BFHI AUSTRALIA

Maternity Facility Handbook

ISBN 978-1-925358-07-0

Baby Friendly Health Initiative, Australia.

Updated 2020 incorporating the revised World Health Organisation (WHO) & UNICEF Global Standards for BFHI.

Contents

Contents ... **2**
Introduction ... **4**
Strengths and Impact of the BFHI ... **5**
Revisions (2018) to the Global Ten Steps to Successful Breastfeeding ... **6**
Implementation of the Revised (2018) Baby Friendly Initiative and the Ten Steps to Successful Breastfeeding ... **7**
Pathway to Achieving BFHI Accreditation ... **8**
Critical Management Procedures ... **13**
Step 1a: Have a Written Infant Feeding Policy that is Routinely Communicated to Staff and Parents ... **13**
Rationale ... 13
Implementation ... 13
Implementation Standards ... 13
Step 1b: Comply Fully with the International Code of Marketing of Breastmilk Substitutes and Relevant World Health Assembly Resolutions ... **16**
Rationale ... 16
Implementation ... 16
Implementation Standards ... 16
Step 1c: Establish Ongoing Monitoring and Data-Management Systems ... **19**
Rationale ... 19
Implementation ... 19
Implementation Standards ... 19
Step 2: Ensure that Staff have Sufficient Knowledge, Competence and Skills to Support Breastfeeding ... **19**
Rationale ... 20
Implementation ... 20
Implementation Standards ... 21
Key Clinical Practices ... **24**
Step 3: Discuss the Importance and Management of Breastfeeding with Pregnant Women and their Families ... **24**
Rationale ... 24
Implementation ... 24
Implementation Standards ... 25
Step 4: Facilitate Immediate and Uninterrupted Skin-to-Skin Contact and Support Mothers to Recognise when their Babies are Ready to Breastfeed, Offering Help if Needed ... **27**
Rational ... 27
Implementation ... 27
Implementation Standards ... 28

Step 5: Support Mothers to Initiate and Maintain Breastfeeding and Manage Common Difficulties **31**
Rationale 31
Implementation 31
Implementation Standards 31
Step 6: Do Not Provide Breastfed Newborns Any Food or Fluids Other than Breastmilk, Unless Medically Indicated **34**
Rationale 34
Implementation 34
Implementation Standards 35
Step 7: Enable Mothers and their Infants to Remain Together and to Practise Rooming-in 24 Hours a Day. **38**
Rationale 38
Implementation 38
Implementation Standards 38
Step 8: Support Mothers to Recognise and Respond to their Infants' Cues for Feeding **40**
Rationale 40
Implementation 40
Implementation Standards 40
Step 9: Counsel Mothers on the Use and Risks of Feeding Bottles, Teats and Pacifiers. **41**
Rationale 41
Implementation: 41
Implementation Standards 42
Step 10: Coordinate Discharge so that Parents and their Infants Have Timely Access to Ongoing Support and Care **44**
Rationale 44
Implementation 44
Implementation Standards 44
Achieving Accreditation **46**
Re-Accreditation **47**
Appendix 1: Definitions **48**
Appendix 2: Ten Steps to Successful Breastfeeding in Lay Terms **51**
Appendix 3: Guidelines for Supplementary Feeding for the Healthy Term Breastfed Neonate **52**
Appendix 4: Summary of the Care of the Mother who is Artificially Feeding her Baby **55**
Appendix 5: Summary of WHO International Code Compliance Standards **61**
Appendix 6: Monitoring and Quality Improvement **66**

Introduction

The role of the Baby Friendly Hospital Initiative (BFHI) is to protect, promote and support breastfeeding. It does this by providing a framework for *Baby Friendly* hospitals to operate within called the *Ten Steps to Successful Breastfeeding*. These standards ensure all mothers and babies receive appropriate support and contemporary information in both the antenatal and postnatal period, regarding infant feeding.

In Australia in 2006, the Baby Friendly Hospital Initiative became the Baby Friendly Health Initiative in order to more accurately reflect the expansion of the initiative into community health settings.

In a *Baby Friendly* accredited facility, breastfeeding is encouraged, supported and promoted. Breastfed babies are not given breastmilk substitutes (infant formula) unless medically indicated or it is the parents informed choice. Regardless of feeding choices and circumstances, every woman is supported to care for her baby in the best and safest way possible.

BFHI is a joint World Health Organization (WHO) and UNICEF project that aims to create a healthcare environment where breastfeeding is the norm, and practices known to promote the wellbeing of all mothers and their babies are promoted. The standards embedded in the Ten Steps to Successful Breastfeeding are the global criteria against which maternity hospitals are assessed and accredited.

Baby Friendly accreditation is a quality assurance measure that demonstrates a facility's commitment to offer the highest standard of maternity care to mothers and babies. Attaining accreditation signifies that the facility is committed to evidence-based, best-practice maternity care and ensuring that every mother is supported with her informed choice of infant feeding during her transition to motherhood.

In a *Baby Friendly* facility, a mother's informed choice of infant feeding is encouraged, respected and supported. At no time are mothers 'forced' to breastfeed. The *Ten Steps to Successful Breastfeeding* are beneficial for <u>all</u> mothers and babies, promoting bonding, parental responsiveness, empowerment and informed choice - regardless of feeding method.

In a *Baby Friendly* facility, breastfeeding mothers are given consistent, accurate information and support. In many cases this results in the duration of breastfeeding being extended.
Mothers who choose to artificially feed their babies, or who are required to supplement with or switch to infant formula, are given individual support and information to help them correctly prepare feeds and to ensure that they know how to feed their babies safely.

The *Ten Steps to Successful Breastfeeding* work synergistically and so therefore are implemented in unison to ensure benefits for mothers and babies.

Maintaining BFHI accreditation, with re-assessment every 3 years, ensures regular independent review, and provides facilities with a framework to continuously improve. It ensures that mothers themselves are heard when it comes to their experience of their care. It draws attention to areas of excellence and can improve staff morale.

BFHI accreditation also aids recruitment and retention of staff through increased professional development opportunities and increased job satisfaction.

Strengths and Impact of the BFHI

Substantial evidence has accumulated proving that the BFHI has the potential to significantly influence success with breastfeeding. A systematic review of 58 studies on maternity and newborn care published in 2016 demonstrated clearly that adherence to the Ten Steps impacts rates of breastfeeding (early initiation immediately after birth, exclusive breastfeeding and total duration of any breastfeeding)[1]. This review found a close-response relationship between the number of BFHI Steps women are exposed to and the likelihood of improved breastfeeding outcomes. Avoiding supplementation of newborn infants with products other than breast milk (Step 6) was demonstrated to be a crucial factor in determining breastfeeding outcomes, possibly because, in order to implement this Step, other Steps also need to be in place. Community support (Step 10) proved crucial to maintaining the improved breastfeeding rates achieved in facilities providing maternity and newborn services[1].

Experiences in BFHI implementation have shown that national leadership (including strong national involvement and support) is the key to successful implementation of the BFHI. National or facility-level engagement, ongoing facility-level monitoring, and making the BFHI part of the continuum of care were also found to be important for BFHI implementation[2].

In anticipation of the 25th anniversary of the BFHI, WHO and UNICEF undertook a broad-based assessment of the current status of the initiative. A global survey among all WHO Member States on the implementation at country level was conducted in June to August 2016, with responses received from 117 countries[3].

For facilities that were designated, the process of becoming Baby-friendly was often transformative, changing the whole environment around infant feeding. In many countries, becoming designated has been a key motivating factor for facilities to transform their practices. As a consequence of this, care in these facilities became more mother centred; attitudes about infant feeding improved; and skill levels dramatically increased. Use of infant formula typically dropped dramatically, and the use of nurseries for newborn infants was greatly reduced. The quality of care for breastfeeding clearly improved in facilities that were designated as "Baby-friendly".

Baby Friendly accreditation is a quality assurance measure that demonstrates a facility's commitment to offer the highest standard of maternity care to mothers and babies. Attaining accreditation signifies that the facility is committed to evidence-based, best-practice maternity care and ensuring that every mother is supported with her informed choice of infant feeding during her transition to motherhood.

[1] Pérez-Escamilla R, Martinez JL, Segura-Pérez S. Impact of the Baby-friendly Hospital Initiative on breastfeeding and child health outcomes: a systematic review. Matern Child Nutr. 2016;12(3):402–17. doi:10.1111/mcn.12294.

[2] Saadeh RJ. The Baby-Friendly Hospital Initiative (BFHI) 20 years on: facts, progress and the way forward. J Hum Lact. 2012. doi:10.1177/0890334412446690.

[3] National implementation of the Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2017 (http://apps.who.int/iris/bitstream/10665/255197/1/9789241512381-eng.pdf?ua=1, accessed 7 March 2018).

Revisions (2018) to the Global Ten Steps to Successful Breastfeeding[1]

The 2018 revised version of the Ten Steps is implemented in this Handbook. The Ten Steps to Successful Breastfeeding are now separated into **Critical Management Procedures**, which provide an enabling environment for sustainable implementation within the facility, and **Key Clinical Practices**, which delineate the care that each mother and baby should receive. The Key Clinical Practices are evidence-based interventions to support mothers to successfully establish breastfeeding. The Ten Steps are outlined and described in detail in the following pages.

Step 1 on the facility's breastfeeding policy has been modified to include three components, 1a., 1b. and 1c. Application of the *WHO International Code* has always been a major component of the BFHI but was not included as part of the original Ten Steps. This revision incorporates full compliance with the *Code* as a Step. In addition, the need for ongoing internal monitoring of adherence to the clinical practices has been incorporated into Step 1. Internal monitoring should help to ensure that adoption of the Ten Steps is sustained over time.

Some of the Steps have been modified in their application to ensure that they are feasible and applicable for all facilities while not compromising evidence-based optimal practices. For example, **Step 2** on training personnel focuses on competency assessment to ensure that all personnel have the knowledge, competence and skills to support breastfeeding.

Step 5 now focuses more on providing mothers with practical support on how to breastfeed, including positioning, suckling, and ensuring the mother is prepared for potential breastfeeding difficulties. There is less emphasis on expression of milk, with more flexibility in the method used.

Step 9 on the use of feeding bottles, teats and pacifiers/dummies now focuses on counselling mothers on their appropriate use, rather than completely prohibiting them. Personnel are required to have the skills to counsel a breastfeeding mother on the best method for feeding her individual baby when EBM or a supplement is required.

Step 10 on post-discharge care focuses more on the responsibilities of the facility providing maternity and newborn services to plan for discharge and make referrals, as well as to coordinate with and work to enhance community support for breastfeeding.

[1] Extracted from: Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2018. https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf Licence: CC BY-NC-SA 3.0 IGO.

Implementation of the Revised (2018) Baby Friendly Initiative and the Ten Steps to Successful Breastfeeding[1]

The core purpose of the BFHI is to ensure that mothers and newborn infants receive timely and appropriate care before and during their stay in a facility providing maternity and newborn services, to enable the establishment of optimal feeding of newborn infants, thereby promoting their lifetime health and development. Given the proven importance of breastfeeding, the BFHI protects, promotes and supports breastfeeding. At the same time, it also aims to enable appropriate optimal care and feeding of newborn infants who are not (yet or fully) breastfed, or not (yet) able to do so.

Families must receive quality and unbiased information about infant feeding. Facilities providing maternity and newborn services have a responsibility to promote breastfeeding, but they must also respect the mother's preferences and provide her with the information required to make an informed decision about the best feeding option for her and her baby in her particular circumstances. The facility has an obligation to support mothers to successfully feed their newborn infants in the manner they choose.

This updated guidance covers only those activities that are specifically pertinent to the protection, promotion and support of breastfeeding in facilities providing maternity and newborn services. The care of small, sick and/or preterm newborn infants cannot be separated from that of full-term infants, as they both occur in the same facilities, often attended by the same personnel. As such, the care for these newborn infants in neonatal intensive care units or in regular maternity or newborn wards is now included in the scope of BFHI implementation. However, since this document is not a clinical guide, it does not provide in-depth guidance on how to care for small, sick and/or preterm newborn infants but merely outlines the standards and key Steps for breastfeeding and/or the provision of human milk to this group. More specific guidance on the feeding of small, sick and/or preterm newborn infants is available elsewhere[2].

While the 2009 BFHI guidance suggested including "mother-friendly" actions focusing on ensuring mothers' physical and psychological health, these updated standards do not include guidance on these aspects. In-depth, relevant, evidence-based guidance on the quality of care of maternal health is already available elsewhere[3], but it is important for all health professionals, whether or not they are responsible for birthing or newborn care, to be fully aware of mother-friendly practices and how they can affect the mother, baby and breastfeeding, so that they can ensure these practices are implemented and achieve the intended quality-of-care benefits.

Similarly, this *BFHI Handbook for Maternity Facilities* does not cover criteria for Baby-friendly communities, Baby-friendly paediatric units or Baby-friendly physicians' offices. Support for breastfeeding is critical in all of these settings, but is beyond the scope of this *Handbook*.

[1] Extracted from: Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2018. https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf Licence: CC BY-NC-SA 3.0 IGO.

[2] Nyqvist KH, Maastrup R, Hansen MN, Haggkvist AP, Hannula L, Ezeonodo A et al. Neo-BFHI: The Baby-friendly Hospital Initiative for neonatal wards. Three guiding principles to protect, promote and support breastfeeding. Core document with recommended standards and criteria. Nordic and Quebec Working Group; 2015 (http://epilegothilasmo.gr/wp-content/uploads/2017/04/Neo_BFHI_Core_document_2015_Edition.pdf, accessed 7 March 2018).

[3] Standards for improving quality of maternal and newborn care in health facilities. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/249155/1/9789241511216-eng.pdf?ua=1, accessed 7 March 2018).

Pathway to Achieving BFHI Accreditation

In order to achieve BFHI Accreditation facilities must implement the Ten Steps to Successful Breastfeeding:

Critical Management Procedures

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

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

   c. Establish ongoing monitoring and data-management systems.

2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding

Key Clinical Practices

3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to recognise when their babies are ready to breastfeed, offering help if needed.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.
8. Support mothers to recognise and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

Full Accreditation

While each of the Ten Steps contributes to improving the support for breastfeeding, optimal impact on breastfeeding practices, and thereby on maternal and child well-being, is only achieved when all Ten Steps are implemented as a package.

Once all standards are fully met, accreditation is awarded.

Re-accreditation

Re-accreditation occurs every 3 years. Exceptional facilities are able over time to achieve the prestigious Silver or Gold Award

Coordination
Many facilities find that it is useful to appoint a BFHI Coordinator who can manage the accreditation process and ensure the facility continues to implement *Baby Friendly* standards following accreditation. It is also beneficial to establish a BFHI Committee comprising midwives, lactation consultants, obstetricians, paediatricians, consumers and other key individuals as appropriate.

Support
Consider contacting other BFHI Coordinators in *Baby Friendly* accredited facilities, particularly ones that are a similar size. The BFHI Manager is also available to provide support at any time.

Review of Policies and Practices
Thoroughly review the facility's policies, including the breastfeeding/infant feeding policy, against requirements listed for Step 1a. Review any clinical pathways/ guidelines that support the breastfeeding policy to ensure they also meet BFHI requirements and reflect contemporary lactation management practices.

Review the facility's compliance with the *International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly resolutions as outlined in Step 1b.

Using BFHI's *Maternity Facility BFHI Bi-Annual Data* spreadsheet, review the facility's breastfeeding data and skin-to-skin contact and early breastfeeding data. Compare the facility's data to the sentinel indicators in Step 1c.

Self-Audit
Complete the *BFHI Self-Appraisal* tool to review the facility's implementation of the Ten Steps. It is also useful to use this tool to monitor progress in preparation for assessment. Conduct specific audits of areas which may need further attention. The results of these internal audits are not required as part of the accreditation process; however, it is a useful tool for the facility to gauge how it measures against *Baby Friendly* standards.

Observations
Walk through the facility, looking at it from a BFHI perspective. Refer to Appendix 6 for guidance on internal auditing for implementation of the *WHO International Code* in a BFHI facility.

Action Plan
With the help of the BFHI Committee, develop an action plan to remedy any areas identified as not yet meeting *Baby Friendly* standards.

Personnel Education
Allocate all relevant personnel to a Group. Refer to Step 2. Establish electronic or hard copy central records which show relevant BFHI education completed by each person, to enable reporting on the percentages of personnel in each Group who have completed the relevant in-service education (and supervised clinical experience where applicable) required for their Group. Determine whether any further education and competency review is needed and if so ensure that it is completed.

Further Self-Appraisal
Complete the BFHI self-appraisal tool again. If the facility appears to meet all the standards in the *Ten Steps to Successful Breastfeeding*, do a further check by interviewing a small sample of mothers, pregnant women and personnel to see if their responses confirm this.

Assessment Type
Determine if a single facility, multi-facility, multi-service or cluster assessment is appropriate.

Multi-Facility/ Multi- Service Assessment
A multi-facility or multi-service assessment is designed for two or more facilities in an area under the same governance to be assessed together. It is primarily designed to provide financial advantage as there is a fee reduction for all facilities.

The facilities must meet the following criteria:

- All facilities follow the same policies for BFHI and clinical protocols that support those policies, and have the same personnel education program (education attendance records may be maintained separately).
- The BFHI Coordinators for each facility work closely together to manage the assessment, the ongoing maintenance of BFHI standards, and to address any recommendations resulting from assessment.

Assessments for all facilities are to occur consecutively. Two full days are required for each facility, and the number of births at each facility will determine the number of assessors required.

Other than interviews with key personnel common to all facilities e.g. Executive Officer, Director of Nursing/Midwifery, Purchasing Officer and review of common documents such as policy, protocols and education programs, a full assessment as per BFHI guidelines will be completed at each facility.

All documentation to support BFHI accreditation e.g. policies etc. are to be available at each facility. The Assessors will review the common documentation at the first facility, but may need to refer to it at the other facilities. Materials relevant to specific facilities, including infant feeding data, must be available at the relevant facility.

An assessment scoring document will be completed for each facility. A conclusion session will be provided at each facility on completion of the assessment.

Each facility will receive an individual confidential assessment which will not be influenced by the results of the assessment in the other facilities. Each facility will receive an individual report, scoring booklet and accreditation certificate.

Cluster Assessment

A cluster assessment is designed for two or more small facilities located in the same region to be assessed as a group. Unlike the multi-facility assessment where each facility is assessed separately, in a cluster assessment, all the facilities are assessed together as one single entity rather than individual assessments for each facility. It is primarily designed for small rural facilities with low birth numbers who may not have the funding for an individual assessment, although it may also be appropriate for other facilities, depending on their unique circumstances.

As for multi-facility assessments, the facilities must meet the following criteria:

- All facilities follow the same policies for BFHI and clinical protocols that support those policies, and the same personnel education program (education attendance records may be maintained separately).
- The BFHI Coordinators for each facility work closely together to manage the assessment, the ongoing maintenance of BFHI standards, and to address any recommendations resulting from assessment.
- Infant feeding data for the previous 12 months (2 x 6-month BFHI Excel spreadsheets) must be submitted as combined numbers for all facilities.

The BFHI Manager will determine the number of assessors and days required, based on the specific cluster of facilities being assessed.

The total number of interviews conducted across the facilities is at least the same number of interviews as for a single facility.

Only one assessment scoring document and one assessment report will be completed for a cluster assessment. A conclusion session will be provided at one facility on completion of the assessment. All the facilities share one report and the outcome of the assessment is as a group. Each facility will receive a copy of the same cluster accreditation certificate.

Applying for Assessment
Once the facility is ready for assessment, the facility must submit to the BFHI Manager 4-6 months prior to the proposed assessment dates, the following documents:

- Request for assessment form,
- Financial agreement form,
- Completed BFHI self-appraisal
- Infant feeding data for the previous 12 months (2 x 6-month BFHI Excel spreadsheets)
- Copy of the facility's breastfeeding policy

Human Subject Research Clearance
If human subject research clearance is required through the facility's ethics review committee, the process must be completed prior to commencement of the assessment.

Working with Children and/or Vulnerable People Checks / Police Checks
Some facilities/states require Assessors to produce a current clearance certificate or letter. If Assessors are required to have this documentation, the facility is required to advise the BFHI Manager at the time of application. The necessary procedure will then be followed according to the requirements applied in the state of Assessor residence and/or state of where the assessment is being carried out. Costs associated with these checks may be invoiced to the facility.

Confirming the Assessment
The BFHI Manager will provide a letter of confirmation along with an invoice for payment, to the BFHI Coordinator at the facility to confirm the dates of the assessment, the assessment team as well as other useful information about the assessment. The Lead Assessor will contact the BFHI Coordinator at the facility leading up to the assessment to discuss the practicalities of the assessment.

Conflict of Interest
The facility will be informed of the proposed Assessors prior to the assessment, and may appeal in writing the proposed selection, if they believe there may be a conflict of interest from their perspective.

The Assessment Team
A Lead Assessor and one or two Co-Assessors will spend two full days at the facility, and may return during the evening on the first day to interview night shift personnel. On some occasions there may also be a trainee Assessor or an observer present at the assessment.

All Assessors are trained by the Australian College of Midwives and have comprehensive knowledge of BFHI and WHO requirements, and experience in contemporary lactation management. Assessors must maintain their skills by completing a required amount of education and experience every 3 years, and by regularly conducting assessments. Assessors are bound by the BFHI Assessor Agreement and are expected to act in a professional manner and dress appropriately.

Assessors must respect the facility's customs and organisational procedures. They are required to undertake the assessment according to the philosophy and policies of BFHI and assess the facility using the BFHI materials provided.

The assessment is confidential and will only be discussed with the assessment team and persons nominated by the BFHI Manager. Privacy for the personnel, women and families involved in the assessment will be maintained. Confidentiality of materials will be maintained.

During Assessment
The assessment team will attend the facility to conduct interviews, review policies and clinical pathways, and make observations in the areas being assessed.

On the day the assessment commences, the Assessors should be provided with a suitable workplace, appropriate identification, access to relevant areas, and be introduced to relevant personnel. To assist with workload and minimise disruptions to the assessment, it is appreciated by assessment teams if the facility is able to provide lunch, morning and afternoon tea, although this is not a requirement. If there are satellite sites, the facility is responsible for the assessors' travel to and from the primary site.

Interviews
Pregnant women, mothers and hospital personnel will be interviewed during the assessment process. The interviews will be conducted in a friendly manner and where possible should be conducted in private, so a suitable interview space is required. Some interviews may be conducted via phone where women are not available to attend the facility. It is important to remember that it is the facility's practices that are being assessed, not the women or personnel personally.

Apart from senior staff interviews, the results of all interviews are anonymous with identification by number rather than name. Most people being interviewed will be nervous and may often not be able to come up with an answer, even when they know the content well. It is the role of the Assessor to put them at ease and to try to prompt them to answer, without actually giving the answer. The Assessor may word the question a slightly different way or use other prompts to gain the required answer.

Interpreters
If interpreters are needed for the assessment, the facility's interpreter service may be used. Personnel with a vested interest in the outcome should not be used as interpreters.

Critical Management Procedures

Steps 1 and 2 are designed to ensure that the necessary policies, guidelines and processes are in place to allow health-care providers to implement the Baby Friendly standards effectively. They also address the required knowledge and competencies of the facility personnel who are providing care for pregnant women, mothers and babies thus enabling the provision of a high standard of care that is consistent, and without conflicting information.

Step 1a: Have a Written Infant Feeding Policy that is Routinely Communicated to Staff and Parents

Rationale

Evidence based policy frames clinical practice. Health-care personnel and facilities are required to follow established policies. The clinical practices articulated in the Ten Steps need to be incorporated into facility policies, to guarantee that appropriate care is equitably provided to all mothers and babies and is not dependent on the preferences of individuals. Written policies ensure women and their families receive consistent, contemporary, evidence-based care, and are an essential tool for facility alignment with BFHI principles. Policies help to sustain practices over time and communicate a standard set of expectations for all personnel.

Implementation

Facilities providing maternity and newborn services should have a clearly written infant feeding policy that is routinely communicated to personnel[1] and parents. All personnel who have contact with mothers and babies should be familiar with the policy and understand their responsibility to adhere to it.

A facility breastfeeding policy may stand alone as a separate document, be included in a broader infant feeding policy, or be incorporated into a number of other policy documents. However organised, the policy should include guidance on how each of the clinical and care practices (Steps 3 to 10) should be implemented, to ensure that they are applied consistently to all mothers. The policy should also outline how each of the Ten Steps is implemented. BFHI recognises that for some organisations policy is only operational not clinical, and therefore a mandatory clinical document, for example a guideline, may serve this purpose.

Implementation Standards

Policies for BFHI
The facility has a written policy or policies that support the implementation of BFHI, including: • Breastfeeding policy and a summary for display • Implementation of the *WHO International Code* • Support for staff to continue to breastfeed when they return to work • Standards of care for the mother who is artificially feeding her baby Most policies are supported by detailed clinical protocols/guidelines which do not belong in a policy. The policy is 'what we will do', whilst the protocols/guidelines are 'how will we do it'. Some facilities have alternate names for policies and clinical protocols; this is acceptable as long as they are mandated and fulfil the criteria. Protocols must be: • consistent with BFHI standards • reflective of contemporary, evidence-based information and practices.

[1] Personnel refers to all persons engaged in relevant activities, not just those who the facility defines as "staff".

The Breastfeeding Policy

At a minimum, the breastfeeding policy addresses the principles and practices that enable implementation of the *Ten Steps to Successful Breastfeeding*, including the Critical Management Procedures (Steps 1 & 2) and each of the Key Clinical Practices (Steps 3 to 10).

Breastfeeding Policy Summary

A summary of the Breastfeeding Policy must be displayed in each area of the facility's antenatal, birthing and maternity services where it can be seen by pregnant women, mothers and their families. It may also be displayed in other areas which potentially serve pregnant women, mothers and their families.

The summary must be displayed in each language used by 10% or more of mothers who use the facility's maternity services and facilities are encouraged to have it available in other languages used by mothers. The *Ten Steps to Successful Breastfeeding* may be used as a summary.

It is acknowledged that some facilities have areas where display of materials such as posters is restricted or not permitted. These facilities will be required to demonstrate how they ensure all pregnant women, mothers and their families are made aware of the facility's breastfeeding policy.

Personnel Interviews

At least 80% of the Group 1 and 2 Personnel:

- can explain at least two elements of the breastfeeding policy that influences how they provide care and information in their role in the facility.

Support for Staff to Continue to Breastfeed when they Return to Work

There is a policy which addresses support for staff to continue to breastfeed when they return to work. This may be a separate policy that the breastfeeding policy refers to, or be an integrated part of the breastfeeding policy. Facilities are encouraged, but not required, to be accredited by the Australian Breastfeeding Association as a Breastfeeding Friendly Workplace.

.

Standards of Care for the Mother who is Artificially Feeding her Baby

There is a policy which addresses standards of care for the mother who is artificially feeding her baby. This may be a separate policy or integrated into an infant feeding policy which refers to it.

The policy includes each of the following points:

- Relevant personnel[1] have received education to ensure that their knowledge about artificial feeding is current.
- Relevant personnel have the skills to teach mothers correct preparation, storage and handling of powdered infant formula[2]
- Mothers who are considering artificial feeding are supported to make a fully informed choice, appropriate to their circumstances.
- All mothers who will be leaving the facility using infant formula are given:

[1] Personnel refers to all persons engaged in relevant activities, not just those who the facility defines as "staff".
[2] Infant Feeding Guidelines for Health Workers, Section 8. *National Health and Medical Research Council (NHMRC)* 2012.

- information and instruction on the safe preparation, storage and handling of reconstituted powdered infant formula, using NHMRC Guidelines[1]
- information on the risks to the baby if the preparation and handling instructions are not followed carefully;
- a demonstration and supervised practice in making up a bottle-feed using powdered infant formula;
- information on where to get help with infant feeding after discharge from the facility.

- Instruction on artificial feeding is given only to parents who require it. The instruction is not given in a group situation. The instruction is conducted privately, away from breastfeeding mothers.
- Instructional materials on artificial feeding shown or given to parents are free from advertising, do not refer to or contain images of an identifiable product, and comply with the WHO International Code.

[1] The NHMRC Infant Feeding Guidelines outline the standard of care for artificial feeding in Australia and are recommended for use in BFHI facilities. However, facilities may elect to use "WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization* 2007", especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

Step 1b: Comply Fully with the International Code of Marketing of Breastmilk Substitutes and Relevant World Health Assembly Resolutions

Rationale

Families are most vulnerable to the marketing of breast-milk substitutes when they are making decisions about infant feeding. The World Health Assembly has called upon health workers and health-care systems to comply with the *International Code of Marketing of Breast-milk Substitutes*[1,2] and subsequent relevant WHA resolutions[3], in order to protect families and health professionals from commercial pressures. Compliance with the Code is important for facilities providing maternity and newborn services, as the promotion of breast-milk substitutes is one of the largest undermining factors for breastfeeding[4].

Implementation

The Code lays out clear responsibilities of health-care systems to not promote infant formula, feeding bottles or teats and to not allow manufacturers and distributors of products under the scope of the Code to have any influence upon the service, its employees, or families accessing the service. This includes the provision that all facilities providing maternity and newborn services must acquire any breast-milk substitutes, feeding bottles or teats they require through normal procurement channels and not receive free or subsidised supplies (WHA Resolution 39.28)[5]. In addition, personnel of facilities providing maternity and newborn services should not engage in any form of promotion or permit the display of any type of advertising of breast-milk substitutes, including the display or distribution of any equipment or materials bearing the brand of manufacturers of breast-milk substitutes, or discount coupons, and they should not give samples of infant formula to mothers to use in the facility or to take home.

In line with the WHO Guidance on ending the inappropriate promotion of foods for infants and young children, published in 2016 and endorsed by the WHA[6], health workers and health systems should avoid conflicts of interest with companies that market foods for infants and young children. Health professional meetings should never be sponsored by industry and industry should not participate in parenting education.

Implementation Standards

Policy
There is a policy which protects breastfeeding by addressing implementation of the *WHO International Code*. This may be a separate policy that the breastfeeding policy refers to, or be an integrated part of the breastfeeding policy.

[1] International Code of Marketing of Breast-milk Substitutes. Geneva: World Health Organization; 1981 (http://www.who.int/nutrition/publications/code_english.pdf, accessed 7 March 2018).

[2] The International Code of Marketing of Breast-Milk Substitutes – 2017 update: frequently asked questions. Geneva: World Health Organization; 2017 (http://apps.who.int/iris/bitstream/10665/254911/1/WHO-NMHNHD-17.1-eng.pdf?ua=1, accessed 7 March 2018).

[3] World Health Organization. Code and subsequent resolutions (http://www.who.int/nutrition/netcode/resolutions/en/, accessed 7 March 2018).

[4] Breaking the rules stretching the rules 2014. Evidence of violations of the International Code of Marketing of Breastmilk Substitutes and subsequent resolutions compiled from January 2011 to December 2013. Penang: International Baby Food Action Network International Code Documentation Centre; 2014 (http://www.ibfan-icdc.org/wp-content/uploads/2017/03/1__Preliminary_pages_5-2-2014.pdf, accessed 7 March 2018 [Executive summary]).

[5] Resolution 39.28. Infant and young child feeding. In: Thirty-ninth World Health Assembly, Geneva, 5–16 May 1986. Resolutions and decisions, annexes. Geneva: World Health Organization; 1986 (http://www.who.int/nutrition/topics/WHA39.28_iycn_en.pdf?ua=1, accessed 7 March 2018).

[6] Maternal, infant and young child feeding. Guidance on ending the inappropriate promotion of foods for infants and young children. In: Sixty-ninth World Health Assembly, Geneva, 23–28 May 2016. Provisional agenda item 12.1. Geneva: World Health Organization; 2016 (A69/7 Add 1; http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf?ua=1, accessed 7 March 2018).

The Policy Includes Each of the Following Points:

- Adherence by the facility and its personnel to the relevant provisions of the *WHO International Code* and subsequent World Health Assembly (WHA) resolutions.
- All promotion of artificial feeding and materials which promote the use of infant formula, feeding bottles and teats is prohibited.
- The facility is not permitted to receive or distribute free and subsidised (low cost) products within the scope of the *WHO International Code*.
- The distribution to parents of take home samples and supplies of infant formula, bottles and teats is not permitted.
- There are restrictions on access to the facility and personnel by representatives from companies in relation to marketing or distributing infant formula products or equipment used for artificial feeding.
- There is no direct or indirect contact of these representatives with pregnant women or mothers and their families.
- The facility does not accept free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events from these companies if there is any association with artificial feeding or potential promotion of brand/product recognition in relation to infant feeding.
- There is careful scrutiny at the institutional level of any research which involves mothers and babies for potential implications on infant feeding or interference with the full implementation of the policy.

Implementation of Policy

The facility has no display of products covered under the *WHO International Code* or items with logos of companies that produce breast-milk substitutes, feeding bottles and teats, or names of products covered under the Code. Nor are these items displayed.

Materials covered under the WHO International Code or which are unsupportive of breastfeeding, or contradict exclusive breastfeeding for around 6 months as the norm, are not used, displayed or distributed to parents, except informational materials given individually to parents who are artificially feeding.

If the facility has retail outlets/kiosks on site, the facility has endeavoured to restrict or minimise the promotion and/or sale of materials that are unsupportive of breastfeeding and/or inconsistent with BFHI. It is recognised that the influence of the facility may be limited when the retail outlets are not under its direct control.

Observations

Observations confirm that:

- infant formula and equipment for artificial feeding are stored discreetly and not openly displayed in the maternity and neonatal areas.
- the facility has adequate space and necessary equipment to give individual instruction on how to prepare formula away from breastfeeding mothers.
- there are no materials being used, distributed or displayed to parents, which are unsupportive of breastfeeding, with the exception of informational material given individually to parents who have chosen to artificially feed their baby.
- there are no educational materials or literature used, displayed or distributed to parents, produced by a company which markets or distributes infant formula products or equipment used for artificial feeding.
- there are no educational materials or literature used, displayed or distributed to parents, which picture or refer to a propriety product that is within the scope of the WHO Code.

Review of Materials

All educational materials including videos/DVDs, handouts and sample bags/gifts which are shown to, made available and/or distributed to pregnant women, new parents or their families are made available for the Assessors to review.

Review of these materials confirms that they are free of:

- promotion of artificial feeding, bottles, teats and dummies and contain no samples or redeemable vouchers for these products.
- information or articles which normalise artificial feeding.
- advertisements or promotion of infant, follow-on or toddler formula.
- advertisements or promotion of equipment for artificial feeding including bottles and teats.
- samples or coupons for products within the scope of the WHO International Code.
- samples or coupons for baby foods.
- information which contradicts exclusive breastfeeding for around 6 months as the norm.
- recommendations for scheduled feeds.
- advertisements for dummies.

For guidance on internal auditing for implementation of the *WHO International Code* in a BFHI facility, refer to Appendix 5.

Purchase of Breastmilk Substitutes, Teats, Bottles or Dummies

The facility and its personnel do not accept or distribute to mothers free or subsidised (low cost) samples or supplies of breastmilk substitutes, teats, bottles or dummies.

Records and receipts indicate that breastmilk substitutes including special formula and other supplies required for artificial feeding are purchased through normal procurement channels or are brought in by parents for feeding their own infants.

Personnel Interviews

At least 80% of the Group 1 and 2 personnel can:

- explain at least two elements of the WHO International Code.

Step 1c: Establish Ongoing Monitoring and Data-Management Systems

Rationale

Ongoing monitoring is important for maintaining standards and for the early identification of practices that need to be escalated and addressed. Data monitoring is an essential component of the quality management cycle. Facilities providing maternity and newborn services need to integrate recording and monitoring of the clinical practices related to breastfeeding and infant feeding into their quality-improvement/monitoring and reporting systems.

Implementation

There is a protocol for ongoing monitoring and a data-management system to comply with the 10 Steps. See Appendix 6: Monitoring and Quality improvement for suggested options that can be used as indicators for facility-based monitoring of the key practices. Two of the indicators, early initiation of breastfeeding and exclusive breastfeeding, are considered "sentinel indicators". All facilities should routinely track these indicators for each mother–baby pair. Recording of information on these sentinel indicators should be incorporated into the documentation and collated into the *Maternity Facility BFHI Bi-Annual Data* spreadsheet.

The group or committee that coordinates the BFHI related activities within a facility should review progress at least every 6 months. The purpose of the review is to continually track the values of these indicators, to determine whether established targets are met, and, if not, plan and implement corrective actions. See Appendix 6 Quality Improvement Process.

The Global Standards call for a minimum of 80% compliance for all process and outcome indicators, including early initiation of breastfeeding and exclusive breastfeeding. Each facility should attempt to regularly achieve at least 80% adherence on each indicator, and facilities that do not meet this target should focus on increasing the percentage over time.

The Global Standards recognise that in some contexts the 80% exclusive breastfeeding rates may be difficult to attain. At this time, BFHI Australia recognises the complexities of the women cared for in many Australian services and has chosen to continue the requirement of at least 75% exclusive breastfeeding or breastmilk-feeding rate on discharge from inpatient care[1]. However, facilities should be working towards as many babies as possible being exclusively breastfed.

Implementation Standards

Sentinel Indicators
The *Maternity Facility BFHI Bi-Annual Data* for the most recent 12 months indicates that: • at least 75% of term and preterm infants were breastfed or breastmilk fed exclusively throughout their stay in the facility[1]. • at least 80% of term infants experienced uninterrupted skin-to-skin contact immediately or within 5 minutes after birth, or within 10 minutes of arriving in recovery following a caesarean and that this contact continued uninterrupted until after the first breastfeed or for at least an hour if the baby fed sooner.

Ongoing Monitoring
• The facility has a protocol for an ongoing monitoring and data management system to comply with the 10 Steps (see Appendix 6). • Clinical personnel at the facility meet at least every 6 months to review implementation of the system

[1] For more specific details on achieving exclusive breastfeeding rates, and special consideration for facilities which find this challenging to achieve, see Step 6.

Step 2: Ensure that Staff have Sufficient Knowledge, Competence and Skills to Support Breastfeeding

Rationale

Timely and appropriate care for breastfeeding mothers can only be accomplished if all personnel have the knowledge, competence and skills to provide it. Education of personnel enables them to develop effective skills, give consistent messages, and implement policy standards. Personnel cannot be expected to implement a practice or educate a woman on a topic for which they have received no training.

Implementation

Health-facility personnel who provide infant feeding services, including breastfeeding support, should have sufficient knowledge, competence and skills to support women to breastfeed.

In general, the responsibility for building this capacity resides with the pre-service education system. However, it is important that all personnel are up-to-date with evidence-based, contemporary information and practices consistent with BFHI standards and the policy. Facilities need to ensure all personnel who provide infant feeding services, including breastfeeding support, have regular ongoing in-service education, and a review of competency. Education needs to be competency based, focusing on practical skills rather than only on theoretical knowledge.

Facilities must be able to provide proof that all personnel who have contact with pregnant women, mothers and infants in the facility have received orientation to, and education on the 'policies for BFHI' outlined in Step 1, and have the skills necessary to implement these policies.

Core Competencies

All personnel who help mothers with infant feeding should be competent in their ability to:

Counselling Skills

1. use listening skills when counselling a mother;
2. use skills for building a mother's confidence and giving support;
3. counsel a pregnant woman about breastfeeding;
4. counsel a mother to make an informed and appropriate decision about infant feeding, suitable to her circumstances;

Establishing Breastfeeding

5. help a mother to recognise when her baby is ready to initiate breastfeeding while in skin-to-skin contact after birth;
6. support a mother to position herself and her baby for breastfeeding;
7. support a mother to attach her baby to the breast, encouraging baby-led attachment;
8. assess a breastfeed; including teaching a mother how to monitor milk transfer
9. explain to a mother about feeding cues and-the optimal pattern of breastfeeding;
10. using hands-off techniques, assist a mother to express her breast milk;
11. explain to a mother how to know if her baby is getting enough milk

Breastfeeding Challenges

12. counsel a mother who thinks she does not have enough milk;
13. counsel a mother with an unsettled baby;
14. counsel a mother on selecting and using an alternative feeding method;
15. counsel a mother whose baby is refusing to breastfeed;
16. counsel a mother who has flat or inverted nipples;
17. counsel a mother with engorged breasts;
18. counsel a mother with sore or cracked nipples;
19. counsel a mother with mastitis;
20. support a mother to breastfeed a low-birth-weight, preterm or sick baby.

Implementation Standards

Personnel Groups for Education

All personnel[1] who have contact with pregnant women, mothers and infants in the facility are divided into three Groups, based on what they do in their role in the facility rather than on their position title. Allocation to the various Groups can be determined by the facility, but should meet the following criteria:

Group 1: Those who counsel and assist mothers with breastfeeding, or provide education in relation to breastfeeding, in any part of the maternity unit, antenatal clinic and/or neonatal nurseries. For example, lactation consultants, midwives (antenatal, birthing unit, postnatal and domiciliary), registered or enrolled nurses who work permanently or on a casual basis in the maternity unit and/or neonatal nurseries, and paediatric unit personnel who frequently assist mothers with breastfeeding or breast expression.

Group 2: Those who may provide general breastfeeding advice but do not assist mothers with breastfeeding. For example, obstetricians, paediatricians, other medical personnel, most paediatric unit personnel (unless they frequently assist mothers with breastfeeding or breast expression), registered nurses who care for postnatal mothers and their babies when midwives are not available (e.g. in small facilities), speech pathologists, physiotherapists and dieticians who advise or provide care related to infant feeding or lactation to mothers and/or their babies.

Group 3: Those who have contact with pregnant women and mothers but do not assist mothers with breastfeeding and do not provide infant feeding advice as part of their role. For example, ward clerks, auxiliary volunteers, some physiotherapists, perioperative and recovery room personnel (unless they assist with skin-to-skin contact and the first breastfeed in which case they are considered to be Group 1).

Group 1 BFHI Education and Competency Requirements

Over the previous 3 years, all Group 1 personnel[1] who have been at the facility for six months or more have had a minimum of 8 hours of competency based in-service education, including updates and revision where applicable. It is recommended the updates and revision are spread over the previous 3 years.

The 20 Core Competencies are considered essential skills for all personnel who counsel and assist mothers with breastfeeding. They should be covered in pre-service and in-service competency-based education, with regular updates.

[1] Personnel refers to all persons engaged in relevant activities, not just those who the facility defines as "staff".

Ongoing competency assessment is the responsibility of an appropriately qualified supervisor (e.g. Senior Midwife, Nurse Unit Manager, Midwifery Educator, or Lactation Consultant) who is experienced and knowledgeable about evidence-based, contemporary breastfeeding practices consistent with BFHI standards. Competency review can be acquired in a single session or cumulatively through direct or indirect supervised experience during a normal working day or simulated activities.

Review of competency might also include

- Peer-reviewed simulated activities in a workshop setting.
- Supervised clinical practice
- Observation and completion of checklist, for example:
    - helping a mother with positioning and attachment;
    - discussing breastfeeding with a pregnant woman.
    - support provided to a mother who is artificially feeding her baby
    - facilitation of skin to skin contact at birth and early initiation of breastfeeding
- Small group discussion of a competency, e.g. "Tell me how you would help a mother who thinks she does not have enough milk…"
- Demonstration of helping a mother with e.g. breast expression

The content delivery of the education is flexible. Group 1 personnel in a *Baby Friendly* facility should have the following knowledge and competencies:

- The facility's policy and key clinical practices (Steps 3-10). The key clinical practices should cover the 20 Core Competencies listed in this Step.
- *Guidelines for Supplementary Feeding for the Healthy Term Breastfed Neonate* (Appendix 3)
- Providing optimal support to all mothers who will be leaving the facility using infant formula (Appendix 4).
- The facility's and personnel's responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.

The facility can report on the percentages of Group 1 personnel, who have been at the facility for six months or more, who have completed the in-service education and competency assessment.

Education Requirements for New Personnel, Casual Personnel, Students, Locums and Others who Assist Mothers with Breastfeeding

Orientation

At commencement of their first shift/placement/visit, orientation should include:

- a review of the 'policies for BFHI'
- being shown where the full policy and protocols can be accessed
- being made aware of their role in implementing it
- being made aware that they are required to work within the facility's policies and protocols

It is recognised that orientation for new short-term personnel, students or locums may be less comprehensive than orientation for other new personnel. For example, a brief orientation might be reading a suitable handout and answering a short questionnaire.

New Personnel

Competency assessment for new Group 1 personnel should be commenced as soon as possible. The appropriate in-service education for all Groups should be completed within 6 months.

Casual/Agency Personnel

- If the maternity unit uses casual or agency personnel on a regular basis, it is important to ensure that support for mothers is consistent with the policies and protocols, and that BFHI standards are maintained. Casual or agency personnel who have worked on a regular basis (20 shifts or more over a period of 6 months in the maternity unit, antenatal clinic and/or neonatal nurseries) are considered the same as new personnel (above).

Group 2 BFHI Education and Competency Requirements

Over the previous 3 years, all Group 2 personal who have been at the facility for 6 months or more have had education in the following knowledge and competencies:

- The facility's policy and key clinical practices (Steps 3-10) with a focus on:
    - Protocols related to Step 4, skin to skin (only if birthing within scope of practice)
    - Why breastfeeding is important
    - Ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
    - How to assist the mother to make a fully informed and appropriate decision about infant feeding, suitable to her circumstances.
- *Guidelines for Supplementary Feeding for the Healthy Term Breastfed Neonate* (Appendix 3) (Note: not required if making decisions about infant formula supplementation is outside the scope of practice of the person being interviewed.)
- The facility's and health workers' responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.

No time is specified for Group 2 education, as long as the competencies are covered. The delivery of the education is flexible. It may be face-to-face sessions individually or group, online sessions, a series of short handouts, or a combination of these.

The facility can report on the percentages of Group 2 personnel, who have been at the facility for six months or more, who have completed the relevant in-service education.

Group 3 BFHI Education/ Information Requirements

No time is specified for Group 3 education/ information, but it is usually around one hour and can be delivered face-to-face individually or in a group.

The content of the education is flexible, but should cover:

- why breastfeeding is important.
- facility policy/practices supportive of breastfeeding.

The facility can report on the percentages of Group 3 personnel, who have been at the facility for six months or more, who have completed the relevant education/information requirement.

Facility Personnel Education Database

Facility Records

The facility maintains electronic or hard copy central records and can report on the percentages of personnel, who have completed the in-service education or orientation required for their Group. The assessors will not need to review these records unless there is an issue. The principle assessment of education will be the competency and knowledge of personnel.

Personnel Interviews

At least 80% of the Group 1, 2 and 3 personnel:

- report they have received the required education on breastfeeding (Groups 1 and 2) or information about breastfeeding (Group 3) they have received in the previous 3 years
- report receiving competency assessments in breastfeeding in the previous 3 years (Group 1 only).
- are able to correctly answer questions on breastfeeding knowledge and competencies (as applicable to their role) (Group 1 and 2).
- are able to correctly answer questions on why breastfeeding is important and practices which support breastfeeding (Group 3)

Key Clinical Practices

Steps 3-10 outline the clinical practices that have been identified as key to the optimal establishment of breastfeeding in a Baby Friendly facility. Support for the mother who is not breastfeeding is also addressed. Implementation of these clinical practices is supported by the policies, education and competencies outlined in Steps 1 and 2.

Step 3: Discuss the Importance and Management of Breastfeeding with Pregnant Women and their Families

Rationale

All pregnant women must have basic information about breastfeeding, in order to make informed decisions. A review of 18 qualitative studies indicated that mothers generally feel that infant feeding is not discussed enough in the antenatal period and that there is not enough discussion of what to expect with breastfeeding[1]. Mothers want more practical information about breastfeeding. Pregnancy is a key time to inform women about the importance of breastfeeding, support their decision making and pave the way for their understanding of the maternity care practices that facilitate its success. Mothers also need to be informed that birth practices have a significant impact on the establishment of breastfeeding.

Implementation

Where facilities provide antenatal care (including booking-in, antenatal clinics, antenatal classes or antenatal inpatient care), pregnant women and their families should be counselled about the importance of breastfeeding and its early management. If the facility directly provides antenatal care services or offers classes for pregnant women, then provision of breastfeeding information and counselling is the direct responsibility of the facility. If facilities providing maternity and newborn services do not have direct authority over the external providers of antenatal care, they should work with them to ensure that mothers and families are fully informed about the importance of breastfeeding and know what to expect when they deliver at the facility.

Antenatal breastfeeding counselling must be tailored to the individual needs of the woman and her family, addressing any concerns and questions they have. This counselling needs to be sensitively given and consider the social and cultural context of each family.

Wherever possible, conversations on breastfeeding should begin with the first or second antenatal visit, so that there is time to discuss any challenges, if necessary. This is particularly important in settings where women have few antenatal visits and/or initiate their visits late in their pregnancy. Additionally, women who birth prematurely may not have adequate opportunities to discuss breastfeeding if the conversations are delayed until late in pregnancy.

Women should be provided with information on breastfeeding by a diverse range of media and sources, so they can choose what best suits their individual needs. Printed or online information that is in a language and literacy level mothers understand is one way to ensure that all relevant topics are covered. However, many women will not read this information, and it may not directly address the key questions they have. Interpersonal counselling, either one-on-one or in small groups, allows women to discuss their feelings, doubts and questions about infant feeding.

[1] Pérez-Escamilla R, Martinez JL, Segura-Pérez S. Impact of the Baby-friendly Hospital Initiative on breastfeeding and child health outcomes: a systematic review. Matern Child Nutr. 2016;12(3):402–17. doi:10.1111/mcn.12294.

The information must be provided free of conflicts of interest and the antenatal service should not in any way promote artificial feeding or products used for this purpose, as stipulated in the Guidance on ending inappropriate promotion of foods for infants and young children[1].

Women at increased risk for birth of a preterm or sick baby (e.g. pregnant adolescents, high-risk pregnancies, known congenital anomalies) must begin discussions with knowledgeable personnel as soon as feasible concerning the special circumstances of feeding a premature, low-birth-weight or sick baby[2].

Implementation Standards

Antenatal Information for Women
There are procedures in place to ensure that the required information is given to all pregnant women by the beginning of the third trimester (28 weeks). A written description of the information in the antenatal education/discussion about breastfeeding is made available to the Assessors. The antenatal education/discussion covers at least the following key points: • the facility's breastfeeding policy including the *Ten Steps to Successful Breastfeeding*. • why breastfeeding is important and the risks associated with not breastfeeding. • the importance of early uninterrupted skin-to-skin contact (the importance of the first hour). • how to recognise when the baby is ready to attach to the breast for the first feed. • basic breastfeeding and lactation management, including positioning and attachment, feeding cues and frequency of feeding. • why 24-hour rooming-in (staying close to baby) is important. • why bottle teats and dummies are discouraged while breastfeeding is being established. • exclusive (full) breastfeeding for around six months and that breastfeeding continues to be important after other foods are introduced and may be continued for up to two years and beyond as per WHO guidelines. Antenatal information about breastfeeding is available for pregnant women in a variety of written and electronic formats, including low literacy or pictorial. It should be available in each language used by 10% or more of the women who use the facility's maternity services, though it is encouraged to have this information available in other languages. All educational materials, handouts or sample bags available and/or distributed to antenatal women are made available for the Assessors to review and are free of promotion of artificial feeding.

[1] Maternal, infant and young child feeding. Guidance on ending the inappropriate promotion of foods for infants and young children. In: Sixty-ninth World Health Assembly, Geneva, 23–28 May 2016. Provisional agenda item 12.1. Geneva: World Health Organization; 2016 (A69/7 Add 1; http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf?ua=1, accessed 7 March 2018).

[2] US Department of Health and Human Services National Institutes of Health. What are the risk factors for preterm labor and birth? (https://www.nichd.nih.gov/health/topics/preterm/conditioninfo/Pages/who_risk.aspx, accessed 7 March 2018).

Pregnant Women Interviews

Assessors are required to interview eligible women, even if the facility does not have an antenatal clinic. A pregnant woman is eligible to be interviewed during the assessment if she meets both the following criteria:

- she is in the third trimester (28+ weeks) - women with earlier gestation may be included if breastfeeding education has been completed; and
- she has attended the facility (or satellite) at least twice - attendances can include booking-in, clinic visits and classes.

At Least 80% of the Pregnant Women Interviewed Can:

- confirm that that they were asked about their previous knowledge and experience with baby feeding.
- confirm they have been given the opportunity to discuss breastfeeding with a staff member.
- state at least two reasons why breastfeeding is important.
- answer questions about
    - skin-to-skin contact immediately after birth; and
    - how to recognise when her baby is ready to attach for the first breastfeed
- state why rooming-in day and night is important.
- state why avoiding early dummy use is important.
- confirm that they have been given information on breastfeeding support groups and services available in the community and how to contact them.
- confirm that they have not received from the facility any group education on artificial feeding

Personnel Interviews

The Senior Midwife Antenatal Services Can:

- confirm pregnant women are provided with information or education on breastfeeding.
- confirm that all pregnant women are asked about their breastfeeding knowledge and previous experience with infant feeding.
- confirm that pregnant women who did not breastfeed a previous child or had problems with breastfeeding are offered antenatal breastfeeding counselling and can describe how this counselling is facilitated.
- describe the community-based breastfeeding and pregnancy support groups and/or classes in the local area and how pregnant women are encouraged to access these.
- describe the support, resources and materials available for culturally and linguistically diverse pregnant women.

Step 4: Facilitate Immediate and Uninterrupted Skin-to-Skin Contact and Support Mothers to Recognise when their Babies are Ready to Breastfeed, Offering Help if Needed

Rational

Optimal benefit is achieved by immediate and uninterrupted skin-to-skin contact, allowing the baby to follow the natural sequence of innate feeding behaviours until breastfeeding is initiated. Immediate and uninterrupted skin-to-skin contact facilitates the newborn infant's natural rooting reflex that helps to imprint the behaviour of looking for the breast, self-attaching and suckling at the breast. Additionally, immediate skin-to-skin contact helps populate the newborn infant's microbiome and prevents hypothermia. This first feed, soon after birth, will trigger the production of breast milk and accelerate lactogenesis. Many mothers stop breastfeeding early or believe they cannot breastfeed because of insufficient milk, so establishment of a good milk supply is critically important for success with breastfeeding. In addition, optimal early initiation of breastfeeding has been proven to reduce the risk of infant morbidity and mortality[1].

Implementation

Skin-to-skin contact is when the baby is placed prone on the mother's abdomen or chest with no clothing separating them. It is recommended that skin-to-skin contact is facilitated regardless of type of birth. It should be uninterrupted until after the first breastfeed or for at least an hour if the baby feeds sooner.

Initiation of breastfeeding is typically a direct consequence of uninterrupted skin-to-skin contact, as it is a natural behaviour for most babies to slowly squirm or crawl toward the breast.

The amount of colostrum a newborn infant receives in the first few feedings is very small, but it is highly nutritious and contains important antibodies and immune-active substances which prime the gut microbiome. Early suckling is important for stimulating milk production and establishing the maternal milk supply. The amount of milk ingested is a relatively unimportant factor.

Skin-to-skin contact is particularly important for preterm and low-birth-weight infants. Kangaroo mother care involves early, continuous and prolonged skin-to-skin contact between the mother and the baby[2], and should be used as the main mode of care as soon as the baby is stable (defined as the absence of severe apnoea, desaturation and bradycardia), owing to demonstrated benefits in terms of survival, thermal protection and initiation of breastfeeding.

Preterm infants may be able to root, attach to the breast and suckle from as early as 27 weeks' gestation[3]. As long as the infant is stable, preterm infants can start breastfeeding. However, early initiation of effective breastfeeding may be difficult for these infants if the suckling reflex is not yet established and/or the mother has not yet begun plentiful milk secretion. Early and frequent milk expression is critical to stimulating milk production and secretion for preterm infants who are not yet able to suckle. Transition to direct and exclusive breastfeeding should be the aim whenever possible[4] and is facilitated by prolonged skin-to-skin contact.

---

[1] NEOVITA Study Group. Timing of initiation, patterns of breastfeeding, and infant survival: prospective analysis of pooled data from three randomised trials. Lancet Glob Health. 2016;4(4):e266–75. doi:10.1016/ S2214-109X(16)00040-1.

[2] Kangaroo mother care: a practical guide. Geneva: World Health Organization; 2003 (http://apps.who.int/iris/bitstream/10665/42587/1/9241590351.pdf accessed 7 March 2018).

[3] Nyqvist KH, Sjoden PO, Ewald U. The development of preterm infants' breastfeeding behavior. Early Hum Dev. 1999;55(3):247–64.

[4] Nyqvist KH, Maastrup R, Hansen MN, Haggkvist AP, Hannula L, Ezeonodo A et al. Neo-BFHI: the Babyfriendly Hospital Initiative for neonatal wards. Three guiding principles to protect, promote and support breastfeeding. Core document with recommended standards and criteria. Nordic and Quebec Working Group; 2015 (http://epilegothilasmo.gr/wp-content/uploads/2017/04/Neo_BFHI_Core_document_2015_Edition.pdf, accessed 7 March 2018).

Implementation Standards

Immediate Skin-to-Skin Contact

After a Vaginal Birth
Unless a medically indicated procedure is required, the baby is immediately placed skin-to-skin on the mother's chest and stays there, without interruption or separation.

Although immediate skin-to-skin is optimal, for the purposes of Step 4 there may be up to 5 minutes of separation before continuous skin-to-skin contact starts. As a guide to measuring 5 minutes, the baby should be on the mother's chest in skin-to-skin contact before the second Apgar.

After a Caesarean Birth
Optimum practice:

- The baby is placed skin-to-skin on the mother's chest while she is on the theatre table, immediately after birth or within 5 minutes.

BFHI minimum requirements:

- When the mother has not had a general anaesthetic, her baby is on her chest in skin-to-skin contact no later than 10 minutes after she arrives in recovery, unless evidence can be provided that the mother's or baby's condition prevented this.
- When the mother has had a general anaesthetic, her baby is on her chest in skin-to-skin contact within 10 minutes of being able to respond to her baby, unless evidence can be provided that the mother's or baby's condition prevented this.

A baby held cheek-to-cheek with the mother on the theatre table is a next-best interim procedure, but is not considered to be in skin-to-skin contact and cannot be counted as such.

N.B. Skin-to-skin contact with another adult, such as the other parent, is an alternative when skin-to-skin is not possible with the mother or has to be interrupted e.g. for medical reasons. It will help stabilise the baby's temperature and respiration, and has other benefits. However, skin-to-skin on the birth mother's chest remains the optimal practice for babies who have had a vaginal or caesarean birth and is important for the optimal establishment of breastfeeding and helps populate the newborn infant's microbiome from the mother's skin. For these reasons, skin-to-skin contact other than with the birth mother does not meet Step 4 requirements.

When a mother or baby is medically unstable following birth, uninterrupted skin-to-skin contact and the initiation of breastfeeding may need to be delayed. However, the mother should still be supported to provide skin-to-skin contact and to breastfeed as soon as she and/or the baby are well enough[1].

[1] Implications of cesarean delivery for breastfeeding outcomes and strategies to support breastfeeding. Washington (DC): Alive & Thrive; 2014 (A&T Technical Brief Issue 8, February 2014; http://aliveandthrive.org/wp-content/uploads/2014/11/Insight-Issue-8-Cesarean-Delivery-English.pdf, accessed 7 March 2018).

Skin-to-Skin Contact "Continues Uninterrupted"

After a vaginal or caesarean birth, once the baby is skin-to-skin on the mother's abdomen or chest, the baby stays there without interruption or separation. If the mother has to be transferred, mother and baby are kept together, without interrupting skin-to-skin contact if possible.

When the Mother is Intending to Breastfeed
The baby is allowed to follow the normal sequence of innate feeding behaviours, seeks the breast and initiates the first breastfeed when the baby is ready. The baby is allowed to finish the feed when he/she is ready.

Although this Step specifies that skin-to-skin contact should continue "for at least an hour", it has been shown that most healthy term babies will follow a sequence of pre-feeding behaviours for about an hour before they are ready to self-attach and initiate the first breastfeed – in one study the median was 62 minutes, with 25% of infants suckling by 43.5 minutes and 75% suckling by 90.3 minutes.

Assistance is provided to keep the mother and baby together and ensuring procedures are in place for appropriate vigilance of the baby, including assessment of airway, breathing and colour. Care should be hands-off, encouraging the mother to recognise and respond to her baby's innate feeding behaviours and allowing the baby to self-attach to the breast. The midwife may help the mother into a more comfortable position. The mother may give the baby assistance if required.

In some uncommon situations, it is acceptable for the midwife to use hands-on to attach the baby. e.g. baby having difficulty self-attaching after being given sufficient time and mother sedated or unwell or where there is the potential for the baby to have low blood sugar levels, e.g. mother with diabetes and she is unable to assist her baby to initiate feeding. Any hands-on intervention should be with an explanation and the mother's permission, and must be documented.

If the first breastfeed is initiated and completed quickly, it is best practice for the baby to remain in skin-to-skin for at least an hour; this meets the requirements for this Step.

'Without interruption'
Weighing, measuring and bathing the baby, and cuddles by others, are delayed; most required medical procedures can be carried out with the baby on the mother's abdomen. A brief interruption may be necessary e.g. transfer from a theatre bed to a recovery bed, however transfer procedures will generally respect the importance of keeping the baby skin-to-skin with the mother. If the mother's condition necessitates a toilet break before the baby has breastfed, then the interruption should be as brief as possible, before resuming skin-to-skin contact.
If skin-to-skin has to be interrupted or terminated for maternal medical reasons, skin-to-skin with another adult, such as the other parent, is the next best option. See above.

When the Mother is not Planning to Initiate Breastfeeding
If the mother is not planning to breastfeed, the skin-to-skin contact should continue uninterrupted for at least an hour after birth. If the mother insists on terminating it earlier, e.g. because the baby shows an unwelcomed interest in breastfeeding, this is acceptable. The time and reason should be documented.

Sentinel Indicator
The Maternity Facility BFHI Bi-Annual Data for the most recent 12 months indicates that at least 80% of term infants experienced uninterrupted skin-to-skin contact immediately or within 5 minutes after birth, or within 10 minutes of arriving in recovery following a caesarean and that this contact continued uninterrupted until after the first breastfeed or for at least an hour if the baby fed sooner.

Mother Interviews[1]

At Least 80% of Mothers Interviewed, unless a Medically Indicated Procedure was Required Can:

- confirm that the baby was immediately placed skin-to-skin, regardless of whether or not they intended to breastfeed as per the standards for this Step.

Of Those who Intended to Breastfeed, at Least 80% of Mothers Interviewed, unless a Medically Indicated Procedure was Required Can:

- confirm the baby stayed skin-to-skin without interruption for at least an hour (even if the baby breastfed early).
- confirm that the baby was allowed to follow the normal sequence of innate feeding behaviours, seek the breast and initiate the first breastfeed, without staff hands-on intervention, as per the standards for this Step.

Of Those who Did Not Intend to Breastfeed, at Least 80% of Mothers Interviewed, unless a Medically Indicated Procedure was Required Can:

- confirm the baby stayed skin-to-skin without interruption for at least an hour, unless earlier separation was at mother's request, which was documented.

N.B. Mothers may have difficulty estimating time immediately following birth. If time and duration of skin-to skin contact and the time of the first breastfeed are routinely recorded in the case-notes then this can be used to verify.

At Least 80% of Mothers with Babies in Special Care[2] Can:

- confirm that they have held their babies' skin-to-skin, or if not, the staff could provide justifiable reasons why this did not occur

Personnel Interviews

The Senior Midwife Birthing Services Can:

- outline the procedures used in this facility for keeping mothers and babies together after a vaginal birth, and after a caesarean birth, and what personnel do to support the optimal initiation of breastfeeding
- outline how the key indicators of skin-to-skin contact and the first breastfeed are documented to allow monitoring and reporting.
- outline the procedures and resources in place to ensure that mothers of babies who did not initiate breastfeeding, and/or who will be separated, are supported to initiate expressing colostrum as soon as possible, but at least within 2 hours of birth.

The Senior Midwife Postnatal Can:

- outline the management of a breastfeeding mother and baby who have been transferred to his/her care prior to the initiation of the first breastfeed.

The Senior Nurse / Midwife or NUM Special Care / NICU:

- explains the procedures and policies in place to support mothers and their babies to have skin-to-skin care.

[1] The relative number of mothers interviewed who have had a vaginal vs. caesarean birth will be determined by the annual percentage of vaginal vs. caesarean births at that facility.
[2] For the purpose of interviewing mothers for BFHI assessments, NICU can be included in the definition of special care.

Step 5: Support Mothers to Initiate and Maintain Breastfeeding and Manage Common Difficulties

Rationale

While breastfeeding is a natural human behaviour, most mothers need practical help in learning how to breastfeed. Even experienced mothers may encounter new challenges when breastfeeding a newborn infant. Postnatal breastfeeding counselling and support has been shown to increase rates of breastfeeding up to 6 months of age[1]. Early adjustments to position and attachment can prevent breastfeeding problems at a later time. Support helps build maternal confidence.

Implementation

Mothers should receive practical support to enable them to initiate and maintain breastfeeding and manage common breastfeeding challenges. Practical support includes providing emotional and motivational support, imparting information and teaching skills to enable mothers to breastfeed successfully. The stay in the facility is a unique opportunity to discuss and assist the mother with questions or problems related to breastfeeding and to build confidence in her ability to breastfeed.

All mothers should receive individualised attention, but first-time mothers and mothers who have not successfully breastfed before will require extra support. Mothers who had a multiple birth, those who birthed by caesarean, and/or obese mothers should be given extra support, especially with positioning and attachment.

In order to establish and maintain the production of breast milk, practical support is particularly critical for mothers of babies who are preterm, late preterm and small for gestational age. Late preterm infants may be able to exclusively breastfeed at the breast, but are at greater risk of jaundice, hypoglycaemia and feeding difficulties than full-term infants, and thus require increased support[2].

Mothers should be taught how to express breast milk as a means of maintaining lactation if the baby is not feeding effectively or if they are temporarily separated from their baby. There is not sufficient evidence that one method of expression (hand expression, manual pump or electric pump) is more effective than another[3], and thus any of these methods may be taught, depending on the mother's context. However, hand expression of at least a few drops of milk at the beginning of a feed should also be taught. Hand expression has the added advantage of being available no matter where the mother is, allowing her to relieve pressure or express milk when a pump is not available. Mothers also need to be informed about storage and use of expressed milk.

Implementation Standards

Postnatal Information for Mothers
All mothers who plan to breastfeed are taught the necessary skills and provided with appropriate support and information to initiate and maintain lactation and to breastfeed their babies. As a minimum, all breastfeeding mothers are taught: • how to position and attach their babies for breastfeeding, and how to recognise that the baby is well attached on the breast, breastfeeding effectively and milk transfer is occurring. • the supply and demand principles and how to maintain optimal milk supply.

[1] McFadden A, Gavine A, Renfrew MJ, Wade A, Buchanan P, Taylor JL et al. Support for healthy breastfeeding mothers with healthy term babies. Cochrane Database Syst Rev. 2017;(2):CD001141. doi:10.1002/14651858. CD001141.pub5.)

[2] Meier PP, Furman LM, Degenhardt M. Increased lactation risk for late preterm infants and mothers: evidence and management strategies to protect breastfeeding. J Midwifery Womens Health. 2007;52(6):579–87.

[3] Becker GE, Smith HA, Cooney F. Methods of milk expression for lactating women. Cochrane Database Syst Rev. 2016;(9):CD006170. doi:10.1002/14651858.CD006170.pub5.

- how to recognise when their baby is ready to feed.
- how to maintain lactation if the baby is not feeding effectively or if temporarily separated
- how to stimulate the milk ejection reflex and express breast milk by hand or pump.
- how to hand express a few drops of milk to entice the baby at the beginning of a feed.
- How to assess whether their baby is getting enough milk.
- Breast and nipple care.

Women who wish to breastfeed but did not breastfeed a previous child, or had problems with breastfeeding, are provided with additional support, assistance and advice from the Personnel of the facility.

If a breastfeeding mother or a breastfed baby/child is admitted to any part of the facility, the support provided is appropriate and facilitates the continuation of breastfeeding.

Mother Interviews (Breastfeeding)

At Least 80% of Breastfeeding Mothers who are Interviewed Can:

- report that they were given further assistance with breastfeeding as required.
- demonstrate or describe correct positioning and attachment.
- describe how to recognise their babies are well attached on the breast and breastfeeding effectively.
- describe cues, other than crying, that indicate their baby is ready to feed.
- describe two ways to maintain an optimal milk supply
- describe two ways to assess whether their baby is getting enough milk

The Mothers who are More Than 24 Hours After Birth (48 hours if Caesarean Birth, or there is a Documented Maternal Medical Reason) Can:

- confirm that they have been shown by staff how to hand express their breastmilk.
- confirm that they have been informed by staff and provided with written information on how to store, transport and use their expressed breastmilk.

At Least 80% of Mothers with Babies who are in Special Care (Including NICU) and who are Breastfeeding or Expressing their Milk Can:

- confirm they have been supported to initiate lactation as soon as possible, but at least within 2 hours of birth unless the mother was severely medically compromised.
- confirm they have been shown how to express their breastmilk and have been provided with assistance as required.
- can describe the technique they are using for hand expressing or pumping their milk.
- confirm they have been informed how to maintain lactation by frequent expression of breastmilk.
- confirm they have been informed and provided with written information on how to store, transport and use their expressed breastmilk (if their babies are 24 or more hours old).
- can describe signs to look for to know that their baby is getting enough breastmilk, after they go home.

Personnel Interviews:
The Divisional Director of Nursing/Midwifery Can: • confirm that support is provided if a breastfeeding mother or a breastfed baby/child is admitted to any part of the facility. **The Senior Midwife Postnatal Can:** • describe the support, resources and materials available for pregnant women from culturally and linguistically diverse backgrounds. **The Senior Nurse / Midwife or NUM Special Care / NICU:** • outlines the procedures in place to ensure that mothers of babies admitted to Special Care / NICU who have not yet initiated breastfeeding or expression of colostrum, are supported to initiate expressing colostrum as soon as possible, but at least within 2 hours of birth. • explains how to maintain optimal lactation when expressing breastmilk for a baby in Special Care / NICU. **At least 80% of the Group 1 Personnel Can:** • outline what they tell mothers about positioning and attaching their baby for a breastfeed • outline what they tell mothers about how to recognise whether their baby is well attached and feeding effectively. • demonstrate an acceptable technique for teaching mothers how to hand express at least a few drops of milk at the beginning of a feed. • describe guidelines for storage and use of expressed breastmilk for a well-baby at home, when the milk is not to be frozen. **At least 80% of the Group 2 Personnel Can:** • describe why breastfeeding is important.

Step 6: Do Not Provide Breastfed Newborns Any Food or Fluids Other than Breastmilk, Unless Medically Indicated

Rationale

Giving newborn infants any foods or fluids other than breast milk in the first few days after birth interferes with the establishment of breast-milk production. Newborn infants who are fed other foods or fluids will suckle less vigorously at the breast and thus inefficiently stimulate milk production, creating a cycle of insufficient milk and supplementation that may lead to breastfeeding failure. Babies who are supplemented prior to facility discharge have been found to be twice as likely to stop breastfeeding altogether in the first 6 weeks of life[1]. In addition, foods and liquids may contain harmful bacteria and carry a risk of disease. Supplementation with artificial milk significantly alters the intestinal microflora[2].

Implementation

Mothers should be discouraged from giving any food or fluids other than breast milk, unless medically indicated. Very few conditions of the mother or baby preclude the feeding of breast milk and necessitate the use of breast-milk substitutes[3]. The Academy of Breastfeeding Medicine has developed a clinical protocol for managing situations in which supplementation of the mother's own milk would become necessary[4]. Infants should be assessed for signs of inadequate milk intake and supplemented only when indicated.

Mothers who are considering mixed feeding (see Appendix 1 Definitions) should be counselled on the importance of exclusive breastfeeding in the first few weeks of life, how to establish a milk supply and how to ensure that the baby is able to suckle and transfer milk from the breast. Supplementation can be introduced at a later date if the mother chooses. Mothers who are feeding their babies with breast-milk substitutes, by necessity or by choice, must be taught about safe preparation and storage of formula[5] and how to respond adequately to their child's feeding cues. The Global documents state that that at least 80% of preterm babies and other vulnerable newborn infants that cannot be fed their mother's own milk are fed with donor human milk. Currently in Australia donor milk is not yet widely available, but it is acknowledged as optimal practice where it is achievable[6].

Where donor milk is unavailable, breast-milk substitutes are required. In most cases, supplementation is temporary, until the mother own milk is available and is then given priority. Even if direct breastfeeding is not possible for a period of time, mothers must be supported and encouraged to continue stimulating production by expressing their milk.

---

[1] DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of maternity-care practices on breastfeeding. Pediatrics. 2008;122(Suppl. 2):S43–9. doi:10.1542/peds.2008-1315e.

[2] Salvatori G, Guaraldi F. Effect of breast and formula feeding on gut microbiota shaping in newborns. Front Cell Infect Microbiol. 2012;2:94. doi:10.3389/fcimb.2012.00094.

[3] World Health Organization, United Nations Children's Fund. Acceptable medical reasons for use of breastmilk substitutes. Geneva: World Health Organization; 2009. (WHO/NMH/NHD?09.1, WHO/FCH/CAH/09.1; http://apps.who.int/iris/bitstream/10665/69938/1/WHO_FCH_CAH_09.01_eng.pdf, accessed 7 March 2018).

[4] Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeed Med. 2017;12)188–98. doi:10.1089/bfm.2017.29038.ajk. (Appendix 3)

[5] Infant Feeding Guidelines, Section 8. *National Health and Medical Research Council (NHMRC)* 2012. See appendix 4. The NHMRC Infant Feeding Guidelines outline the standard of care for artificial feeding in Australia and are recommended for use in BFHI facilities. However, facilities may elect to use "WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization* 2007", especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

[6] DeMarchis A, Israel-Ballard K, Mansen KA, Engmann C. Establishing an integrated human milk banking approach to strengthen newborn care. J Perinatol. 2017;37(5):469–74. doi:10.1038/jp.2016.198.

Implementation Standards

Exclusive Breastfeeding and Use of Supplements

Babies are exclusively breastfed or breastmilk-fed from birth. The baby is given no infant formula, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines. Breastmilk-fed includes mother's expressed milk or donor milk. Parents are made aware of the importance of exclusive breastfeeding to around 6 months and the risks associated with giving formula or other supplements to a breastfed baby.

Before a supplement of infant formula is given to a breastfed baby, the mother/baby's individual circumstances and alternative management strategies are considered. If a mother requests that her baby is given a supplement, the importance of exclusive breastfeeding, the risks of supplementation and alternative management strategies are discussed with her. Wherever possible, supplements are avoided.

Facilities are encouraged to monitor and audit their use of supplements and associated practices, and to try to reduce the use of supplements to the lowest possible level.

If a supplement is given to a breastfed baby:

- it is for an acceptable medical indication (Appendix 3), which has been documented, or
- it is at the mother's request, after she has made an informed decision which has been documented.

The volume of the supplement takes into account the newborn infant's stomach size.

The documentation is to include the amount given, and the circumstances and reason/s for supplementation. Mother's request or consent for supplementation needs to be recorded in the case notes at the time the supplement was given, if a signed consent is used, that should also be included; advance consent for supplementary feeds, e.g. on admission, does not meet this requirement and is considered inappropriate.

In accordance with policy, the facility does not give parents and their families samples or supplies of infant formula, bottles or teats to take home.

Sentinel Indicator Exclusive Breastfeeding Rates

BFHI accredited facilities are required to achieve and maintain at least a 75% exclusive breastfeeding or breastmilk-feeding rate for mothers and their babies discharged from the facility[1]. They submit their infant feeding data to BFHI every six months.

Facilities applying for their first assessment are required to submit the most recent 12 months of infant feeding data, demonstrating that they have achieved at least a 75% exclusive breastfeeding or breastmilk-feeding rate.

Facilities that are unable to achieve an average 75% exclusive breastfeeding rate over the required period, because of high-risk clientele, must apply to the BFHI Manager before the assessment for special consideration on this requirement. Facilities must provide evidence that their exclusive breastfeeding rate would be at least 75% if the calculation excluded babies who were supplemented for documented acceptable medical reasons. The approval of this special consideration must be confirmed before the assessment can proceed. An application form for special consideration can be requested from the BFHI Manager.

[1] The Global Standards call for a minimum of 80% for all outcome indicators, including exclusive breastfeeding, but they recognise that in some contexts this may be difficult to attain. At this time, BFHI Australia has chosen to continue the requirement of at least 75% exclusive breastfeeding or breastmilk-feeding rate on discharge from inpatient care, but facilities should be working towards achieving 80% exclusive breastfeeding.

Care of Mothers who are Artificial Feeding

Mothers who are considering artificial feeding are supported to make a fully informed and appropriate decision about infant feeding, suitable to their circumstances.

The following standards apply to all mothers who will be leaving the facility using infant formula, including mothers who are artificial feeding, mothers who are mixed feeding, and mothers who have been advised or have chosen to give their baby infant formula as a supplement or pre-lacteal feed.

All mothers who will be leaving the facility using infant formula are given:

- information and instruction on the safe preparation, storage and handling of reconstituted powdered infant formula, using NHMRC Guidelines[1].
- information on the risks to the baby if the preparation and handling instructions are not followed carefully.
- a demonstration and supervised practice in making up a bottle-feed using powdered infant formula[2];
- information on the importance of ensuring the correct concentration by following the instructions on the can exactly, regarding water volume and scoops of powder, and are made aware that these will be different for each brand of formula.
- information on best practice for feeding their babies with a bottle, including paced bottle-feeding.
- information on where to get help with infant feeding after discharge from the facility.

Instruction is given only to parents who need it; there is no group instruction; it is done privately, away from breastfeeding mothers. If the mother's condition prevents this instruction, it can be given to another family member instead.

Parents with low literacy skills or from a non–English speaking background may need extra help to be sure they have the required skills and understanding of the risks.

Materials on artificial feeding which are shown or given to parents are free from advertising, do not refer to or contain images of an identifiable product, and comply with the *WHO International*

Personnel Interviews

The Senior Midwife Postnatal:

- can state at least two of the Indications for Supplementation in Healthy Term Infants and one practice that can help prevent the need for supplementation[3].
- confirms that mothers who will be leaving the facility using infant formula are given instruction and supervised practice on the reconstitution of powdered infant formula and how to bottle-feed.
- describe what should be considered when determining where and how instruction on the preparation of infant formula is given on the postnatal ward.

[1] Infant Feeding Guidelines, Section 8. *National Health and Medical Research Council (NHMRC)* 2012. See appendix 4. The NHMRC Infant Feeding Guidelines outline the standard of care for artificial feeding in Australia and are recommended for use in BFHI facilities. However, facilities may elect to use "WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization* 2007", especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

[2] If liquid infant formula (ready-to-feed) is used in the facility, arrangements must be made to have powdered formula available for teaching reconstitution, even if it is discarded after preparation. The NHMRC Guidelines are clear that health workers must know how to demonstrate the preparation of infant formula and have a responsibility to check that it is being prepared according to instructions.

[3] See: Appendix 3.

The Senior Nurse / Midwife or NUM Special Care / NICU:

- confirms that eligible preterm babies and other vulnerable newborn infants that cannot be fed their mother's own milk are fed with donor human milk (only asked when donor human milk from a milk bank is available at the facility)

At Least 80% of Personnel from Group 1 Can:

- state at least two of the Indications for Supplementation in Healthy Term Infants and one practice that can help prevent the need for supplementation[1].
- outline ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
- outline key safety and hygiene points that should be covered when instructing reconstitution of powdered infant formula.
- describe briefly the key issues to be covered when instructing a mother on how to feed her baby with a bottle.

At Least 80% of Personnel from Group 2 Can:

- state at least two of the Medical Indications for Supplementation in Healthy Term Infants and one practice that can help prevent the need for supplementation[1]. *(Not asked if making decisions about using infant formula is outside the role of the person being interviewed)*
- outline ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
- briefly describe what should be discussed with a breastfeeding mother who is considering feeding her baby with infant formula, including the potential risks.

Mother Interviews

Breastfeeding

At least 80% of the breastfeeding mothers can:

- confirm their babies have not been fed food or drink other than breastmilk.

If a supplement was given, there is documented evidence in the case notes that there was an acceptable medical reason (per the Indications for Supplementation in Healthy Term Infants[1]) or it was at the mother's request, having made an informed decision which was documented.

Artificial Feeding

At least 80% of mothers who have been feeding their babies with infant formula for at least 24 hours (or whose babies are at least 48 hours old if caesarean birth or there is a documented maternal medical reason) can:

- report that the various feeding options were discussed with them and they were helped to decide what was suitable in their situations.
- confirm they have been given individual education about making up a bottle-feed using powdered infant formula.
- confirm they have made up a bottle-feed using powdered infant formula under supervision, or have been offered the opportunity to do so.
- adequately answer questions about:
  - making up and using powdered infant formula to feed their babies.
  - the risks to the baby if the preparation and handling instructions are not carefully adhered to.
  - how to feed a baby with a bottle.

[1] See: Appendix 3.

Step 7: Enable Mothers and their Infants to Remain Together and to Practise Rooming-in 24 Hours a Day.

Rationale

Rooming-in day and night is necessary to enable mothers to practise responsive feeding, as mothers cannot learn to recognise and respond to their babies' cues for feeding if they are separated. This, along with the close presence of the mother to her baby, will facilitate the establishment of breastfeeding.

Minimising disruption to breastfeeding during the stay in the facility enables a mother to breastfeed for as frequently and for as long as her baby needs it.

Implementation

Facilities providing maternity and newborn services should enable mothers and their infants to remain together and to practise rooming-in throughout the day and night. Babies are with their mothers (or the mother's partner or support person) 24 hours per day from birth to discharge, except when there is a justifiable reason[1] that necessitates separation, such as a mother or baby medical reason or a mother whose condition means that she is not able to respond to and/or be responsible for her baby and there is not an alternative carer, such as her partner, who is able to do this.

Implementation Standards

Rooming-in and Separations
The time, duration and the reason/circumstances of all separations are documented. Every effort should be made to support the mother to have her baby close to her at all times. Her partner or support person, if available, can assist with this. Mother's request or staff suggestion, without a justifiable reason that necessitates separation, is not acceptable. There are many evidence-based reasons why mothers and their babies should be together; any separations should be uncommon, only when necessary, and fully documented. The facility has suitable provision to ensure direct supervision of babies for any period that they are not with their mothers. Rooming-in may not be possible in circumstances when babies need to be moved for specialised medical care. If preterm or sick babies need to be in a separate room to allow for adequate treatment and observation, efforts must be made for the mother to recuperate postpartum with her baby, or to have no restrictions for visiting her baby.

Personnel Interviews
The Senior Midwife Postnatal Can: • outline provisions that ensure direct supervision of babies on the postnatal unit if they are separated from their mothers **At Least 80% of Group 1 Personnel Interviewed Can:** • outline the circumstances when an exception can be made to mothers and babies rooming-in 24 hours a day in the postnatal unit. • outline what must be documented for every mother/baby separation on the postnatal unit.

[1] Mother's request or staff suggestion, without a justifiable reason, is not acceptable in the BFHI Global Standards which have been implemented in Australia.

Mother Interviews
At Least 80% of Mothers whose Babies are not in Special Care, whether they are Breastfeeding or not, Can: • report that since birth their babies have been with them day and night. If any of these mothers' report that their babies have been separated from them, the separation was necessary for a justifiable reason, which was adequately documented. • state one reason why rooming-in (staying close to their babies 24 hours a day) is important. **At Least 80% of Mothers whose Babies are in Special Care/ NICU:** • confirm that, if they are separated from their babies, or their babies are in Special Care/ NICU, they were encouraged to stay close to their babies as much as possible, without restrictions on access to the NICU/Preterm unit

Step 8: Support Mothers to Recognise and Respond to their Infants' Cues for Feeding

Rationale

Breastfeeding involves recognising and responding to the baby's display of feeding cues, as part of a nurturing relationship between the mother and baby. Responsive feeding (also called on-demand or baby-led feeding) puts no restrictions on the frequency or length of the baby's feeds, and mothers are advised to breastfeed whenever the baby is hungry or as often as the baby wants. Scheduled feeding, which prescribes a predetermined frequency and schedule of feeds is not recommended. It is important that mothers know that crying is a late cue and that it is better to feed the baby earlier, since optimal positioning and attachment are more difficult when a baby is in distress.

Implementation

Mothers should be supported to practise responsive feeding as part of nurturing care. Regardless of whether they breastfeed or not, mothers should be supported to recognise and respond to their babies' cues for feeding, closeness and comfort, and encouraged to respond appropriately to these cues. This enables them to build a caring, nurturing relationship with their babies and increases their confidence in themselves and in breastfeeding.

Implementation Standards

Cue Based Feeding

No restrictions are placed on the frequency or length of babies breastfeeds and mothers of well newborn infants are not advised to feed at set times or feed for a specific number of minutes. Mothers can recognise early feeding cues before crying.

Assuming the baby is breastfeeding *effectively,* mothers are advised to breastfeed:

- in response to early feeding cues or as often as the baby wants.
- if their breasts become uncomfortable or too full.

Some babies will have a medical indication that necessitates a feeding regime that differs from the above. The reasons for this intervention should be explained to the mother and documented. When the mother and baby are not in the same room for medical reasons, the mother should be supported to visit the baby as often as possible, so that she can recognise feeding cues. When staff notice feeding cues, they should bring the mother and baby together.

Personnel Interviews

The Senior Midwife Postnatal and at Least 80% of Group 1 Personnel Interviewed Can:

- confirm that they advise mothers to breastfeed their babies in response to early feeding cues, as often and for as long as the baby wants.
- report that no restrictions are placed on breastfeeding unless frequency or timing of feeds is medically indicated.

Mother Interviews

At Least 80% of Mothers Interviewed who are Breastfeeding and whose Babies are not in Special Care Can:

- report that they have been advised to breastfeed their babies in response to early feeding cues, as often and for as long as the baby wants (assuming the baby is breastfeeding effectively).
- describe two early feeding cues before crying.

Step 9: Counsel Mothers on the Use and Risks of Feeding Bottles, Teats and Pacifiers.

Rationale

Proper guidance and counselling of mothers and other family members enables them to make informed decisions on the use or avoidance of pacifiers and/or feeding bottles and teats until the successful establishment of breastfeeding. While WHO guidelines[1] do not call for absolute avoidance of feeding bottles, teats and pacifiers/dummies for term infants, there are a number of reasons for caution about their use, including recognition of feeding cues, hygiene, sucking physiology and oral formation. For these reasons, the use of artificial teats and dummies is not generally recommended while breastfeeding is being established.

Implementation:

An optimal supplemental feeding device has not yet been identified, and may vary from one infant to another. No method is without potential risk or benefit[2,3]. If expressed milk or other feeds are medically indicated for term infants, feeding methods such as cups, spoons, syringes or feeding bottles and teats may be used during their stay at the facility. However, it is important that personnel do not become reliant on teats instead of counselling the mother on the best option for her baby and her circumstances.

The use of a feeding bottle and teat may sometimes lead to breastfeeding difficulties, particularly if use is prolonged. The physiology of suckling at the breast is different from the physiology of suckling from a feeding bottle and teat[4]. The faster flow from a bottle teat can result in the baby taking an unnecessary higher volume of the milk offered. Cup feeding has been shown to be safe for both term and preterm infants and there is evidence it may help preserve breastfeeding duration among those who require multiple supplemental feedings[5,6].,

For preterm infants, the use of feeding bottles and teats is discouraged. There is concern that the use of teats interferes with learning to suckle at the breast and there is evidence that cup feeding of late preterm infants may increase breastfeeding rates up to six months of age[7]. One study found better physiologic stability and no difference in untoward effects and concluded that cup feeding is at least as safe, if not safer, than bottle-feeding for preterm infants[8]. If expressed breast milk or other feeds are medically indicated for preterm infants, alternative feeding methods are generally preferable to feeding bottles and teats.

While these infants are unable to feed at the breast, non-nutritive sucking and oral stimulation may be beneficial until breastfeeding is established. Non-nutritive sucking or oral stimulation involves the use of dummies, a gloved finger or the mother's breast after expressing.

---

[1] Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. Geneva: World Health Organization; 2017 (http://apps.who.int/iris/bitstream/10665/259386/1/9789241550086-eng.pdf?ua=1, accessed 7 March 2018).

[2] Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeed Med. 2017;12)188–98. doi:10.1089/bfm.2017.29038.ajk.

[3] Cloherty M, Alexander J, Holloway I, et al. The cup-versus-bottle debate: A theme from an ethnographic study of the supplementation of breastfed infants in hospital in the United Kingdom. J Hum Lact 2005;21:151–162.

[4] Geddes DT, Sakalidis VS. Breastfeeding: how do they do it? Infant sucking, swallowing and breathing. Infant 2015; 11(5):146-160 (http://www.infantjournal.co.uk/pdf/inf_065_swa.pdf accessed 19 May 2019).

[5] Howard CR, Howard FM, Lanphear B, et al. Randomized clinical trial of pacifier use and bottle-feeding or cupfeeding and their effect on breastfeeding. Pediatrics 2003;111:511–518.

[6] Howard CR, de Blieck EA, ten Hoopen CB, et al. Physiologic stability of newborns during cup- and bottlefeeding. Pediatrics 1999;104(Pt 2):1204–1207.

[7] Flint A, New K, DaviesMW. Cup feeding versus other forms of supplemental enteral feeding for newborn infants unable to fully breastfeed. Cochrane Database Syst Rev 2016; CD005092. DOI: 10.1002/14651858.CD005092.pub3.

[8] Marinelli KA, Burke GS, Dodd VL. A comparison of the safety of cupfeedings and bottlefeedings in premature infants whose mothers intend to breastfeed. J Perinatol 2001;21:350–355.

For term babies, there is evidence that dummy use in the neonatal period is detrimental to exclusive and any breastfeeding[1]. The use of dummies may interfere with recognition of feeding cues and therefore delay feeding until the infant is crying and agitated. Dummies may also replace suckling and thus reduce the number of times an infant stimulates the mother's breast physiologically, leading to fewer feeds and a reduction of maternal milk production. For these reasons, the use dummies are not recommended while breastfeeding is being established. Dummies are not provided by the facility, except where there is a clinical indication for an individual baby, which is documented.

There should be no promotion of feeding bottles or teats in any part of the facility, or by any of the personnel. As is the case with breast-milk substitutes, these products fall within the scope of the International Code[2,3,4].

Implementation Standards

Use and Risks of Feeding Bottles, Teats and Pacifiers/ Dummies
Breastfeeding mothers are counselled on the use and risks of feeding bottles, teats and pacifiers/dummies. Personnel have the clinical skills to assist mothers to use alternative feeding methods, other than artificial teats and bottles, when they are required. Personnel have the skills to counsel a breastfeeding mother on the best method for feeding her baby with EBM or a supplement, taking into account[5]: • volume to be given • whether anticipated use is short- or long-term • whether the method enhances development of breastfeeding skills. • maternal preference • potential stress to the baby The method of feeding and volume is documented. Pregnant women and mothers are informed of the following reasons why dummies are not recommended in the early weeks of breastfeeding: • different type of suck so there is the potential for suck confusion. • harder to recognise feeding cues. • babies tend to feed less often. • can reduce the time at the breast and decrease milk supply. The facility does not provide dummies in the postnatal areas.

[1] Howard CR, Howard FM, Lanphear B, et al. Randomized clinical trial of pacifier use and bottle-feeding or cupfeeding and their effect on breastfeeding. Pediatrics 2003;111:511–518.

[2] International Code of Marketing of Breast-milk Substitutes. Geneva: World Health Organization; 1981 (http://www.who.int/nutrition/publications/code_english.pdf, accessed 7 March 2018).

[3] The International Code of Marketing of Breast-Milk Substitutes – 2017 update: frequently asked questions. Geneva: World Health Organization; 2017 (http://apps.who.int/iris/bitstream/10665/254911/1/WHO-NMHNHD-17.1-eng.pdf?ua=1, accessed 7 March 2018).

[4] World Health Organization. Code and subsequent resolutions (http://www.who.int/nutrition/netcode/resolutions/en/, accessed 7 March 2018).

[5] See Appendix 3.

Personnel Interviews

The Senior Midwife Postnatal Can:

- Personnel have the clinical skills to assist mothers to use alternative feeding methods, other than artificial teats and bottles, when they are required.
- confirm the facility does not provide dummies to mothers who request them for use in the postnatal unit.

At Least 80% of Group 1 Personnel Can:

- assist mothers to use alternative feeding methods, other than artificial teats and bottles, when they are required.
- describe the factors that need to be taken into account when counselling a breastfeeding mother on the best method for feeding her baby with EBM or a supplement
- explain why dummy use is not recommended while breastfeeding is being established.

Antenatal Interviews

At Least 80% of Pregnant Women Interviewed Can:

- explain why dummy use is not recommended while breastfeeding is being established.

Mother Interviews

At Least 80% of Mothers who are Breastfeeding and whose Babies are not in Special Care Can:

- explain why dummy use is not recommended while breastfeeding is being established.
- report that, if their babies have been fed other than at the breast, they were counselled on the use, risks and benefits of the feeding method used.
- breastfeeding mothers are counselled on the use and risks of feeding bottles, teats and pacifiers/dummies.

At Least 80% of Mothers Can:

- explain why dummy use is not recommended for a baby who is feeding from the breast, while breastfeeding is being established.

Step 10: Coordinate Discharge so that Parents and their Infants Have Timely Access to Ongoing Support and Care

Rationale

Mothers need sustained support to continue breastfeeding. Contemporary maternity care models mean more mothers are discharged early, often before breastfeeding is established. The facility should have processes in place to ensure mothers have the minimal skills to breastfeed prior to discharge, are given additional feeding support as soon as possible after discharge from the service, and know where to seek assistance in the interim. Breastfeeding support is especially critical in the succeeding days and weeks, for early identification and problem solving of breastfeeding challenges that may occur. The mother will encounter several different phases in her production of breast milk, her baby's growth and her own circumstances (e.g. going back to work or school), in which she will need to expand her knowledge and skills and additional support may be needed. Receiving timely support after discharge is essential in maintaining breastfeeding rates. Maternity facilities must know about and refer mothers to the variety of resources that exist in the community.

Implementation

As part of protecting, promoting and supporting breastfeeding, discharge from inpatient care should be planned for and coordinated, ensuring parents and their babies have access to ongoing support. Facilities need to provide appropriate referrals to lactation-support resources to ensure that mothers and babies are seen 2 to 4 days after birth and again in the second week, by a skilled breastfeeding support person who can assess feeding and give the support needed. Mothers who are artificially feeding similarly need to be seen with their babies by an appropriately skilled support person.

Follow-up care is especially crucial for preterm and low-birth-weight babies. Ongoing support from appropriately skilled professionals is needed.

Printed and/or online information can be useful to provide contacts for support, but this should not substitute for active follow-up care by a skilled professional.

The key to the fulfilment of Step 10 is ensuring ongoing support for mothers and babies when they transition from inpatient care to community-based support and services. The facility has procedures which facilitate this transition so that mothers and babies have continued access to skilled help with infant feeding concerns and challenges.

The facility should maintain contact with the groups and individuals providing the support as much as possible, and invite them to the facility where feasible.

Implementation Standards

After Discharge Care
After discharge care is discussed with the mother and written information is provided about both health services and mother/peer support. Mothers are referred to services at the facility or in the community for ongoing management after discharge from the facility's care.

Personnel Interviews
The Senior Midwife Postnatal Can: • describe the infant feeding support groups and follow-up services available in the local area or from the hospital and explain how mothers are encouraged to access these. • describe how the facility works with and includes the local breastfeeding support groups and services.

At Least 80% of Group 1 Personnel can:

- describe how women made aware of community peer support at discharge

Mother Interviews

Mothers are interviewed on this Step only if their babies are 24 or more hours old (48 hours if caesarean or if documented maternal medical reason), whether or not they are breastfeeding.

At Least 80% of Mothers Interviewed Can:

- identify at least two support groups and/or services where they could get help with feeding their baby after discharge from the facility.

Observations

The review of the documents and clinical pathways indicates that written information is distributed to mothers before discharge on where and how they can find help with infant feeding after returning home.

Achieving Accreditation

Conclusion of the assessment
On completion of the assessment a suitable time will be arranged with the BFHI Coordinator so the Assessors can formally conclude the assessment. This is usually on the afternoon of the second day. This informal session will allow the BFHI Coordinator and any other relevant key maternity staff to ask questions and/or add any further information. The assessment team will provide general results including achievements and Steps still needing further work; however, it is important to note that the assessment team cannot provide the outcome of the assessment.

The Assessment Report
The assessment team will submit a detailed assessment report, scoring booklet and any supporting documentation to the BFHI Manager with a recommendation regarding the facility's overall achievements. The assessment documents will undergo an independent review before the final accreditation decision is made.

Assessment Outcomes
Baby Friendly Accreditation
Once your facility has passed all 10 Steps it will receive the prestigious Baby Friendly Accreditation recognising excellence in the care of mothers, babies and their families.

Accreditation is awarded by the Chief Executive Officer of the Australian College of Midwives. Accredited facilities will receive an Accreditation Certificate to mark their achievement, as well as Baby Friendly accredited logos to use on resources and webpages. Your status will be recorded in our online awards chart and your achievement will be announced and celebrated online and at our large Annual Conference.

The initial accreditation typically lasts for three years. Although no formal assessment will take place during this time, services are expected to continue to collect infant feeding statistics and audit their implementation of the standards. Facilities should submit their bi-annual data to the Baby Friendly Health Initiative team as evidence that the standards are being maintained along with their Annual Interim Report.

Partial Re-accreditation Required
If the assessment and review indicate the facility has not yet met all the standards for each of the 10 Steps, the BFHI Manager will contact the BFHI Coordinator at the facility. A copy of the assessment report and scoring booklet will be provided with a letter detailing the recommendations and the expected time frame for implementation. Once the due date for the recommendations is reached, a partial re-assessment will occur, either by document review and/or by return visit to the facility. Only the criteria not achieved previously will be assessed during the partial re-assessment. A partial re-assessment by return visit will incur an additional cost of 40% of the original assessment cost.

Appeals Process
If the facility wishes to the appeal the outcome of the assessment, the appeal should be made in writing to the BFHI Manager within 14 days of receipt of the outcome.

Facility Feedback
After the assessment, the facility BFHI Coordinator is asked to complete an online survey to give feedback to the BFHI Manager on their experience of the assessment, the assessment team and the process, before, during and after the assessment. The aim of the survey is to gather information in order to help improve and refine the assessment process. Feedback may be communicated to the assessment team.

Accreditation Period
Accreditation is awarded for three years at which time the facility will need to undergo another full assessment to remain accredited.

Maintaining Accreditation
Once accredited, it is the facility's responsibility to ensure BFHI standards are maintained for the 3-year period of accreditation. The facility will be required to submit the facility's breastfeeding data and data on skin-to-skin contact including initiation of breastfeeding bi-annually to the Baby Friendly Health Initiative team as evidence that the standards are being maintained along with their Annual Interim Report.

Facilities are also be encouraged to complete an annual BFHI self-appraisal to track standards and should also conduct regular internal audits, although these documents will not be required to be submitted annually.

Re-Accreditation

Approximately three years after accreditation, a re-assessment will take place to ensure that all the standards from all 10 Steps are being maintained and to explore how the service is building on the good work it has already done.

Preparations for re-accreditation are the same process as for initial accreditation. Ensuring that a three-year action plan for BFHI requirements is developed and implemented on a rolling schedule will mean less stress and work in the lead up to re-accreditation.

Re-assessment will consist of interviews with mothers, staff and managers to establish how the standards are being maintained. Internal audit results and outcomes such as breastfeeding initiation, continuation, exclusive breastfeeding and supplementation rates (where applicable) will be reviewed.

Appendix 1: Definitions

Artificial Feeding
Baby being fed fully or predominantly with breastmilk substitutes, including infant formula.

Assessors
Assessors and Lead Assessors are individuals who have completed a training program specific to the role and have met the requirements to conduct BFHI assessments on behalf of the Australian College of Midwives. The Lead Assessor takes the leadership role in assessments and has extra responsibilities beyond the Assessor role. Trainee Assessors are individuals who have completed a training program specific to the assessor role and are required to undertake a mentored practicum in order to meet the requirements to conduct BFHI assessments on behalf of the Australian College of Midwives. Trainee Assessors can be used as additional members of the assessment team after appropriate mentoring and supervision.

Bottle Feeding
Baby receiving any food or drink, including breastmilk, from a bottle.

Breastfeeding at Discharge from Facility
Baby was fully or partially breastfeeding or breastmilk-fed (including expressed or donor milk) at time of discharge. Includes breastfed babies having supplementary feeds.

Breastfeeding Initiated
Baby received at least one feed of colostrum or breastmilk.

Breastfeeding Mothers
Mothers who are breastfeeding their babies, or expressing and breastmilk feeding.

Breastfeeding Support and Services
Mother support includes groups such as the Australian Breastfeeding Association (ABA) or other mother-to-mother/peer groups who have members educated in how to provide breastfeeding support. Services include all services which have staff/members appropriately educated in how to provide breastfeeding support. This could include lactation consultants, breastfeeding clinics, telephone support such as ABA or 24-hour help lines, staff at the maternity facility, maternal and child health services.

Breastmilk Substitute
Any food being marketed or otherwise represented as a partial or total replacement for breastmilk whether or not it is suitable for that purpose.

Complementary Feeding
This term is widely used in the WHO Global Strategy for Infant and Young Child Feeding, and other international documents, to indicate the feeding of solid foods. Therefore, for BFHI purposes including data collection, fluid feeds given to breastfed babies are called supplementary feeds. See also the definition of supplementary feeding.

Discharged from the Facility
For hospital assessment purposes, including interviews with mothers, women are deemed to be "discharged from the facility" when they leave inpatient care. For BFHI pre-assessment data collection, mothers and babies are deemed to be "discharged from the facility" when they are discharged from domiciliary/midwifery care, or two weeks after leaving inpatient care, whichever is the sooner.

Domiciliary Care
For BFHI purposes, this definition includes ongoing care provided by the facility's staff in the mother's home, a hotel or similar setting, to a maximum of 14 days. For example, "Midcall", "Hospital in the Home", "Midwifery in the Home", "Extended Midwifery Service" or "Domiciliary Midwifery Care". Re-admissions, outpatient breastfeeding clinics and domiciliary services contracted to other providers are not included.

Exclusive Breastfeeding from Birth to Discharge
Baby received only breast milk, including expressed or from a wet nurse or breast milk donor. Prescribed vitamins/minerals, medicines permitted. No other liquids or foods.

Facility
For BFHI purposes, "facility" means the entity which is preparing for accreditation or being assessed. It is usually a hospital but may be another type of facility which provides maternity services. The assessment of a facility includes all areas which may be accessed by pregnant women or mothers who are breastfeeding, or which may provide care for infants or children who are breastfeeding. A facility may have more than one site. For definitions of facility classifications please visit the Australian Institute of Health and Welfare website for the Rural, Remote and Metropolitan Areas (RRMA) classification.
http://www.aihw.gov.au/home

Hands-off Techniques
Techniques used to empower mothers by teaching them to correctly position and attach their babies for breastfeeding, without the staff member touching the mother or baby, or doing it for them. It is recognised that individual care takes priority and these techniques are not applicable to every situation.

Mixed Feeding
A combination of both breastfeeding and feeding with breastmilk substitutes.

Nursery (Well Baby Nursery)
For BFHI purposes, this includes any area where well newborn babies are cared for when separated from their mothers. It includes being cared for at the postnatal ward nursing desk or station, or a Special Care Nursery being used for well babies.

Rooming-In
Babies are with their mothers (or mother's partner or support person) 24 hours per day from birth to discharge from inpatient care except when there is a justifiable reason that necessitates separation. The time and the reason/circumstances of all separations are documented.

Samples/Supplies
For BFHI purposes, samples/supplies refer to free or subsidised (low cost) products within the scope of the WHO International Code. BFHI facilities may not accept or distribute such samples or supplies. Samples are single or small quantities of a product provided without cost, but not including products purchased by the facility and provided to mothers for immediate use within the facility. Supplies are quantities of a product provided for use over an extended period.

Skin-to-Skin Contact
The baby is naked, or wears only a nappy and is prone on the mother's naked chest/ abdomen with the baby's head between her breasts. Mother and baby may then be covered appropriately in a way that does not restrict their interaction or the baby's innate feeding behaviours.

Special Care
For the purpose of interviewing mothers for BFHI assessments, Neonatal Intensive Care Unit (NICU) is included in the definition of Special Care.

Supervised Clinical Experience
Supervision should be undertaken by someone who is experienced and knowledgeable about evidenced based, contemporary breastfeeding practices consistent with BFHI standards. The supervised clinical experience can be acquired in a single session or cumulatively through direct or indirect supervised experience during a normal working day or simulated activities. It may include observation and or assisting with a particular practice e.g. breast expression, assisting with a breastfeed, discussing breastfeeding with pregnant women (antenatal clinic or booking-in), facilitation of skin to skin contact at birth and early initiation of breastfeeding as well as support provided to a non-breastfeeding mother.

Supplementary Feeding
A breastfed baby has been given one or more fluid feeds, including infant formula. For the purposes of BFHI data collection and for calculating exclusive breastfeeding rates, feedings of expressed breastmilk are not considered a supplementary feeding. See also the definition of complementary feeding.

Supplement Rate
The percentage of babies who have been given infant formula or other fluids by mouth at least once between birth and discharge from the facility's inpatient care.

WHO International Code
In BFHI materials, "WHO International Code" means the WHO International Code of Marketing of Breast-milk Substitutes and the subsequent relevant WHA resolutions. Available at: http://ibfan.org/the-full-code.

WHO Global Criteria
The BFHI Australia standards for hospital assessment are based closely on, and incorporate, the revised WHO/UNICEF global standards for BFHI. Hospitals accredited by BFHI Australia are accredited to the standards of the Global Criteria.

Appendix 2: Ten Steps to Successful Breastfeeding in Lay Terms

	Hospitals Support Mothers to Breastfeed by…	Because…
1. Hospital Policies	• Making breastfeeding care standard practice • Not promoting infant formula, bottles or teats • Keeping track of support for breastfeeding	Hospital policies help make sure that all mothers and babies receive the best care
2. Staff Competency	• Educating staff on supporting mothers to breastfeed • Assessing staff knowledge and skills	Well-educated staff provide the best support for breastfeeding
3. Antenatal Care	• Discussing the importance of breastfeeding for babies and mothers • Preparing women on how to feed their baby	Most women are able to breastfeed with the right support
4. Care Right After Birth	• Encouraging skin-to-skin contact between mother and baby • Allowing babies to find the breast and breastfeed soon after birth	Mother and baby skin-to-skin helps breastfeeding get off to a good start
5. Support Mothers with Breastfeeding	• Checking positioning, attachment and suckling • Giving practical breastfeeding support • Helping mothers with common breastfeeding problems	Breastfeeding is natural, but most mothers need help at first
6. Not Supplementing	• Giving only breastmilk unless there are medical reasons • When a supplement is needed, donor human milk from a milk bank is first choice, infant formula is second choice • Helping mothers who want to formula feed do so safely	Giving babies infant formula in the hospital makes it hard to get breastfeeding going
7. Rooming-In	• Letting mothers and babies stay together day and night • Making sure that mothers of sick babies can stay near their baby	Mothers need to be near their babies to notice and respond to feeding cues
8. Responsive Feeding	• Helping mothers know when their baby is ready for a feed • Not limit on how often baby breastfeeds	Breastfeeding babies whenever they are ready helps everybody
9. Bottles, Teats, and Pacifiers	• Counselling mothers about the use and risks of feeding bottles and pacifiers/dummies	Bottles and dummies make it harder to get breastfeeding going
10. Discharge	• Referring mothers to community resources for breastfeeding support • Working with communities to improve breastfeeding support • support services	Learning to breastfeed takes time and support is needed

Appendix 3: Guidelines for Supplementary Feeding for the Healthy Term Breastfed Neonate[1,2]

This appendix is synthesised and summarised, as applicable to facilities in Australia, from the resources footnoted below. For further information and references please access these documents.

Personnel who make decisions or counsel mothers on supplementation of breastfed infants in a BFHI facility are required to be familiar with and implement these guidelines.

Preventing the Need for Supplementation

Many practices will prevent or reduce the need for supplementation, including:

- knowledgeable, competent and skilled staff.
- early initiation of breastfeeding or expression.
- postnatal counselling and support of mothers.
- early skilled evaluation and adjustments to positioning and attachment.
- rooming-in and careful attention to an infant's early feeding cues.
- increased skin-on-skin time to encourage more frequent feeding.
- responsive or baby-led feeding.
- gently rousing the sleepy infant to attempt frequent breastfeeds.
- teaching the mother hand expression of drops of colostrum.
- understanding that cluster feeding is normal newborn behaviour, but it warrants a feeding evaluation to ensure that the infant is attached deeply and effectively.
- using ten percent weight loss an indicator for infant evaluation, not necessarily an indicator for supplementation.

Possible Medical Indications for Supplementation in Healthy Term Infants (37–42 weeks)

In each case, a decision must be made as to whether the clinical benefits outweigh the potential negative consequences of such feedings.

1. Infant indications
    a. Hypoglycaemia, documented by laboratory blood glucose measurement or similar reliable measurement that is unresponsive to appropriate frequent breastfeeding or measures such as the application of a glucose gel inside of the infant's cheek. (It is acknowledged that this protocol is for healthy term infants. Protocols for e.g. babies of women with diabetes may be different.)
    b. Clinical or laboratory evidence of significant dehydration (e.g., high sodium, poor feeding, lethargy, etc.)
    c. Significant weight loss may be an indication of inadequate milk transfer or low milk production, but a thorough evaluation of infant feeding is required before automatically ordering supplementation. It should also be noted that excess newborn weight loss is correlated with positive maternal intrapartum fluid balance (received through intravenous fluids) and may not be directly indicative of breastfeeding success or failure.
    d. Delayed or inadequate bowel movements or continued meconium stools on day 5 may be an indication of inadequacy of breastfeeding. Newborns with more bowel movements

[1] Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeed Med. 2017;12)188–98. doi:10.1089/bfm.2017.29038.ajk.

[2] UNICEF/WHO. Baby Friendly Hospital Initiative, revised, updated and expanded for integrated care, Section 4, Hospital Self-Appraisal and Monitoring. 2006. Available at www.who.int/nutrition/topics/BFHI_Revised_Section_4.pdf (accessed November 21, 2016).

during the first 5 days following birth have less initial weight loss, earlier transition to yellow stools, and earlier return to birth weight.

e. Hyperbilirubinemia associated with poor breast milk intake despite appropriate intervention and marked by ongoing weight loss and limited stooling.
f. Macronutrient supplementation is indicated, such as for the rare infant with inborn errors of metabolism.

2. Maternal indications
   a. Delayed secretory activation [72–120 hours] with signs of inadequate intake by the infant.
   b. Primary glandular insufficiency as evidenced by abnormal breast shape, poor breast growth during pregnancy, and minimal indications of secretory activation.
   c. Breast pathology or prior breast surgery resulting in poor milk production.
   d. Certain maternal medications (e.g., chemotherapy, psychotherapeutic drugs, anti-epileptic drugs, long-lasting radioactive compounds).
   e. Intolerable pain during feedings unrelieved by interventions.
   f. Severe illness that prevents a mother caring for her infant, e.g. sepsis.

Recommendations

Address early indicators of the possible need for supplementation

All infants should be formally evaluated for position, latch, and milk transfer before the provision of supplemental feedings. This evaluation should be undertaken by a healthcare provider with expertise in breastfeeding management, when available.

Determine whether supplementation is required and supplement with care

1. Decisions should be made on a case-by-case basis
2. Parents should be fully informed of the benefits and risks of supplementation, parental decisions documented, and they should be supported after they have made an informed decision.
3. All supplemental feedings should be documented, including the content, volume, method of delivery, and medical indication or reason.
4. When supplementary feeding is medically necessary, the primary goals are to feed the infant and to optimize the maternal milk supply while determining the cause.
5. Supplementation should be performed in ways that help preserve breastfeeding such as:
   - limiting the volume to what is necessary for the normal newborn physiology
   - stimulating the mother's breasts with hand expression or pumping
   - allowing the infant continued access to the breast.
6. Optimally, mothers need to express milk frequently, usually once for each time the infant receives a supplement, or at least 8 times in 24 hours if the infant is not feeding at the breast.
7. Underlying factors should be addressed and mothers should be assisted with increasing their milk supply, latch, and confidence with assessing the signs that their infant is adequately fed.
8. A plan and criteria for stopping supplementation should be considered from the time the decision is made to supplement, and should be discussed with the parents.
9. It is important to closely follow up mother and infant.

Choice of Supplement

1. Expressed breast milk from the infant's mother is the first choice for extra feeding for the breastfed infant.
2. If the volume of the mother's own colostrum/milk does not meet her infant's feeding requirements and supplementation is required, donor human milk is preferable to other supplements.

3. When donor human milk is not available or appropriate, supplementation should be with infant formula
4. Supplementation with glucose water is not appropriate because it does not provide sufficient nutrition, does not reduce serum bilirubin, and might cause hyponatremia.

Volume of Supplemental Feeding

1. Unrestricted breastfeeding is the biological norm. Formula-fed infants usually take in larger volumes than breastfed infants, therefore may be overfed. The volume of supplementary feeds for breastfed infants should not be based on the intakes of formula fed infants.
2. The amount of supplement given should reflect the normal amounts of colostrum available, the size of the infant's stomach (which changes over time), and the age and size of the infant.
3. Based on the limited research available, suggested intakes for healthy, term infants are given in in the table below, although feedings should be based on infant cues.

Average Reported Intakes of Colostrum
by Healthy Term Breastfed Infants

Time (hours)	**Intake (mL/feed)**
First 24	2 - 10
24 - 48	5 - 15
48 - 72	15 - 30
72 - 96	30 - 60

Methods of Providing Supplementary Feedings

1. When supplementary feedings are needed, there are a number of delivery methods from which to choose: a supplemental nursing device at the breast, cup feeding, spoon feeding, finger-feeding, syringe feeding, or bottle feeding.
2. An optimal supplemental feeding device has not yet been identified, and may vary from one infant to another. No method is without potential risk or benefit.
3. When selecting an alternative feeding method, clinicians should consider several criteria:
    a. cost and availability
    b. ease of use and cleaning
    c. stress to the infant
    d. whether adequate milk volume can be fed in 20–30 minutes
    e. whether anticipated use is short- or long-term
    f. maternal preference
    g. expertise of healthcare staff
    h. whether the method enhances development of breastfeeding skills.
4. There is no evidence that any of these methods are unsafe or that one is necessarily better than the other. There is some evidence that avoiding teats/artificial nipples for supplementation may help the infant return to exclusive breastfeeding.

Resources

1. Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeed Med. 2017;12)188–98. doi:10.1089/bfm.2017.29038.ajk.
2. UNICEF/WHO. Baby Friendly Hospital Initiative, revised, updated and expanded for integrated care, Section 4, Hospital Self-Appraisal and Monitoring. 2006. Available at www.who.int/nutrition/topics/BFHI_Revised_Section_4.pdf (accessed November 21, 2016).

Appendix 4: Summary of the Care of the Mother who is Artificially Feeding her Baby

This appendix is simply extracted parts of Steps 1 to 10 that apply to the care of the mother who is artificially feeding her baby. These extracts are grouped together under a theme for convenience.

Support for mothers who are using breastmilk substitutes
The revised version of the *WHO Global Criteria* for BFHI now includes more specific criteria related to the care given to the mother who is artificially feeding her baby. The inclusion of these criteria does not mean that BFHI is promoting artificial feeding but, rather, that BFHI wants to help ensure that ***all*** mothers, regardless of feeding method, get the feeding support they need.
The criteria are integrated into the relevant Steps in the *Standards for Implementation of the Ten Steps to Successful Breastfeeding*, but for convenience are also copied in this Appendix so they can be reviewed as a whole.
Section 8 of the NHMRC Infant Feeding Guidelines[1] outlines the standard of care for artificial feeding in Australia and these standards are recommended for use in BFHI facilities. However, facilities may elect to use the WHO Guidelines[2], especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.
It should be noted that many of the requirements relating to the care of the mother who is artificially feeding her baby are applicable to ***all mothers who will be leaving the facility using infant formula***. Babies, who are not breastfed, or not fully breastfed, are at increased risk and it is just as important that their mothers are fully informed.

Step 1a
Policies for BFHI
The facility has a written policy or policies that support the implementation of BFHI, including:

- Breastfeeding policy and a summary for display
- Implementation of the *WHO International Code*
- Support for staff to continue to breastfeed when they return to work
- Standards of care for the mother who is artificially feeding her baby

Standards of care for the mother who is artificially feeding her baby
There is a policy which addresses standards of care for the mother who is artificially feeding her baby. This may be a separate policy or integrated into an infant feeding policy which refers to it.

The policy includes each of the following points:

- Relevant personnel[3] have received education to ensure that their knowledge about artificial feeding is current.
- Relevant personnel have the skills to teach mothers correct preparation, storage and handling of powdered infant formula[4].
- Mothers who are considering artificial feeding are supported to make a fully informed choice, appropriate to their circumstances.

[1] Infant Feeding Guidelines, Section 8. *National Health and Medical Research Council* (NHMRC) 2012

[2] WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization 2007*; How to Prepare Formula for Bottle-Feeding at Home. *World Health Organization* 2007.

[3] Personnel refers to all persons engaged in relevant activities, not just those who the facility defines as "staff".

[4] Infant Feeding Guidelines for Health Workers, Section 8. *National Health and Medical Research Council (NHMRC)* 2012.

- All mothers who will be leaving the facility using infant formula are given:
    - information and instruction on the safe preparation, storage and handling of reconstituted powdered infant formula, using NHMRC Guidelines[1],
    - information on the risks to the baby if the preparation and handling instructions are not followed carefully;
    - a demonstration and supervised practice in making up a bottle-feed using powdered infant formula;
    - information on where to get help with infant feeding after discharge from the facility.
- Instruction on artificial feeding is given only to parents who require it. The instruction is conducted privately, away from breastfeeding mothers, and is not in a group situation.
- Instructional materials on artificial feeding shown or given to parents are free from advertising, do not refer to or contain images of an identifiable product, and comply with the *WHO International Code*.

Step 2
Group 1 BFHI Education and Competency Requirements
Over the previous 3 years, all Group 1 personnel[1] who have been at the facility for six months or more have had a minimum of 8 hours of competency based in-service education, including updates and revision where applicable. It is recommended the updates and revision are spread over the previous 3 years.
The content delivery of the education is flexible. Group 1 personnel in a *Baby Friendly* facility should have the following knowledge and competencies:

- The facility's policy and key clinical practices (Steps 3-10). The key clinical practices should cover the 20 Core Competencies listed in this Step.
- *Guidelines for Supplementary Feeding for the Healthy Term Breastfed Neonate* (Appendix 3)
- Providing optimal support to all mothers who will be leaving the facility using infant formula (Appendix 4).
- The facility's and personnel's responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.

Group 2 BFHI Education Requirements and Curriculum
Over the previous 3 years, Group 2 personnel have had education in the following knowledge and competencies:

- The facility's policy and key clinical practices (Steps 3-10) with a focus on:
    - Protocols related to step 4, skin to skin (only if birthing within scope of practice)
    - Why breastfeeding is important
    - Ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
    - How to assist the mother to make a fully informed and appropriate decision about infant feeding, suitable to her circumstances.
- *Guidelines for Supplementary Feeding for the Healthy Term Breastfed Neonate* (Appendix 3) (Note: not required if making decisions about infant formula supplementation is outside the scope of practice of the person being interviewed.)
- The facility's and health workers' responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.

Step 4
When the mother is not planning to initiate breastfeeding
If the mother is not planning to breastfeed, the skin-to-skin contact should continue uninterrupted for at least an hour after birth. If the mother insists on terminating it earlier, e.g. because the baby shows an unwelcomed interest in breastfeeding, this is acceptable. The time and reason should be documented.

[1] The NHMRC Infant Feeding Guidelines outline the standard of care for artificial feeding in Australia and are recommended for use in BFHI facilities. However, facilities may elect to use "WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization* 2007", especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

Mother interviews
Unless a medically indicated procedure was required:

- at least 80% of the mothers who are interviewed, whether or not they intended to breastfeed, confirm that the baby was immediately placed skin-to-skin as per the standards for this step.

Of those who did not intend to breastfeed, at least 80% of mothers, unless a medically indicated procedure was required, can:

- confirm the baby stayed skin-to-skin without interruption for at least an hour, unless earlier separation was at mother's request, which was documented.

Step 6
Care of mothers who are artificial feeding
Mothers who are considering artificial feeding are supported to make a fully informed and appropriate decision about infant feeding, suitable to their circumstances.
The following standards apply to all mothers who will be leaving the facility using infant formula, including mothers who are artificial feeding, mothers who are mixed feeding, and mothers who have been advised or have chosen to give their baby infant formula as a supplement or pre-lacteal feed.

All mothers who will be leaving the facility using infant formula are given:

- information and instruction on the safe preparation, storage and handling of reconstituted powdered infant formula, using NHMRC Guidelines[1].
- information on the risks to the baby if the preparation and handling instructions are not followed carefully.
- a demonstration and supervised practice in making up a bottle-feed using powdered infant formula[2];
- information on the importance of ensuring the correct concentration by following the instructions on the can exactly, regarding water volume and scoops of powder, and are made aware that these will be different for each brand of formula.
- information on best practice for feeding their babies with a bottle, including paced bottle-feeding.
- information on where to get help with infant feeding after discharge from the facility.

Instruction is given only to parents who need it; there is no group instruction; it is done privately, away from breastfeeding mothers. If the mother's condition prevents this instruction, it can be given to another family member instead.
Parents with low literacy skills or from a non–English speaking background may need extra help to be sure they have the required skills and understanding of the risks.
Materials on artificial feeding which are shown or given to parents are free from advertising, do not refer to or contain images of an identifiable product, and comply with the *WHO International Code*.

<u>Mother interviews (artificial feeding)</u>
At least 80% of mothers who have been feeding their babies with infant formula for at least 24 hours (or whose babies are at least 48 hours old if caesarean birth or there is a documented maternal medical reason) can:

- report that the various feeding options were discussed with them and they were helped to decide what was suitable in their situations.
- confirm they have been given individual education about making up a bottle-feed using powdered infant formula.

[1] Infant Feeding Guidelines, Section 8. *National Health and Medical Research Council (NHMRC)* 2012. See appendix 4.
The NHMRC Infant Feeding Guidelines outline the standard of care for artificial feeding in Australia and are recommended for use in BFHI facilities. However, facilities may elect to use "WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization* 2007", especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

[2] If liquid infant formula (ready-to-feed) is used in the facility, arrangements must be made to have powdered formula available for teaching reconstitution, even if it is discarded after preparation. The NHMRC Guidelines are clear that health workers must know how to demonstrate the preparation of infant formula and have a responsibility to check that it is being prepared according to instructions.

- confirm they have made up a bottle-feed using powdered infant formula under supervision, or have been offered the opportunity to do so.

- adequately answer questions about:
  - making up and using powdered infant formula to feed their babies.
  - the risks to the baby if the preparation and handling instructions are not carefully adhered to.
  - how to feed a baby with a bottle.

Personnel interviews

The Senior Midwife Postnatal:

- can state at least two of the Indications for Supplementation in Healthy Term Infants and one practice that can help prevent the need for supplementation[1].
- confirms that mothers who will be leaving the facility using infant formula are given instruction and supervised practice on the reconstitution of powdered infant formula and how to bottle-feed.
- describe what should be considered when determining where and how instruction on the preparation of infant formula is given on the postnatal ward.

The Senior Nurse / Midwife or NUM Special Care / NICU:

- confirms that eligible preterm babies and other vulnerable newborn infants that cannot be fed their mother's own milk are fed with donor human milk (only asked when donor human milk from a milk bank is available at the facility)

At least 80% of personnel from group 1 can:

- state at least two of the Indications for Supplementation in Healthy Term Infants and one practice that can help prevent the need for supplementation[2].
- outline ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
- outline key safety and hygiene points that should be covered when instructing reconstitution of powdered infant formula.
- describe briefly the key issues to be covered when instructing a mother on how to feed her baby with a bottle.

At least 80% of personnel from group 2 can:

- state at least two of the Indications for Supplementation in Healthy Term Infants and one practice that can help prevent the need for supplementation. *(Not asked if making decisions about using infant formula is outside the role of the person being interviewed)*
- outline ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
- briefly describe what should be discussed with a breastfeeding mother who is considering feeding her baby with infant formula, including the potential risks.

NHMRC Infant Feeding Guidelines

For your convenience, the following boxed information and table are reproduced, with NHMRC permission, from the *Infant Feeding Guidelines* – Section 8. *National Health and Medical Research Council (NHMRC)* 2012.

It is important to note that all group 1 personnel should be familiar with the whole of Section 8 (pages 73-83) of the *NHMRC Infant Feeding Guidelines* 2012.

[1] See: Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeed Med. 2017;12)188–98. doi:10.1089/bfm.2017.29038.ajk.

[2] See: Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeed Med. 2017;12)188–98. doi:10.1089/bfm.2017.29038.ajk.

8.2 NHMRC Health workers and infant formula

Health workers have a responsibility to promote breastfeeding first but, where it is needed, to educate and support parents about formula feeding. Some mothers may experience feelings of grief or loss if they decide not to breastfeed. A mother's informed decision not to breastfeed should be respected and support from a health worker and/or other members of the multidisciplinary team provided.

This responsibility is outlined in the *WHO International Code* and the *Australia New Zealand Food Standards Code*.

Under the *WHO International Code*:

- feeding with infant formula should only be demonstrated by health workers, or other community workers if necessary, and only to the mothers or family members who need to use it
- the information given should include a clear explanation of the hazards of improper use.

Chapter 10 [of the NHMRC Infant Feeding Guidelines] provides more information on the *WHO International Code* and its implementation in Australia. Under Standard 2.9.1 of the *Australia New Zealand Food Standards Code*, labels of infant formula products must contain a statement that a doctor or health worker should be consulted before deciding to use the product. Health workers are seen by the public as the main source of advice on infant feeding and are well placed to advise mothers and carers, regardless of the feeding option they have chosen for their infant.

For mothers who do not breastfeed, or do so only partially, advice should include:

- that a suitable infant formula should be used until the infant is 12 months of age
- the cost of formula feeding
- the hazards of improper formula preparation and storage.

8.3 NHMRC Preparing infant formula

Safe bottle-feeding depends on a safe water supply, sufficient family income to meet the costs of continued purchase of adequate amounts of formula, effective refrigeration, clean surroundings and satisfactory arrangements for sterilising and storing equipment. Tap water is preferred for preparing infant formula (consistent with the *Australian Dietary Guidelines).* All tap water used to prepare infant formulas should be boiled and cooled according to the instructions on the formula package label. Bottled water (but not sparkling mineral water or soda water) can be used to prepare formula if unopened, but it is not necessary.

As health workers are the only group authorised to demonstrate infant formula feeding, it is essential that they show the correct methods and monitor methods regularly. Parents without literacy skills or from a non–English speaking background may need extra help to make sure bottle-feeding is done safely.

Table 8.1: NHMRC Preparation of infant formula
• Always wash hands before preparing formula and ensure that formula is prepared in a clean area. • Wash bottles, teats, caps and knives – careful attention to washing is essential – and sterilise by boiling for 5 minutes or using an approved sterilising agent (see Section 8.3.3). • Boil fresh water and allow it to cool until lukewarm. To cool to a safe temperature, allow the water to sit for at least 30 minutes. In places with clean water supply which meets Australian standards, hot water urns such as hydro boils are safe to use for formula reconstitution, provided the supply of very hot water has not been depleted. • Ideally prepare only one bottle of formula at a time, just before feeding. • Always read the instructions to check the correct amount of water and powder as shown on the feeding table on the back of the pack. This may vary between different formulas • Add water to the bottle first, and then powder. • Pour the correct amount of previously boiled (now cooled) water into a sterilised bottle. • Always measure the amount of powder using the scoop provided in the can, as scoop sizes vary between different formulas. • Fill the measuring scoop with formula powder and level off using the levelling device provided or the back of a sterilised knife. The scoop should be lightly tapped to remove any air bubbles. • Take care to add the correct number of scoops to the water in the bottle. Do not add half scoops or more scoops than stated in the instructions. • Keep the scoop in the can when not in use. Do not wash the scoop as this can introduce moisture into the tin if not dried adequately. • Place the teat and cap on the bottle and shake it until the powder dissolves. • Test the temperature of the milk with a few drops on the inside of your wrist. It should feel just warm, but cool is better than too hot. • Feed infant. Any formula left at the end of the feed must be discarded. • A feed should take no longer than 1 hour. Any formula that has been at room temperature for longer than 1 hour should be discarded. • Formula that has been at room temperature for less than 1 hour may be stored in a refrigerator for up to 24 hours (in a sterile container). Discard any refrigerated feed that has not been used within 24 hours. • When a container of formula is finished, throw away the scoop with the container, to ensure that the correct scoop is used next time.

Appendix 5: Summary of WHO International Code Compliance Standards

This appendix includes the Aim and the Scope of the *WHO International Code of Marketing of Breast-milk Substitutes* and brings together, for convenience, all aspects of compliance with the Code which are included in the standards for implementation of the *Ten Steps to Successful Breastfeeding*.

Aim: the aim of the *WHO International Code* is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, including infant formula, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

Scope: the *WHO International Code* applies to the marketing, and practices related thereto, of the following products: breastmilk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breastmilk; feeding bottles and teats. It also applies to their quality and availability, and to information concerning their use.

Step 1a
Policies for BFHI
The facility has a written policy or policies that support the implementation of BFHI, including:

- Breastfeeding policy and a summary for display
- Implementation of the *WHO International Code*
- Support for staff to continue to breastfeed when they return to work
- Standards of care for the mother who is artificially feeding her baby

Policy
There is a policy which protects breastfeeding by addressing implementation of the *WHO International Code*. This may be a separate policy that the breastfeeding policy refers to, or be an integrated part of the breastfeeding policy. The policy includes each of the following points:

- Adherence by the facility and its personnel to the relevant provisions of the *WHO International Code* and subsequent World Health Assembly (WHA) resolutions.
- All promotion of artificial feeding and materials which promote the use of infant formula, feeding bottles and teats is prohibited.
- The facility is not permitted to receive or distribute free and subsidised (low cost) products within the scope of the *WHO International Code*.
- The distribution to parents of take home samples and supplies of infant formula, bottles and teats is not permitted.
- There are restrictions on access to the facility and personnel by representatives from companies in relation to marketing or distributing infant formula products or equipment used for artificial feeding.
- There is no direct or indirect contact of these representatives with pregnant women or mothers and their families.
- The facility does not accept free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events from these companies if there is any association with artificial feeding or potential promotion of brand/product recognition in relation to infant feeding.
- There is careful scrutiny at the institutional level of any research which involves mothers and babies for potential implications on infant feeding or interference with the full implementation of the policy.

Implementation of Policy
The facility has no display of products covered under the *WHO International Code* or items with logos of companies that produce breast-milk substitutes, feeding bottles and teats, or names of products covered under the Code. Nor are these items displayed.
Materials covered under the WHO International Code or which are unsupportive of breastfeeding, or contradict exclusive breastfeeding for around 6 months as the norm, are not used, displayed or distributed to parents, except informational materials given individually to parents who are artificially feeding.
If the facility has retail outlets/kiosks on site, the facility has endeavoured to restrict or minimise the promotion and/or sale of materials that are unsupportive of breastfeeding and/or inconsistent with BFHI. It is recognised that the influence of the facility may be limited when the retail outlets are not under its direct control.

Observations confirm that:
- infant formula and equipment for artificial feeding are stored discreetly and not openly displayed in the maternity and neonatal areas.
- the facility has adequate space and necessary equipment to give individual instruction on how to prepare formula away from breastfeeding mothers.
- there are no materials being used, distributed or displayed to parents, which are unsupportive of breastfeeding, with the exception of informational material given individually to parents who have chosen to artificially feed their baby.
- there are no educational materials or literature used, displayed or distributed to parents, produced by a company which markets or distributes infant formula products or equipment used for artificial feeding.
- there are no educational materials or literature used, displayed or distributed to parents, which picture or refer to a propriety product that is within the scope of the WHO International Code.

All educational materials including videos/DVDs, handouts and sample bags/gifts which are shown to, made available and/or distributed to pregnant women, new parents or their families are made available for the Assessors to review.

Review of these materials confirms that they are free of:
- promotion of artificial feeding, bottles, teats and dummies and contain no samples or redeemable vouchers for these products.
- information or articles which normalise artificial feeding.
- advertisements or promotion of infant, follow-on or toddler formula.
- advertisements or promotion of equipment for artificial feeding including bottles and teats.
- samples or coupons for products within the scope of the WHO International Code.
- samples or coupons for baby foods.
- information which contradicts exclusive breastfeeding for around 6 months as the norm.
- recommendations for scheduled feeds.
- advertisements for dummies.

Purchase of breastmilk substitutes, teats, bottles or dummies
The facility and its personnel do not accept or distribute to mothers free or subsidised (low cost) samples or supplies of breastmilk substitutes, teats, bottles or dummies. Records and receipts indicate that breastmilk substitutes including special formula and other supplies required for artificial feeding are purchased through normal procurement channels, or are brought in by parents for feeding their own infants.

Personnel Interviews
At least 80% of the group 1 and 2 personnel can:
- explain at least two elements of the WHO International Code.

Step 2

Group 1 BFHI Education and Competency Requirements

Over the previous 3 years, all Group 1 personnel[1] who have been at the facility for six months or more have had a minimum of 8 hours of competency based in-service education, including updates and revision where applicable. It is recommended the updates and revision are spread over the previous 3 years.

The content delivery of the education is flexible. Group 1 personnel in a *Baby Friendly* facility should have the following knowledge and competencies:

- The facility's policy and key clinical practices (Steps 3-10). The key clinical practices should cover the 20 Core Competencies listed in this Step.
- *Guidelines for Supplementary Feeding for the Healthy Term Breastfed Neonate* (Appendix 3)
- Providing optimal support to all mothers who will be leaving the facility using infant formula (Appendix 4).
- The facility's and personnel's responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.

Group 2 BFHI Education Requirements and Curriculum

Over the previous 3 years, Group 2 personnel have had education in the following knowledge and competencies:

- The facility's policy and key clinical practices (Steps 3-10) with a focus on:
    - Protocols related to step 4, skin to skin (only if birthing within scope of practice)
    - Why breastfeeding is important
    - Ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
    - How to assist the mother to make a fully informed and appropriate decision about infant feeding, suitable to her circumstances.
- The facility's and health workers' responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.

Step 3

The antenatal service complies with the relevant provisions of the *WHO International Code* and does not promote artificial feeding or products used for this purpose.

All educational materials, handouts or sample bags available and/or distributed to antenatal women are made available for the assessors to review and are free of promotion of artificial feeding.

Step 6

Instruction is given only to parents who need it; there is no group instruction; it is done privately, away from breastfeeding mothers. If the mother's condition prevents this instruction, it can be given to another family member instead.

Materials on artificial feeding which are shown or given to parents are free from advertising, do not refer to or contain images of an identifiable product, and comply with the *WHO International Code*.

[1] The NHMRC Infant Feeding Guidelines outline the standard of care for artificial feeding in Australia and are recommended for use in BFHI facilities. However, facilities may elect to use "WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization* 2007", especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

NHMRC Infant Feeding Guidelines

8.2 NHMRC Health workers and infant formula
Health workers have a responsibility to promote breastfeeding first but, where it is needed, to educate and support parents about formula feeding. Some mothers may experience feelings of grief or loss if they decide not to breastfeed. A mother's informed decision not to breastfeed should be respected and support from a health worker and/or other members of the multidisciplinary team provided. This responsibility is outlined in the *WHO International Code* and the *Australia New Zealand Food Standards Code*. Under the *WHO International Code*: • feeding with infant formula should only be demonstrated by health workers, or other community workers if necessary, and only to the mothers or family members who need to use it • the information given should include a clear explanation of the hazards of improper use. Chapter 10 [of the NHMRC Infant Feeding Guidelines] provides more information on the *WHO International Code* and its implementation in Australia. Under Standard 2.9.1 of the *Australia New Zealand Food Standards Code*, labels of infant formula products must contain a statement that a doctor or health worker should be consulted before deciding to use the product. Health workers are seen by the public as the main source of advice on infant feeding and are well placed to advise mothers and carers, regardless of the feeding option they have chosen for their infant. For mothers who do not breastfeed, or do so only partially, advice should include: • that a suitable infant formula should be used until the infant is 12 months of age • the cost of formula feeding • the hazards of improper formula preparation and storage.

Guidance on internal auditing for implementation of the WHO International Code implementation in a BFHI facility

When reviewing activities, materials, handouts and sample bags, facilities should be guided by the intent behind the *WHO International Code* and its implementation in BFHI facilities, rather than trying to make a strict interpretation of the wording of the Code. The intent is to protect pregnant women, mothers and their families from materials and practices that may impact adversely on the establishment and continuation of exclusive breastfeeding. Code compliance also serves to protect the reputation and image of the facility, its Baby Friendly accreditation and indirectly BFHI itself.

Facilities are advised to be cautious about permitting products, posters or literature from companies that produce items within the scope of the *WHO International Code*. Companies which market infant formula and equipment used for artificial feeding stand to gain a commercial advantage by association with a maternity facility; it can be perceived by parents as an endorsement. They also have a commercial interest in gaining brand/product recognition by parents, for example on 'free' products such as baby care items, or printed literature/posters that feature a logo or brand.

If sample bags are distributed by the facility, it is recommended that they are checked monthly and that completion of this monthly audit is documented. Try to review the contents through the eyes of new parents and ask how their infant feeding decisions and practises might be influenced. For example:

- A sample of baby food labelled 4-6 months, given to parents of a newborn infant in a hospital sample bag, may undermine exclusive breastfeeding to 6 months. It may also serve to advertise the company that also produces infant formula.

- A poster on baby massage featuring the logo of a company that manufactures products within the scope of the Code. The poster has lots of photos of beautiful and healthy mothers and babies and may associate the company or brand with 'good health' and the company's benevolence, creating a subconscious positive association with that company.
- Breastfeeding information which focuses only on the negatives may affect the confidence of a pregnant woman or new mother.
- Advertisements for 'breastfeeding equipment' (such as breast pumps) that over-emphasise the need for various products are inappropriate.
- Direct advertising of artificial feeding equipment assists in portraying bottle-feeding as a normal activity.

If such logos, products, posters, or literature are observed during a BFHI assessment, the assessors would take into account risk vs. benefit to parents and babies.

Appendix 6: Monitoring and Quality Improvement

This Appendix has been extracted and put together from two related documents:

Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2018. *https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf*.

Appendix: Indicators for monitoring. Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2018. https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018-appendix.pdf

Monitoring

Suggested options that can be used as indicators for facility-based monitoring of the key practices are listed in Table 1 and Table 2 at the end of this Appendix. Two of the indicators, early initiation of breastfeeding and exclusive breastfeeding, are considered "sentinel indicators". All facilities should routinely track these two sentinel indicators for each mother–infant pair. Recording of information on these sentinel indicators should be incorporated into the medical records and collated into relevant registers.

The group or committee that coordinates the BFHI related activities within a facility needs to review progress at least every 6 months. During concentrated periods of quality improvement, monthly review is needed. The purpose of the review is to continually track the values of these indicators, to determine whether established targets are met, and, if not, plan and implement corrective actions. In addition, if the facility has an ongoing system of maternal discharge surveys for other quality-improvement/quality assurance assessments, and it is possible to add question(s), one or both indicators could be added for additional verification purposes or periodic checks. Additional process indicators for monitoring adherence to the key clinical practices are also recommended. These indicators are particularly important during an active process of quality improvement and should be assessed monthly during such a process. Once acceptable levels of compliance have been achieved, the frequency of data collection on these additional indicators can be reduced, for example to annually. However, if the level of the sentinel indicators falls below the national standard, it will be important to assess both the clinical practices and all management procedures, to determine where the bottlenecks are and what needs to be done to achieve the required standards.

The suggested indicators do not cover all of the standards outlined in the Ten Steps because of the need to keep the monitoring system as simple as possible. Individual facilities could include additional indicators where feasible. Two alternative methods for verification are proposed – newborn registries and maternal discharge surveys (which could be done in a written or oral way or via a cell phone [SMS]). Facilities are not expected to use both methodologies at the same time. Depending on what other monitoring systems facilities are using, either may be more practical and feasible.

The frequency of data collection will depend on the method of verification. For example, if questions are added to maternal discharge surveys that are already ongoing, the periodicity will, by default, be a function of the periodicity of the ongoing survey. If the information is collected through newborn registries and the registries are already being reviewed to collect data on the sentinel outcome indicators, collection of data on the key clinical practices for all newborn infants is recommended. Alternatively, a sample of registries could be reviewed every 6 months to collect this information, to reduce the burden of abstracting, summarising and reviewing large amounts of data from the registries. If a new system of maternal discharge surveys is put into place, a minimum periodicity of every 6 months is needed. However, monitoring needs to be streamlined and manageable within the facilities' existing resources.

Thus, to the extent possible, it is best to not implement new methods of data collection, unless necessary or for periodic purposes of verification. The same goes for the amount of data collected; more is not necessarily better if systems are not in place to analyse and use the information to improve breastfeeding support. For the key clinical practice indicators (Steps 3 – 10), monitoring is best if based on maternal report. Collection of data for some indicators could be done through electronic medical records or from paper reports on each mother–infant pair, but runs the risk that personnel completing these records will over-report practices that they have been taught they are supposed to do.

Options for maternal data collection include:

- exit interviews with mothers (preferably by a person not directly in charge of their care);
- short paper questionnaires to mothers for confidential completion upon discharge;
- sending questions to the mother via SMS.

It is recommended that a minimum of 20 mother– infant pairs be included for each indicator, each time the data are reviewed, although small facilities may need to settle for a smaller number if 20 pairs are not available.

The global standards call for a minimum of 80% compliance for all process and outcome indicators, including early initiation of breastfeeding and exclusive breastfeeding. Each facility should attempt to regularly achieve at least 80% adherence (preferably more) on each indicator, and facilities that do not meet this target should focus on increasing the percentage over time.

Quality improvement

The process of changing health-care practices takes time. There are well-documented methods for implementing changes and building systems to sustain the changes once a specific goal has been reached. Quality improvement is a management approach that health professionals can use to reorganise care to ensure that patients receive good-quality health care[1]. Quality improvement can be defined as "systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups"[2].

Quality-improvement processes are cyclical and comprise the following steps: (i) planning a change in the quality of care; (ii) implementing the changes; (iii) measuring the changes in care practices and/or outcomes; and (iv) analysing the changed situation and taking further action to either further improve or maintain the practices. In the IHI model, these steps are called plan, do, study and act (PDSA) and are visualised in Fig. 3.

In the context of the BFHI, a PDSA cycle can be used to improve implementation of each of the Ten Steps. Application of the quality-improvement methodology is particularly important for steps that the facility has found especially difficult and for which the global standards have not been achieved. Once the desired level is achieved, the implementing team can focus on monitoring the performance of the sentinel indicators. The quality-improvement approach is very relevant for the BFHI, and countries are strongly encouraged to apply this approach. It helps to improve sustainability, since standard processes require fewer external resources or additional personnel. The BFHI-related aspects can be combined with other quality-improvement initiatives that are already ongoing in newborn health or maternal and child health at the facility.

Regardless of what model of quality improvement is used, some key principles of quality improvement are central:

[1] Improving the quality of hospital care for mothers and newborns: coaching manual. POCQI: point-of-care quality improvement. New Delhi: World Health Organization Regional Office for South-East Asia; 2017 (http://apps.who.int/iris/bitstream/10665/255876/1/9789290225485-eng.pdf, accessed 7 March 2018).

[2] Improving the quality of hospital care for mothers and newborns: coaching manual. POCQI: point-of-care quality improvement. New Delhi: World Health Organization Regional Office for South-East Asia; 2017 (http://apps.who.int/iris/bitstream/10665/255876/1/9789290225485-eng.pdf, accessed 7 March 2018).

- the triad of planning, improvement and control is central to the approach: implementing teams need guidance on how to move through these steps; active participation of the main service providers or front-line implementers: a team of personnel in the facility should review their own practices and systems and decide on the processes or actions that need to be changed; the day-to-day service providers like nurses, and possibly one or more physicians, know best what works and which obstacles they face;

- engagement of leadership personnel: facility administrators, heads of medical departments and thought leaders need to be convinced of the importance of the protection, promotion and support of breastfeeding and achieving high rates for early initiation of and exclusive breastfeeding; they need to encourage the front-line implementers to adapt their practices where needed, and facilitate and actively support necessary changes; facility managers also play a pivotal role in implementing the critical management procedures;

- measurement and analysis of progress over time: using data to identify where problems are occurring allows a more focused approach to solving them (see the list of possible indicators in Table 1 and Table 2 at the end of this Appendix); the team needs to decide on the key indicators to measure in addition to the two sentinel indicators;

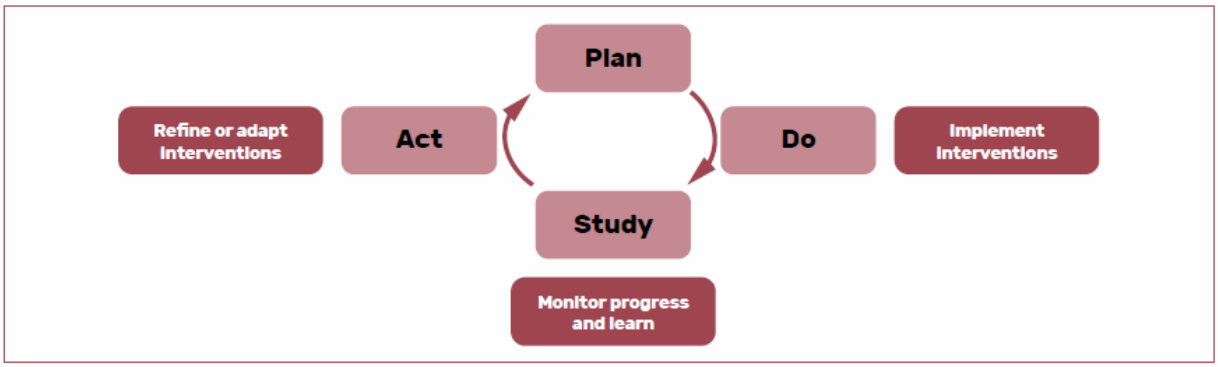

Fig. 3. Visualization of the four steps of quality improvement

Table 1. Suggested options that can be used as indicators for facility-based assessment of critical management procedures for the protection, promotion and support of breastfeeding. Please note that these indicators do not cover all of the global standards and everything in an external assessment, because of the need to keep the internal monitoring system as simple as possible.

Management Procedures	Suggested Options for Indicators	Target	Means of Verification
Step 1a: Have a written infant feeding policy that is routinely communicated to staff and parents.	Existence of a written policy or policies that addresses the implementation of BFHI, including: • Breastfeeding policy which addresses the Ten Steps • Implementation of the *WHO International Code* • Support for breastfeeding staff returning to work • Standards of care for the mother who is artificially feeding her baby	Exists	Review of BFHI policies
	Display of a summary of the policy for pregnant women, mothers and their families	Displayed	Observation of posted policy
	Alignment of clinical protocols or standards related to breastfeeding and infant feeding with BFHI standards and current evidence-based guidelines.	In alignment	Review of clinical protocols and standards
	The percentage of Group 1 and 2 personnel who can explain at least two elements of the infant feeding policy that influence their role in the facility	≥80%	Interviews with Group 1 and 2 personnel

Step 1b: Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions (the Code).	Evidence that all breast-milk substitutes, feeding bottles and teats used in the facility have been purchased through normal procurement channels and not received through free or subsidised supplies	Demonstrated	Review of facility purchasing records
	No open display of products covered under the Code or items with names or logos of companies that produce breast-milk substitutes, feeding bottles and teats, or names of products covered under the Code.	Not displayed	Observations in the facility
	Educational materials including DVDs, handouts and sample bags/gifts which are accessed by pregnant women, new parents or their families	No promotion of products within the scope of the Code or inappropriate information	Review of materials
	Existence of a policy that describes how the facility abides by the Code and addresses the required points in Step 1b	Exists	Review of infant feeding policy
	The percentage of Group 1 and 2 personnel who can explain at least two elements of the WHO International Code	≥80%	Interviews with Group 1 and 2 personnel
Step 1c: Establish ongoing monitoring and data-management systems.	Existence of a protocol for an ongoing monitoring to comply with the eight key clinical practices	Exists	Documentation of protocol
	The frequency with which clinical staff at the facility meet to review implementation of the system	At least every 6 months	Documentation meeting schedule

Step 2: Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.	The percentage of Group 1 personnel who report they have received at least 8 hours of in-service education on breastfeeding during the previous 3 years	≥80%	Interviews with Group 1 personnel
	The percentage of Group 1 personnel who report receiving competency assessments in breastfeeding in the previous 3 years	≥80%	Interviews with Group 1 personnel
	The percentage of Group 2 personnel who report they have received education in the required knowledge and competencies for their role during the previous 3 years	≥80%	Interviews with Group 2 personnel
	The percentage of Group 3 personnel who report they have received the relevant education/information during the previous 3 years	≥80%	Interviews with Group 3 personnel
	The percentage of personnel who are able to correctly answer questions on breastfeeding knowledge appropriate to their group	≥80%	Interviews with Group 1, 2 and 3 personnel

Table 2. Suggested options that can be used as indicators for facility-based monitoring of the key clinical practices for the protection, promotion and support of breastfeeding. Please note that these indicators do not cover all of the global standards and everything in an external assessment, because of the need to keep the internal monitoring system as simple as possible.

Key Clinical Practice	Suggested Options for Indicators	Target	Primary Source	Additional Sources
Step 3: Discuss the importance and management of breastfeeding with pregnant women and their families.	The percentage of antenatal women who received prenatal care at the facility who received prenatal counselling on breastfeeding	≥80%	Interviews with last trimester antenatal and postnatal women	Clinical records

Step 4: Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to recognise when their babies are ready to breastfeed, offering help if needed.	**Sentinel Indicator**: The percentage of term infants who experienced uninterrupted skin-to-skin contact immediately or within 5 minutes after birth, or within 10 minutes of arriving in recovery following a caesarean and that this contact continued uninterrupted until after the first breastfeed or for at least an hour if the baby fed sooner	≥80%	Clinical records	Interviews with mothers of term infants
Step 5: Support mothers to initiate and maintain breastfeeding and manage common difficulties.	The percentage of breastfeeding mothers of term infants who can • demonstrate or describe correct positioning and attachment. • describe how to recognise their babies are well attached on the breast and breastfeeding effectively. • describe two ways to maintain an optimal milk supply • describe two ways to assess whether their baby is getting enough milk	≥80%	Interviews with mothers of term infants	
	The percentage of breastfeeding mothers with babies who are in Special Care who can • confirm they have been supported to initiate lactation within 2 hours of birth • confirm they have been informed how to maintain lactation by frequent expression of breastmilk.	≥80%	Interviews with mothers with babies who are in Special Care	
	The percentage of mothers of breastfed preterm and term infants who can correctly demonstrate or describe how to express breast milk	≥80%	Interviews with mothers of term infants and babies in Special Care	

Step 6: Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.	**Sentinel Indicator:** The percentage of infants (preterm and term) who received only breast milk (either from their own mother or from a human milk bank) throughout their stay at the facility	≥75%	Clinical records	Interviews with mothers of preterm and term infants
	The percentage of mothers who are artificial feeding who can adequately answer questions about making up powdered infant formula	≥80%	Interviews with mothers who are artificial feeding their infants	
Step 7: Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.	The percentage of mothers of term infants whose babies stayed with them since birth, without separation	≥80%	Interviews with mothers of term infants	Clinical records
Step 8: Support mothers to recognize and respond to their infants' cues for feeding.	The percentage of breastfeeding mothers of term infants who can describe at least two early feeding cues	≥80%	Interviews with mothers of term infants	
Step 9: Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.	The percentage of breastfeeding mothers of preterm and term infants who report having been counselled on the use and risks of using feeding bottles, teats and pacifiers/dummies	≥80%	Interviews with mothers of preterm and term infants	
Step 10: Coordinate discharge so that parents and their infants have timely access to ongoing support and care.	The percentage of mothers of preterm and term infants who can report at least two support groups and/or services they could access in their community	≥80%	Interviews with mothers of preterm and term infants	