Baby Friendly Hospital Initiatives

1. The Ten Steps to Successful Breastfeeding
2. The Baby Friendly Hospital Initiative—Baby Friendly USA
3. Fleur—Overcoming Barriers to Baby Friendly

The 10 Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.

2. Educate all staff in skills necessary to implement this policy.

3. Inform pregnant women about the benefits and management of breastfeeding.

4. Help mothers initiate breastfeeding within 1 hour of birth.

5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.

6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.

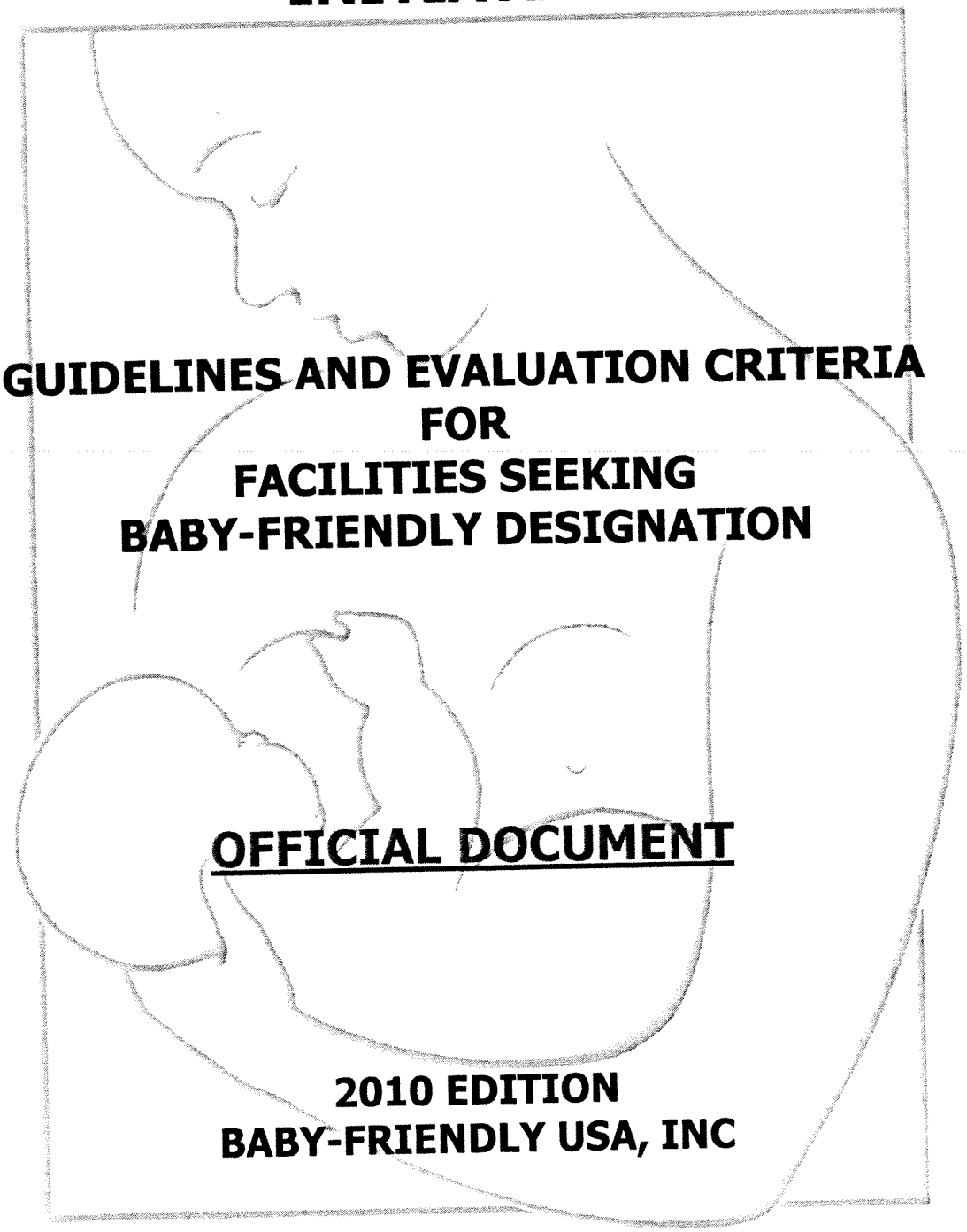
7. Practice rooming-in, allowing mothers and infants to remain together for 24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no pacifiers or artificial nipples to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

THE BABY-FRIENDLY HOSPITAL INITIATIVE



GUIDELINES AND EVALUATION CRITERIA FOR FACILITIES SEEKING BABY-FRIENDLY DESIGNATION

OFFICIAL DOCUMENT

2010 EDITION
BABY-FRIENDLY USA, INC

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This document is an adaptation of the following documents:

- The UNICEF/WHO *Global Criteria for the Baby-friendly Hospital Initiative* developed in 1991
- The *Guidelines & Evaluation Criteria for the U.S. Baby-Friendly Hospital Initiative* developed in 1996 by the United States Fund for UNICEF and Wellstart International
- The 2004 adaptation of the U.S. *Guidelines & Evaluation Criteria for the U.S. Baby-Friendly Hospital Initiative*
- The 2006 UNICEF/WHO *Global Criteria for the BFHI*

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Preamble to the US Baby-Friendly Hospital Initiative Guidelines and Criteria

Currently, scientific evidence overwhelmingly indicates that breastfeeding is the optimal method of infant feeding and should be promoted and supported to ensure the best health for American women and their children. Breastfeeding is the single most powerful and well documented preventive modality available to health care providers to reduce the risk of common causes of infant morbidity. Significantly lower rates of diarrhea, otitis media, lower respiratory tract infections, Type 1 and Type 2 diabetes, childhood leukemia, necrotizing enterocolitis and Sudden Infant Death Syndrome occur among those who were breastfed.[1] Women who breastfeed have a lower risk of Type 2 diabetes, breast, and ovarian cancer.[2] Recent evidence suggests that reduction in the risk for cardiovascular and other related diseases may be added to the benefits of breastfeeding for women.[3]

Numerous professional organizations actively encourage a sound program of information and support necessary to promote the successful establishment and maintenance of breastfeeding, including the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Hospital Association, Association of Women's Health, Obstetric and Neonatal Nurses, the American Dietetic Association, and the American Public Health Association. In addition, the U.S. Department of Health and Human Services has included breastfeeding among in the national Healthy People objectives for the nation since their inception for the year 1990. The 2010 objective[4] states:

> Increase the proportion of mothers who breastfeed their babies:
>
> a) in the early postpartum period to 75%
> b) at 6 months to 50%
> c) at 1 year to 25%
> d) exclusively to 3 months to 40%
> e) exclusively to 6 months to 17%

The diverse benefits of breastfeeding translate into hundreds of dollars of savings at the family level, and billions of dollars at the national level through decreased hospitalizations and pediatric visits. Researchers have estimated that were the national

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[1] Ip S, Chung M, Raman G, et al. *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries.* Evidence Report/Technology Assessment NO. 153 (Prepared by Tufts-New England Medical Center Evidence-Based Practice Center, under Contract No. 290-02-0022). AHRQ Publication No. 07-E007. Rockville, MD: Agency for Healthcare Research and Quality. April 2007, p. v.

[2] Ip et al., p. v.

[3] Schwarz EB, Ray RM, Stuebe AM, et al. Duration of lactation and risk factors for maternal cardiovascular disease. *Obstet Gynecol.* 2009;113(5):974-82.

[4] These goals will be replaced with the 2020 goals as soon as they are finalized.

initiation and 6 months goals (above) to be met, between $3.6 and 13 billion would be saved on pediatric health care costs[5],[6]. Consequently, activities to promote the national objectives are clearly among the best and most cost effective health promotional strategies available.

Despite numerous benefits of breastfeeding that cannot be achieved with artificial feeding, the initiation, duration, and exclusivity of breastfeeding continue to lag behind the national objectives, particularly among the most vulnerable populations of low income and African American women. While causes of this trend are multifactoral and complex, health care practices have been shown to play a fundamental role in decreasing the numbers of women who continue any breastfeeding, as well as decreasing the number who continue to breastfeed exclusively. Hospitals and birthing centers are an integral part of the total continuum of health care of the mother and her infant(s). Unsupportive practices during the perinatal period can disrupt the unique and critical link between the prenatal education and the community postpartum support provided after discharge from the birthing facility.

To address the most common of these problems, in 1991 the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) established the Baby-Friendly Hospital Initiative (BFHI). The BFHI is a global program to encourage and recognize hospitals and birthing centers that offer an optimal level of care for breastfeeding. The core components of the BFHI are the UNICEF/WHO *Ten Steps to Successful Breastfeeding*, which are designed to facilitate the role of the hospital/birthing center inn providing women the choice and opportunity to breastfeed, regardless of the method of birth. More than 170 countries have undertaken implementation of the *Ten Steps to Successful Breastfeeding*, resulting in the designation of more than 20,000 birth facilities throughout both the developing and industrialized world. The BFHI has been endorsed by hundreds of organizations worldwide.

In the United States, Wellstart International in cooperation with the U.S. Fund for UNICEF piloted the development of tools for the assessment of the first US Baby-Friendly®[7] hospitals, including the original *Guidelines and Evaluation Criteria*, which provided the basic guidance for hospital/birthing center level implementation in the program. In 1997, Baby-Friendly USA was created at the request of US Fund for UNICEF to administer the BFHI program in U.S. hospitals and birthing centers. While the *Guidelines and Evaluation Criteria* give hospital/birthing center personnel step-by-step instructions in implementation of the *Ten Steps to Successful Breastfeeding,* the accompanying criteria provide the specific quantifiably measures used by BFHI assessors to determine hospital/birthing center conformity with the BFHI.

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[5] Weimer, Jon. *The Economic Benefits of Breastfeeding: A Review and Analysis.* Washington, DC: ERS Food Assistance and Nutrition Research Report No. 13, March 2001.

[6] Bartick M, Reinhold A. The burden of suboptimal breastfeeding in the United States: a pediatric cost analysis. *Pediatrics* 2010 May;125(5):e1048-56.

[7] Baby-Friendly is a registered certification mark of UNICEF.

Guidelines & Evaluation Criteria for the U.S. Baby-Friendly Hospital Initiative, 2010 (updated 11/28/11)

The U.S. BFHI Guidelines, Criteria and the assessment and award process are predicated on the following principles:

1) Breastfeeding has been recognized by scientific authorities as the optimal method of infant feeding and should be promoted as the norm within all maternal and child health care facilities.
2) The most sound and effective procedural approaches to supporting breastfeeding and human lactation in the birthing environment that have been documented in the scientific literature to date should be followed by the health facility.
3) The health care delivery environment should be neither restrictive nor punitive and should facilitate informed health care decisions on the part of the mother and her family.
4) The health care delivery environment should be sensitive to cultural and social diversity.
5) The mother and her family should be protected within the health care setting from false or misleading product promotion and/or advertising within the health care setting which interferes with or undermines informed choice regarding infant health care practices.
6) When a mother has chosen not to breastfeed, when supplementation of breastfeeding is medically indicated, and when supplementation is chosen by the breastfeeding mother (after appropriate counseling and education), it is crucial that safe and appropriate methods of formula mixing, handling, storage, and feeding is taught to the parents.
7) Recognition as a Baby-Friendly institution should have both national and international credibility and prestige, so that it is marketable to the community, increases demand, and thereby improves motivation among facilities to participate in the Initiative.
8) Participation of any facility in the U.S. BFHI is entirely voluntary and is available to any institution providing birthing services. Each participating facility assumes full responsibility for assuring that its implementation of the BFHI is consistent with all of its safety protocols, existing contractual agreements, and legal obligations.

THE GUIDELINES AND EVALUATION CRITERIA FOR HOSPITAL/BIRTHING CENTER LEVEL IMPLEMENTATION OF THE UNITED STATES BABY-FRIENDLY HOSPITAL INITIAITVE

Baby-Friendly USA, Inc., 2010

Step 1:
Have a written breastfeeding policy that is routinely communicated to all health care staff.

GUIDELINE: Breastmilk should be the standard for infant feeding. All infants in the facility should be considered to be breastfeeding infants unless, after giving birth and being offered help to breastfeed, the mother has specifically stated that she has no plans to breastfeed (see steps 4 and 5). The facility should have a written policy (Step 1) that addresses the implementation of Steps 2-10 as well as the *International Code of Marketing of Breast Milk Substitutes*, and communicates the Baby-Friendly philosophy that mothers room with, care for, and feed their own well infants and should be protected from the promotion of breastmilk substitutes and other efforts that undermine an informed feeding choice. All areas of the facility that potentially interact with childbearing women and babies will have language in their policies about the promotion, protection and support of breastfeeding. Policies of all departments will support, and will not countermand the facility's breastfeeding policy, and be based on recent and reliable scientific evidence.

Criteria for evaluation:

- *The facility will have written maternity care and infant feeding policies that address all Ten Steps, protect breastfeeding, and adhere to the International Code of Marketing of Breast-milk Substitutes. All areas of the facility that potentially interact with childbearing women and babies will have language in their policies about the promotion, protection and support of breastfeeding. Policies of all departments will not countermand the facility's breastfeeding policy. Review of all clinical protocols, standards, and educational materials related to breastfeeding and infant feeding used by the maternity services indicates that they are in line with BFHI standards and current evidence-based guidelines.*
- *The Nursing Director/Manager will be able to identify the health care professional(s) who have ultimate responsibility for assuring the implementation of the breastfeeding policy.*

GUIDELINE: The designated health care professional(s) should ensure that maternity care and infant feeding policies are readily available for reference to all staff that care for mothers, infants, and/or young children and are communicated to new employees in their orientation and at other times as determined by the health care facility. The facility should have a mechanism for monitoring the effectiveness of the maternity care and infant feeding policies that is incorporated into routine quality improvement procedures.

Criteria for evaluation:

- *The Nursing Director/Manager on the maternity unit and/or the designated health care professional within the facility will be able to locate the maternity care and infant feeding policies, and describe how the other staff, including new employees, are made aware of the content.*
- *At least 80% of randomly selected maternity staff members will confirm that they are aware of the facility's maternity care and infant feeding policies, know where the policies are kept or posted, and have received orientation regarding the policies.*
- *The Nursing Director/Manager on the maternity unit and/or the designated health care professional within the facility will be able to produce evidence of routine quality improvement procedures that have monitored the maternity care and infant feeding policies.*

GUIDELINE: Summaries of the policy, including at minimum the Ten Steps and the institutional philosophy regarding the purchase and promotion of breastmilk substitutes, nipples and pacifiers, should be prominently displayed in all areas that serve mothers, babies and young children. This information should be available in the language(s) most commonly understood by patients and, if needed and/or possible, should be available in appropriate formats for illiterate and visually impaired patients.

Criteria for evaluation:

- *The Ten Steps and a statement which communicates the institution's policy restricting the promotion of breastmilk substitutes will be prominently displayed in all areas of the health care facility which serve mothers, infants, and/or young children, including labor and delivery, the postpartum unit, all infant and child care areas, affiliated prenatal areas such as clinics, ultrasound, screening, antenatal testing, and the emergency room. This information will be displayed in the language(s) most commonly understood by patients.*

STEP 2:
Train all health care staff in the skills necessary to implement this policy.

GUIDELINE: A designated health care professional should be responsible for assessing needs, planning, implementing, evaluating, and periodically updating competency-based training in breastfeeding and parent teaching for formula preparation and feeding for all health care staff caring for mothers, infants and/or young children. Such training may differentiate the level of competency required and/or needed based on staff function, responsibility, and previously acquired training, and should include documentation that essential skills have been mastered.

Training for nursing staff on maternity should comprise a total of 20 hours, inclusive of the 15 sessions identified by UNICEF/WHO [Appendix A] plus 5 hours of supervised clinical experience. The facility should determine the amount and content of training required by staff in other units and roles by their anticipated workplace exposure to mothers and babies. Physicians, Midwives, Physician Assistants and Advanced Practice Registered Nurses (APRNs) with privileges for labor, delivery, maternity, and nursery/newborn care should have a minimum of 3 hours of breastfeeding management education pertinent to their role. The content and number of hours of training for staff working outside maternity will be developed by each facility, based on job description and workplace exposure to breastfeeding couplets.

Clinical competency verification will be a focus of all staff training. Maternity staff will receive training and mentorship necessary to attain competence in counseling the feeding decision, providing skin-to-skin contact in the immediate postpartum, assisting and assessing the mother and baby in achieving comfortable and effective positioning and attachment at the breast, counseling mothers regarding maintaining exclusive breastfeeding, learning feeding cues, assuring rooming-in, teaching and assisting mothers with hand expression of milk, teaching formula preparation and feeding to parents when necessary, and assisting mothers in finding support upon discharge.

Criteria for evaluation:

- *The head of maternity services will report that all health care staff members who have any contact with pregnant women, mothers, and/or infants, have received sufficient orientation on the infant feeding policies.*
- *The head of maternity services will be able to identify the health care professional(s) who have responsibility for all aspects of planning, implementing, and evaluating staff training in breastfeeding and parent teaching for formula preparation and feeding.*
- *The designated health care professional(s) will provide documentation that training for breastfeeding and parent teaching for formula preparation and feeding is provided for all health care staff caring for mothers, infants, and/or young children, and that new staff are oriented on arrival and scheduled for training within six months (for example, by providing a list of new staff who are scheduled for training).*
- *If training acquired prior to employment with this facility is accepted as a means of meeting the minimum competencies, the designated health care professional will be able to describe the process used to verify the previously acquired competencies.*

- *The designated health care professional(s) will provide documentation of training offered to staff outside the maternity unit.*
- *A copy of the curricula or course outlines for competency based training in breastfeeding, lactation management, and parent teaching for formula preparation and feeding will be available for review and a schedule for training all newly hired staff will exist. Maternity staff training will cover steps 3 through 10 and include the primary topics of all 15 sessions identified by UNICEF/WHO 20 hour curriculum (Breastfeeding Promotion and Support in a Baby-Friendly Hospital). A US version (The Curriculum in Support of the Ten Steps to Successful Breastfeeding) is available through Baby-Friendly USA, Inc. The training will include a minimum of five hours of supervised clinical experience.*
- *At least 80% of randomly selected maternity staff members, including the nursery staff, will confirm that they have completed the described training and competency verification or, if they have been on the unit less than six months, have at least been oriented.*
- *At least 80% of randomly selected maternity staff members will be able to answer 4 out of 5 questions on breastfeeding management correctly.*
- *At least 80% of randomly selected maternity staff members will be able to identify 2 topics to discuss with women who are considering feeding their babies something other than human milk.*

STEP 3:
Inform all pregnant women about the benefits and management of breastfeeding.

▸ GUIDELINES AND CRITERIA FOR FACILITIES WITH AN AFFILIATED PRENATAL CLINIC OR SERVICES:

GUIDELINE: Education about breastfeeding, including individual counseling, should be made available to pregnant women for whom the facility or its associated clinics provide prenatal care. The education should begin in the first trimester, whenever possible.

Criteria for evaluation:

- *If the facility has an affiliated prenatal clinic or services, the Nursing Director/Manager will report that individual counseling or group education on breastfeeding is given to at least 80% of the pregnant women using those services.*

GUIDELINE: The education should cover the importance of exclusive breastfeeding, non-pharmacologic pain relief methods for labor, the importance of early skin-to-skin contact, early initiation of breastfeeding, rooming-in on a 24-hour basis, feeding on demand or baby-led feeding, frequent feeding to help assure optimal milk production, effective positioning and attachment, exclusive breastfeeding for the first six months, and that breastfeeding continues to be important after 6 months when other foods are given. Individualized education on the documented contraindications to breastfeeding and other special medical conditions should be given to pregnant women when indicated.

Criteria for evaluation:

- *A written description of the content of the prenatal education will be available and will cover, at minimum, the importance of breastfeeding, the importance of exclusive breastfeeding for about six months, and basic breastfeeding management.*
- *Of the randomly selected pregnant women of in the third trimester who are using the facility prenatal services:*
  - *at least 80% will confirm that a staff member has talked with them or offered a group talk that includes information on breastfeeding.*
  - *at least 80% are able to adequately describe what was discussed about two of the following topics: importance of skin-to-skin contact, rooming-in, and risks of supplements while breastfeeding in the first 6 months.*

GUIDELINES FOR FACILITIES WITHOUT AN AFFILIATED PRENATAL CLINIC OR SERVICES

GUIDELINE: The facility should foster programs that make education about breastfeeding, including individual and group counseling, available to pregnant women for whom the facility provides inpatient services. The education should begin in the first trimester, whenever possible.

Criteria for evaluation:

- *If the facility does not have an affiliated prenatal clinic or services, the Nursing Director/Manager will report that the facility has provided in-house breastfeeding education (e.g. through childbirth education), and/or fostered the development of community-based programs that make available individual counseling or group education on breastfeeding, and coordinated messages about breastfeeding with those messages given by these programs.*

GUIDELINE: Prenatal education should cover the importance of exclusive breastfeeding, non-pharmacologic pain relief methods for labor, the importance of early skin-to-skin contact, early initiation of breastfeeding, rooming-in on a 24-hour basis, feeding on demand or baby-led feeding, frequent feeding to help assure optimal milk production, effective positioning and attachment, exclusive breastfeeding for the first six months, and the fact that breastfeeding continues to be important after 6 months when other foods are given. Individualized education on the documented contraindications to breastfeeding and other special medical conditions should be given to pregnant women when indicated.

Criteria for evaluation:

- *A written description of the in-house and/or community-based programs and projects the facility has fostered will be available and will cover, at minimum, the importance of breastfeeding, the importance of exclusive breastfeeding for about six months, and basic breastfeeding management (e.g., skin-to-skin contact, rooming-in, and risks of supplements while breastfeeding in the first 6 months).*

STEP 4:
Help mothers initiate breastfeeding within one hour of birth.

- **This step is now interpreted as: *Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed.***

- **This step applies to all babies, regardless of feeding method.**

GUIDELINE: All mothers should be given their babies to hold with uninterrupted and continuous skin-to-skin contact immediately after birth and until the completion of the first feeding, unless there are medically justifiable reasons for delayed contact. Routine procedures (e.g., assessments, Apgar scores, etc.) should be done with the baby skin to skin with the mother. Procedures requiring separation of the mother and baby (bathing, for example) should be delayed until after this initial period of skin-to-skin contact, and should be conducted, whenever feasible, at the mother's bedside. Additionally, skin-to-skin contact should be encouraged throughout the hospital stay.

Criteria for evaluation:

Of randomly selected mothers in the postpartum unit who have had normal vaginal births[8]:

- *at least 80% will confirm that their babies were placed in skin-to-skin contact with them immediately after birth and that skin-to-skin contact continued*

[8] Note: mothers may have difficulty estimating time immediately following birth. If time and length of skin-to-skin contact following birth is listed in the mothers' charts, this can be used as a cross-check.

uninterrupted until the completion of the first feeding (or for at least one hour if not breastfeeding), unless there were medically justifiable reasons for delayed contact.

- *at least 80% will confirm that they were encouraged to look for signs for when their babies were ready to feed during this first period of contact and offered help, if needed. (The baby should not be forced to feed but, rather, supported to do so when ready.)*

Observations of vaginal births, if necessary to confirm adherence to Step 4, show that (regardless of the mothers' feeding intentions):

- *at least 80% of the babies are placed with their mothers and are held continuously skin-to-skin within five minutes after birth until the completion of the first feeding, or for at least one hour if not breastfeeding.*
- *at least 80% of mothers are shown how to recognize the signs that their babies are ready to feed and offered help, or there are justifiable reasons for not following these procedures.*

GUIDELINE: After cesarean birth, mothers will report that their babies were placed in continuous, uninterrupted skin-to-skin contact with them as soon as the mother was responsive and alert, with the same staff support identified above regarding feeding cues, unless separation was medically indicated.

Criteria for evaluation:
Of randomly selected mothers in the postpartum unit who have had cesarean births of a healthy baby[9]:

- *at least 80% will confirm that their babies were placed in skin-to-skin contact with them as soon as the mother was responsive and alert and that skin-to-skin contact continued uninterrupted until the completion of the first feeding (or for at least one hour if not breastfeeding), unless there were medically justifiable reasons for delayed contact.*
- *at least 80% will confirm that they were encouraged to look for signs for when their babies were ready to feed during this first period of contact and offered help, if needed. (The baby should not be forced to feed but, rather, supported to do so when ready.)*

Observations of cesarean births and recovery, if necessary to confirm adherence to Step 4, show that (regardless of the mothers' feeding intentions):

- *at least 80% of the babies are placed with their mothers and are held continuously skin-to-skin as soon as mother was responsive and alert and until the completion of the first feeding,*
- *at least 80% of mothers are shown how to recognize the signs that their babies are ready to feed and offered help, or there are justified reasons for not following these procedures.*

[9] Note: mothers may have difficulty estimating time immediately following birth. If time and length of skin-to-skin contact following birth is listed in the mothers' charts, this can be used as a cross-check.

GUIDELINE: In the event that a mother and/or baby are separated for medical reasons, skin-to-skin contact will be initiated as soon as the mother and baby are reunited.

Criteria for evaluation:

- *Of randomly selected mothers who gave birth either vaginally or via cesarean, at least 80% will confirm that in the event of medically-indicated separation, skin-to-skin contact was initiated when they were reunited with their babies.*

RECOMMENDATION FOR FACILITIES WITH AN AFFILIATED SPECIAL CARE UNIT OR NEONATAL INTENSIVE CARE UNIT: Mothers whose babies are being cared for in the special care nursery will report that they have had the opportunity to practice Kangaroo Mother Care as soon as the baby is considered ready for such contact.

Recommended criteria for evaluation:

- *The facility has a quality improvement goal and tracking method to assure that at least 80% of randomly selected mothers with babies in special care unit will have the opportunity to practice Kangaroo Mother Care (unless there are justifiable medical reasons why they could not).*

STEP 5:
Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants.

GUIDELINE: Health care professionals should assess the mother's breastfeeding techniques and, if needed, should demonstrate appropriate breastfeeding positioning and attachment with the mother and baby, optimally within three hours and no later than six hours after birth. Prior to discharge, breastfeeding mothers should be educated on basic breastfeeding practices, including: 1) the importance of exclusive breastfeeding, 2) how to maintain lactation for exclusive breastfeeding for about 6 months, 3) criteria to assess if the baby is getting enough breastmilk, 4) how to express, handle, and store breast milk, including manual expression, and 5) how to sustain lactation if the mother is separated from her infant or will not be exclusively breastfeeding after discharge.

Criteria for evaluation:

- *Of randomly selected postpartum mothers (including those who have had cesarean births), at least 80% will report that nursing staff offered further assistance with breastfeeding the next time they fed their babies or within six hours of birth (or of when they were able to respond).*
- *Out of the same group of mothers, at least 80% of those who are breastfeeding will be able to demonstrate correct positioning and attachment with their own babies, and will report that breastfeeding is comfortable for them. At least 80% of those who are breastfeeding will report that they were shown how to express their milk by hand.*

- *Of randomly selected health care staff on duty in postpartum units, at least 80% will report that they teach mothers how to position and attach their babies for breastfeeding and are able to describe or demonstrate correct techniques for both. At least 80% will report that they teach mothers how to hand express breast milk and can describe or demonstrate an adequate technique for this.*

GUIDELINE: Additional individualized assistance should be provided to high risk and special needs mothers and infants and to mothers who have breastfeeding problems and/or who must be separated from their infants. The routine standard of care should include procedures that assure that milk expression is begun within 6 hours of birth and expressed milk is given to the baby as soon as the baby is medically ready and that the mother's expressed milk is used before any supplementation with breastmilk substitutes when medically appropriate.

Criteria for evaluation:

- *Of randomly selected mothers with babies in special care, at least 80% of those who are breastfeeding or intending to do so will report that they have been offered help to begin expressing and collecting milk within 6 hours of their babies' births.*
- *At least 80% of those breastfeeding or intending to do so report that they have been shown how to express their milk by hand or other method.*
- *At least 80% of those breastfeeding or intending to do so can adequately describe and demonstrate how they were shown to express their milk.*
- *At least 80% of those breastfeeding or intending to do so will report that they have been told they need to breastfeed or express their milk 8 times or more every 24 hours to establish and maintain their milk supply.*

GUIDELINE: Mothers who have chosen to feed formula should receive written instruction, not specific to a particular brand, and verbal information about safe preparation, handling, storage and feeding of infant formula. Staff should document completion of formula preparation instruction and safe feeding in the record. This information should be given on an individual basis only to women who have chosen to formula feed or mixed feed their babies.

Criteria for evaluation:

At least 80% of maternity staff members can describe how non-breastfeeding mothers can be assisted to safely prepare and feed formula to their babies.
At least 80% of the mothers who have decided to feed formula will report that:

- *someone discussed their feeding choice with them;*
- *they have been provided education about preparing and giving their babies feedings; and,*
- *they can describe the advice they were given.*

STEP 6:
Give infants no food or drink other than breastmilk unless medically indicated.

Exclusive breast milk feeding shall be the breastfeeding method expected from birth to discharge.

Eligibility criteria for exclusive breastfeeding and exclusive breastmilk feeding (based on the definition in Joint Commission's Perinatal Care Core Measure Set #PC-05[10]) includes **all live-born newborns discharged from the hospital, with the exception of those who:**

- *were discharged from the hospital while in NICU,*
- *were diagnosed with galactosemia during the hospital stay*
- *were fed parenterally during the hospital*
- *experienced death*
- *had a length of stay >120 days,*
- *were enrolled in clinical trials*
- *Documented Reason for Not Exclusively Feeding Breast Milk. (See Appendix B for the WHO/UNICEF list of acceptable reasons[11])*

The facility will track exclusive breast milk feeding according to The Joint Commission definition of exclusive breast milk feeding referenced above.[12] The facility should compare its annual rate of supplementation of breastfed babies to that rate reported by the CDC's National Immunization Survey data for the geographic-specific region in which the facility is located.[13] In addition, a year-by-year reduction in non-medically indicated supplementation is expected in Baby-Friendly designated facilities.

GUIDELINE: When a mother specifically states that she has no plans to breastfeed (see steps 4 and 5), or requests that her breastfeeding baby be given a breastmilk substitute, the health care staff should first explore the reasons for this request, address the concerns raised and educate her about the possible consequences to the health of her baby and/or the success of breastfeeding. If the mother still requests a substitute, her request should be granted and the process and the informed decision should be documented. Any other decisions to give breastfeeding babies food or drink other than breastmilk should be for acceptable medical reasons and require a written order documenting when and why the supplement is indicated (see Appendix 2 for acceptable medical reasons).

Criteria for Evaluation:

- *Of randomly selected mothers in the postpartum unit, at least 80% of those who are breastfeeding will report that:*
  - *to the best of their knowledge, their babies have received no food or drink other than breastmilk while in the facility, or*
  - *that formula has been given for a medically acceptable reason, or*
  - *that formula has been given in response to a parental request.*

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[10] The Joint Commission. *Specifications Manual for Joint Commission National Quality Measures (v2010A)2: Measure Information Form. Author, pp. 34-35. Accessed at:* http://manual.jointcommission.org/releases/TJC2010A/rsrc/Manual/TableOfContentsTJC/PC_Brief_v2010A2.pdf.

[11] WHO/UNICEF. *Acceptable medical reasons for use of breast-milk substitutes.* Geneva, Switzerland: World Health Organization. WHO/NMH/NHD/09.01; WHO/FCH/CAH/09/01.

[12] Also defined in Appendix C.

[13] Centers for Disease Control and Prevention. *Provisional Geographic-specific Formula Supplementation Rates among Children born in 2006 (Percent +/- half 95% Confidence Interval).* Accessed at http://www.cdc.gov/breastfeeding/data/NIS_data/2006/state_formula.htm.

- *For any breastfeeding mothers interviewed whose babies are being given food or drink other than breastmilk:*
  - *at least 80% of those who have no acceptable medical reason will report that the health care staff explored the reasons for and the possible negative consequences of the mothers' decisions.*
  - *the reasons for supplementation and evidence of parental counseling (in the event of parental choice) will be clearly documented in the record.*
- *At least 80% of randomly selected mothers who have decided to feed formula report that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situations.*
- *At least 80% of the randomly selected mothers with babies in special care who have decided to feed formula report that staff have talked with them about the risks and benefits of the various feeding options, including feeding expressed breast milk.*
- *Observations in the postpartum wards/rooms and any well baby observation areas show that at least 80% of the breastfed babies are being fed only breastmilk, or documentation indicates that there are acceptable medical reasons or fully informed choices for formula-feeding.*

Step 7:
Practice rooming-in – allow mothers and infants to remain together twenty-four hours a day.

▶ **This step applies to all babies, regardless of feeding method.**

GUIDELINE: The facility should provide rooming-in twenty-four hours a day as the standard for mother-baby care for healthy, full-term infants, regardless of feeding choice. When a mother requests that her baby be cared for in the nursery, the health care staff should explore the reasons for the request and should encourage and educate the mother about the advantages of having her infant stay with her in the same room twenty-four hours a day. If the mother still requests that the baby be cared for in the nursery, the process and informed decision should be documented. In addition, the medical and nursing staff should conduct newborn procedures at the mother's bedside whenever possible, and should avoid frequent separations and/or absences of the newborn from the mother for more than an hour. If the baby is kept in the nursery for medical reasons, the mother should be provided access to feed her baby at any time.

Criteria for Evaluation:

- *Of randomly selected mothers with vaginal births, at least 80% will report that their babies were not separated from them before starting rooming-in, unless there are medical reasons for separation.*

- *Of all randomly selected mothers with healthy term babies, at least 80% will report that since they came to their room after birth (or since they were able to respond to their babies in the case of cesarean birth), their infants have stayed with them in the same room day and night except for periods of up to an hour per day for facility procedures, unless there are justifiable reasons for a longer separation.*
- *Observations in the postpartum unit and any well-baby observation areas and discussions with mothers and staff confirm that at least 80% of the mothers and babies are rooming-in or, if not, have justifiable reasons for being separated.*

STEP 8:
Encourage breastfeeding on demand.

▶ **This step applies to all babies, regardless of feeding method, and is now interpreted as "Encourage feeding on cue."**

GUIDELINE: Health care professionals should help all mothers (regardless of feeding choice): 1) understand that no restrictions should be placed on the frequency or length of feeding, 2) understand that newborns usually feed a minimum of eight times in 24 hours, 3) recognize cues that infants use to signal readiness to begin and end feeds, and 4) understand that physical contact and nourishment are both important.

Criteria for Evaluation:

- *Of randomly selected mothers of normal babies (including those of cesarean birth), at least 80% will report that they have been told how to recognize when their babies are hungry and can describe at least two feeding cues.*
- *At least 80% of breastfeeding mothers will report that they have been advised to feed their babies as often and as long as the babies want.*
- *At least 80% of mothers electing to feed their babies formula will report that they have been taught appropriate formula feeding techniques including: feeding on cue, eye-to-eye contact, and holding the baby closely.*
- *The Nursing Director/Manager on the maternity unit will confirm that no restrictions are placed on the frequency or length of feeds.*

STEP 9:
Give no pacifiers or artificial nipples to breastfeeding infants.

GUIDELINE: Health care professionals, including nursery staff, should educate all breastfeeding mothers about how the use of bottles and artificial nipples may interfere with the development of optimal breastfeeding. When a mother requests that her breastfeeding baby be given a bottle, the health care staff should explore the reasons for this request, address the concerns raised, educate her on the possible consequences to the success of breastfeeding, and discuss alternative methods for soothing and feeding her baby.

If the mother still requests a bottle, the process of counseling and education, and the informed decision of the mother should be documented.

Any fluid supplementation (whether medically indicated or following informed decision of the mother) should be given by tube, syringe, spoon or cup in preference to an artificial nipple or bottle.

Criteria for Evaluation:

- *At least 80% of the randomly selected breastfeeding mothers will report that, to the best of their knowledge, their infants have not been fed using bottles.*
- *Observations in the postpartum unit and any well baby observation areas will indicate that at least 80% of the breastfeeding babies are <u>not</u> using bottles, or if they are, that their mothers have been informed of the risks and this interchange is documented in the medical record.*
- *The Nursing Director will confirm that breastfed babies are not routinely given bottles.*

GUIDELINE: Health professionals, including nursery staff, should educate all breastfeeding mothers about how the use of pacifiers may interfere with the development of optimal breastfeeding. Breastfeeding babies should not be given pacifiers by the staff of the facility, with the exception of limited use to decrease pain during procedures when the baby cannot safely be held or breastfed (pacifiers used should be discarded after these procedures), by babies who are being tube-fed in NICU, or for other rare, specific medical reasons.

When a mother requests that her breastfeeding baby be given a pacifier, the health care staff should explore the reasons for this request, address the concerns raised, educate her on the possible consequences to the success of breastfeeding, and discuss alternative methods for soothing her baby.

If the breastfeeding mother still requests a pacifier, the process of counseling and education and informed decision should be documented.

Criteria for Evaluation:

- *At least 80% of the randomly selected mothers will report that, to the best of their knowledge, their breastfed infants have not sucked on pacifiers (unless such use was limited to painful procedures or, if chosen by parents after receipt of appropriate education and counseling from staff).*
- *Observations in the postpartum unit and any well baby observation areas will indicate that at least 80% of the breastfeeding babies are <u>not</u> using pacifiers, or if they are, their mothers have been informed of the risks and this interchange is documented in the medical record.*
- *The Nursing Director will confirm that breastfeeding babies are not routinely given pacifiers, and that use of pacifiers in term babies is restricted to painful procedures.*

STEP 10:
Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

GUIDELINE: The designated health care professional(s) should ensure that, prior to discharge, a responsible staff member explores with each mother and a family member or support person (when available) the plans for infant feeding after discharge. Discharge planning for the breastfeeding mothers and infants should include information on the importance of exclusive breastfeeding for about 6 months and available and culturally specific breastfeeding support services without ties to commercial interests. Examples of the information and/or support to be provided include giving the name and phone numbers of La Leche League or other community-based support groups, WIC Program breastfeeding support services, telephone help lines, lactation clinics, home health services, and individualized specialized resource persons. An early post-discharge follow-up appointment with their pediatrician, family practitioner or other pediatric care provider should also be scheduled. The facility should establish in-house breastfeeding support services if no adequate source of support is available for referral (e.g., support group, lactation clinic, home health services, help line, etc.).

Criteria for Evaluation:

The Nursing Director/Manager on the maternity unit will report that:

- *Mothers are given information on where they can find support if they need help with feeding their babies after returning home.*
- *The facility fosters the establishment of and/or coordinates with mother support groups and other community services that provide breastfeeding/infant feeding support to mothers, and the designated staff member can describe at least one way this is done.*
- *The staff assures that mothers and babies receive breastfeeding assessment and support after discharge (preferably 2-4 days after birth and again the second week) at the facility or in the community by a skilled breastfeeding support person who can assess feeding and give any support needed.*
- *The staff can describe an appropriate referral system and adequate timing for the visits.*

A review of documents indicates that printed information is distributed to mothers before discharge on how and where mothers can find help on feeding their infants after returning home and includes information on the types of help available.

Of randomly selected mothers, 80% of those who are breastfeeding will report that they have been given information about how to get help from the facility and how to contact support groups, peer counselors, or other community health services if they have questions about feeding their babies after return home, and can describe at least one type of help that is available.

Compliance with the International Code of Marketing of Breast-milk Substitutes

GUIDELINE: The facility will demonstrate its compliance with the International Code of Marketing of Breast-milk Substitutes by refusing to accept supplies of breast milk substitutes and feeding supplies at no cost or below fair market cost (see definition in Appendix C), by protecting new parents from influence of vendors of such items, by practicing in accordance with its vendor/ethics policy regarding appropriate interaction between vendors of such items and facility staff, and by educating staff members about the Code and its role in ethical health care practices.

Criteria for Evaluation:

- *The director of maternity services will report that:*
  - *No employees of manufacturers or distributors of breast milk substitutes, bottles, nipples or pacifiers have any direct or indirect contact with pregnant women or mothers*
  - *The facility and its staff members do not receive free gifts, non-scientific literature, materials or equipment, money, or support for breastfeeding education or events from manufacturers or distributors of breast milk substitutes, bottles, nipples, or pacifiers. All other interactions with these manufacturers/distributors are in compliance with the facility's vendor/ethics policy.*
  - *Pregnant women, mothers or their families are not given marketing materials or samples or gift packs by the facility that include breast milk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for any of the above items.*
  - *Any educational materials distributed to breastfeeding mothers are free of messages that promote or advertise infant food or drinks other than breastmilk.*
  - *No educational materials used refer to proprietary product(s) or bear the product logo(s), unless specific to the mother's or baby's needs or condition (e.g., information about how to safely use a needed product such as a formula or breast pump would be acceptable to give to a mother or baby needing such a product. Marketing information for such products would not be considered acceptable.)*
- *A review of records and receipts indicates that any breast milk substitutes, including special formulas and other supplies, are purchased by the health care facility at a fair market price*[14].
- *Observations in the antenatal and maternity services and other areas where nutritionists and dietitians work indicate that no materials that promote breast milk substitutes, bottles, nipples, or pacifiers are displayed or distributed to mothers, pregnant women, or staff.*
- *Infant formula cans and prepared bottles are kept out of view of patients and the general public.*
- *At least 80% of the randomly selected clinical staff members can give two reasons why it is important not to give free samples or other items from formula companies to mothers.*

[14] See definition in Appendix C.

Appendix A
20-Hour Course Topic and Competency Skills List for the U.S.
Adapted for use in the United States from the WHO/UNICEF International Guidelines[15]

Objectives	Content
Discuss the rationale for professional, government and international policies that promote, protect and support breastfeeding in the United States.	***Session 1: the BFHI – a part of the Global Strategy*** • The Global Strategy for Infant and Young Child Feeding and how the Global Strategy fits with other activities • The Baby-Friendly Hospital Initiative • How this course can assist health facilities in making improvements in evidence based practice, quality care and continuity of care
Demonstrate the ability to communicate effectively about breastfeeding.	***Session 2: Communication skills*** • Listening and Learning • Skills to build confidence and give support • Arranging follow-up and support suitable to the mother's situation
Describe the anatomy and physiology of lactation and the process of breastfeeding.	***Session 3: How milk gets from the breast to the baby*** • Parts of the breast involved in lactation • Breastmilk production • The baby's role in milk transfer • Breast care
Identify teaching points appropriate for prenatal classes and in interactions with pregnant women.	***Session 4: Promoting breastfeeding during pregnancy*** • Discussing breastfeeding with pregnant women • Why breastfeeding is important • Antenatal breast and nipple preparation • Women who need extra attention
Discuss hospital birth policies and procedures that support exclusive breastfeeding.	***Session 5: Birth practices & breastfeeding*** • Labor and birth practices to support early breastfeeding • The importance of early skin-to-skin contact • Helping to initiate breastfeeding • Ways to support breastfeeding after a Cesarean birth • BFHI practices and women who are not breastfeeding

[15] *WHO/UNICEF Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care, Section 3, Breastfeeding Promotion and Support in a Baby-Friendly Hospital: A 20 Hour Course for Maternity Staff.* Geneva, Switzerland: WHO, 2006. Accessed at http://www.who.int/nutrition/topics/BFHI_Revised_Section_3.1.pdf on 3/31/10.

Demonstrate the ability to identify the hallmarks of milk transfer and optimal breastfeeding.	***Session 6: Helping with a breastfeed*** • Positioning for comfortable breastfeeding • How to assess a breastfeeding • Recognize signs of optimal positioning and attachment • Help a mother to learn to position and attach her baby • When to assist with breastfeeding • The baby who has difficulty attaching to the breast
Discuss hospital postpartum management policies and procedures that support exclusive breastfeeding.	***Session 7: Practices that assist breastfeeding*** • Rooming-in • Skin-to-skin contact • Baby-led feeding • Dealing with sleepy babies and crying babies • Avoiding unnecessary supplements • Avoiding bottles and teats
Discuss methods that may increase milk production in a variety of circumstances.	***Session 8: Milk supply*** • Concerns about "not enough milk" • Normal growth patterns of babies • Improving milk intake and milk production
Identify teaching points to include when educating or counseling parents who are using bottles and/or formula.	***Session 9: Supporting the non-breastfeeding mother and baby*** • Counseling the formula choice: a pediatric responsibility • Teaching/assuring safe formula preparation in the postpartum • Safe bottle feeding; issues with overfeeding and underfeeding

Discuss contraindications to breastfeeding in the United States as well as commonly encountered areas of concern for breastfeeding mothers and their babies.	***Session 10: Infants and Mothers with special needs*** • Breastfeeding infants who are preterm, low birth weight or ill • Breastfeeding more than one baby • Prevention and management of common clinical concerns • Medical reasons for food other than breastmilk • Nutritional needs of breastfeeding women • How breastfeeding helps space pregnancies • Breastfeeding management when the mother is ill • Medications and breastfeeding • Contraindications to breastfeeding
Describe management techniques for breast and nipple problems.	***Session 11: Breast and nipple concerns*** • Examination of the mother's breasts and nipples • Engorgement, blocked ducts and mastitis • Sore nipples
Identify acceptable medical reasons for supplementation of breast fed babies according to national and international authorities.	***Session 12: If the baby cannot feed at the breast*** • Learning to hand express • Use of milk from another mother • Feeding expressed breastmilk to the baby
Describe essential components of support for mothers to continue breastfeeding beyond the early weeks.	***Session 13: On-going support for mothers*** • Preparing a mother for discharge • Follow-up and support after discharge • Protecting breastfeeding for employed women • Sustaining continued breastfeeding for 2 years or longer
Describe strategies that protect breastfeeding as a public health goal.	***Session 14: Protecting breastfeeding*** • The effect of marketing on infant feeding practices • The International Code of Marketing of Breast-milk Substitutes • How health workers can protect families from marketing • Donations in emergency situations • The role of breastfeeding in emergencies • How to respond to marketing practices
Identify barriers and solutions to implementation of the Ten Steps to Successful Breastfeeding that comprise the Baby-Friendly Hospital Initiative.	***Session 15: Making your hospital or birth center Baby-Friendly*** • The Ten Steps to Successful Breastfeeding • What "Baby-Friendly" Practices mean • The process of becoming a "Baby-Friendly" hospital or birth center

Skills Competencies for Maternity Staff:

1. *Communicating with pregnant and postpartum women about infant feeding*
2. *Observing, assessing and assisting with breastfeeding*
3. *Teaching hand expression and safe storage of milk*
4. *Teaching safe formula preparation and feeding*

Appendix B

Acceptable medical reasons for use of breast-milk substitutes.

WHO/UNICEF. Geneva, Switzerland: World Health Organization. WHO/NMH/NHD/09.01; WHO/FCH/CAH/09/01.[1]

Introduction

Almost all mothers can breastfeed successfully, which includes initiating breastfeeding within the first hour of life, breastfeeding exclusively for the first 6 months and continuing breastfeeding (along with giving appropriate complementary foods) up to 2 years of age or beyond.

Exclusive breastfeeding in the first six months of life is particularly beneficial for mothers and infants.

Positive effects of breastfeeding on the health of infants and mothers are observed in all settings. Breastfeeding reduces the risk of acute infections such as diarrhoea, pneumonia, ear infection, *Haemophilus influenza*, meningitis and urinary tract infection (1). It also protects against chronic conditions in the future such as type I diabetes, ulcerative colitis, and Crohn's disease. Breastfeeding during infancy is associated with lower mean blood pressure and total serum cholesterol, and with lower prevalence of type-2 diabetes, overweight and obesity during adolescence and adult life (2). Breastfeeding delays the return of a woman's fertility and reduces the risks of post-partum haemorrhage, pre-menopausal breast cancer and ovarian cancer (3).

Nevertheless, a small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently (4). These conditions, which concern very few mothers and their infants, are listed below together with some health conditions of the mother that, although serious, are not medical reasons for using breast-milk substitutes.

Whenever stopping breastfeeding is considered, the benefits of breastfeeding should be weighed against the risks posed by the presence of the specific conditions listed.

[1] This document is quoted in its entirety, and is the property of the World Health Organization and UNICEF.

INFANT CONDITIONS

Infants who should not receive breast milk or any other milk except specialized formula

- classic galactosemia: a special galactose-free formula is needed;
- maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed;
- phenylketonuria: a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring).

Infants for whom breast milk remains the best feeding option but who may need other food in addition to breast milk for a limited period

- very low birth weight infants (those born weighing less than 1500g);
- very preterm infants, i.e. those born less than 32 weeks gestational age;
- newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic (5) if their blood sugar fails to respond to optimal breastfeeding or breast-milk feeding.

MATERNAL CONDITIONS

Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines.

Mothers who may need to avoid breastfeeding

- HIV infection[2]: if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) (6).

[2] The most appropriate infant feeding option for an HIV-infected mother depends on her and her infant's individual circumstances, including her health status, but should take consideration of the health services available and the counselling and support she is likely to receive. When replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), avoidance of all breastfeeding by HIV-infected women is recommended. Mixed feeding in the first 6 months of life (that is, breastfeeding while also giving other fluids, formula or foods) should always be avoided by HIV-infected mothers.

Mothers who may need to avoid breastfeeding temporarily

- Severe illness that prevents a mother from caring for her infant, for example sepsis;
- Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved;
- Maternal medication:
  - sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available (7);
  - radioactive iodine-131 is better avoided given that safer alternatives are available – a mother can resume breastfeeding about two months after receiving this substance;
  - excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided;
  - cytotoxic chemotherapy requires that a mother stops breastfeeding during therapy.

Mothers who can continue breastfeeding, although health problems may be of concern

- ☐ Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started (8).
- ☐ Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter (9).
- ☐ Hepatitis C.
- ☐ Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition(8).
- ☐ Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines (10).
- ☐ Substance use[3] (11):
  - maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
  - alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

  Mothers should be encouraged not to use these substances and given opportunities and support to abstain.

[3] Mothers who choose not to cease their use of these substances or who are unable to do so should seek individual advice on the risks and benefits of breastfeeding depending on their individual circumstances. For mothers who use these substances in short episodes, consideration may be given to avoiding breastfeeding temporarily during this time.

References

(1) *Technical updates of the guidelines on Integrated Management of Childhood Illness (IMCI). Evidence and recommendations for further adaptations.* Geneva, World Health Organization, 2005.

(2) *Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses.* Geneva, World Health Organization, 2007.

(3) León-Cava N et al. *Quantifying the benefits of breastfeeding: a summary of the evidence.* Washington, DC, Pan American Health Organization, 2002. http://www.paho.org/English/AD/FCH/BOB-Main.htm,accessed 26 June 2008).

(4) Resolution WHA39.28. Infant and Young Child Feeding. In: *Thirty-ninth World Health Assembly, Geneva, 5–16 May 1986. Volume 1. Resolutions and records. Final.* Geneva, World Health Organization, 1986 (WHA39/1986/REC/1), Annex 6:122–135.

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(7) *Breastfeeding and maternal medication: recommendations for drugs in the Eleventh WHO Model List of Essential Drugs.* Geneva, World Health Organization, 2003.

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(9) *Hepatitis B and breastfeeding.* Geneva, World Health Organization, 1996. (Update No. 22).

(10) *Breastfeeding and Maternal tuberculosis.* Geneva, World Health Organization, 1998 (Update No. 23).

(11) *Background papers to the national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn.* Commissioned by the Ministerial Council on Drug Strategy under the Cost Shared Funding Model. NSW Department of Health, North Sydney, Australia, 2006. http://www.health.nsw.gov.au/pubs/2006/bkg_pregnancy.html

Further information on maternal medication and breastfeeding is available at the following United States National Library of Medicine (NLM) website: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

For further information, please contact:
Department of Child and Adolescent Health and Development
Email: cah@who.int Web: www.who.int/child_adolescent_health

Department of Nutrition for Health and Development
Email: nutrition@who.int Web: www.who.int/nutrition
Address: 20 Avenue Appia, 1211 Geneva 27, Switzerland

APPENDIX C
Definitions of Terms Used in this Document

Exclusive Breast Milk Feeding: refers to the optimal practice of feeding infants no food or drink other than human milk unless another food is determined to be medically necessary. In order to determine which infants should be considered eligible for exclusive breast milk feeding, Baby-Friendly USA, Inc. has adopted The Joint Commission's set of criteria for identifying babies who should be exempted from the expectation of exclusive breast milk feeding, below:

"**Excluded Populations**[4]**:**

- Discharged from the hospital while in the Neonatal Intensive Care Unit (NICU)
- *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for galactosemia as defined in Appendix A, Table 11.21
- *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for parenteral infusion as defined in Appendix A, Table 11.22
- Experienced death
- Length of Stay >120 days
- Enrolled in clinical trials
- Documented *Reason for Not Exclusively Feeding Breast Milk"*

Fair Market Price: The International Code of Marketing of Breast-milk Substitutes, and subsequently, the BFHI, calls for health systems to purchase infant foods and feeding supplies at a fair market value. Fair market pricing can be determined by 1) purchasing through a buying group that the facility participates in, or 2) determining the margin of retail price the facility pays on other items available on the retail market. To do this, take the following steps:

- Ask a facility purchasing agent to provide unit prices for 3 or more items purchased for use on the maternity unit that are also available on the retail market (e.g., diapers, wipes, sanitary napkins, etc.).
- Price those items, as well as the brands of infant formula and feeding supplies (bottles, nipples, pacifiers, etc.) used in the hospital, at retail and discount outlets such as Sams Club, BJs, grocery stores, drug store chains, etc. and average the unit retail price.

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[4] The Joint Commission: *Specifications Manual for Joint Commission National Quality Measures (v2010A2) - PC Brief Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10).* pp 34-35. Accessed at http://manual.jointcommission.org/releases/TJC2010A/rsrc/Manual/TableOfContentsTJC/PC_Brief_v2010A2.pdf

- Calculate the percentage of retail price paid for those items by the hospital. For example, if the hospital purchases diapers at 55% of retail cost, wipes at 75% and sanitary napkins at 40%, then the hospital pays a range of 40-75% of retail price. A price paid for formula in that discount range would be considered a fair market price.

Kangaroo Mother Care (KMC): In this document, the term Kangaroo Mother Care refers to skin-to-skin (STS) care provided by the mother or father of a preterm infant. The infant is worn against the parent's naked chest in such a fashion that the infant held upright. The parent is then wrapped in a blanket or other clothing to secure the infant against their chest. Babies may be held continuously in this fashion for several hours. Optimally KMC begins as soon as the baby is judged ready for STS contact.

Skin-to-Skin Contact (STS): Skin-to-skin contact or skin-to-skin care refers to contact between the newborn infant and its mother (although in the case of incapacitation of the mother, another adult such as the baby's father or grandparent may hold the baby skin-to-skin). After birth, the healthy term baby should be completely dried and the baby should be placed naked against the mother's naked ventral surface. The baby may wear a diaper and/or a hat, but no other clothing should be between the mother's and baby's bodies. The baby and mother are then covered with a warmed blanket, keeping the baby's head uncovered. STS contact should continue, uninterrupted, until the completion of the first feeding (or for at least 1 hour if the mother is not breastfeeding). STS contact should be encouraged beyond the first hours and into the first days after birth.

Abbreviations Used in this Document

APRN: Advanced Practice Registered Nurse
BFHI: Baby-Friendly Hospital Initiative
EBF: Exclusive Breastfeeding
EBMF: Exclusive Breast Milk Feeding
KMC: Kangaroo Mother Care
MD: medical doctor or physician
NICU: Neonatal Intensive Care Unit
STS: Skin-to-skin contact (see definition above)
UNICEF: United Nations Children's Fund
WHO: World Health Organization
WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

Notes

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Overcoming Barriers to Baby-Friendly Status: One Hospital's Experience

Joyce McKeever, RN, MS, IBCLC, LCCE[1], and Rose St. Fleur, MD, FAAP, MABM[1]

Abstract

The journey toward Baby-Friendly status at Jersey Shore University Medical Center in Neptune, NJ began with a desire to improve overall breastfeeding rates at the hospital. Although evidence showed that hospitals that incorporated some or all of the Ten Steps to Successful Breastfeeding had improved breastfeeding rates, it was difficult to overcome barriers that prevented the hospital physicians and nursing staff from seeing the value in adopting this quality initiative. Long-standing practices combined with misinformation compounded the problem. That situation changed when several factors nationally and statewide came together to create a prime environment for implementation of the Baby-Friendly Hospital Initiative. This article will discuss the barriers that one hospital encountered and the strategies used to overcome these common barriers to achieving Baby-Friendly status. This hospital is not yet designated as Baby-Friendly but is awaiting the outcome of a site visit in 2012.

Keywords

Baby-Friendly Hospital Initiative (BFHI), breastfeeding practices, challenges to implementation of Baby-Friendly, culturally compassionate care, hospital practices, New Jersey, overcoming barriers to baby-friendly status, Ten Steps to Successful Breastfeeding

Background

Breast milk provides the best medical outcomes for infants and mothers, including reduction of respiratory and gastrointestinal illness, necrotizing enterocolitis, and breast and ovarian cancers.[1] Centers for Disease Control and Prevention data show that 75.3% of infants born in New Jersey hospitals receive breast milk in the first 2 days of life, which falls short of the Healthy People (HP) 2020 goal. By 6 months of life, exclusive breastfeeding rates are only 10.3%, well below the HP 2020 goal of 25.5%.[2,3] Most United States maternity care centers fail to support breastfeeding with evidence-based practices outlined by the World Health Organization's "Ten Steps to Successful Breastfeeding" according to the 2009 National Survey of Maternity Practices in Infant Nutrition and Care (mPINC); even fewer hospitals have Baby-Friendly designation.[4] As of January 2012, New Jersey had no Baby-Friendly hospitals.[5]

The HP 2020 goals call for an increase in the number of US Baby-Friendly hospitals from the current 4% to 8%, yet the path to Baby-Friendly status proves difficult for many hospitals. This article discusses some of the challenges that Jersey Shore University Medical Center (JSUMC) in Neptune, New Jersey, faced in the journey toward the final phase of Baby-Friendly designation, and how these challenges were addressed.

Jersey Shore University Medical Center (JSUMC) is a level III regional perinatal center with 27 maternity beds and 21 neonatal intensive care beds. The quest for Baby-Friendly status began when the medical center became the first hospital in the state to implement the Family-Centered Maternity Care concept in 1991. With this concept came the conversion of the traditional maternity unit to one in which mothers and babies were encouraged to stay together in the same room, with minimal interruptions, from delivery to discharge. Under the influential leadership of the maternity unit's nurse manager, the hospital began to incorporate some of the concepts into daily practice. For example, crib cards from formula companies were eliminated in favor of hospital designed crib cards. Tape measures branded with formula names were also discarded; instead, we purchased from another manufacturer that did not violate the WHO International Code of Marketing of Breast Milk Substitutes. Formula representatives were restricted from coming to the hospital unless they had an appointment with the manager for a specific purpose. By 2002, our hospital was exploring the possibility of becoming Baby-Friendly designated. Attitudes, misinformation, culture, and long-standing practices made it difficult for the maternity clinical staff to accept the concepts of the Baby-Friendly Hospital Initiative. Despite these obstacles, the maternity department continued to

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modify practices slowly over time, and by 2009, many of the "Ten Steps" were already in place. With support from the hospital president and chief nurse executive, the determination to become Baby-Friendly certified was included as a top strategic goal for the hospital.

In 2010, JSUMC had an opportunity to apply for a grant from the New Jersey chapter of the American Academy of Pediatrics. We were informed that the New Jersey Chapter received funding via the State of New Jersey from the CDC Communities Putting Prevention to Work (CPPW) to assist the state in achieving the Healthy People 2020 goals of increasing the proportion of births occurring at Baby-Friendly designated hospitals. Every birthing facility in New Jersey was encouraged to apply for this grant; however, Jersey Shore University Medical Center was 1 of only 10 hospitals that were awarded the funding through a highly competitive process. As the recipient of this grant, we participated in the New Jersey Baby-Friendly Hospital Initiative (NJBFHI), which included monthly technical assistance calls, networking, collaborative summits, and auditing tools. The NJBFHI was invaluable in creating the momentum needed to rapidly move us through the phases required for Baby-Friendly designation. The NJBFHI—a highly publicized statewide project—reinforced the importance of the Initiative for our administration.

Physician Education

In 2009, we realized that physician education would be a daunting challenge, since the literature shows that physicians are often unfamiliar with how to give appropriate breastfeeding support and management.[6-8] We began by giving continuing medical education presentations for the OB/GYN and pediatric physicians, allowing opportunities to voice concerns and views. Many were apprehensive about the risk of inducing guilt in their patients if breastfeeding was actively promoted and supported in the maternity unit. To alleviate this concern, we employed our patient representative, who follows up all patients by phone after discharge to assess satisfaction of care, to conduct a short survey on patients' perception of breastfeeding support. In the survey, we asked postpartum mothers how they chose to feed their babies; if they chose infant formula, we asked whether they felt "guilty" or "less supported" by the health care team for their feeding choice. Out of the 106 mothers surveyed, no mothers stated that they were made to feel guilty by staff for their feeding choices. These data were presented to both the OB/GYN and pediatric physicians at subsequent meetings, and the subject of guilt did not come up again.

Skin-to-Skin Care

Some nursing staff hesitated to practice skin-to-skin care, fearing that it would place infants at risk for hypothermia if a radiant warmer was not used. The evidence supporting skin-to-skin care was presented at in-services held for both the day and night shift. These in-services sparked the interest of some nurse pioneers to try skin-to-skin care. Simultaneously, OB physicians enthusiastically supported the process by placing infants skin-to-skin with their mothers immediately after birth. The effects of skin-to-skin care were immediately apparent: infants did not get hypothermic, most breastfed within an hour, and they maintained breastfeeding success the following day. Our nursing staff perceived how skin-to-skin care positively affected their workflow in many ways, as mothers demonstrated fewer problems breastfeeding during their hospital stay and required less nursing time devoted to lactation management. They could also complete other tasks, such as charting, while the baby was on the mother's chest. Finally, based on weekly patient interviews by the nurse manager, most mothers remarked on the bonding effects of skin-to-skin care, which boosted patient satisfaction and staff morale. Through word of mouth, experiences with skin-to-skin care spread among the staff, and compliance rapidly increased. We monitored our compliance by revising our nursing computer documentation to include skin-to-skin data on the newborn admission form. In May 2010, we reported our skin-to-skin data as 0%, since skin-to-skin care was not previously a nursing practice at our hospital. By December 2010, compliance with this practice improved to over 85%. This is a testament to the fact that long-standing hospital practices can be modified to incorporate current evidence-based standards of care.

Rooming-In

Many health care providers tending to postpartum mothers believe that separating the infant from the mother helps the mother to recover after a delivery.[9] However, mother-infant separation carries no benefit in the mother's recovery from birth and may actually impede breastfeeding success.[10,11] Dispelling the perceived need for mother-infant separation proved to be a difficult challenge. We addressed the challenge by using the in-service teaching model once more, again drawing from the volumes of evidence to support this practice. At the same time, we educated parents in their prenatal registration packets and prenatal classes about rooming-in. Rooming-in education was also given on admission: nurses assured the mother that she would not be separated from her baby except for emergencies or procedures, and that she would receive help any time it was needed during the hospital stay. We found that education of the staff and patients established the foundation for full implementation of the practice.

Traditional hospital practices commonly encourage mother-baby separation by creating nurseries that allow for public viewing of infants through glass windows. However, we shielded our nursery's public view by pulling down the horizontal blinds. Doing so conveyed the message to everyone that infants were expected to stay with their mothers, not with their nurses. It also prevented open displays of patient names (posted in bassinets), respecting patients' right to privacy. Finally, we began to call the nursery the "neonatal observation unit." The idea of changing the name of the nursery has been successfully used by other Baby-Friendly

Hospitals to promote rooming-in. In changing the expectation of the nursery's function, we successfully modified hospital practices toward one that is evidence-based and in compliance with the "Ten Steps." Currently, more than 80% of our patients room-in.

Culturally Compassionate Care

Jersey Shore University Medical Center captures patients from both Monmouth and Ocean Counties, with over 1.2 million residents total.[12,13] Lakewood, the fastest-growing town in the state and located in Ocean County, is home to an emerging Orthodox Jewish community.[14] JSUMC's patient demographic is changing to reflect the increase in Orthodox Jewish mothers electing to deliver at our facility. In 2011, 13.4% of our maternity patients declared Judaism as their religion. With this change came many differences in patient needs during postpartum care.

Since it was apparent that our staff needed education, we began by first collaborating with our hospital's specialty patient liaison to the Orthodox Jewish community. She assisted us in educating the staff about the religious beliefs of this community, which included a high awareness of the importance of breastfeeding. She also helped us conduct a small survey in which we asked Orthodox Jewish mothers what their "cultural norm" is after delivery of an infant. Since religious beliefs restrict family planning, mothers may have many children, heightening the need for recovery after delivery. In response to this information, we attended a Lakewood community event and discussed the benefits of rooming-in and exclusive breastfeeding. We also provided a forum for mothers to discuss what their expectations are of our facility in regard to postpartum care and breastfeeding support. We have made some progress in understanding the cultural differences in our patients and have adapted our education accordingly; the nurses and hospital staff receive additional training time to provide education in a more culturally sensitive manner while also maintaining patients' views of their cultural norms. Reinforcing among staff that support for choice is paramount for culturally compassionate care has greatly assisted in creating a hospital experience that meets the patient's expectations for care while providing vital information on feeding choices and preserving the philosophy of the Baby-Friendly Hospital Initiative.

Summary

In our experience, changing the culture and attitudes of people requires time and determination to assimilate new processes into practice, as the process of becoming Baby-Friendly was a slow drift from traditional methods of care to evidence-based, and often unfamiliar, practices. Today's patients expect to receive competent medical care from skilled professionals, but what they remember is the supportive, nurturing hospital environment that is focused on their needs and expectations. This journey toward Baby-Friendly designation is enabling us to fulfill our ultimate obligation to practice evidence-based medicine so that our families have the best possible start. The strategies we used to address our challenges can be applied to other hospitals that are seeking Baby-Friendly Hospital designation or are implementing the "Ten Steps to Successful Breastfeeding."

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