components in breastmilk not only affect the microbiota of the gut, but also the development of the immune system, which impact health from infancy to adulthood.
   母乳中的獨特成分不只影響孩子腸道菌叢的生長，亦有助免疫系統的發育，對從嬰兒到成年期的健康都有深遠的影響。

2. Breastmilk protects against diarrhoea by coating the intestinal lining and killing pathogens that can cause infections.
   母乳在嬰兒的腸道建立一道保護塗層，並消滅可引起感染的病原體，以減低患腹瀉的機會。

3. Breastmilk should be used to feed premature babies whenever possible, as it provides the optimal nutrition and lowers the risk of necrotising enterocolitis.
   母乳可為早產兒提供最佳營養，和減低患壞死性小腸結腸炎的風險。所以，應盡可能以母乳餵養早產兒。

4. Breastfeeding is associated with a lower risk of inflammatory bowel disease, with the magnitude of protection significantly greater among Asians.
   母乳餵哺可減低孩子日後患炎症性腸病的機會，這保護在亞洲人尤其顯注。

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Infant & Toddler Feeding Case Files
嬰幼餵哺檔案
Baby Friendly Hospital Initiative Hong Kong Association Mar 2021

Exclusive Breastfeeding Without Suckling: Exclusive Pumping

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Case History

Elaine is a 28-year-old healthy housewife living with her husband and mother-in-law. She gave birth to her first baby, Alex, at full term with a birth weight of 3.5 kg by normal vaginal delivery at a public hospital. Alex was admitted for phototherapy because of neonatal jaundice at 6 days of life. Due to infection control measures of the COVID-19 pandemic, Elaine could not breastfeed Alex directly nor feed him with expressed breastmilk (EBM). She had to keep expressing and storing up the EBM in the refrigerator. Unfortunately, after returning home, Alex was reluctant to suckle. When breastfeeding, he often slept on her breast but woke up frequently to demand feeding. Elaine's breasts were full after nursing. She was very frustrated and struggled to maintain the milk supply. At the same time, she was urged by family members to bottle-feed Alex to gauge how much he had taken. Elaine finally decided to boost up her breastmilk after reading about "powerful pumping" on the web. She topped up the pumping in repeated cycles of 15 – 20 minutes lasting about 2 hours a day and continued for a week. Finally, she managed to feed Alex exclusively with EBM. She pumped her breast 6 to 7 times a day, producing 100ml each, despite repeated sore nipples and on-and-off breast pain with pumping.

About 2+ weeks postpartum, Elaine developed high fever and breast engorgement. She attended the Accident and Emergency Department (AED) and was prescribed antibiotics. She recovered a week later.

Around 5 weeks postpartum, Elaine developed another episode of high fever, sore nipples, and left breast pain for 2 days. She attended AED again and was admitted to the surgical ward for left mastitis. Assessment by the lactation consultant revealed she was not confident in breastfeeding Alex directly. Besides, she perceived herself as having inadequate milk although Alex had already gained 1.5kg by one month of age. She had stored 8 bags of EBM and was determined to pump as much as possible to ensure adequate reserve in case he demanded more later. She was worried about adverse drug effects on Alex. As suggested by her friends and mother-in-law, she planned to continue pumping but discard the milk as long as she needed medication for her mastitis. Examination revealed sore nipples with blisters. Both breasts were full and lumpy with inflammation in the left breast. Her pumping was problematic. She had used the strongest suction force and an under-sized breast shield. Both were likely the culprits of her repeated sore nipples and blocked ducts. The lactation consultant counselled on her various misbeliefs as well as proper pumping suction and schedule, using a shield with a larger flange to avoid traumatisation and over-stimulation. She was encouraged to breastfeed directly after discharge. As Alex was not present, key points on optimal attachment were explained.

At 6 weeks postpartum, Elaine attended a follow-up session at the lactation clinic. Her symptoms subsided completely. The lactation consultant encouraged her to breastfeed Alex directly and discussed with her further information on transition to direct breastfeeding.

At 8 weeks postpartum, Elaine brought Alex to the lactation clinic. His body weight increased by another 1.2kg in the past one month while he was still taking EBM exclusively. Elaine pumped 6 times a day, yielding 150ml each. She was still unconfident about breastfeeding Alex directly because of her past unpleasant experience and preference for bottle-feeding among family members. The lactation consultant coached her on proper positioning and attachment. She was amazed that her nipples did not hurt. Her breast was soft after effective suckling by Alex, who was contented after the feed. She regained her confidence in direct breastfeeding. The lactation consultant further counselled her on the benefits of direct breastfeeding and potential risks of exclusive pumping.

The phone follow-up session at 12 weeks postpartum revealed that Elaine was breastfeeding Alex directly and exclusively, without any pumping. She very much enjoyed the loving relationship especially when breastfeeding Alex directly.

Discussion

Lactating mothers express their breastmilk for a variety of reasons. The common ones are initiating milk production or maintaining milk supply during transient separation from the baby because of maternal or the baby's health issues; resuming work; breastfeeding difficulties, etc. Expressing breastmilk to improve milk removal is also indicated in milk stasis conditions.

In Hong Kong, there is an increasing prevalence of breastfeeding in healthy full-term infants, either by way of direct breastfeeding or feeding with EBM. The commonest reason for expressing breastmilk within the first 2 to 3 months postpartum was breastfeeding difficulties and returning to work.[1] However, pumping without direct breastfeeding is associated with a shorter duration of breastfeeding and earlier introduction of formula feeding.[2]

Bottle Feeding with Expressed Breastmilk Has Higher Risks[3-6]

Studies have shown bottle-feeding with EBM, as compared with direct breastfeeding, has higher risk of otitis media, respiratory infection, asthma, overweight and obesity.

Gut Microbiota in Expressed Breastmilk vs Direct Breastfeeding[2, 7-9]

Gut microbiota is crucial for the development of the immune system in infants whose gut microbiome can be enhanced through direct breastfeeding especially when the baby is nursed skin-to-skin. However, many mothers perceive feeding EBM to a baby the same as direct breastfeeding. Studies have shown that bacterial contamination is more common in EBM from breast pump than that by hand expression. **Pumped breastmilk is associated with increased gram-negative bacteria such as E. Coli and Salmonella, and depletion of bifidobacterium** (one of the major genera of bacteria making up the gastrointestinal tract microbiota).

Components in Stored Expressed Breastmilk[10-13]

Studies have shown that cortisol level is higher in EBM collected in the morning while melatonin level rises in the evening and peaks in the early morning hours. Melatonin fosters sleep and relaxes digestion. Besides, daytime milk has higher levels of immune factors. A circadian clock controls rhythm in sleep-wake cycles, respiratory rate, body temperature, digestion, and metabolism. Direct feeding from the breast matches maternal circadian rhythms and thus communicates the time of a day to the baby. However, **EBM may not be circadian-matched**.

Vitamin C can be reduced by one third after 24 hours of refrigeration. Calorie and fat content as well as antioxidant capacity decrease with duration of freezing. Some photo-sensitive nutrients degrade when breastmilk is stored in transparent containers allowing light exposure.

Rancid flavours and odours of stored breastmilk may occur with prolonged storage due to the normally present lipase in breastmilk, breaking down the fats. In case a baby refuses thawed milk, mothers may try providing fresh EBM or that frozen for less than 7 days.

Flange Size and Milk Pump

Understanding the impact of a pump on the breast or nipple tissue can help improve the pumping experience and breastfeeding outcomes. The pumping action can cause swelling, or traumatisation of tissue inside the tunnel if too strong a suction force is applied. A well-fitting flange should have adequate room to accommodate tissue distension in order to avoid rubbing during pumping. Soreness and abnormally enlarged and lengthened nipples persisting after pumping indicate soft tissue injury.

If a flange is too small, the nipple cannot go in and out of the tunnel freely but rubs against the wall, causing abrasions. If an over-sized flange is used, apart from less effective suction, milk ducts within the areolar may be drawn inside the tunnel, causing compression. This may lead to incomplete milk removal and blocked duct may occur. From the author's experience, **a flange tunnel allowing a rim of 3-5mm away from the nipple before pumping and 1-2mm after pumping is recommended**. Some mothers may need to try different-sized flanges to fit their breasts. Hand expression can also be considered when encountering sore nipples or when milk let-down is not apparent.

All milk pumps have their life spans. Some mothers may borrow or purchase a second-hand pump. Some pumps may not be functioning normally, e.g., ill-fitting parts causing leakage, defective motor with ineffective suction, etc. Pumps with open system (breastmilk may come in contact and be retained inside the pump) impose a risk of cross infection.

Cleansing a pump is important especially for hospitalised babies. Mothers should discuss with healthcare professionals on how each procedure (e.g., sterilization of milk bottles, storage and handling of EBM) is done to prevent contamination. Moisture in the tubing should be got rid of and parts of the pump thoroughly cleansed by swinging the tubing and/or running the pump for several minutes to prevent growth of bacteria and mould.

More support is needed for Mothers Feeding EBM

Mothers adopting exclusive pumping need extra support. They can be emotionally stressed with physical and mental fatigue. Some may feel being negatively judged for not breastfeeding the baby directly. It is crucial to be empathetic and patient to listen to their discourse and support their informed choice of infant feeding. Strengthened education on breastfeeding and enhanced support are required for mothers to sustain feeding EBM exclusively.

The successful transition from pumping to direct breastfeeding, while effortful, is imperative in achieving exclusive and sustained breastfeeding. Extra patience and step-by-step guidance from experienced healthcare professionals on optimal attachment and positioning are essential.

Key Messages:

1. Compared with direct breastfeeding, bottle-feeding with expressed breastmilk imposes higher risks.
   相對直接授乳，以奶瓶餵哺母乳有較高的風險。

2. Expressed breastmilk is not equivalent to breastmilk suckled directly from the breast.
   擠出的母乳並不等同直接吸啜的母乳。

3. Mothers pumping improperly would have sore nipples and blocked ducts. Ensuring their proper use of the pump and selection of appropriate-sized flange is crucial.
   不正確泵奶的媽媽會有乳頭破損及乳管淤塞的情況。確保她們明白怎樣正確使用泵奶器和選擇合適的喇叭十分重要。

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Infant & Toddler Feeding Case Files
嬰幼餵哺檔案
Baby Friendly Hospital Initiative Hong Kong Association
Sep 2021

Strawberry Milk in the Early Postpartum Period

Ms Wong Nga Wai Agnes
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文章內容摘錄中文版本
產後授乳初期的士多啤梨奶

Strawberry milk – my favourite drink! Many people like this pink sweet lovely drink too, especially in this hot summer. However, if it appears in the breastmilk, this is another story. I would like to share my experience in supporting a mother having early onset of strawberry milk in the postnatal ward of a private hospital.

Photo 1: Expressed breastmilk on postpartum day 1
(With permission from St. Paul's Hospital)

Mrs. C, a 35-year-old first-time mother, was very keen on breastfeeding. She went through Caesarean Section because of breech presentation of her baby. On the first postpartum day, she started to hand-express her breastmilk. However, she was astonished when she found her expressed breastmilk looked rusty brown instead of golden yellow. It appeared whenever she expressed her breastmilk from either breast. Very soon, the obstetrician and surgeon came to assess her and respectively arranged some investigations. She was also recommended to stop breastfeeding while waiting for the results. She was very worried and sought help from me.

My consultation with Mrs. C found that this was her first episode of brown nipple discharge. She did not experience any pain or discomfort when expressing the breastmilk. She did not have any history of pain, recent infection, or trauma to her breasts. She had her body check including a mammogram just before this pregnancy, which was normal. She had no family history of breast cancer. Examination of the breasts was normal without any erythema, engorgement or tenderness. There were no erosions, ulcers or cracks on the nipples or areolae. My presumptive diagnosis was a relatively rare but benign condition, Rusty Pipe Syndrome.

What is Rusty Pipe Syndrome (RPS)?

This term was first used at the La Leche League Conference in 1990 by Chele Marmet. The name was coined because of the breastmilk appearance of rusty water from old pipes. Typically, a lactating mother presents with painless, bilateral, sometimes unilateral, blood-stained breastmilk in the early postpartum period which generally resolves within a few days. It is more common in mothers expressing breastmilk than those breastfeeding directly, partly because the latter may remain unnoticed. Occurrence is in the early stage of lactogenesis i.e., in the early postpartum period and sometimes late pregnancy; and is more common in the primigravida. It is thought to be caused by increased vascularisation of the rapidly developing alveolae and ducts of the mammary tissues. As they can be easily traumatized, blood may escape into the milk secretion causing rusty brown appearance.[1]

Prevalence of Rusty Pipe Syndrome

The earliest published study was by Merlob and colleagues[2] in 1990 where 7774 live births in Israel were studied prospectively for 2 years. Eight mothers reported atypical breast discharge, characterized by early appearance of atypical colour but normal cytology and bacteriology. It became normal milk colour without reappearance of atypical breastmilk in 2 to 5 days which signified an important differentiating feature from other pathological breast lesions. All had no adverse effects on the mothers and their babies. The prevalence was about 0.1%.

Management of the Mother with Rusty Pipe Syndrome

RPS is a relatively rare clinical entity. Many healthcare workers may not have encountered it before, let alone lactating mothers in the general public. Being clinicians promoting breastfeeding, we play an important role in supporting the mother as well as liaising with other healthcare professionals.

The commonest cause of blood in the breastmilk is a cracked nipple. A less common condition that may cause blood in the breastmilk is an intraductal papilloma – a small benign wart-like growth on the lining of a milk duct, which bleeds. Although this lesion is not malignant and usually resolves in a few days, medical evaluation is needed. Diagnosis of RPS is usually made by a typical history, a normal physical examination, followed by complementary examinations such as breastmilk cytology and ultrasonography of the breasts, if indicated.

Collaboration with other healthcare professionals taking care of a lactating mother is important.[3] Advice to the mother from different professionals may be diverse or even contradicting. This would confuse the mother and erode her confidence in breastfeeding. RPS is a rare physiological condition which is self-limiting. Knowledge of RPS among health professionals would be very helpful to prevent causing undue anxiety for mothers and avoid unnecessary investigations. We should follow up these

mothers closely and support them to continue breastfeeding, either direct breastfeeding or expression of breastmilk. If the bleeding continues, the mother should be medically evaluated. Once the red tint of the breastmilk has faded out, we should facilitate direct breastfeeding.

Mrs. C had a typical RPS presentation together with a normal physical examination and a normal mammogram one year before. Conservative management was therefore adopted. I discussed with the surgeon who agreed to withhold the breast ultrasonography and observe for a few more days.

I counselled Mrs. C. We had a discussion on the cause and natural course of RPS. We talked about the harmless effect on the baby after taking a small amount of serosanguineous discharge as well as the possible irritation to the baby's stomach causing regurgitation or vomiting. She felt more relieved afterwards. She finally decided to continue breastmilk expression while observing the evolution of the RPS. Meanwhile, Mrs. C actively prepared for direct breastfeeding. She expressed her breastmilk every 3 hours and stored them in bottles (see Photo 1 and 2).

She was further reassured as the red-tint of the breastmilk faded day by day. At the same time, she cup-fed her baby with formula milk. She frequently held her baby skin-to-skin to build their bonding as well as to facilitate her baby's recognition of her odour so as to help the attachment. Her milk came in on day 4 postpartum when the bleeding had largely ceased. The expressed milk became golden yellow,

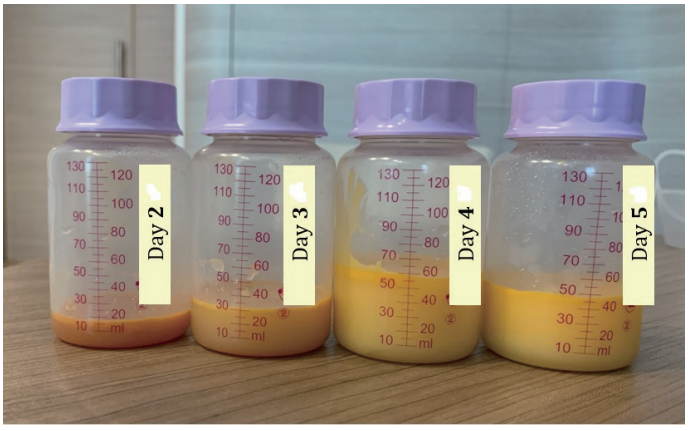

Photo 2: Expressed breastmilk from day 2 to day 5 postpartum
(With permission from St. Paul's Hospital)

the typical colour of colostrum. On day 5, she started direct breastfeeding. It did not take long for her baby to learn the attachment skill because of all the preparatory work done to facilitate the switch to direct breastfeeding. The rusty colour of the breastmilk did not re-appear. The breastmilk cytology result was normal.

Conclusions

Bleeding during breastfeeding is alarming. Suggesting to a mother to quit breastfeeding too early should always be avoided. As healthcare professionals, we should analyse the situation carefully by taking a thorough history, examining the breasts, and checking breastfeeding skills / expression techniques. Giving correct information as well as offering psychological support to the mother are crucial in reassuring her and enabling her to make informed choices. Engaging the mother in discussing and planning every step goes a long way towards achieving the final goal of exclusive breastfeeding.

Key Messages:

1. Rusty Pipe Syndrome (RPS) is a relatively rare and self-limiting condition in which a lactating mother produces brownish breastmilk in the early postpartum period.
   鏽管症候群是指產後初期的媽媽排出啡褐色的母乳，是頗為罕見並會自愈的症狀。
2. When dealing with blood-stained breastmilk, healthcare professionals need to take a thorough history, examine the breasts and check breastfeeding and expression skills.
   當母乳有染血情況時，醫護人員須詳細了解媽媽的病史，檢查乳房，並觀察餵哺和擠奶技巧。
3. Providing correct information and offering psychological as well as technical skill support to the mother are important in enabling the mother to achieve exclusive breastfeeding.
   為媽媽提供正確資訊，給予心理輔導及具體的技巧支援，對於讓媽媽實現全母乳餵哺至為重要。

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Obstetricians: Buckle Down and Go the Extra Mile

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文章內容摘錄中文版本
產科醫生：努力邁進

I was fortunate enough to be involved in preparing Queen Mary Hospital for the designation as Baby-friendly Hospital (BFH). Looking back, I could see myself and my colleagues transforming. As obstetricians, we are aware that breastfeeding confers medical, economical, societal and environmental advantages, and we know that support for breastfeeding is part of obstetric service. However, we are often occupied with or even overwhelmed by the rapid advancements in various aspects of the specialty. Accreditation for BFH was a golden opportunity to direct our focus in restructuring and reinforcing breastfeeding support in our service.

As maternity health care professionals and advocates for women's health who work with other obstetric and paediatric health care providers, obstetricians are obligated to facilitate women to achieve their infant feeding goals. The breastfeeding rate on hospital discharge in Hong Kong increased from 19% in 1992 to 87.2% in 2019[1]. However, the exclusive breastfeeding rate at 4 months was only 29.1% in 2018[2]. Apparently, many mothers started breastfeeding, but the majority did not sustain. Nobody can be in a better position than obstetricians to assist women to make informed choices about infant feeding, offer anticipatory guidance, support normal lactation and manage breastfeeding problems.

Education

Previous studies have shown that obstetricians and residents have reported that their training in infant nutrition was inadequate and their practices were found discrepant with what were recommended for promoting breastfeeding[3,4]. Obstetricians and residents should be adequately trained and continuously educated such that they can provide accurate and unbiased information about breastfeeding and be prepared to support women when they encounter breastfeeding problems. They should also be equipped with the knowledge of local and regional breastfeeding support services where patients can be referred for additional breastfeeding support after delivery. In addition to knowledge and practical skills, obstetricians' attitude to their responsibility for safeguarding infant feeding are equally important and are key influences on breastfeeding success.

Prenatal Care

Taking a breastfeeding history, identification of concerns and risks for breastfeeding difficulties, as well as a breast assessment, are recommended by the American College of Obstetricians and Gynecologists (ACOG) as part of prenatal care[5]. Women should be counselled about the benefits of breastfeeding, starting as early as the first trimester. Encouragement from health care providers have been shown to increase breastfeeding initiation, especially among low-income, young, less-educated or single women[6]. A patient-centered approach should be adopted to allow the woman and her family to anticipate challenges, develop strategies to address them and to collaborate to develop an infant feeding plan[5]. Obstetricians can also help to clarify misconceptions about breastfeeding, for example, those associated with maternal hepatitis B infection. It has been shown that the infection was one of the reasons for persistently low breastfeeding rate[7].

Intrapartum Care

The World Health Organization's 'Ten Steps to Successful Breastfeeding' is an evidence-based set of practices which support breastfeeding physiology, including early skin-to-skin care, enabling rooming-in and feeding on demand. These steps should be incorporated into maternity care to increase the likelihood that a woman will initiate and sustain breastfeeding. Obstetricians should be aware that Caesarean delivery is associated with delayed lactogenesis, whereas unmedicated spontaneous vaginal delivery is associated with positive breastfeeding outcomes. Women who undergo Caesarean delivery may need extra support to initiate and sustain breastfeeding. Also, mother-friendly practices should be encouraged, such as non-pharmacological pain relief, mobilization and labour support by birth partners.

Postnatal Care

Women should be supported in their informed decision to infant feeding. Obstetricians should collaborate with lactation consultants and infant care providers to manage breastfeeding problems, such as pain, perceived or actual low milk supply, breast infection and maternal medication safety.

Breast pain of various degrees is common in breastfeeding women, at the same time, pain is a common cause of premature weaning. Early nipple pain may indicate a need for checking of positioning and latching. On the other hand, causes of persistent pain include dermatitis, infection, vasospasm, functional pain and other rare conditions should be investigated. Women should be referred to lactation consultants for further management when needed. It is important for obstetricians to be aware that women are at risk of depression when they experience breastfeeding problems, and they should be screened, managed and referred as appropriate.

Women with preterm infants may encounter challenges, including delayed onset of lactation and insufficient milk. Obstetricians can help women to make an informed decision to breastfeed in NICU and provide appropriate support. Both options of expressed breastmilk and feeding from the breasts should be discussed.

Low milk supply is a common concern. The commonest cause of low milk supply is inadequate breast stimulation. Evaluation by a lactation consultant to ensure frequent breast stimulation and milk removal is the most effective strategy to increase milk production.

Most medications are safe to use during breastfeeding. Obstetricians should consult lactation pharmacology resources for up-to-date information on individual medications to avoid women discontinuing breastfeeding unnecessarily. LactMed is a free resource updated monthly from the National Institute of Health National Library of Medicine and available online or as an app. Before prescription, careful assessment of the infant is necessary in all cases, particularly in those who are preterm or sick. Counselling regarding medication use during lactation should address the risk of drug exposure through breastmilk and the risks of interrupting lactation. For example, breastfeeding can be continued without interruption after the use of iodinated contrast during a computed tomography or gadolinium contrast with magnetic resonance imaging[8]. For women needing contraception, non-hormonal contraceptive methods are preferred as oestrogen-containing contraceptives may reduce milk supply.

In addition, neonatal management protocols can be developed in collaboration with paediatricians to facilitate initiation and sustaining breastfeeding. Strategies can be revamped in monitoring of newborns with risk factors so as to minimize mother-baby separation, for example, monitoring for early onset group B streptococcus disease and neonatal hypoglycaemia. Treatment protocols, like buccal glucose gel application for mild neonatal hypoglycaemia, can reduce separation, infant formula supplementation and also encourage sustaining breastfeeding.

Policy and Breastfeeding in the Community

Obstetricians should support women and encourage policies which allow women to integrate breastfeeding into their daily lives and the workplace. The ACOG recommends that obstetricians be at the forefront of policy efforts. The Baby-Friendly Hospital Initiative was first launched in 1991 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to give every baby the best start in life by removing breastfeeding barriers in health facilities and to encourage health facilities, especially maternity hospitals, to implement the 'Ten Steps to Successful Breastfeeding'. Obstetricians are important players in achieving the goals.

The International Code of Marketing of Breast-Milk Substitutes was developed by the WHO and UNICEF in 1981 to promote breastfeeding. Obstetricians should ensure no promotion of products (including breastmilk substitutes, feeding bottles and teats) in the health care facilities. Health care providers should not receive gifts or personal samples, nor pass these samples to the women.

Policies and facilities to create a breastfeeding-friendly workplace should be advocated to accommodate the breastfeeding needs of women at work. Provision of appropriate space and privacy for milk expression by women during breaks encourages a positive attitude towards the practice of breastfeeding, thereby improving the future health of the community.

Summary

Obstetricians can play an active role in promoting, protecting and supporting breastfeeding in different stages of women's journey with their pregnancy and motherhood. Keeping up with continuous quality education helps to update their knowledge and skills in breastfeeding management. They can work in collaboration with lactation consultants, paediatricians and other health care providers in supporting women, as well as championing breastfeeding policies in hospitals and the workplace. The influence of obstetricians in successful breastfeeding cannot be underestimated.

Key Messages:

1. As maternity health care professionals and advocates for women's health , obstetricians are obliged to facilitate women to make informed choices about infant feeding, offer anticipatory guidance, support normal lactation and manage breastfeeding problems.
   產科醫生有責任幫助孕婦就嬰兒餵哺作明智的選擇，提供預早的指導，支援她們授乳和處理母乳餵哺問題。

2. Obstetricians and residents should be adequately trained and continuously educated such that they can provide accurate and unbiased information about breastfeeding.
   所有產科醫生都應該接受充分的培訓並持續進修，讓他們能夠提供準確以及不偏頗的母乳餵哺資訊。

3. Obstetricians' attitude to their responsibility for safeguarding infant feeding are equally important and are key influences on breastfeeding success. Encouragement from health care providers have been shown to increase breastfeeding initiation.
   產科醫生對維護嬰兒餵哺的態度也同樣重要，並對母乳餵哺的成功具關鍵影響。醫護人員的鼓勵已證實能令更多的婦女開始用母乳餵哺。

4. Obstetricians should consult lactation pharmacology resources for up-to-date information on individual medications to avoid women discontinuing breastfeeding unnecessarily, for example, LactMed.
   產科醫生應查閱最新藥物的資訊，例如 LactMed，以獲取有關個別藥物的最新及正確的信息，避免婦女因為要用藥而不必要地停止授乳。

5. Obstetricians should collaborate with lactation consultants and infant care providers to manage breastfeeding problems.
   產科醫生應與母乳餵哺顧問及兒科同事合作，以解決母乳餵哺問題。

6. Neonatal management protocols can be developed in collaboration with paediatricians to facilitate initiation and sustaining breastfeeding.
   產科醫生應與兒科醫生合作制訂初生兒醫療程序，以便促進母乳餵哺及達至持續授乳。

7. Obstetricians should support women and be at the forefront to encourage policies which allow women to integrate breastfeeding into their daily lives and the workplace.
   產科醫生應支持婦女，並走在最前線，鼓勵制定政策，使婦女能把母乳餵哺融入其日常生活和工作。

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Views expressed in this article are the author's and do not necessarily reflect the opinion or position of the BFHIHKA.

作者在本文章表達的見解，未必代表愛嬰醫院香港協會的意見或立場

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Baby Friendly Watch
愛嬰情報
Baby Friendly Hospital Initiative Hong Kong Association
Dec 2021

Ensuring Staff Competency to Support Breastfeeding

Dr Patricia Ip
Chairperson, Committee on Designation of Baby-Friendly Health Facilities,
Baby Friendly Hospital Initiative Hong Kong Association (BFHIHKA)

文章內容摘錄中文版本
確保員工有能力支持母乳餵哺

Introduction

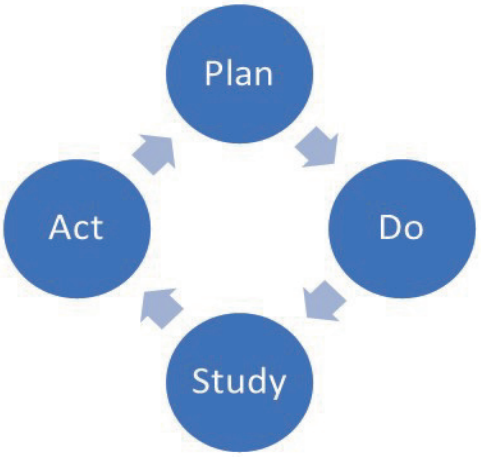
The WHO/ UNICEF launched the Baby Friendly Hospital Initiative (BFHI) in 1991. The evidence for the BFHI was updated in 2017.[1] In 2018 the implementation guidance based on the updated evidence was published, including the revised Ten Steps to Successful Breastfeeding (Ten Steps).[2] This was summarised in a previous BFHIHKA newsletter.[3] Central to the success of the BFHI is health care staff with the competency, i.e., the related knowledge, skills and attitude, for its implementation. The WHO prepared a Competency Verification Toolkit (the toolkit)[4] in 2020 to assist facilities which are joining or have joined the programme. Below is a brief description of the toolkit and some related resources.

Revised Step 2 of the Ten Steps

"Train all health care staff in skills necessary to implement the policy" to "Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding""

The revised Step 2 shifted the focus from hours of training to verification of competency, i.e., from process to outcome. This paradigm shift was explained by the team that devised the toolkit in a recent article.[5]

Ensuring Competency



Health care staff is expected to have had basic training on breastfeeding either pre-service or in-service. The WHO 3-day BFHI training course for maternity staff[6] has been revised in the light of the revised Ten Steps with the inclusion of all newborns in the programme rather than only healthy term infants. For the application of BFHI to small, sick and preterm newborns, the WHO/ UNICEF had published a supplementary guidance in 2020.[7]

The BFHI is a continuous quality improvement programme. The quality improvement cycle can be applied to the process of ensuring competency. The health care facility identifies a goal or set of goals it wants to achieve. It then plans, implements the plan, monitors or studies the outcome and takes action so that the goal(s) could be achieved. Hence the facility decides which staff performance areas need enhancement, conducts baseline assessments, targets training in these areas, reassesses, and plans further actions as necessary.

Competency Verification Toolkit

Instead of the 20 competencies identified in the WHO 2018 guidance[2] for Step 2, the toolkit has rearranged them into 7 domains with 16 competencies as some previous competencies were considered beyond the scope of BFHI. There are also 64 performance indicators which are specific and action-oriented to document the staff having acquired the competencies.

Domains and Competencies

Domain 1: Critical management procedures to support the Ten Steps

01. Implement the Code in a health facility
02. Explain a facility's infant feeding policies and monitoring systems

Domain 2: Foundational skills: communicating in a credible and effective way

03. Use listening and learning skills whenever engaging in a conversation with a mother
04. Use skills for building confidence and giving support whenever engaging in a conversation with a mother

Domain 3: Prenatal period

05. Engage in antenatal conversation about breastfeeding

Domain 4: Birth and immediate postpartum

06. Implement immediate and uninterrupted skin-to-skin

07. Facilitate breastfeeding within the first hour, according to cues

Domain 5: Essential issues for a breastfeeding mother

08. Discuss with a mother how breastfeeding works

09. Assist mother getting her baby to latch

10. Help a mother respond to feeding cues

11. Help a mother manage milk expression

Domain 6: Helping mothers and babies with special needs

12. Help a mother to breastfeed a low-birth-weight or sick baby

13. Help a mother whose baby needs fluids other than breastmilk

14. Help a mother who is not feeding her baby directly at the breast

15. Help a mother prevent or resolve difficulties with breastfeeding

Domain 7: Care at discharge

16. Ensure seamless transition after discharge

The second domain of foundational skills for effective communication and counselling applies throughout the other domains. Health care workers are not only to be able to support breastfeeding clinically but women's informed decisions, respecting them as partners in care.

For the performance indicators, each is clearly stated as to its relationship with which competency and BFHI Step, whether one or more competencies of knowledge, skills and attitudes are being assessed and which means of verification could be used.

Competency Verification Forms

There are two sets of competency verification forms with the same performance indicators but sorted by domain and competency or by BFHI Steps. Facilities could elect to use the former when developing training or the latter if the facility wishes to improve a certain BFHI Step or set of Steps. The form can be used to record each health care worker's competencies and provide feedback to the worker to guide future learning. Being verified to be competent could enhance staff confidence, accountability and professional pride.

Assessment Tools and Related Resources

The toolkit provides various tools to verify staff competency. There is a set of 64 multiple choice questions to verify staff's basic knowledge. Answer keys with explanation for the appropriate responses are included. A number of case studies and observation tools are also provided to help assess knowledge, skills, attitude and logical thinking for various clinical situations involving different performance indicators. There is the option to add or modify questions and expected responses to suit local policies, guidelines and the use of language.

There are resources for examiners to assist and guide them or to train new examiners. These contain appropriate responses with references should the examiner require further information.

To distinguish between internal and external assessments, internal assessments are done by examiners and external assessments by assessors. Facilities should identify examiners who are able to stimulate professional growth while identifying gaps through the exercise of competency verification. They should be knowledgeable about what is correct and incorrect, be observant and possess interviewing skills, able to probe without influencing results and are accurate recorders.

Use of the Toolkit

The toolkit can be used as a whole or for certain Steps. Health care workers can use the multiple-choice questions for self-assessment. The facility can use the toolkit to assess individual staff or teams of a unit or across units. It can also be used before designing training or when preparing for external assessment.

Way forward

For institutions responsible for the pre-service and in-service training of healthcare professionals, the training curriculum should be revised according to the WHO revised Ten Steps. The toolkit can serve to identify gaps and training needs at the individual, departmental and institutional levels.

For the assessment of Baby-friendly health facilities, the WHO is in the process of preparing new external assessment tools based on the revised Ten Steps. Currently BFHIHKA is performing external assessments using the existing WHO tools for facilities already enrolled in the BFHI programme but will consider revising the assessment criteria for new facilities joining the programme and for revalidation. Any changes will be announced in advance on BFHIHKA's website.

Key Messages:

1. Ensuring staff competency is central to the success of BFHI.

   確保員工能力是愛嬰醫院行動成功的關鍵。

2. The WHO Competency Verification Toolkit facilitates the targeted training and assessment of health care workers.

   世界衛生組織的「能力驗證工具套」有助於對醫護人員進行有針對性的培訓和評估。

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Illustrations from Infographics on
Baby-friendly hospitals initiative - Ten steps to successful breastfeeding:
https://apps.who.int/nutrition/bfhi/infographics/en/index.html

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The Designation of Baby-Friendly Health Facilities in Hong Kong
愛嬰醫療機構在香港的認證情況

(updated to 更新至 12/2021)

In Hong Kong, maternity units in hospitals and Maternal and Child Health Centres (MCHCs) provide the continuum of care that supports mothers to feed their babies optimally. As an extension of BFHI, we are including Maternal and Child Health Centres in our designation programme.

There are 5 stages to achieve Full accreditation: Registration of Intent, Certificate of Commitment, Award of Level 1 Participation, Award of Level 2 Participation and Award of Baby-Friendly Hospital (BFH) / Maternal and Child Health Centre (MCHC). BFHs/ MCHCs need to apply for revalidation every 3 years.

For details, please refer to our website: https://www.babyfriendly.org.hk/en/healthcare-facilities/

在香港，醫院的產科部門聯同母嬰健康院提供連貫的服務，以協助母親採用最佳方法餵哺嬰兒。作為愛嬰醫院行動的延伸，我們已涵蓋母嬰健康院於定名計劃中。

認證有5個階段：意向登記、承諾認證、第一階段實踐證書、第二階段實踐證書、定名為愛嬰醫院 / 愛嬰母嬰健康院。及後，每三年需申請重新認證為愛嬰醫院 / 愛嬰母嬰健康院。

有關詳情，請參閱我們的網站: https://www.babyfriendly.org.hk/en/healthcare-facilities/

Hospitals in BFHI programme 參與計劃的醫院

Name of Hospital 醫院名稱	Level of Designation achieved 達到的認證階段	Date 日期
Queen Elizabeth Hospital 伊利沙伯醫院	Award of Baby-Friendly Hospital 定名為愛嬰醫院	5/2016
	Revalidation of Baby-Friendly Hospital 重新認證為愛嬰醫院	8/2019
Queen Mary Hospital 瑪麗醫院	Award of Baby-Friendly Hospital 定名為愛嬰醫院	1/2018
	Revalidation of Baby-Friendly Hospital 重新認證為愛嬰醫院	7/2021
Prince of Wales Hospital 威爾斯親王醫院	Award of Baby-Friendly Hospital 定名為愛嬰醫院	7/2019
Kwong Wah Hospital 廣華醫院	Award of Baby-Friendly Hospital 定名為愛嬰醫院	11/2021
Pamela Youde Nethersole Eastern Hospital 東區尤德夫人那打素醫院	Award of Baby-Friendly Hospital 定名為愛嬰醫院	11/2021
Tuen Mun Hospital 屯門醫院	Award of Baby-Friendly Hospital 定名為愛嬰醫院	12/2021
United Christian Hospital 基督教聯合醫院	Award of Level 1 Participation 第一階段實踐證書	3/2021
Princess Margaret Hospital 瑪嘉烈醫院	Award of Level 1 Participation 第一階段實踐證書	3/2021
Gleneagles Hong Kong Hospital 港怡醫院	Certificate of Commitment 承諾證書	10/2019

MCHCs in BFHI programme 參與計劃的母嬰健康院

Name of MCHC 母嬰健康院名稱	Level of Designation achieved 達到的認證階段	Date 日期
Kowloon City MCHC 九龍城母嬰健康院	Award of Baby-Friendly MCHC 定名為愛嬰母嬰健康院	7/2019
Sai Ying Pun MCHC 西營盤母嬰健康院		8/2019
Yaumatei MCHC 油麻地母嬰健康院		8/2019
Lam Tin MCHC 藍田母嬰健康院	承諾證書 Certificate of Commitment	8/2021
Ma On Shan MCHC 馬鞍山母嬰健康院		8/2021
North Kwai Chung MCHC 北葵涌母嬰健康院		8/2021
Sai Wan Ho MCHC 西灣河母嬰健康院		8/2021
Tin Shui Wai MCHC 天水圍母嬰健康院		8/2021

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