BFHI AUSTRALIA

Community Health Services Handbook

Contents

Introduction

The role of the Baby Friendly Health Initiative (BFHI) is to protect, promote and support breastfeeding. It does this for Community Health Services by providing a framework for them to operate within called the *Seven Point Plan*. These standards ensure all clients receive appropriate support and contemporary information regarding infant feeding.

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

In a *Baby Friendly* accredited service, breastfeeding is encouraged, supported, and promoted. However, every woman is supported to care for her baby in the best and safest way possible, regardless of feeding choices and circumstances.

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 infants are promoted.

Baby Friendly accreditation is a quality assurance measure that demonstrates the commitment of a Community Health Service (CHS) to offer the highest standard of care to mothers and infants. Attaining accreditation signifies that the service is committed to evidence-based, best-practice care and ensuring that every mother is supported with her informed choice of infant feeding.

In a *Baby Friendly* CHS, a mother's informed choice of infant feeding is encouraged, respected, and supported. At no time are mothers 'forced' to breastfeed. The *Seven Point Plan* is beneficial for all mothers and babies, promoting parental responsiveness, empowerment, and informed choice - regardless of feeding method.

In a *Baby Friendly* service, clients 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 *Seven Points* work synergistically and so therefore are implemented in unison, to ensure benefits for mothers and infants.

Maintaining BFHI accreditation, with re-assessment every 3 years, ensures regular independent review, and provides CHSs with a framework to continuously improve. It ensures that mothers 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 may also aid recruitment and retention of staff through increased professional development opportunities and increased job satisfaction.

Revisions (2021) to the Seven Point Plan

The Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services is now separated into Critical Management Procedures, which provide an enabling environment for sustainable implementation within the CHS, and Key Clinical Practices, which delineate the care that each mother and her infant or young child should receive. The Key Clinical Practices are evidence-based interventions to support mothers to successfully establish and maintain optimal feeding of their infants and young children. The Seven Point Plan is outlined and described in detail in the following pages.

Point 1 on the CHS's *Infant and Young Child 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 Seven Point Plan. This revision incorporates full compliance with the *Code* as a Point. In addition, the need for ongoing internal monitoring of adherence to the clinical practices has been incorporated into Point 1. Internal monitoring should help to ensure that implementation of the Seven Point Plan is sustained over time.

Some of the Points have been modified in their application to ensure that they are evidence-based optimal practices, feasible and applicable for all services. For example, **Point 2** on training personnel focuses on competency assessment to ensure that all personnel have the knowledge, competence, and skills to support optimal infant feeding.

Implementation of the Revised Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services

The core purpose of the Baby Friendly Health Initiative (Community) is to ensure that mothers and infants receive timely and appropriate care to enable the establishment and continuation of optimal feeding of infants and young children, 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 infants who are not breastfed.

Families must receive quality and unbiased information about infant feeding. Community Health 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 CHS has an obligation to support mothers to successfully feed their infants in the manner they choose.

Acknowledgement of Diversity

This document uses the word 'mother' to identify the primary care giver. However, it is intended to be inclusive of the diversity of primary care givers that exist in the LGBTQI community.

Pathway to Achieving BFHI Accreditation

In order to achieve BFHI Accreditation a Community Health Service (CHS) must implement the 7 Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services:

Critical Management Procedures

1. a: Have a written infant and young child feeding policy that is routinely communicated to all 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 implement the infant and young child feeding policy

Key Clinical Practices

3. Inform women and their families about breastfeeding being the biologically normal way to feed a baby.

4. Provide timely support to mothers while they are establishing breastfeeding and during challenges maintaining breastfeeding.

5. Support mothers to exclusively breastfeeding up to six months of age, with continued breastfeeding along with appropriate introduction of complementary foods.

6. Provide a supportive environment and information for all families, regardless of feeding choice.

7. Work collaboratively with maternity facilities, breastfeeding support groups and the local community in order to protect, promote and support breastfeeding.

Full Accreditation

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

Once all standards for the Seven Points are fully met, accreditation is awarded.

Re-accreditation

Re-accreditation occurs every 3 years.

Coordinator
Many CHSs find that it is useful to appoint a BFHI Coordinator who can manage the accreditation process and ensure the service continues to implement *Baby Friendly* standards following accreditation. It is also beneficial to establish a BFHI Committee comprising personnel, consumers, and other key individuals as appropriate.

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

Review of Policies and Practices
Thoroughly review the service's policies, including the breastfeeding/infant and young child feeding policy, against requirements listed for Point 1a. Review any clinical pathways/ guidelines that support the policy to ensure they also meet BFHI requirements and reflect contemporary management practices. Enable the best process for the CHS to do ongoing monitoring of the five key clinical practices (Points 3 to 7), as outlined in Point 1b.

Self-Audit
Complete the *Self-Appraisal* tool to review the CHS's implementation of the Seven Points. 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 service to gauge how it measures against *Baby Friendly* standards.

Observations
Walk through the facility, looking at it from a BFHI perspective.

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 Point 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 *Self-Appraisal* tool again. If the facility appears to meet all the standards in the *Seven Point Plan*, do a further check by interviewing a small sample of mothers and personnel to see if their responses confirm this.

Applying for Assessment
Once the CHS is ready for assessment, the service 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
- Copy of the facility's Breastfeeding or Infant and Young Child Feeding Policy

Human Subject Research Clearance
If human subject research clearance is required through the service'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 CHSs/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 CHS 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 CHS leading up to the assessment to discuss the practicalities of the assessment.

Conflict of Interest
The CHS 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
All Assessors are trained by the Australian College of Midwives and have comprehensive knowledge of BFHI and WHO requirements, and experience in contemporary lactation and infant feeding 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 CHS's customs and organisational procedures. They are required to undertake the assessment according to the philosophy and policies of BFHI and assess the CHS 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 some or all sites of the CHS 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. The CHS is responsible for the assessors' travel from the primary site to any other sites under management of the CHS, and a part of the assessment, for visits as requested by the assessors.

Interviews
Mothers and 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 or personnel are not available to attend in person, of if it is a remote assessment. It is important to remember that it is the CHS'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 service's interpreter service may be used. Personnel with a vested interest in the outcome should not be used as interpreters.

Critical Management Procedures

Points 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 service's personnel who are providing care for mothers and infants thus enabling the provision of a high standard of care that is consistent, and without conflicting information.

Point 1a: Have a written infant and young child feeding policy that is routinely communicated to all staff and parents

Rationale

Evidence based policy frames clinical practice. Health-care personnel and services are required to follow established policies. The clinical practices articulated in the *Seven Point Plan* need to be incorporated into CHS policies, to guarantee that appropriate care is equitably provided to all mothers and infants 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 CHS alignment with BFHI principles. Policies help to sustain practices over time and communicate a standard set of expectations for all personnel.

Implementation

Community Health Services should have a clearly written *Infant and Young Child Feeding Policy* that is routinely communicated to personnel[1] and parents. All personnel who have contact with mothers and infants should be familiar with the policy and understand their responsibility to adhere to it.

The breastfeeding policy may stand alone as a separate document, be included in a broader infant and young child 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 (Points 3 to 7) should be implemented, to ensure that they are applied consistently to all clients. The policy should also outline how each of the Seven Points 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 CHS has a written policy or several policies that are routinely communicated to all staff and parents. The policy/policies support the implementation of BFHI, including: • Breastfeeding or *Infant and Young Child Feeding 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 • reference of a system to ensure continuity of care between external services through effective communication between health care staff. 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 CHSs have alternate names for policies and clinical protocols; this is acceptable as long as they are mandated and fulfil the criteria. The policies and any supporting protocols must be: • consistent with BFHI standards

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

- reflective of contemporary, evidence-based information and practices.

Development of the policy/policies, and their subsequent review, should be multidisciplinary, with representation from consumers, local breastfeeding support groups, physicians, nursing and midwifery staff and management.

The Breastfeeding or Infant and Young Child Feeding Policy

At a minimum, the Breastfeeding or *Infant and Young Child Feeding Policy* addresses the principles and practices that enable implementation of the *Seven Point Plan*, including the Critical Management Procedures (Points 1 & 2) and each of the Key Clinical Practices (Points 3 to 7).

Breastfeeding Policy Summary

A summary of the *Infant and Young Child Feeding Policy* must be displayed in each area of the CHS where it can be seen by clients and their families.

The summary must be displayed in each language used by 10% or more of clients who use the CHS. Services are also encouraged to have it available in other languages used by clients. The *Seven Point Plan* may be used as a summary.

It is acknowledged that some CHSs have areas where display of materials such as posters is restricted or not permitted. These services will be required to demonstrate how they ensure all clients and staff are made aware of the CHS's policy.

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 *Infant and Young Child Feeding Policy* refers to or be an integrated part of the policy. Community Health Services 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 Infant

There is a policy which addresses standards of care for the mother who is artificially feeding her infant. This may be a separate policy or integrated into the Infant and Young Child Feeding Policy.

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 use the CHS and are using infant formula have been given adequate information and instruction
- 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

comply with the WHO International Code.

[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.

Personnel Interviews
The Head of Service is able to: • confirm that the CHS has a written policy/procedure and practices to enable and support staff to continue breastfeeding after returning to work Senior staff and at least 80% of the Group 1 and 2 Personnel: • can explain several practices or points in the *Seven Point Plan* that help promote breastfeeding in the CHS?

Observations
At each site, observations confirm that there is an Infant and Young Child Feeding Policy (or summary / Seven Point Plan) posted where it can be seen by clients and staff. It is in languages most commonly understood by staff and clients.

Point 1b: Comply fully with the International Code of Marketing of Breast-milk 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 Community Health 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. Personnel of facilities providing community health 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 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[5], 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 *Infant and Young Child Feeding Policy* refers to or be an integrated part of the 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] 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 CHS 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 CHS 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 CHS and staff 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 clients and their families.
- The CHS 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 CHS 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 CHS has retail outlets/kiosks on site, the CHS 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 CHS may be limited when the retail outlets are not under its direct control.

Observations

Observations confirm that:

- 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.
- at residential sites, infant formula and equipment for artificial feeding are stored discreetly and not openly displayed.
- at residential sites, there is adequate space and necessary equipment to give individual instruction on how to prepare formula away from breastfeeding mothers.

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 have:

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

For guidance on internal auditing for implementation of the *WHO International Code* in a BFHI facility, refer to Appendix 4.

Purchase of Breastmilk Substitutes, Teats, Bottles or Dummies

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

Breastmilk substitutes including special formula and other supplies required for artificial feeding at residential services are purchased through normal procurement channels or are brought in by parents for feeding their own infants.

Personnel Interviews

Senior staff and at least 80% of the Group 1 and 2 personnel can:

- explain at least two elements of the WHO International Code that are relevant to them as a health worker in this service.

Client Interviews

- No clients who were interviewed report having been given any samples or supplies of infant formula by staff in the CHS.

Point 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 or addressed. Data monitoring is an essential component of the quality management cycle. Community Health Services should integrate recording and monitoring of the clinical practices related to infant and young child feeding into their quality-improvement/monitoring and reporting systems.

Implementation

There is a data-management system for ongoing monitoring of the Seven Points. 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.

Each facility should attempt to regularly achieve at least 80% adherence on each indicator, and CHSs that do not meet this target should focus on increasing the percentage over time.

Implementation Standards

Ongoing Monitoring
• The facility has a data management system for ongoing monitoring of the five key clinical practices (Points 3 to 7). • Clinical personnel at the CHS meet at least every 6 months to review the results of the monitoring. • If previously assessed, relevant recommendations from the last assessment have been satisfactorily addressed

Point 2: Ensure that staff have sufficient knowledge, competence, and skills to implement the infant and young child feeding policy

Rationale

Timely and appropriate care for mothers, regardless of feeding method, can only be accomplished if all personnel have the knowledge, competence[1] 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 accurately discuss relevant topics with a client on a topic for which they have received limited undergraduate or in-service education.

Implementation

CHS personnel who provide infant feeding services, including breastfeeding support, should have sufficient skills and knowledge to provide the required support. Ideally, the undergraduate education system takes responsibility for building this capacity, but in practice this cannot be assumed due to diverse curriculum provision.

It is important that all personnel are up to date with evidence-based, contemporary information and practices consistent with BFHI standards and the policy. The CHS needs to ensure all personnel who provide infant feeding services, including breastfeeding support, have regular ongoing in-service education which focuses on practical skills rather than only on theoretical knowledge. There should also be provision for monitoring skills and knowledge, either in an ongoing, locally determined way or by specific review.

In-service education refers to all internal and external education that the CHS's personnel participate in, including e.g. online courses from another provider. Note that orientation and education on the CHS's policies and key clinical practices needs to be specific to the facility, region, or state that the policies and procedures cover.

Core Skills and Knowledge

All Group 1 personnel who help mothers with infant feeding should have the following *Core Skills and Knowledge*:

Counselling Skills

1. use listening skills when counselling a mother;
2. build a mother's confidence and give support;
3. counsel a mother to make an informed and appropriate decision about infant feeding, suitable to her circumstances;

Establishing Breastfeeding

4. support a mother to position herself and her baby for breastfeeding;
5. support a mother to attach her baby to the breast, encouraging baby-led attachment;
6. assess a breastfeed; including teaching a mother how to monitor milk transfer
7. explain to a mother about feeding cues and the optimal pattern of breastfeeding;
8. explain to a mother how to know if her baby is getting enough milk
9. explain to a mother why exclusive breastfeeding for six months is recommended

[1] The word 'competency' is used in the WHO global documents to mean the ability to apply skills and knowledge in the clinical setting. Competency should be determined by the facility when the individual demonstrates they have the skills and knowledge to provide contemporary, evidence based infant feeding information and support. It is not intended to have the same strict meaning as the essential competencies that health care providers are required to have.

Breastfeeding Challenges

10. counsel a mother who thinks she does not have enough milk;
11. counsel a mother with an unsettled baby;
12. counsel a mother on the appropriate use of lactation aids including a breast pump
13. counsel a mother whose baby is refusing to feed at the breast;
14. counsel a mother who has flat or inverted nipples;
15. counsel a mother with sore or cracked nipples;
16. counsel a mother with blocked ducts and/or mastitis;
17. counsel a mother with oversupply/fast flow/overactive letdown;
18. support a mother to breastfeed a low-birthweight, preterm or sick baby.
19. Counsel a mother about the timing and appropriate introduction of complementary foods
20. support mothers to successfully combine breastfeeding with returning to work

Implementation Standards

Personnel Groups for Education

All personnel[1] who have contact with 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 CHS. For example, lactation consultants, maternal and child health nurses, midwives, registered or enrolled nurses.

Group 2: Those who may provide general breastfeeding advice but do not assist mothers with breastfeeding. For example, medical personnel, cultural health workers (if advice is part of their role), and allied health workers who advise or provide care related to infant feeding.

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, psychology, pharmacy or cultural health workers, social workers, ward clerks, auxiliary volunteers.

Group 1 BFHI Education and Competency Requirements

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

The 20 *Core Skills and Knowledge* are considered essential for all personnel who counsel and assist mothers with breastfeeding. Personnel who do not have these skills and knowledge from their undergraduate education, or from education at another facility, will need more comprehensive in-service education than more experienced personnel.

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

Ongoing monitoring of skills and knowledge is the responsibility of a supervisor with the appropriate knowledge and skills who is experienced and knowledgeable about evidence-based, contemporary breastfeeding practices consistent with BFHI standards. Review of skills and knowledge 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 skills and knowledge might also include

- Peer-reviewed simulated activities in a workshop setting.
- Observation and completion of checklist, for example:
    - helping a mother with positioning and attachment;
    - support provided to a mother who is artificially feeding her baby
- Small group discussion of a skill, 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. optimal use of a breast pump

The content delivery of the education is flexible. Group 1 personnel in a *Baby Friendly* CHS should have the following skills and knowledge;

- The CHS's policy and key clinical practices (Points 3-7). The key clinical practices should cover the 20 *Core Skills and Knowledge* listed in this Point.
- Providing optimal support to all mothers who are using infant formula to feed or supplement their infant (Appendix 3).
- The CHS's and personnel's responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions. (Point 1b and Appendix 4)

The CHS can report that at least 80% of Group 1 personnel, who have been at the facility for six months or more, have completed at least 8 hours of in-service education in the previous three years, and can report how skills and knowledge are monitored.

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 *Infant and Young Child Feeding Policy*
- 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 CHS'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

Review of the existing skills and knowledge of new Group 1 personnel should be commenced as soon as possible. The appropriate in-service education should be completed within 6 months.

Casual/Agency Personnel

If the CHS uses casual or agency personnel on a regular basis, it is important to ensure that support for clients 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 any area/s of the CHS) are considered the same as new personnel (above).

Group 2 BFHI Education and Competency Requirements

Over the previous 3 years, Group 2 personnel who have been at the facility for 6 months or more have had education in the following skills and knowledge: The *Infant and Young Child Feeding Policy* and key clinical practices (Points 3-7) with a focus on:

  - Why breastfeeding is important
  - How to assist the mother to make a fully informed and appropriate decision about infant feeding, suitable to her circumstances.
- The CHS'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, but it is usually around two hours if delivered face-to face. The delivery of the education is flexible. It may be face-to-face sessions, individually or in a group; online learning options, a series of handouts or articles to access, or a combination of these.

The CHS can report that at least 80% of Group 2 personnel, who have been at the facility for six months or more, have been provided with the relevant information.

Group 3 BFHI Education/ Information Requirements

No time is specified for Group 3 education/information sharing. It can be delivered face-to-face or online, individually or in a group.

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

- why breastfeeding is important.
- How breastfeeding is promoted or supported in the CHS (can be the Seven Point Plan).

Facility Personnel Education Database

Facility Records

The facility maintains electronic or hard copy central records and can report on

- the percentage of Group 1 personnel, who have completed at least 8 hours of in-service education (or orientation if at the facility less than 6 months)
- the percentage of Group 2 personnel who have been provided with the relevant information.

The facility will self-report this information at the time of assessment or reassessment. The assessors will not need to review these records.

Records of education completed are optional for Group 3; the facility will not be asked to report on the percentages of this group who have been provided with the relevant information.

The principle assessment of education for all Groups will be the skills and knowledge of personnel, as evident in personnel interviews and holistically throughout the assessment.

BFHI Coordinator

The BFHI Coordinator adequately reports on:

- where the policy summary is displayed and the languages it is available in (if applicable)
- key aspects of the policies relating to Points 1a, 1b and 1c
- the BFHI education options for Group 1, 2 and 3
- how the requirement for assessment/review/monitoring of Group 1 skills and knowledge is met
- the percentage of groups 1 and 2 who have completed the required education

Note that documentation on education programs and curriculum will not be reviewed by the assessors. As stated above, the principle assessment of education will be the skills and

knowledge of personnel, as evident in personnel interviews and holistically throughout the assessment.

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) in the previous 3 years
- are able to correctly answer questions on skills and knowledge related to Infant and Young Child Feeding (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

Point 3: Inform women and their families about breastfeeding being the biologically normal way to feed a baby

Rationale

Breastfeeding is the biologically normal way to feed babies and is important for baby's optimal growth, development, and health.

NHMRC Infant Feeding Guidelines Information for Health Workers (2012)

1.2.1 Benefits to the infant

Breastfeeding has positive effects on the nutritional, physical and psychological wellbeing of the infant.

Nutritional benefits

The composition of breast milk is uniquely suited to the newborn infant, at a time when growth and development are occurring rapidly while many of the infant's systems – such as the digestive, hepatic, neural, renal, vascular, and immune systems – are functionally immature. Many of the nutrients contained in breast milk are in forms that are readily absorbed and bioavailable.

Breast milk contains many valuable components including bile salt–stimulated lipase, glutamate, certain polyunsaturated long-chain fatty acids, oligosaccharides, lysozyme, immunoglobulin A, growth factors and numerous other bioactive factors. These components facilitate optimal function of the infant's immature systems and confer both active and passive immunity. The living cells found in breast milk are also important functionally.

Health benefits

Breastfeeding confers a range of benefits to the developing infant, including improved visual acuity, psychomotor development and cognitive development, and reduced malocclusion as a result of better jaw shape and development.

Numerous studies have shown that breastfeeding reduces the risk or severity of a number of conditions in infancy and later life, including:

- physiological reflux
- pyloric stenosis
- gastrointestinal infections
- respiratory illness
- otitis media
- urinary tract infections
- bacteraemia-meningitis
- sudden infant death syndrome (SIDS)
- necrotising enterocolitis in preterm infants
- atopic disease
- asthma
- some childhood cancers
- type 1 and type 2 diabetes
- coeliac disease
- inflammatory bowel disease
- cardiovascular disease risk factors including blood pressure and total and low-density lipoprotein (LDL) cholesterol
- obesity in childhood and in later life.

Source: National Health and Medical Research Council. Referencing included in the source document.

The breastfeeding relationship[1]

A mother feeding her baby from the breast forms a breastfeeding relationship with her child. This unique relationship offers a powerful source of comfort for a mother and her infant while helping to facilitate their bonding and connection.

The psychological effects of the breastfeeding relationship on both children and their mothers are critical and far-reaching. Breastfeeding impacts children's brain, cognitive, and socio-emotional development. In mothers, breastfeeding influences mood, affect, stress, and maternal care.

There is a body of research from different countries providing evidence for a link between breastfeeding experience and cognitive development later in life, including improved memory retention, greater language skills, and intelligence

Implementation

CHS personnel who provide infant feeding support, or come into contact with women, are aware that breastfeeding is the biologically normal way to feed babies and can explain why it is important for baby's optimal growth, development, and health.

Women and their families are informed that breastfeeding is the biologically normal way to feed a baby and understand why it is important.

Implementation Standards

Personnel Interviews
• The Senior Staff can explain how women are informed that breastfeeding is the biologically normal way to feed a baby • A least 80% of Group 2 personnel can give at least two reasons why breastfeeding is important • At least 80% of Group 3 personnel can give at least two reasons why breastfeeding is important

[1] Krol KM, Grossmann T. Psychological effects of breastfeeding on children and mothers. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2018 Aug;61(8):977-985. doi: 10.1007/s00103-018-2769-0. PMID: 29934681; PMCID: PMC6096620.

Point 4: Provide timely support to mothers while they are establishing breastfeeding and during challenges maintaining breastfeeding

Rationale

Mothers need timely and sustained support to continue breastfeeding. While the time in the facility providing maternity and newborn services should provide a mother with basic breastfeeding skills, it is most likely that her milk supply is not fully established before discharge. Timely breastfeeding support is especially critical in the succeeding days and weeks after discharge, to identify and address early breastfeeding challenges that occur.

Mothers and babies should be seen by an appropriated skilled professional from community health soon after discharge from care provided by maternity facility and again in the following week, to assess feeding.

Each mother will encounter several different phases in her production of breast milk, her infant's growth, and her own circumstances (e.g. going back to work or school), in which she will need to apply her knowledge and skills in different ways and additional support may be needed. Receiving timely support is instrumental in maintaining breastfeeding rates.

A Cochrane Review (n=29,385 mother-infant pairs from 14 countries) reported that professional support increased the rate of intermediate duration of breastfeeding (up to 4 months) and had a beneficial effect on exclusive breastfeeding, particularly in the first 3 months.[1]

"All women should be offered support to breastfeed their babies to increase the duration and exclusivity of breastfeeding. Support may be offered either by professional or lay/peer supporters, or a combination of both. Strategies that rely mainly on face-to-face support are more likely to succeed. Support that is only offered reactively, in which women are expected to initiate the contact, is unlikely to be effective; women should be offered ongoing visits on a scheduled basis so they can predict that support will be available. Support should be tailored to the needs of the setting and the population group.[2]"

Supporting vulnerable groups[3]

There is evidence that certain groups are less likely to breastfeed than others and would benefit from increased antenatal and postnatal support. These include Aboriginal and Torres Strait Islander women, younger women (particularly those younger than 20 years of age), less educated women, obese women and/or those of lower socioeconomic status

There is evidence that younger maternal age, particularly being aged under 20, is negatively associated with both initiation and duration of breastfeeding. Many adolescents view breastfeeding negatively and have adverse experiences in relation to breastfeeding. Younger mothers generally require more support to maintain satisfactory breastfeeding levels.

Implementation

The transition from maternity care to community-based support and services is managed so that mothers and babies have timely access to skilled help with infant feeding.

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[1] Britton C, McCormick FM, Renfrew MJ, wade A, king SE. Support for breastfeeding mothers. *Cochrane Database Syst Rev 2009*(Issue 1):DOI:10.1002/14651858.CD001141.pub3.

[2] Renfrew, M. J., McCormick, F. M., Wade, A., Quinn, B., & Dowswell, T. (2012). Support for healthy breastfeeding mothers with healthy term babies. *The Cochrane database of systematic reviews*, *5*(5), CD001141. https://doi.org/10.1002/14651858.CD001141.pub4

[3] National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: *National Health and Medical Research Council*. www.nhmrc.gov.au/guidelines-publications/n56

There is an appropriate referral pathway for extra support within the Community Health Service for a mother who is experiencing breastfeeding difficulties or challenges.

There is appropriate support for mothers from groups less likely to breastfeed successfully.

Implementation Standards

Personnel Interviews
• The Senior Staff can explain how the CHS ensures timely and appropriate support as mothers establish breastfeeding. • The Senior Staff and at least 80% of Group 1 and Group 2 personnel can describe an appropriate referral pathway within the Community Health Service for a mother who is experiencing breastfeeding difficulties. • At least 80% of Group 1 personnel can describe acceptable information that they provide to mothers about positioning and attaching their babies for a breastfeed.

Breastfeeding mother interviews
• At least 80% of mothers report that they were satisfied with how soon the service contacted them and provided support with feeding after they were discharged from the care of the maternity facility • At least 80% of mothers with babies <6 months old: o report that they were given information or assistance with positioning and attachment if required. o report that they were given information or assistance on how to manage their breasts if they become uncomfortably full and their baby is asleep or separated from them. o answer questions on breastfeeding management. • At least 80% of mothers with babies >6 months old, who had difficulties with breastfeeding, report that they were provided with information or assistance by CHS staff to manage those difficulties.

Point 5: Support mothers to exclusively breastfeeding up to six months of age, with continued breastfeeding along with appropriate introduction of complementary foods

Rationale

It is recommended that infants are exclusively breastfed to around six months of age and that mothers then continue breastfeeding with the addition of appropriate foods until one year of age, and beyond if both mother and infants wish.

In 2001 the report of a WHO Expert Consultation recommended exclusive breastfeeding for about 6 months, with introduction of complementary foods and continued breastfeeding after that. The 2001 WHA combined these various recommendations in one resolution, recommending exclusive breastfeeding until 6 months of age. This recommendation has since been endorsed by many national authorities. In Australia the wording is to recommend exclusive breastfeeding to 'around 6 months' of age. Although infants should still be managed individually so that insufficient growth or other adverse outcomes are recognised and appropriate interventions are provided, the available evidence demonstrates no apparent risks in recommending, as a general policy, exclusive breastfeeding for the first 6 months of life.[1]

The first prevention activity a mother can undertake for a newborn child is breastfeeding. Breastfeeding has positive effects on nutritional, physical and psychological wellbeing of infants and where environmental conditions may be less than ideal, breastfeeding provides optimum protection against infection and under-nutrition[2].

NHMRC Infant Feeding Guidelines Information for Health Workers (2012)

9.2 When should solid foods be introduced

Infancy is the period of most rapid growth in weight, height, and all of the developmental parameters. Continued growth and development through good nutrition is important to protect the infant against morbidity and mortality. Appropriate growth during infancy protects against stunting at one extreme and obesity at the other. There is increasing evidence of the importance of growth and nutrition in relation to obesity rates and cognitive development. Appropriate early growth and development also protects against the development of chronic disease in adulthood and influences future bone mass.

Maintenance of a positive energy and nutrient balance is critical in achieving and sustaining normal growth and development. By around 6 months of age breast milk (or infant formula) no longer provides sufficient nutrients and energy for growth and development. Between 6 and 12 months, breast milk continues to be a major source of bioavailable nutrients.

9.2.1 Introducing solid foods at around 6 months

By around 6 months of age most infants are able to adapt to different foods, food textures and modes of feeding. This age has been identified as a time when:

- appetite and nutritional requirements are no longer satisfied by breast milk or infant formula alone

[1] National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: *National Health and Medical Research Council*. www.nhmrc.gov.au/guidelines-publications/n56

[2] Department of Health, National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families, *Australian Government*, Canberra, 2016

- stores of several nutrients – for example, iron and zinc – are often falling in exclusively milk-fed infants (both breast and formula), with iron status a particular concern after 6 months
- feeding behaviour has progressed from sucking to biting (most infants are chewing by 7–9 months and can manage finger foods at 8 months)
- the tongue-extrusion reflex has disappeared and the infant's increasing ability to sit without support allows greater manipulation of food before swallowing, so that thicker foods can be managed
- the digestive system has matured, and the infant is able to digest starches
- most infants have developed an interest in their environment, which prompts a willingness to accept new textures and flavours – it is useful to exploit this exploratory phase by gradually introducing new food tastes and textures.

Infants adjust more quickly to solids introduced at around 6 months. In a longitudinal study (n=506), infants took a median of 28 days from the introduction of solid foods to consumption of more than 10 mL daily and 46 days to the consumption of 100 mL daily. The younger the infant at the time solid foods were introduced, the longer it took to establish the new pattern.

9.2.2 Problems associated with earlier or later introduction of solid foods

Introducing solid foods too soon can lead to several problems:

- if less time is spent on the breast, maternal milk production may decline because of reduced stimulation and under-nutrition may result in extreme cases
- if solid foods are introduced while the tongue-extrusion reflex is still strong, the infant will reject the spoon (a hard object) – the mother might then feel that the infant is rejecting the food, when in fact he or she is rejecting the object in the mouth
- Exclusive breastfeeding to around 6 months, and continued breastfeeding to 12 months and beyond while foods are being introduced is consistent with available evidence around reducing risk of food allergies
- exposure to pathogens present in foods can cause increased rates of diarrhoeal diseases.

Introducing solid foods too late can also cause problems:

- growth can falter because breast milk or infant formula alone is insufficient after 6 months
- immune protection can be compromised
- micronutrient deficiencies, especially of iron and zinc, can develop – iron stores are likely to become depleted if a bioavailable source of iron from complementary foods is not provided
- optimal development of motor skills such as chewing can be delayed and the infant may be unwilling to accept new tastes and textures
- there is an association with increased risk of developing allergic syndromes.

Implementation

- All mothers are provided with appropriate support and information to breastfeed their babies exclusively for six months.
- Mothers are counselled on the importance of exclusive breastfeeding.
- As soon as possible after discharge from the maternity facility's care, a breastfeed is assessed to ensure that the infant is able to suckle and transfer milk from the breast.
- Mothers are counselled on how to establish and maintain a milk supply and how to assess the simple signs that their baby has an adequate milk intake.
- Mothers are discouraged from giving any food or fluids other than breast milk, unless medically indicated, for the first six months. Very few conditions of the infant or mother preclude the feeding of breast milk and necessitate the use of breast-milk substitutes.
- Health workers assess infants for signs of inadequate milk intake and recommend supplementation only when indicated and when other means of increasing milk supply or milk transfer have been tried.
- From around 6 months, infants are offered a range of foods of an appropriate texture and consistency for their developmental stage.
- When solids are to be introduced, mothers are counselled to continue to breastfeed as often as the infant desires and the mother is able – this helps to avoid displacement of breast milk by solid foods and to maximise nutrients and immunological benefits, particularly in the first 12 months. Except for cooled boiled tap water, other drinks are avoided until the infant is 12 months old.
- Health workers are informed and positive when advising parents about combining breastfeeding and paid work.

Implementation Standards

Personnel Interviews

• The Senior Staff and at least 80% of Group 1 and Group 2 personnel can
  ○ describe at least two of the acceptable medical reasons for recommending / feeding breastmilk substitutes to a breastfeeding baby. *(If making decisions about using infant formula is part of their role)*
  ○ describe what should be discussed with a breastfeeding mother who is considering changing to feeding her baby with infant formula, including the potential risks.
• At least 80% of Group 1 personnel can describe the WHO or NHMRC recommendations regarding exclusive breastfeeding, introduction of solids and optimal duration of breastfeeding

Breastfeeding mother interviews
• At least 80% of breastfeeding mothers can answer questions on exclusive breastfeeding and introduction of solids. • At least 80% of breastfeeding mothers with babies >6 months old report that they have been offered advice and where to find further information about maintaining breastfeeding when separated from their baby, perhaps for work or study, if needed.

Point 6: Provide a supportive environment and information for all families, regardless of feeding choice

Rationale

"Women have the right to accurate, unbiased information needed to make an informed choice about breastfeeding. They also have the right to good quality health services, including comprehensive sexual, reproductive, and maternal health services. And they have the right to adequate maternity protection in the workplace and to a friendly environment and appropriate conditions in public spaces for breastfeeding which are crucial to ensure successful breastfeeding practices.[1]"

An environment supportive for all families, regardless of feeding choice, will enable all eligible participants to feel comfortable about accessing services. It will be responsive to their needs and deliver equitable outcomes. There will be policies and processes in place to actively engage and accommodate clients who are vulnerable, including people who are living with a disability, are culturally and linguistically diverse, identify as Indigenous, or are subject to violence.

All infants and mothers gain benefits from breastfeeding. In remote communities where Aboriginal and Torres Strait Islander people may live, there are frequently poor environmental conditions, housing, and hygiene. Breastfeeding provides the optimum protection to infants against infection and under-nutrition in these conditions. Where infant formula is used, cost and water supply are important factors in assuring adequate infant feeding standards. Health workers need to be culturally sensitive in promoting the benefits of breastfeeding in communities.[2]

Implementation

- All mothers are made to feel welcome at the facility, regardless of age, gender, cultural or ethnic background, disability, sexuality, language skills or literacy level.
- Given the significant health benefits to both infant and mother, health workers have a responsibility to promote breastfeeding first but, if infant formula is needed, to educate and support parents about formula feeding.
- 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.
- When infants under 12 months are not breastfed, infant formula is the only suitable and safe alternative to meeting their primary nutritional needs.
- Mothers who are feeding breast-milk substitutes must be taught about safe preparation and storage of formula and how to respond adequately to their child's feeding cues
- Infant formula requires accurate reconstitution and hygienic preparation to ensure its safety, so it is important that health workers know how to demonstrate the preparation of infant formula and how to feed an infant with a bottle.
- Cow's milk-based formula is suitable for the first 12 months of life unless the infant cannot take cow's milk-based products for specific medical, cultural, or religious reasons, in which case special formulas may be used under medical supervision.

[1] Joint statement of the Office of the UN High Commissioner on Human Rights and the World Health Assembly, quoted in the *Australian National Breastfeeding Strategy, 2019 and Beyond*.

[2] National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: *National Health and Medical Research Council*. www.nhmrc.gov.au/guidelines-publications/n56

NHMRC Choice of Infant Formula[1]
In Australia, a range of cow's milk and goat's milk formulas that meet the Food Standards Australia New Zealand Code for infant formula are available. There is little evidence that, if breastfeeding is discontinued for any reason, one infant formula is better than another: • interchange between formulas within the same generic group is optional, however frequent changes may generate confusion and increases the risk of inaccurate preparation/dosing • the use of 'follow-on formula' for infants aged 6–12 months is not considered necessary, and no studies have shown advantages over using 'infant formula'

Implementation Standards

Personnel Interviews
• The Head of Service can explain how the service communicates to mothers and families attending the service that breastfeeding is welcome. • Senior staff report that mothers who start using infant formula are given instruction and supervised practice on the reconstitution of powdered infant formula and on how to bottle-feed.

Mothers Interviews
• At least 80% of mothers who have fed their baby with infant formula, regardless of feeding choice: o report that they were given information or support from staff at the CHS if they needed it o report that they felt welcome to feed their babies at the CHS if they needed to. • At least 80% of formula feeding mothers with babies >6 months old, can correctly answer questions about feeding their babies.

Observations
• Each site in the CHS has a clean, pleasant, comfortable area for feeding babies, regardless of feeding choice, and where space allows, a private area can be provided on request.

[1] National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: *National Health and Medical Research Council*. www.nhmrc.gov.au/guidelines-publications/n56

Point 7: Work collaboratively with maternity facilities, breastfeeding support groups and the local community in order to protect, promote and support breastfeeding

Rationale

Working collaboratively with maternity facilities enables a smooth transition of support from maternity services to community health services. There is ample evidence that many mothers stop breastfeeding in the early weeks after discharge from inpatient care, often for reasons that could have been prevented with timely and adequate support.

Mothers need sustained support to continue breastfeeding. They need options for continued and consistent breastfeeding support that is culturally and socially sensitive to their needs. Community Health Services have a responsibility to engage with the surrounding community to enhance such resources. Community resources – provided by the CHS or other organisations – include primary health-care centres, community health workers, breastfeeding clinics, midwives/child health nurses, lactation consultants, peer counsellors, mother-to-mother support groups, phone counselling (hot-lines) and live-chat services. The facility should maintain contact with the groups and individuals providing the support as much as possible and invite them to collaborate where feasible.

Implementation

There is a process for the transition from hospital, birthing centre, or midwife to the CHS that ensures a continuum of care including the following:

- A system of follow-up for all mothers after they are discharged from external services (e.g. Early postnatal or lactation clinic check-up, home visit, clinic visit, telephone call, referral to a mother support group)
- An appropriate referral pathway to support mothers who require more specialised assistance with breastfeeding
- Collaboration between the CHS and the local community to promote/support breastfeeding

Implementation Standards

Personnel Interviews
• The Head of Service can report that collaboration in the production or review of the *Infant and Young Child Feeding Policy* included consultation with representatives outside the CHS. • Senior staff report on how the CHS works collaboratively with maternity facilities, breastfeeding support groups and the local community in order to protect, promote and support breastfeeding. • Senior staff can outline the infant feeding support groups and services available in the local area. • If there is a residential service, the Senior staff report how the CHS facilitates ongoing support for mothers following discharge.

Mothers Interviews
• At least 80% of breastfeeding mothers with babies <6 months old can identify at least one infant/breastfeeding support group and/or service in the local area.

Appendix 1: Definitions

Artificial Feeding
Baby being fed fully or predominantly fed 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 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 those 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.

Community Health Service (CHS)
Community health services offer support to the public beyond hospital or institutional care. The support may be information, advice, health monitoring, practical help, or a combination of these. The community service may be run by federal, state, or local government or a non-government source.

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.

Exclusive Breastfeeding
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. The assessment of a facility includes all areas which may be accessed by mothers who are breastfeeding, or which may provide care for infants or children who are breastfeeding. A facility may have more than one site.

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

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.

Supplementary Feeding
A breastfed baby has been given one or more non-breastmilk 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.

Supplementation for a documented medical reason
A breastfed baby has been given one or more fluid feeds, including infant formula, after an individual assessment of the mother and baby. A valid reason for the decision to supplement, and all subsequent supplementary feeds, have been documented. Where possible, other management options such as skin-to-skin and more frequent feeding have been tried first to address the issue. For guidance, see Appendix 2: *Guidelines for Supplementary Feeding for the Healthy Term Breastfed Neonate.*

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: 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.

These guidelines are written with reference to the healthy term breastfed neonate, but they are included here because much of the content is applicable to supplementary feeding of breastfed babies at any age.

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 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.

[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).

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.
    g. Uncommon maternal conditions (e.g. HSV lesions on the breasts, HCV positive and bleeding nipples, HIV positive using guidelines based on CD4 count and ART prophylaxis)

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

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.

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, CHSs 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 are 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.

NHMRC Infant Feeding Guidelines
For 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.

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.

[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.

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 4: 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 relevant information from the NHMRC Infant Feeding Guidelines.

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, based on 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.

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 practices 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-emphasize 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 consider risk vs. benefit to parents and babies.

Appendix 5: 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

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 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 standards fall 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 frequency of data collection will depend on the method of verification. 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 (Points 3 – 7), 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.

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. 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 Seven Points. Application of the quality-improvement methodology is particularly important for Points that the facility has found especially difficult and for which the global standards have not been achieved. The BFHI-related aspects can be combined with other quality-improvement initiatives that are already ongoing in maternal and child health at the facility.

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

- 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;

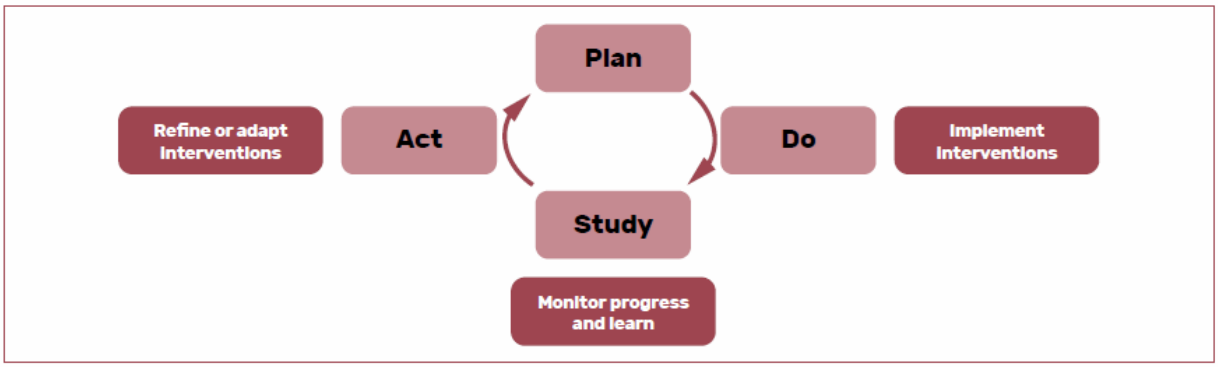

Fig. 3. Visualization of the four steps of quality improvement

[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).