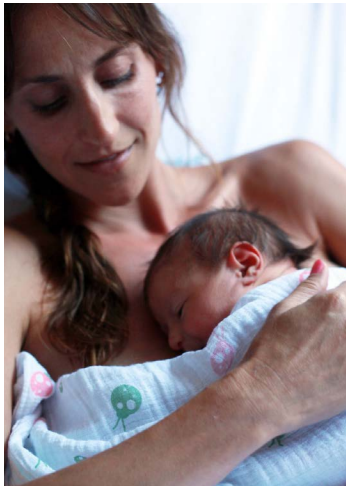




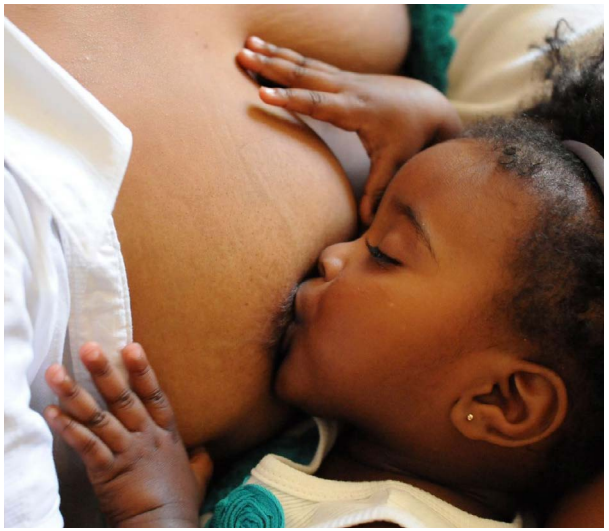

THE BABY-FRIENDLY HOSPITAL INITIATIVE

Guidelines and Evaluation Criteria

SIXTH EDITION

Baby-Friendly USA

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The 2018 UNICEF/WHO Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services: the revised Baby-Friendly Hospital Initiative.

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American College of Obstetricians and Gynecologists (ACOG)
Association of Women's Health Obstetric and Neonatal Nurses (AWHONN)
United States Lactation Consultant Association (USLCA)

Baby-Friendly USA

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INTRODUCTION

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BABY-FRIENDLY HOSPITAL INITIATIVE (BFHI) was established in 1991 by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). The BFHI is a global program to support the implementation of the *Ten Steps to Successful Breastfeeding (the Ten Steps)* and the *International Code of Marketing of Breast-milk Substitutes (the International Code)* in maternity facilities. "The core purpose of the BFHI is to ensure that mothers and newborns receive timely and appropriate care before and during their stay in a facility providing maternity and newborn services, to enable the establishment of optimal feeding of newborns, which promotes their health and development. Given the proven importance of breastfeeding, the BFHI protects, promotes and supports breastfeeding while enabling timely and appropriate care and feeding of newborns who are not *(yet or fully)* breastfed."[1]

An important philosophy of the Initiative is that "families must receive quality and unbiased information about infant feeding. Facilities providing maternity and newborn services have a responsibility to promote breastfeeding, but they must also respect the mother's preferences and provide her with the information needed to make an informed decision about the best feeding option for her and her infant. The facility needs to support mothers to successfully feed their newborns in the manner they choose."[1]

In 2015, WHO and UNICEF embarked on a process to review the most current scientific evidence pertaining to each of the Ten Steps and update the implementation guidance for the BFHI. Their goal was to reinvigorate the BFHI with the aim of worldwide adoption of the Ten Steps in all facilities providing birthing services.

The results of their work were published in two separate key documents:

GUIDELINE: ***Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services***[2] This is a review of the evidence for each individual step of the Ten Steps. It is NOT a review the evidence for the combined impact of multiple steps.

IMPLEMENTATION GUIDANCE: ***Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: the revised BABY-FRIENDLY HOSPITAL INITIATIVE***[1] (2018 Implementation Guidance)

The 2018 Implementation Guidance established global standards for each of the Ten Steps while calling on nations to customize the materials to address specific national goals. BFUSA engaged in a robust process to revise the Initiative for the US. An immediate and thorough review of the two key documents was conducted. A document was developed comparing the new guidance and standards with the existing US Guidelines and Evaluation Criteria (GEC) to determine if any immediate changes could be implemented. It was determined that adjustments to the requirements for Step 9 were warranted. Therefore, revised versions of the US GEC were published in July 2018 and December 2019.

In the meantime, an expert panel consisting of individuals with widespread knowledge and experience with implementing the BFHI standards was convened for a face-to-face meeting in August 2018. Based on its review of the updated evidence, the new implementation guidance, and the comparison with the existing standards, the panel recommended revisions to customize the global guidance for applicability to the US. These revisions were incorporated into updated documents and submitted to the expert panel, the BFUSA Board of Directors, Clinical Committee and several key national professional health organizations for further input. Those organizations included: Academy of Breastfeeding Medicine, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Nurse Midwives, Association of Women's Health, Obstetric and Neonatal Nurses and the United States Lactation Consultant Association.

The expert panel was reconvened in July 2019 to review the comments received in the latest review stage and assist with finalizing the guidance, standards and evaluation criteria for the US. The last component of the process was the incorporation of "Performance indicators demonstrating staff competency to implement" based on WHO and UNICEF's Competency Verification Toolkit: Ensuring Competency of Direct Care Providers to Implement the Baby-Friendly Hospital Initiative released on August 5, 2020.[3]

REVISIONS TO THE TEN STEPS TO SUCCESSFUL BREASTFEEDING

An important component of the effort to reinvigorate the BFHI by WHO and UNICEF was a review of the evidence for each of the Ten Steps to Successful Breastfeeding. Upon completing this task, the WHO and UNICEF then evaluated the actual wording for each Step. They concluded that the theme of each Step was appropriate but some of the phrasing needed to be changed to better align with the evidence.

Several noteworthy changes include: the incorporation of the International Code of Marketing of Breast-milk Substitutes and monitoring procedures into Step 1 and a shift in the focus of Step 2 from an emphasis on a specific number of hours of training to competency verification.

It is also worth pointing out that the steps are now divided into critical management procedures and key clinical practices. The chart to the right compares the 2018 revised version to the original 1989 Ten Steps.

TEN STEPS TO SUCCESSFUL BREASTFEEDING	
REVISED IN 2018	**ORIGINAL**
CRITICAL MANAGEMENT PROCEDURES **1 A.** Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions. **1 B.** Have a written infant feeding policy that is routinely communicated to staff and parents. **1 C.** Establish ongoing monitoring and data-management systems. **2.** Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.	**1.** Have a written breastfeeding policy that is routinely communicated to all health care staff. **2.** Train all health care staff in the skills necessary to implement this policy. **3.** Inform all pregnant women about the benefits and management of breastfeeding. **4.** Help mothers initiate breastfeeding within one hour of birth. **5.** Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants. **6.** Give infants no food or drink other than breast-milk, unless medically indicated. **7.** Practice rooming-in — allow mothers and infants to remain together 24 hours a day. **8.** Encourage breastfeeding on demand. **9.** Give no pacifiers or artificial nipples to breastfeeding infants. **10.** Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.
KEY CLINICAL PRACTICES **3.** Discuss the importance and management of breast-feeding with pregnant women and their families. **4.** Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth. **5.** Support mothers to initiate and maintain breastfeeding and manage common difficulties. **6.** Do not provide breastfed newborns any food or fluids other than breast-milk, unless medically indicated. **7.** Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day. **8.** Support mothers to recognize and respond to their infants' cues for feeding. **9.** Counsel mothers on the use and risks of feeding bottles, artificial nipples (teats) and pacifiers. **10.** Coordinate discharge so that parents and their infants have timely access to ongoing support and care.	

DOCUMENT CONTENT AND FORMAT

It is the goal of BFUSA to implement a program for the US that remains as closely aligned with the global initiative as possible, while at the same time, addressing the US needs and circumstances. As such, within the Guidelines and Evaluation Criteria section, as much specific language as possible was used from the 2018 (WHO/UNICEF) Implementation Guidance. (**NOTE:** some words were changed from the European to American spelling and some small amounts of text containing guidance unrelated to US hospitals were removed in order to avoid confusion.) Where necessary, additional US language within the implementation for each step were added in *italics*.

The document is organized according to the 2018 Ten Steps to Successful Breastfeeding. It must be noted that "while each of the Ten Steps contributes to improving the support for breastfeeding, optimal impact on breastfeeding practices, and thereby on maternal and child well-being, is only achieved when all Ten Steps are implemented as a package."[1] This entire document should be read with this point in mind.

Each step consists of the following sections:

- THE STEP NUMBER AND NAME
- RATIONALE
- IMPLEMENTATION GUIDANCE
- CONSIDERATIONS FOR SAFE IMPLEMENTATION
- PERFORMANCE INDICATORS DEMONSTRATING STAFF COMPETENCY TO IMPLEMENT
- STANDARDS
- CRITERIA FOR EVALUATION
- REFERENCES ARE FOUND AT THE END OF THE DOCUMENT

It is also important to point out that the BFHI is typically focused on the healthy term infant, however, in the US many late preterm infants are cared for on the postpartum floor. Therefore, some guidance and standards are relevant to their care. In some cases, the 2018 Implementation Guidance specifies if a standard applies to term infants or preterm infants. BFUSA felt it was more appropriate to remove the "term" and "preterm" language from the standard. Instead, the standard applies to where the mother, baby, or both are being cared for. In addition, a NICU Toolkit offering a comprehensive set of clinical practice recommendations geared towards increasing the use of breastfeeding and human milk in neonatal intensive care management has been developed.

This toolkit will be posted to www.babyfriendllyusa.org by the end of summer 2021.

DESCRIPTION OF SECTIONS INCLUDED IN EACH STEP

STEP NAME AND NUMBER: appears exactly as it is worded in the 2018 BFHI Implementation Guidance.

RATIONALE: offers insight into the purpose of the step and appears in this document exactly as it is worded in the 2018 BFHI Implementation Guidance.

IMPLEMENTATION GUIDANCE: provides critical information to support the standards which facilities should strive to achieve for all patients. This language is predominantly taken from the 2018 Implementation Guidance, with some adjustments in *italics* for applicability to the US. (NOTE: some words were changed from the European to American spelling and some small amounts of text containing guidance unrelated to US hospitals were removed in order to avoid confusion.)

US CONSIDERATIONS FOR SAFE IMPLEMENTATION: are suggested documents, policies, and/or protocols from either a recognized national/international medical professional organization or US governmental department, WHO or UNICEF that may assist facilities with the safe implementation of the step.

PERFORMANCE INDICATORS DEMONSTRATING STAFF COMPETENCY TO IMPLEMENT: are the knowledge, skills and attitudes that are necessary for staff to properly implement the step. They are mostly drawn from the WHO/UNICEF Competency Verification Toolkit titled "Ensuring Competency of Direct Care Providers to Implement the Baby-Friendly Hospital Initiative", however six Performance Indicators were developed specifically for the United States.

STANDARDS: are predominantly taken from the 2018 Implementation Guidance, with some adjustments in *italics* for applicability to the US.

CRITERIA FOR EVALUATION: are the specific quantifiable measures used by Baby Friendly USA (BFUSA) assessors to determine the birthing facility's conformity with the BFHI.

IMPORTANCE OF BREASTFEEDING

Human milk provided by direct breastfeeding is the biologically normal way to feed an infant. There are very few true contraindications to breastfeeding and scientific evidence overwhelmingly indicates that it is nutritionally superior, offers substantial immunological and health benefits, facilitates mother-baby bonding, and should be promoted and supported to ensure the best health for women and their children. Breastfeeding is the single most powerful and well-documented preventative modality available to health care providers to reduce the risk of common causes of infant morbidity. Significantly lower rates of diarrhea, otitis media, lower respiratory tract infections, Type 1 and Type 2 diabetes, childhood leukemia, necrotizing enterocolitis, and Sudden Infant Death Syndrome occur among those who were breastfed.[4, 5] Breastfeeding also supports the healthy development of an infant's gut microbiome[6] and is shown to be inversely associated with overweight risk.[7]

Women who breastfeed have a lower risk of Type 2 diabetes, hypertension and breast and ovarian cancers.[4, 8, 9] Evidence suggests that reduction in the risk of cardiovascular and other related diseases may be added to the benefits of breastfeeding for women.[10, 11] The American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the Centers for Disease Control and Prevention, and the World Health Organization all recommend exclusive breastfeeding for about 6 months and continued breastfeeding while adding complimentary foods for one year and beyond.

Despite the significant gains made during the past few years, the initiation, duration, and exclusivity of breastfeeding continue to lag

behind the national objectives, and racial disparities persist. In 2017, approximately 84% of all women initiated breastfeeding; however, only 74% of non-Hispanic black women and 77% of women with incomes below the poverty line initiated breastfeeding.[12]

While causes of this trend are multifactorial and complex, health care practices have been shown to play a fundamental role in impacting breastfeeding initiation, exclusivity, and duration. Unsupportive practices during the perinatal period can disrupt the unique and critical link between the prenatal education and the community postpartum support provided after discharge from the birthing facility. Conversely, supportive practices positively impact breastfeeding outcomes. The Ten Steps to Successful Breastfeeding, which form the foundation of the Baby-Friendly Hospital Initiative, are a package of evidence-based practices shown to improve breastfeeding outcomes. Studies have shown that the more steps a mother reports experiencing, the more likely she is to meet her breastfeeding goals.[13, 14]

CULTURAL HUMILITY AND RESPECT: ADDRESSING THE DIVERSE NEEDS OF PATIENTS

The Guidelines and Evaluation Criteria will directly affect all birthing individuals, pregnant women, mothers, and their infants and children. The practices described in this document apply equally to parents who may not identify as "women" or "mothers", including transgender and non-binary parents. The terms "mother" and "breastfeeding" are used throughout this document, reflecting the fact that the biological norm is female persons who give birth to infants and feed them at the breast. However, BFUSA wants to emphasize that we are respectful and mindful of the many different family types that exist in the US in which these terms do not necessarily represent the circumstances or norms of the family. This includes, but is not limited to, situations such as surrogacy, chest-feeding, or other circumstances in which persons who give birth to infants do not identify as "women" or "mothers," including transgender and nonbinary parents who may experience difficultly accessing culturally safe care.

We also want to highlight that different racial and ethnic groups have unique cultural norms that may affect a family's decision-making process. Achieving equity in breastfeeding is a key objective of the BFHI. This requires that leadership create an environment that enables and supports the availability of and access to quality breastfeeding support for all patients equally. It also requires that practitioners address the needs of diverse populations through breastfeeding counselling, safeguard privacy, and respect each individual's right to make informed and autonomous decisions.

Our expectation is that all families will be embraced and supported equally and that all patients will be provided the highest standard of individualized infant feeding care. Staff should engage in meaningful conversations with families — especially those with unique circumstances — to ensure the health professionals in charge have a clear understanding of each family's specific wishes and fully support each family's unique birth plan.

GUIDELINES AND EVALUATION CRITERIA FOR FACILITIES SEEKING TO ATTAIN AND SUSTAIN BABY-FRIENDLY® DESIGNATION

The Baby-Friendly USA *Guidelines and Evaluation Criteria* and the assessment and accreditation processes are predicated on the following tenets:

1. Well-constructed, comprehensive policies effectively guide staff to deliver evidence-based care.

2. Well-trained staff provide quality, evidence-based care.

3. Monitoring of practice is required to ensure adherence to policy and sustained standard of care.

4. The mother and her family should be protected within the health care setting from false or misleading product promotion and/or advertising which interferes with or undermines informed decisions regarding infant health care practices.

5. Facility staff should be protected from product promotion and/or advertising which may impact their professional activities and judgment.

6. Breastfeeding has been recognized by scientific authorities as the optimal method of infant feeding and should be the norm within all maternal and child health care facilities.

7. Facilities should follow the most scientifically sound, respectful, safe and effective procedural approaches to supporting breastfeeding and human lactation in the birthing environment.

8. The health care delivery environment should facilitate informed health care decisions on the part of the mother and her family. It should not be either restrictive or punitive.

9. The health care delivery environment should be culturally respectful and mindful of the diverse needs of the patients.

10. When a mother has chosen not to breastfeed, when supplementation of breastfeeding is medically indicated, or when supplementation is a decision by the breastfeeding mother (after appropriate conversations and education), it is crucial that safe and appropriate methods of formula preparation, handling, storage, and feeding are taught to the parents.

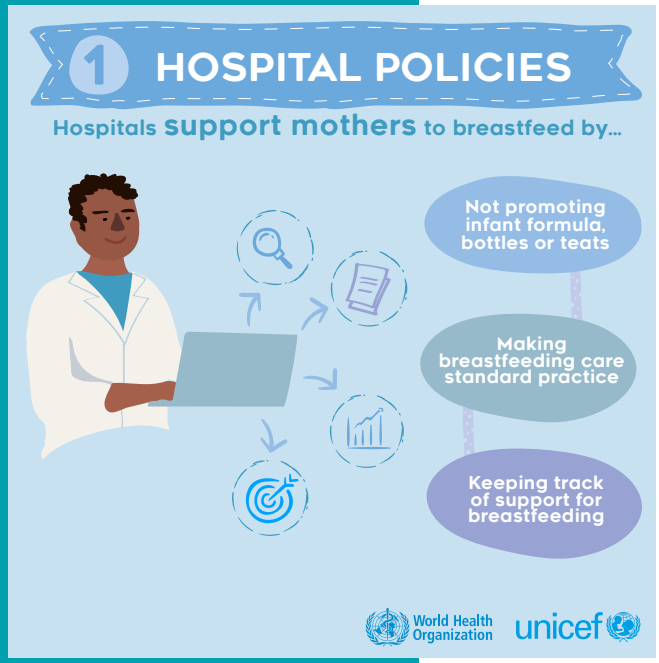
11. Recognition as a Baby-Friendly institution should have both national and international credibility and prestige, so that it is marketable to the community, increases demand, and thereby improves motivation among facilities to participate in the Initiative.

12. Participation of any facility in the U.S. BFHI is entirely voluntary and is available to any institution providing birthing services.

13. Each participating facility assumes full responsibility for assuring that its implementation of the BFHI is consistent with all of its safety protocols.

STEP 1

FACILITY POLICIES



Step 1 includes three critical management procedures:

STEP 1A
Application of the International Code of Marketing of Breast-milk Substitutes

STEP 1B
Development of written policies

STEP 1C
Operation of monitoring and data-management systems

STEP 1A

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 during the entire prenatal, perinatal, and postnatal period when they are making decisions about infant feeding. The WHA *(World Health Assembly)* has called upon health workers and health-care systems to comply with the International Code of Marketing of Breast-milk Substitutes[15, 16] and subsequent relevant WHA resolutions[17] (the *International* Code), in order to protect families from commercial pressures and influences. Additionally, health professionals themselves need protection from commercial influences that could affect their professional activities and judgement. Compliance with the *International* Code is important for facilities providing maternity and newborn services, since the promotion of breast-milk substitutes is one of the largest undermining factors for breastfeeding.[18]

Companies marketing breast-milk substitutes, feeding bottles and *artificial nipples [including pacifiers]* are repeatedly found to violate the *International Code*.[19, 20] It is expected that the sales of breast-milk substitutes will continue to increase globally, which is detrimental for children's survival and well-being.[21, 22] This situation means that ongoing concerted efforts will be required to protect, promote and support breastfeeding, including in facilities providing maternity and newborn services.[1]

IMPLEMENTATION GUIDANCE:

THE *INTERNATIONAL* CODE[15, 16] lays out clear responsibilities of healthcare systems to not promote infant formula, feeding bottles or *artificial nipples [including pacifiers]* and to not be used by manufacturers and distributers of products under the scope of the *International* Code for this purpose. This includes the provision that all facilities providing maternity and newborn services must acquire any breast-milk substitutes, feeding bottles or *artificial nipples [including pacifiers]* they require through normal procurement channels and not receive free or subsidized supplies.[23] Furthermore, staff of facilities providing maternity and newborn services should not engage in any form of promotion or permit the display of any type of advertising of breast-milk substitutes, *feeding bottles*, and/or infant feeding supplies *[pacifier promotion must meet the requirements specified in Criterion 9.2.1]* 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 routinely give samples of infant formula to mothers to take home.[1]

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,[24], 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 *covered by the International Code* and industry covered by the *International Code* should not participate in parenting education.[1]

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

Health professionals and institutions should avoid activities with commercial influences that could affect their professional activities and judgement. Below are a few examples:

AVOIDANCE OF CONFLICTS OF INTEREST

POTENTIAL CONFLICT	*Allowing companies that manufacture and/or market breast-milk substitutes, feeding bottles and artificial nipples [including pacifiers] to sponsor and/or host trainings, events, meetings, and scientific seminars on breastfeeding.*
POTENTIAL HARM	*Associating the name of the respected health facility with a company implies facility endorsement of that company and/or its products. This may unintentionally sway health professionals to recommend products to patients that are not specific to their needs.*
REQUIREMENT	*Criterion 1A.3.1 requires that no items bear product images or product logos of companies that produce breast-milk substitutes, feeding bottles and artificial nipples [including pacifiers] or names of products covered under the International Code unless specific to the pregnant woman's, mother's or infant's needs or conditions. Criterion 1A.4.4 calls for the facility to have a policy that describes how the facility and its staff members: do not receive support/sponsorship for events/meetings.*

POTENTIAL CONFLICT	*Health professionals attending trainings sponsored by companies that manufacture and/or market breast-milk substitutes, feeding bottles and artificial nipples [including pacifiers].*
POTENTIAL HARM	*Receipt of meals and/or free registration to meetings creates a potential obligation to favor that company's products over other products.*
REQUIREMENT	*Criterion 1A.4.4 calls for the facility have a policy that describes how the facility and its staff members do not receive free gifts.*

POTENTIAL CONFLICT	*Receipt of awards and gifts by the staff or facility from companies that manufacture and/or market breast-milk substitutes, feeding bottles and artificial nipples [including pacifiers].*
POTENTIAL HARM	*It associates a company's name with a respected staff member setting that staff member up as "role model" for others. This may imply the staff member's endorsement of a product or company.*
REQUIREMENT	*Criterion 1A.4.4 calls for the facility have a policy that describes how the facility and its staff members do not receive free gifts, [Examples include meals, conference fees].*

US CONSIDERATIONS FOR FACILITIES THAT COORDINATE WITH OUTSIDE AGENCIES THAT ALSO DISCUSS INFANT FEEDING WITH MOTHERS AND THEIR SUPPORT SYSTEMS:

All facilities are encouraged to coordinate services with other community programs that provide counseling, support, and education on breastfeeding. Some facilities have developed processes that begin coordinating services during the birth hospitalization. While these services offer many benefits to families, hospitals should coordinate efforts to minimize interruptions to mothers during the hospital stay. This will allow maximum opportunity for mothers to recover from birth, bond with their babies and learn their feeding cues. Outside agencies interacting with mothers in the hospital setting should have sufficient training to support exclusive breastfeeding. Procedures should be established between the facility and the outside agency as to how the outside agency should respond and support the breastfeeding mother who requests formula from them while in the hospital setting. ***Compliance with the International Code is essential in protecting mothers who are still making decisions about infant feeding.***

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

STEP 1A

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 1A	VERIFICATION METHOD
*1. **List** at least 3 products that are covered by the Code.	**Question or case study**
*2. **Describe** at least 3 ways a direct care provider/direct care staff member protects breastfeeding in practice.	**Question or case study**
*3. **Describe** at least 1 way a direct care provider/direct care staff member should respond if offered information provided by manufacturers and/or distributors of products within the scope of the Code.	**Question or case study**
*4. **Describe** at least 1 type of financial or material inducement that might be offered to a direct care provider/direct care staff member by a manufacturer and/or distributor of products within the scope of the Code.	**Question or case study**
*5. **Describe** at least 1 harm of a direct care provider/direct care staff member accepting financial or material inducements.	**Question or case study**
*6. **Explain** at least 2 ways that the facility and any affiliated prenatal services ensure that there is no promotion of infant formula, feeding bottles, or *artificial nipples* in any part of facilities providing maternity and newborn services, or by any of the direct care providers/direct care staff.	**Question or case study**

STEP 1A

THE FOLLOWING STANDARDS APPLY

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
1A.1 All infant formula, feeding bottles and *artificial nipples [including pacifiers]* used in the facility have been purchased through normal procurement channels and not received through free or subsidized supplies.	**A review of records will confirm:** ***Criterion 1A.1.1*** *A review of records [invoices and proofs of payment] indicates that infant formula, feeding bottles and artificial nipples [including pacifiers] used in the facility have been purchased at a fair market price through normal procurement channels and not received through free or subsidized supplies or rebates that drop the price below the fair market price.*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
1A.2 Health professionals who provide *prenatal*, delivery and/or newborn care can explain at least two elements of the International Code.	**Interviews with direct care nursing staff and direct care providers will confirm:** ***Criterion 1A.2.1*** *At least 80% of health professionals who provide prenatal, delivery, postpartum, and/or well newborn units can explain at least two elements of the International Code.* *A. Direct care nursing staff,* AND *B. Direct care providers with privileges*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
1A.3 The facility *[including affiliated prenatal services]* has no display of products covered under the *International* Code or items with logos of companies that produce breast-milk substitutes, feeding bottles and *artificial nipples [including pacifiers]*, or names of products covered under the *International* Code.	**A review and/or observation of items will confirm:** ***Criterion 1A.3.1*** *A review of submitted and/or observed items in the facility [including affiliated prenatal services] will confirm that no items bear product images or product logos of companies that produce breast-milk substitutes, feeding bottles and artificial nipples [including pacifiers] or names of products covered under the International Code unless specific to the pregnant woman's, mother's or infant's needs or conditions. (For example, information about how to safely use a needed product such as a formula or a specialty bottle would be acceptable to give to a mother or infant needing that specific product. Marketing information for such products would not be acceptable.)* *A. In the affiliated prenatal clinic/service, AND* *B. In the birthing facility* *continued*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
1A.3 The facility *[including affiliated prenatal services]* has no display of products covered under the *International* Code or items with logos of companies that produce breast-milk substitutes, feeding bottles and *artificial nipples [including pacifiers]*, or names of products covered under the *International* Code.	**A review and/or observation of items will confirm:** ***Criterion 1A.3.2*** *A review of submitted and/or observed items displayed and/or distributed to pregnant women, mothers, or staff in the facility [including affiliated prenatal services] will confirm all items are free of messages that promote or advertise breast-milk substitutes, feeding bottles, and artificial nipples or other infant feeding supplies.* *A. In the affiliated prenatal clinic/service, AND* *B. In the birthing facility* ***Criterion 1A.3.3**** *A review of submitted and/or observed items in the facility [including affiliated prenatal services] will confirm that any items displayed or distributed to pregnant women and mothers are free of messages that promote or advertise the use of pacifiers, except safe sleep and SUIDS/SIDS risk reduction materials which must contain additional language to promote breastfeeding. [See criterion 9.2.1]* *A. In the affiliated prenatal clinic/service, AND* *B. In the birthing facility* **Observation will confirm:** ***Criterion 1A.3.4*** *Observations will confirm that infant formula is kept out of view of patients and the general public.* *A. In the affiliated prenatal clinic/service, AND* *B. In the birthing facility*

CLARIFICATION: CRITERION 1A.3.3* PACIFERS AND SUIDS/SIDS REDUCTION INFORMATION

BFUSA acknowledges the evidence pertaining to pacifier use related to SUIDS/SIDS risk reduction.[25] Safe sleep and SUIDS/SIDS risk reduction information is important for parents to receive during the birth hospital stay.[26, 27] This education may be compatibly provided to parents by using safe sleep materials that also promote breastfeeding. SEE STANDARD 9.2 FOR ADDITIONAL GUIDANCE.

WHO/UNICEF STANDARD	US CRITERIA FOR EVALUATION
1A.4 The facility has a policy that describes how it abides by the *International* Code, including procurement of breast-milk substitutes, not accepting support or gifts from producers or distributors of products covered by the *International* Code and not giving samples of breast-milk substitutes, feeding bottles or *artificial nipples [including pacifiers]* to mothers.	**The facility has a policy that describes how it abides by the *International* Code, including:** ***Criterion 1A.4.1*** *How the facility procures infant feeding products.* ***Criterion 1A.4.2*** *How the facility [including affiliated prenatal services] protects pregnant women, mothers, and their families by not allowing the receipt or distribution of:* ▪ *Marketing materials* ▪ *Samples* ▪ *Gift packs* ▪ *Coupons* *that include breast-milk substitutes, feeding bottles, artificial nipples, and pacifiers, or other infant feeding supplies.* ***Criterion 1A.4.3*** *How the facility [including affiliated prenatal services] protects pregnant women, mothers and their families by preventing direct contact or indirect contact with the manufacturers and/or distributors of breast-milk substitutes, feeding bottles, artificial nipples, and pacifiers.* ▪ *Direct contact [examples include providing infant feeding hotline numbers staffed by company employees/contractors]* ▪ *Indirect contact [examples include use of mechanisms to collect mothers' names and provide to companies/contractors through photographers and special discharge programs]* ***Criterion 1A.4.4*** *How the facility [including affiliated prenatal services] protects itself and its staff members from marketing by manufacturers or distributors of breast-milk substitutes, bottles, nipples, pacifiers or other infant feeding supplies, by precluding the receipt of:* ▪ *Free gifts [Examples include meals, conference fees]* ▪ *Information that is not scientific, factual, and unbiased* ▪ *Materials [Examples include posters, magazines]* ▪ *Promotional items* ▪ *Equipment* ▪ *Money* ▪ *Support for breastfeeding education* ▪ *Support/sponsorship for events/meetings* *All other interactions with these manufacturers/distributors are in compliance with the facility's vendor/ethics policy.*

STEP 1B

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

RATIONALE:

Policy drives practice. *Health professionals* and institutions are required to follow established policies. The clinical practices articulated in the Ten Steps need to be incorporated into facility policies, to guarantee that appropriate care is equitably provided to all mothers and babies and is not dependent on the *routines and/or* preferences of each *direct* care provider. Written policies are the vehicle for ensuring patients receive consistent, evidence-based care, and are an essential tool for *direct care* staff accountability. Policies help to sustain practices over time and communicate a standard set of expectations for all health workers.[1]

IMPLEMENTATION GUIDANCE:

Facilities providing maternity and newborn services should have a clearly written breastfeeding policy that is routinely communicated to staff and parents.[2] A facility breastfeeding policy may stand alone as a separate document, be included in a broader infant feeding policy, or be incorporated into a number of other policy documents *or protocols*. However organized, the policy should include guidance on how each of the clinical and care practices should be implemented, to ensure that they are applied consistently to all mothers. The policy should also spell out how the management procedures should be implemented, preferably via specific processes that are institutionalized.[1]

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

Orient all direct care staff and direct care providers who are impacted by the infant feeding policy as soon as possible, no later than 12 weeks post hire.

In order to have safe, effective and sustained improvement in practices, infant feeding policies in facilities providing maternity and newborn services need to cover all established standards of practice, be fully implemented and regularly communicated to direct care staff and direct care providers.[2] Frequency of communication to staff must occur, minimally, every 2 years.

STEP 1B

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 1A	VERIFICATION METHOD
*7. **Describe** at least 2 elements that are in the facility's infant feeding policy.	**Question or case study**
*8. **Explain** at least 3 ways that the infant feeding policy affects a direct care provider's/direct care staff member's work in *providing safe, equitable and appropriate care.*	**Question or case study**

THE FOLLOWING STANDARDS APPLY

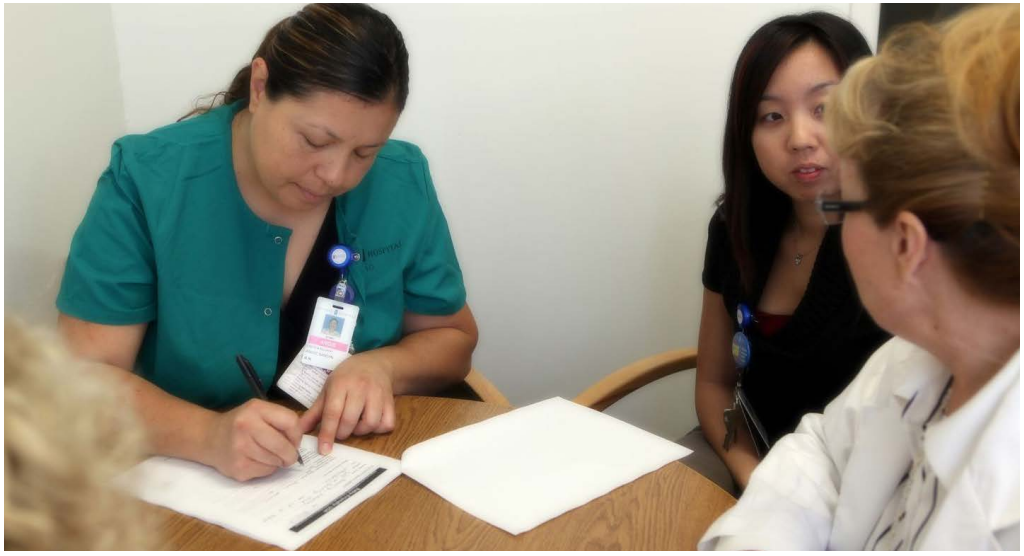
WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
1B.5 The health facility has a written infant feeding policy that addresses the implementation of all eight key clinical practices of the Ten Steps, *International* Code implementation, and regular competency assessment.	**A review of the policy will confirm:** ***Criterion 1B.5.1*** *The facility will have comprehensive, evidence-based, written maternity care and infant feeding policies that address all Ten Steps, protect breastfeeding, and which includes adherence to the International Code.*
1B.6 A review of all clinical protocols or standards related to breastfeeding and infant feeding used by the maternity services indicates that they are in line with BFHI standards and current evidence-based guidelines.	**A written description will confirm:** ***Criterion 1B.6.1*** *The Director of Maternity will provide a written description of how all the clinical protocols or standards related to breastfeeding and infant feeding used by the maternity services are reviewed and aligned with BFHI standards and current evidence-based guidelines.*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
1B.7 Observations in the facility confirm that a summary of the policy is visible to pregnant women, mothers and their families.	**Observations will confirm:** ***Criterion 1B.7.1*** *Observations in the facility and affiliated prenatal services confirm that The Ten Steps to Successful Breastfeeding (WHO/UNICEF revised 2018) will be visible to pregnant women, mothers and their families. The Ten Steps poster locations include the waiting room and/or admission areas of the following units:* *A. Labor and delivery unit* *B. Postpartum unit* *C. Affiliated prenatal services* *D. Ultrasound, screening/lab, prenatal testing areas* *E. Newborn nursery/observation area/procedure room* *F. Neonatal intensive care unit* *G. Emergency room* *This information will be displayed in the language(s) most commonly understood by patients.* **A review of materials will confirm:** ***Criterion 1B 7.2*** *A review of the content of the Ten Steps posters will verify alignment to the Ten Steps Poster Guide requirements [4-D Pathway document].*
1B.8 Clinical staff *[Health professionals]* who provide *prenatal*, delivery and/or newborn care can explain at least two elements of the infant feeding policy that influence their role in the facility.	**Interviews with direct care nursing staff and direct care provider will confirm:** ***Criterion 1B. 8.1*** *At least 80% of health professionals who provide prenatal, delivery, postpartum, and/or well newborn care can explain at least two elements of the infant feeding policy that influence their role in providing safe, equitable and appropriate care. [PI 8]* *A. Direct care nursing staff, AND* *B. Direct care providers with privileges* ***Criterion 1B.8.2*** *At least 80% of health professionals who provide prenatal, delivery, postpartum, and/or well newborn care will confirm that they are aware of the facility's maternity care and infant feeding policies and know where the policies are kept or posted.* *A. Direct care nursing staff, AND* *B. Direct care providers with privileges* *continued*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
1B.8 Clinical staff *[Health professionals]* who provide *prenatal*, delivery and/or newborn care can explain at least two elements of the infant feeding policy that influence their role in the facility.	**A review of materials will confirm:** ***Criterion 1B.8.3*** *A designated health professional will provide a written description that includes a summary of how and when health professionals are made aware of the infant feeding policy including:* *A. A Process and timeline to orient direct care staff and direct care providers who provide prenatal, delivery and/or newborn care in the implementation of the infant feeding policy, AND* *B. A Process and frequency for routine communication of all direct care staff and direct care providers who provide prenatal, delivery and/or newborn care. Considerations for routine communication may include:* ▪ *A review of high-risk/safety-related procedural steps, and/or* ▪ *Updates regarding revisions, and/or* ▪ *Review of practical skills, and/or* ▪ *Quality improvement efforts when monitoring data indicates one or more policy practices are not being fully adhered to.*

US STANDARD	CRITERION FOR EVALUATION
1B.9 All forms of patient educational materials related to infant feeding (booklets, applications, videos, text, etc.) and a written description of the content of the education, will be made available at assessment. A review of these materials must demonstrate current evidence-based guidance, include all of the required topics listed in Appendix A, and align with both the facility's infant feeding policy and the Ten Steps to Successful Breastfeeding.	**A review of educational materials will confirm:** ***Criterion 1B.9.1*** *Prenatal Education: All forms of patient educational materials related to infant feeding (booklets, applications, videos, text, etc.) and a written description of the content of the education provided to pregnant women during the prenatal period [including both affiliated prenatal services and in-house programs], will be made available at assessment. A review of these materials must:* *A. Demonstrate current evidence-based guidance, AND* *B. Include all of the required topics listed in Appendix A, AND* *C. Align with both the facility's infant feeding policy and the Ten Steps to Successful Breastfeeding.* ***Criterion 1B.9.2*** *Postpartum Breastfeeding Education: All forms of educational materials related to infant feeding (booklets, applications, videos, text, etc.) and/or a description of the content of the education, provided to postpartum breastfeeding mothers during the birth hospitalization will be made available at assessment. A review of these materials must:* *A. Demonstrate current evidence-based guidance, AND* *B. Include all of the required topics listed in Appendix A, AND* *C. Align with both the facility's infant feeding policy and the Ten Steps to Successful Breastfeeding.* *continued*

US STANDARD	CRITERION FOR EVALUATION
1B.9 All forms of patient educational materials related to infant feeding (booklets, applications, videos, text, etc.) and a written description of the content of the education, will be made available at assessment. A review of these materials must demonstrate current evidence-based guidance, include all of the required topics listed in Appendix A, and align with both the facility's infant feeding policy and the Ten Steps to Successful Breastfeeding.	**A review of educational materials will confirm:** ***Criterion 1B.9.3*** *Postpartum Infant Formula Feeding Education: All forms of educational materials related to infant feeding (booklets, applications, videos, text, etc.) and/or a description of the content of the education, provided to formula feeding mothers during the birth hospitalization will be made available at assessment. A review of these materials must:* *A. Demonstrate current evidence-based guidance, AND* *B. Include all of the required topics listed in Appendix A, AND* *C. Align with both the facility's infant feeding policy and the Ten Steps to Successful Breastfeeding.*



STEP 1C

Establish ongoing monitoring and data-management systems.

RATIONALE:

Facilities providing maternity and newborn services need to integrate recording and monitoring of the clinical practices related to breastfeeding into their quality-improvement/monitoring systems.[1]

IMPLEMENTATION GUIDANCE:

IMPLEMENTATION: *A fundamental principle of the BFHI is that monitoring of practices is required to confirm adherence to policies and evidence-based care. Indicators for facility-based monitoring of the required key clinical practices are listed in APPENDIX B: INDICATORS FOR FACILITY MONITORING KEY CLINICAL PRACTICES. The monitoring data for certain indicators will be collected from medical records and reported on the Facility Data Sheet located in the BFUSA portal. Specific guidance on numerator and denominator inclusions and exclusions are found in the instructions for each indicator on the Facility Data Sheet. Two of the indicators, early initiation of breastfeeding and exclusive breastfeeding, are considered "sentinel indicators". A sentinel indicator captures an essential element that serves as a bellwether in a complex change process. "Sentinel indicators are placed at critical points in a system map to help monitor and inform the mutually influencing relationship between the program and its context."[28, 29] Facilities should routinely track all required indicators for each mother—infant pair. Recording of information on the indicators should be incorporated into the medical charts and extracted into relevant reports and/or dashboards.[1] The monitoring data for indicators not included on the Facility Data Sheet will be collected through audits and/or surveys, also located in the BFUSA portal.*

Each facility must form a multi-disciplinary committee, which must consist of some direct care providers and direct care staff, to guide the work towards implementation of these Guidelines and Evaluation Criteria. This committee will retain a key post-designation role which will include monitoring the required key clinical practices to ensure sustainability and should meet to review progress at least every 6 months. During concentrated periods of *implementation of a practice and/or* 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, *mother's surveys and/or audits are to be used* for additional verification purposes or periodic checks.[1]

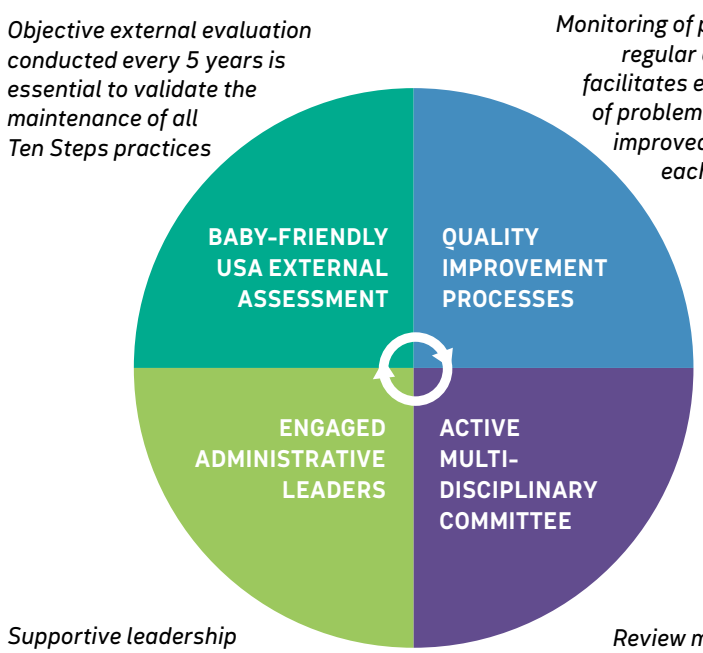
Once acceptable levels of compliance have been achieved, the frequency of data collection on these additional indicators can be reduced, for example to annually. However, if the level of the sentinel indicators falls below 80% (or below national standards), it will be important to assess both the clinical practices and all management procedures, to determine where the *breakdown is* and what needs to be done to achieve the required standards.[1]

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

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."[22] Sustaining practices requires facilities to build systems to monitor key clinical Indicators. Key principles of sustaining safe, evidence-based practices include cyclical quality improvement methodologies, active participation of a multi-disciplinary committee, engaged administrative leaders, meeting consistently over time, and external assessment.[1]

As facilities strive to achieve the metrics described in these Guidelines and Evaluation Criteria, it is important they do so while continuing to focus on providing individualized, culturally sensitive care equitably provided to all mothers and babies.

SUSTAINING PRACTICES



REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 1C	VERIFICATION METHOD
*9. **Explain** at least 2 reasons why monitoring of hospital practices is important to ensure quality of care.	**Question or case study**
*10. **Explain** at least 2 ways practices are monitored in this facility.	**Question or case study**

THE FOLLOWING STANDARDS APPLY

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
1C.10 The facility has a protocol for an ongoing monitoring and data-management system to comply with the eight key clinical practices.	**A review of the policy will confirm:** ***Criterion 1C.10.1*** *A review of the infant feeding policy and any related protocols includes a description of how the facility will routinely collect and track clinical practice indicators in order to report and improve on quality of care involving the data to evaluate the 8 key clinical practice steps [Steps 3-10].*
1C.11 Clinical staff *(direct care providers and direct care staff)* at the facility meet at least every 6 months to review implementation of the system.	**The nursing director/manager will confirm:** ***Criterion 1C.11.1*** *The Nursing Director/Manager will confirm that the multi-disciplinary committee, which must consist of some direct care providers and direct care staff, meets at least every 6 months, ideally every 3 months, for monitoring purposes that include:* *A. Analyzing the key clinical practice indicator data to determine if targets are met, AND* *B. Defining corrective actions to improve quality of care, if needed.* ***NOTE:*** *"During concentrated periods of quality improvement, monthly review may be needed." Facilities should consider ways to provide constructive feedback to direct care providers and direct care staff and support for practice improvement when monitoring data indicate practices are not fully implemented.*

COMPETENCY ASSESSMENT—SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
1C.12 Health professionals who provide prenatal, delivery and/or newborn care will demonstrate their competence regarding the facility's monitoring systems.	**The nursing director/manager will confirm:** **Criterion 1C.12. 1** *At least 80% of health professionals who provide prenatal, delivery, postpartum, and/or well newborn care will be able to explain at least 2 reasons why monitoring of hospital practices is important to ensure quality of care. [PI 9]* *A. Direct care nursing staff, AND* *B. Direct care providers with privileges*

STEP 2

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

RATIONALE:

Timely and appropriate care for all mothers can only be accomplished if staff have the knowledge, skills and *attitudes* to carry it out. Training of health staff enables them to develop effective skills, give consistent messages, and implement policy standards. Staff cannot be expected to implement a practice or educate a patient on a topic for which they have received no training.[1]

IMPLEMENTATION GUIDANCE:

COMPETENCY REQUIREMENTS: *Health professionals who provide infant feeding services must be competent in the knowledge, skills and attitudes to implement the Ten Steps to Successful Breastfeeding.*

TABLE 1 *(on the next page) provides the high-level competency framework in which 16 specific management and support competencies are organized into seven unique domains.* The domains begin with critical management procedures that health professionals need to participate in to create such needed environments. Foundational skills include effective communication and counseling that transversally apply throughout clinical competencies. They then progress through the various perinatal stages along the continuum of care and services, from the prenatal period until discharge from the site of birth.[3] ***VERIFICATION OF THE 16 COMPETENCIES IS THE PRIMARY FOCUS ON ENSURING SAFE, EVIDENCE-BASED, COMPASSIONATE CARE.***

TABLE 1: DOMAINS AND COMPETENCIES[3]

DOMAINS	COMPETENCIES NECESSARY FOR IMPLEMENTING THE TEN STEPS TO SUCCESSFUL BREASTFEEDING
DOMAIN 1: Critical management procedures to Support the Ten Steps (Step 1A, 1B, and 1C)	01. **Implement** the Code in a health facility 02. **Explain** a facility's infant feeding policies and monitoring systems
DOMAIN 2: Foundational skills: communicating in a credible and effective way (All Steps)	03. **Use** listening and learning skills whenever engaging in a conversation with a mother 04. **Use** skills for building confidence and giving support whenever engaging in a conversation with a mother
DOMAIN 3: Prenatal period (Step 3)	05. **Engage** in antenatal conversation about breastfeeding
DOMAIN 4: Birth and immediate postpartum (Step 4)	06. **Implement** immediate and uninterrupted skin-to-skin 07. **Facilitate** breastfeeding within the first hour, according to cues
DOMAIN 5: Essential issues for a breastfeeding mother (Steps 3, 5, 6, 7, 8, 9)	08. **Discuss** with a mother how breastfeeding works 09. **Assist** mother getting her baby to latch 10. **Help** a mother respond to feeding cues 11. **Help** a mother manage milk expression
DOMAIN 6: Helping mothers and babies with special needs (Steps 5, 6, 7, 8, 9)	12. **Help** a mother to breastfeed a low-birth-weight or sick baby 13. **Help** a mother whose baby needs fluids other than breast milk 14. **Help** a mother who is not feeding her baby directly at the breast 15. **Help** a mother prevent or resolve difficulties with breastfeeding
DOMAIN 7: Care at discharge (Step 10)	16. **Ensure** seamless transition after discharge

PERFORMANCE INDICATORS: *Performance indicators are a subset of the competencies that provide measurable guidance to evaluate each competency listed in **TABLE 1**. Each performance indicator represents only one action, so only one action verb is used.[3] Performance indicators have been included in their relative steps throughout this document. Appendix C includes a comprehensive list of all performance indicators. All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *. **TABLE 2** provides an example from Domain 5, Competency 9, Assist mother getting her baby to latch.*

TABLE 2: EXAMPLE: PERFORMANCE INDICATORS AND MEASURABLE ACTIONS[46]

DOMAIN	COMPETENCY	PERFORMANCE INDICATORS	MEASURABLE ACTIONS
Essential issues for a breastfeeding mother	09. Assist mother getting her baby to latch	32. **Evaluate** a full breastfeeding session observing at least 5 points.	**Observation**
		33. **Demonstrate** at least 3 aspects of how to help a mother achieve a comfortable and safe position for breastfeeding within the first 6 hours after birth and later as needed during the hospital stay.	**Observation**
		34. **Demonstrate** how to help a mother achieve an effective and comfortable latch, noting at least 5 points.	**Observation**

TRAINING, ASSESSMENT, AND VERIFICATION OF COMPETENCIES: *Health professionals need to know what to explain to a mother, why it is important, how to do what is necessary and how to do it respecting the mother's concerns and circumstances.* **STEP 2** *focuses on verification of the performance indicators [Appendix C] to ensure that health professionals are competent in supporting breastfeeding, especially during the first few days of the birth hospitalization. Ideally,* the responsibility for assessing, training, and verifying the competencies of health professionals should reside with the pre-service education system [professional degree programs]. However, if this has not occurred and staff training is deficient in this area, facilities providing maternity and newborn services will need to take corrective measures to strengthen that capacity, such as by offering courses at the facility or requiring that staff to take courses elsewhere. While some material can be taught through didactic lectures (including electronic resources), some supervised clinical experience with assessing of competencies is necessary. It is important to focus not on a specific curriculum but on the knowledge and skills obtained.[1] **TABLE 3** *describes 2 options for implementing Step 2 competency-based training.*

TABLE 3: FACILITY OPTIONS FOR COMPETENCY-BASED TRAINING.

OPTION 1: COMPETENCY-BASED TRAINING SPECIFIC TO IDENTIFIED NEEDS	OPTION 2: COMPETENCY-BASED TRAINING FOR ALL HEALTH PROFESSIONALS
1. Assess *the competencies of each health professional to identify specific training needs.* ***2. Provide*** *competency-based training specific to needs identified.* ***3. Verify*** *each health professional is competent.* ***4. Remediate*** *as needed.*	***1. Provide*** *competency-based training program [internal or external] for all health professionals.* ***2. Verify*** *all health professionals are competent.* ***3. Remediate*** *as needed.*

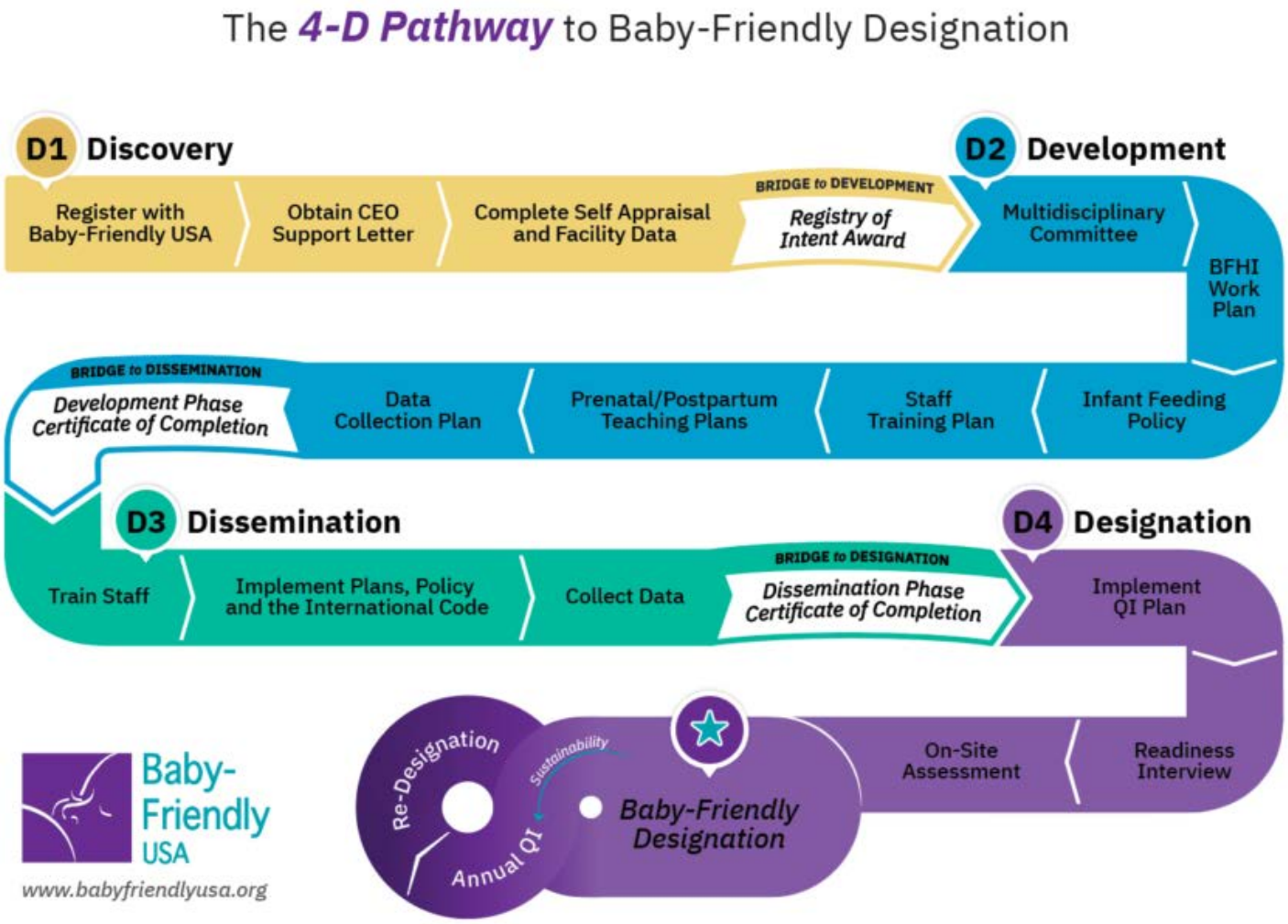
HEALTH PROFESSIONAL ROLES REQUIRING COMPETENCY-BASED TRAINING: *All direct care staff and direct care providers [physicians, midwives, physician's assistants, and advanced practice registered nurses] who provide education, assessment, support, intervention, assistance and/or follow-up with regards to infant feeding must have required competencies verified and completed training on identified areas needing improvement, within 6 months of hire. Typically, this will involve the following units/services including: Affiliated Prenatal Services, Labor and Delivery Unit, Postpartum Unit, Newborn Unit.* ***NOTE:*** *Steps 1-10 include unit/care-based competency and training requirements specific to staff/provider roles.*

OTHER ROLES *with anticipated workplace exposure to mothers and babies should have training and competency verification in accordance with their roles. Examples of other positions that may need training include:*

- *Administrative Leaders/Managers*
- *Purchasing Agent*
- *Pharmacists*
- *Anesthesiologists*
- *Outside agencies that make inpatient visits*

US PRE-DESIGNATION, ASSESSMENT, AND POST-DESIGNATION CONSIDERATIONS

The 4-D Pathway, consisting of 4 pre-designation and 2 post-designation phases was developed to guide facilities through the designation process. Facilities have specific tasks to complete in each phase and are provided with a variety of tools and resources to assist with their implementation of the Baby-Friendly USA Guidelines and Evaluation Criteria.



- **D1: DISCOVERY PHASE:** *The Discovery Phase is a time for facilities to learn about the processes and requirements for becoming Baby-Friendly designated. The Discovery Phase toolkit provides a self-appraisal tool to help facilities identify which requirements are already in place and which ones still need additional work.*

- **D2: DEVELOPMENT PHASE:** *The Development Phase provides a template titled,* ***DIRECT CARE STAFF AND DIRECT CARE PROVIDER COMPETENCY VERIFICATION AND TRAINING PLAN*** *to assist facilities in developing a comprehensive plan for verifying competencies and helping health professionals gain the knowledge, skills and attitudes necessary to competently implement the facility's infant feeding policy in a safe and effective manner.*

- **D3: DISSEMINATION PHASE:** *The Dissemination Phase involves the verifying of competencies and implementation of training plans that address identified gaps in knowledge and skills, for all direct care staff and direct care providers.*

- **D4: DESIGNATION PHASE:** *The Designation Phase is the time for facilities to reverify competencies for those areas where additional training was provided.*

- **EXTERNAL ASSESSMENT:** *During the Assessment, interviews with health professionals will include facility-based direct care nursing staff and privileged direct care providers. Evaluation of performance indicators at assessment will include a selection of knowledge-based questions and skills-based demonstrations specific to the interviewee's role and responsibilities. Baby-Friendly USA has aligned competency-based assessment tools of health "professionals with the WHO/UNICEF Competency Verification Toolkit: Ensuring Competency of Direct Care Providers to Implement the Baby-Friendly Hospital Initiative released on August 5, 2020."*

- **ANNUAL QUALITY IMPROVEMENT-SUSTAINABILITY PHASE:** *During the first-year post-designation facilities must develop an Ongoing Competency Evaluation, Training and Verification Plan similar to the one prepared during the Development Phase. (A template for this plan will be provided by Baby-Friendly USA) In-service training must take place minimally every 2 years. The facility will determine the number of hours and content of this training for each staff and provider role. Competency assessment and in-service training must also take place on specific topics when monitoring data indicates one or more practices are not being fully adhered to.*

- **RE-DESIGNATION YEAR 1 PHASE:** *Facilities entering the Re-Designation Year 1 Phase will complete assigned competency assessments and audits to ensure that practices have been sustained. If the results of either reveal practices have slipped, targeted training must be completed to address identified knowledge and/or skills gaps for each direct care provider and direct care staff member.*

STEP 2

US CONSIDERATION FOR SAFE IMPLEMENTATION:

Facilities are encouraged to review the American Academy of Pediatrics' "Clinical Report: Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns" for suggested safe skin-to-skin care and rooming-in practices.[25] Staff should receive training that supports safe implementation of these practices.

Sufficient knowledge, skills and attitudes to support breastfeeding are essential for the provision of safe, evidence-based, compassionate care. In addition, how information is communicated is equally important. Direct care providers and staff should engage in meaningful conversations that **ENCOURAGES** *the patient and family members.*

E MPATHIZE
N ON-JUDGMENTAL
C ONFIRM
O PEN-ENDED QUESTIONS
U SE COMPETENT SKILLS
R ESPONSIVE CARE
A FFIRM
G IVE EVIDENCE-BASED INFORMATION
E MPOWER
S UPPORT

E — *Empathize while listening and engaging in the conversation.*

N — *Be Non-judgmental by respecting each individual's experiences with breastfeeding, current infant feeding goals, and/or cultural and social considerations.*

C — *Confirm you understand the specific circumstances, issues and/or concerns.*

O — *Ask Open-ended questions to evaluate each person's understanding of breastfeeding, infant formula feeding and/or specific maternity care practices applicable to the conversation. For example, "What have you heard about breastfeeding?" "What do you know about infant formula?"*

U - *Use competent skills to assess any potential or current concerns or challenges.*

R - *Responsive care that provides anticipatory guidance [including suitable options] and/or addresses the specific concerns and circumstances.*

A - *Affirm successes and the desire to do what is right for the baby.*

G — *Give evidenced based, scientific, unbiased, and factual information in a sensitive manner that emphasizes the protections provided by breastfeeding/maternity care practices to enable an informed decision.*

E — *Empower each individual to make the decision that is right for her/his circumstances.*

S — *Support informed decisions by providing an individualized plan that encourages a mother to have a safe, responsive, caring, and nurturing relationship with her baby.*

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT THE STEP	VERIFICATION METHOD
Foundational skills: communicating in a credible and effective way	
*11. **Demonstrate** at least 3 aspects of listening and learning skills when talking with a *pregnant woman*/mother.	**Observation**
*12. **Demonstrate** at least 3 ways to adapt communication style and content when talking with a mother.	**Observation**
*13. **Demonstrate** at least 2 ways to encourage a mother to share her views, taking time to understand and consider these views.	**Observation**
*14. **Demonstrate** at least 3 aspects of building confidence and giving support when talking with a mother.	**Observation**

THE FOLLOWING STANDARDS APPLY

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
2.1 Health professionals who provide *prenatal*, delivery and/or newborn care report they have received pre-service or in-service training on breastfeeding during the previous 2 years.	**Interviews with health professionals will confirm:** ***Criterion 2.1.1*** *At least 80% of health professionals who provide prenatal, delivery and/or newborn care can describe what pre-service or in-service training on breastfeeding they have received during the previous 2 years.* *A. Direct care nursing staff, AND* *B. Direct care providers with privileges* ***Considerations for in-service sessions may include:*** ▪ *Initial competency evaluation, training and verification, AND/OR* ▪ *Ongoing competency training and verification with a focus on changing evidence, high-risk performance indicators, and a refresher for common practical skills, AND/OR* ▪ *Ongoing competency training and verification with a focus on quality improvement efforts when monitoring data indicates one or more practices are not being fully adhered to.*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
2.2 Health professionals who provide *prenatal*, delivery and/or newborn care report receiving competency assessments in breastfeeding in the previous 2 years.	**Interviews with health professionals will confirm:** ***Criterion 2.2.1*** *At least 80% of health professionals who provide prenatal, delivery and/or newborn care can describe what type of competency assessments in breastfeeding they have received during the previous 2 years.* *A. Direct care nursing staff, AND* *B. Direct care providers with privileges* ***Considerations for competency assessments in breastfeeding may involve:*** ▪ *Initial competency assessments of performance indicators to ensure direct care staff and direct care providers have the necessary knowledge, skills, and attitudes to deliver compassionate, safe, and evidence-based care according to their defined roles and the infant feeding policy, AND/OR* ▪ *Ongoing competency assessments to evaluate job performance and identify gaps to sustain and ensure the delivery of consistent and safe care practices, AND/OR* ▪ *Ongoing competency assessments aligned with quality improvement efforts regarding specific monitoring indicators.*
2.3 Health professionals who provide *prenatal*, delivery and/or newborn care are able to correctly answer three out of four questions on breastfeeding knowledge and skills to support breastfeeding.	**BFUSA external assessment will confirm:** *During the external assessment, direct care providers and direct care staff who provide prenatal, delivery and/or newborn care will be asked questions relating to performance indicators pertinent to their role in the care of patients. The specific performance indicators to be discussed are identified in each step under the heading of COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS.*

US STANDARD	CRITERION FOR EVALUATION
2.4 Facilities providing maternity and newborn services have the responsibility for assessing, training, and verifying the required competencies ensuring that all health professionals who provide education, assessment, support, intervention, assistance and/or follow-up with regards to infant feeding have the appropriate knowledge, skills and attitudes to provide safe, evidence-based care.	**A review of the competency verification and training plan will confirm:** ***Criterion 2.4.1*** *The head of maternity services will be able to identify the health professional(s) responsible for all aspects of planning, implementing, and verifying direct care staff's and direct care provider's competencies.* **Criterion 2.4.2** *A copy of the Direct Care Staff and Direct Care Provider Competency Verification and Training Plan [BFUSA materials] will be available for review and analysis demonstrating a comprehensive plan for assessing, training, and verifying the competencies for all required health professionals.*

STEP 3

Discuss the importance and management of breastfeeding with pregnant women and their families.

RATIONALE:

All pregnant women must have basic information about breastfeeding, in order to make informed decisions. A review of 18 qualitative studies indicated that mothers generally feel that infant feeding is not discussed enough in the *prenatal* period and that there is not enough discussion of what to expect with breastfeeding.[14]Mothers want more practical information about breastfeeding. Pregnancy is a key time to inform women about the importance of breastfeeding, support their decision-making and pave the way for their understanding of the maternity care practices that facilitate its success. Mothers also need to be informed that birth practices have a significant impact on the establishment of breastfeeding.[1]

IMPLEMENTATION GUIDANCE:

Where facilities provide *prenatal care [see the Affiliated Prenatal Services Questionnaire in Appendix D]*, pregnant women and their families should be counseled about the benefits and management of breastfeeding.[2] In many settings, prenatal care is predominantly provided through primary health-care clinics or by community health workers. If facilities providing maternity and newborn services do not have authority over these care providers *[as defined by the Affiliated Prenatal Services Questionnaire]*, they should work with them to ensure that mothers and families are fully informed about the importance of breastfeeding and know what to expect when they deliver at the facility. In other cases, the facility directly provides prenatal care services or offers classes for pregnant women. In this case, provision of breastfeeding information and counseling is the direct responsibility of the facility.[1]

Breastfeeding education should include information on the importance of breastfeeding and the risks of giving formula or other breast-milk substitutes, along with national and health-professional recommendations for infant feeding. Practical skills such as positioning and attachment, on-demand feeding, and recognizing feeding cues are a necessary component of *prenatal* counseling. Families should be presented with up-to-date information on best practices in facilities providing maternity and newborn services regarding skin-to-skin contact, initiation of breastfeeding, supplementation protocols and rooming-in. Women also need to be informed about possible challenges they might encounter (such as engorgement, or a perception of not producing enough milk) and how to address them.[1]

Prenatal breastfeeding counseling must be tailored to the individual needs of the woman and her family, addressing any concerns and questions they have. This counseling needs to be sensitively given and consider the social and cultural context of each family.[1]

Wherever possible, conversations on breastfeeding should begin with the first or second *prenatal* visit, so that there is time to discuss any challenges, if necessary. This is particularly important in settings where women have few *prenatal* visits and/or initiate their visits late in their pregnancy. Additionally, women who deliver prematurely may not have adequate opportunities to discuss breastfeeding if the conversations are delayed until late in pregnancy.[1]

Information on breastfeeding should be provided in multiple ways. *According to the U.S. Department of Health & Human Services, over a third of adults have below basic health literacy, verbal communication as a primary teaching tool with patients is recommended.* Printed or online information that is in a language mothers understand *[usually recommended at or below a 5th grade reading level]* is one way to ensure that all relevant topics are covered. However, there is no assurance that all women will read this information, and it may not directly address the key questions they have. Interpersonal counseling, either one-on-one or in small groups, is important to allow women to discuss their feelings, doubts and questions about infant feeding.[1]

The information must be provided free of conflicts of interest. *As* stipulated in the "Guidance on ending inappropriate promotion of foods for infants and young children",[24] companies that market foods for infants and young children should not "directly or indirectly provide education to parents and other caregivers on infant and young child feeding in health facilities".[1]

Women at increased risk for preterm delivery or birth of a sick infant (e.g. pregnant adolescents, *women with* high-risk pregnancies, known congenital anomalies) must begin discussions with knowledgeable providers as soon as feasible concerning the special circumstances of feeding a premature, low-birth-weight or sick baby.[1, 30]

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

Engaging pregnant women in a conversation about creating a safe environment for both breastfeeding and sleep is extremely important as this is a time when many parents are preparing these settings. The American Academy of Pediatrics', "SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment" and the "Clinical Report: Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns", provide recommendations regarding the education that should be provided to reduce the risk of SIDS and sleep-related suffocation, asphyxia, and entrapment among infants.[25, 26] While providing the education on safe sleep practices, mothers should gain an understanding that sleepiness is a hormonally-driven, physiological response to breastfeeding. This normal response can lead to a mother, unintentionally, falling asleep while breastfeeding. Mothers should also understand that other factors such as exhaustion, fatigue, and pain medications can make falling asleep while breastfeeding common. Families should be offered information about how to create a safe sleep environment for breastfeeding and what hazardous situations are with open, honest, non-judgmental discussions to inform their decisions.

REFER TO APPENDIX A: PATIENT EDUCATION TOPICS for the comprehensive list of all required education topics for all pregnant mothers.

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 3	VERIFICATION METHOD
*15. **Engage** in a conversation with a pregnant woman on 3 aspects of the importance of breastfeeding.	**Observation**
*16. **Assess** at least 3 aspects of a pregnant woman's knowledge about breastfeeding in order to fill the gaps and correct inaccuracies.	**Observation**
*17. **Engage** in a conversation with a pregnant woman about at least 4 care practices a mother/infant dyad will experience at the birthing facility that will support breastfeeding.	**Observation**
*29. **Engage** in a conversation with a pregnant woman regarding at least 3 reasons why effective exclusive breastfeeding is important.	**Observation**

THE FOLLOWING STANDARDS APPLY ONLY FOR FACILITIES WITH AFFILIATED PRENATAL SERVICES:

[See Affiliated Prenatal Services Questionnaire in Appendix D]

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
3.1 Mothers who received prenatal care at the facility report having received prenatal counseling on breastfeeding.	**Affiliated services: interviews with pregnant women in the third trimester who have had at least 2 visits at an affiliated prenatal service will confirm:** ***Criterion 3.1.1*** *At least 80% of pregnant women will report that a staff member/provider at the affiliated prenatal services:* *A. Assessed their understanding of breastfeeding and the specific maternity care practices that support it, AND* *B. Entered into a meaningful conversation [see Step 2] with them on the required WHO/UNICEF prenatal conversation topics provided in Appendix A either one-on-one or in small groups, or by following up to education provided through another learning mode [videos, podcasts, texts] based on their specific needs.* ***NOTE:*** *if mothers have questions about infant formula, their issues, concerns and circumstances will be discussed on an individual basis.*

US CLARIFICATION: PRENATAL EDUCATION AND MEANINGFUL CONVERSATIONS

While education may be provided by a variety of different learning modes including videos, podcasts, texts, etc., meaningful prenatal breastfeeding conversations must be tailored to the individual needs of the woman and her family, addressing any concerns and questions they have. This counseling needs to be sensitively given and consider the social and cultural context of each family.[1] *"The Guideline: Counseling of Women to Improve Breastfeeding Practices" states that the "aim of breastfeeding counseling is to empower women to breastfeed, while respecting their personal situations and wishes."*[18] *As you enter into conversations with pregnant women, consider incorporating appropriate components of the following acronym, E.N.C.O.U.R.A.G.E.S as you enter into meaningful conversations [see Step 2].*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
3.2 Mothers who received prenatal care at the facility *[affiliated prenatal services]* are able to adequately describe what was discussed about two of the *required WHO/UNICEF prenatal conversation topics provided in Appendix A.*	**Affiliated prenatal services: interviews with pregnant women in the third trimester who have had at least 2 visits at an affiliated prenatal service will confirm:** ***Criterion 3.2.1*** *At least 80% of pregnant women who received prenatal care at the affiliated prenatal services are able to adequately describe two topics from required WHO/UNICEF prenatal conversation topics provided in Appendix A.*

THE FOLLOWING STANDARDS OF CARE APPLY FOR ALL FACILITIES WITH AND WITHOUT AFFILIATED PRENATAL SERVICES:

US STANDARD	CRITERION FOR EVALUATION
3.3 All facilities should foster the development of and coordinate services with programs to promote consistent education about breastfeeding that is made available to pregnant women.	**A written description will confirm:** ***Criterion 3.3.1*** *A written description will confirm how the facility has fostered the development of and coordinated services with in-house programs and/or community-based projects to promote consistent education about breastfeeding that is made available to all pregnant women.*

US CLARIFICATION: PRENATAL EDUCATION AND RETURNING TO WORK

Pregnant women who know they will be returning to work and/or school often ask questions about their options for continuation of breastfeeding and/or breast-milk feeding. While it is appropriate to answer these questions and to provide basic information about maintaining lactation when direct breastfeeding is not possible or desired, it is important that prenatal breastfeeding education focus on building mothers' knowledge, skills, and confidence in their ability to breastfeed. As needed, more in-depth, education on breast pumps, milk storage, and handling can be given.

Prenatal education that discusses pumping and bottle use must only be given in the context of discussing infant feeding options when mother and baby are separated [e.g., mother going back to school or work], to help mothers initiate or maintain lactation [Step 5], and to support exclusive breastfeeding. Prenatal education on pumping and bottle use must address the following points:

- *Bottle use should be delayed until breastfeeding is well-established.*
- *Possible negative consequences of bottle use on the success of breastfeeding.*

COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
3.4 Health professionals who provide care to pregnant women will be competent in engaging in a prenatal conversation about breastfeeding.	**Interviews with direct care nursing staff and direct care providers will confirm:** DIRECT CARE NURSING STAFF ***Criterion 3.4.1*** *At least 80% of* ***direct care nursing staff who provide labor & delivery care*** *will be able to describe how they engage in a conversation with a pregnant woman on 2 aspects of the importance of breastfeeding. [PI 15]* ***Criterion 3.4.2*** *At least 80% of* ***direct care nursing staff who provide labor & delivery care*** *will be able to describe how to assess at least 2 aspects of a pregnant woman's knowledge about breastfeeding in order to fill the gaps and correct inaccuracies. [PI 16]* ***Criterion 3.4.3*** *At least 80% of* ***direct care nursing staff who provide labor & delivery care*** *will be able to describe how they engage in a conversation with a pregnant woman about at least 2 care practices a mother/infant dyad will experience at the birthing facility that will support breastfeeding. [PI 17]* ***Criterion 3.4.4*** *At least 80% of* ***direct care nursing staff who provide labor & delivery care*** *will be able to describe how they engage in a conversation with a pregnant woman regarding at least 2 reasons why effective exclusive breastfeeding is important. [PI 29]* DIRECT CARE PROVIDERS ***Criterion 3.4.5*** *At least 80% of* ***direct care providers with privileges to provide care to pregnant women in the labor and delivery unit*** *will be able to describe how they engage in a conversation with a pregnant woman on 2 aspects of the importance of breastfeeding. [PI 15]* ***Criterion 3.4.6*** *At least 80% of* ***direct care providers with privileges to provide care to pregnant women in the labor and delivery unit*** *will be able to describe how to assess at least 2 aspects of a pregnant woman's knowledge about breastfeeding in order to fill the gaps and correct inaccuracies. [PI 16]* ***Criterion 3.4.7*** *At least 80% of* ***direct care providers with privileges to provide care to pregnant women in the labor and delivery unit*** *will be able to describe how they engage in a conversation with a pregnant woman regarding at least 2 reasons why effective exclusive breastfeeding is important. [PI 29]*

STEP 4

Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.

RATIONALE:

Immediate skin-to-skin contact and early initiation of breastfeeding are two closely linked interventions that need to take place in tandem for optimal benefit. Immediate and uninterrupted skin-to-skin contact facilitates the newborn's natural rooting reflex that helps to imprint the behavior of looking for the breast and suckling at the breast. Additionally, immediate skin-to-skin contact helps populate the newborn's microbiome and prevents hypothermia. Early suckling at the breast will trigger the production of breast-milk and accelerate lactogenesis. Many mothers stop breastfeeding early or believe they cannot breastfeed because of insufficient milk, so establishment of a milk supply is critically important for success with breastfeeding. In addition, early initiation of breastfeeding has been proven to reduce the risk of infant mortality.[1, 31]

IMPLEMENTATION GUIDANCE:

Early and uninterrupted skin-to-skin contact between mothers and infants should be facilitated and encouraged as soon as possible after birth. Skin-to-skin contact is when the infant is placed prone on the mother's abdomen or chest with no clothing separating them. It is recommended that skin-to-skin contact begins immediately, regardless of method of delivery. It should be uninterrupted for at least 60 minutes [1] *or longer if the mother wishes and/or if the infant needs more time to complete a breastfeed. To clarify, immediately after birth, an infant may be on the abdomen until the cord is clamped and cut. Then the infant moves his/herself or is moved to the chest, atop the sternum.*

Initiation of breastfeeding is typically a direct consequence of uninterrupted skin-to-skin contact, as it is a natural behavior for most babies to slowly squirm or crawl toward the breast *[this may take up to an hour]*. Mothers may be supported to help the baby to the breast if desired. Mothers should be helped in understanding how to support the baby and how to make sure the baby is able to self-attach and suckle at the breast. All mothers should be supported to initiate breastfeeding as soon as possible after birth, within the first hour after delivery *[unless there are medically justifiable reasons]*.[1, 2] *This first breastfeed should be allowed to continue until the baby indicates that the breastfeed is completed. This may take up to another hour. The initial period of skin-to-skin contact until completion of the first feeding may take up to 2 hours.*

It should be noted that the milk a newborn consumes immediately after birth is colostrum, which is highly nutritious and contains important antibodies and immune-active substances. The amount of colostrum a newborn will receive in the first few feedings is very small. Early suckling is important for stimulating milk production and establishing the maternal milk supply. The amount of milk ingested is a relatively unimportant factor.[1, 2] During immediate skin-to-skin contact, and for at least the first 2 hours after delivery, sensible vigilance and safety precautions should be taken so that health professionals can observe for, assess and manage any signs of distress *in infants*. Mothers who are sleepy or under the influence of anesthesia or drugs will require closer observation.[1] When mothers are not fully awake and responsive, a health professional should accompany the mother, to prevent the baby from being hurt accidentally.

Immediate skin-to-skin care and initiation of breastfeeding is feasible following a cesarean section with local/*regional* anesthesia (epidural).[32] After a cesarean section with general anesthesia, skin-to-skin contact and initiation of breastfeeding can begin when the mother is sufficiently alert to hold the infant. Mothers or infants who are medically unstable following delivery may need to delay the initiation of breastfeeding. However, even if mothers are not able to initiate breastfeeding during the first hour after birth, they should still be supported to provide skin-to-skin contact and to breastfeed as soon as they are able *(responsive and alert)*.[1, 32, 33] *Routine procedures (e.g. assessment, vital signs, security steps, APGAR scoring) should be done with the infant skin-to-skin with the mother. Procedures that are painful or may require separation from skin-to-skin (e.g., eye ointment, weights, vitamin K, bathing) should be delayed until the completion of first feeding or after the initial first hour of skin-to-skin contact (if formula feeding).* [13] *To diminish pain, where feasible, painful procedures should be conducted while in skin-to-skin contact. Procedures requiring separation of the mother and infant (bathing, for example) should be delayed until after this initial period of skin-to-skin contact and should be conducted, whenever possible, at the mother's bedside. Staff should be vigilant during this time and support mothers to look for signs that their babies are ready to feed and offer help if necessary.*

Preterm infants may be able to root, attach to the breast and suckle.[34] As long as the infant is stable, with no evidence of severe apnea, desaturation or bradycardia, preterm infants can start breastfeeding. However, early initiation of effective breastfeeding may be difficult for these infants if the suckling reflex is not yet established and/or the mother has not yet begun plentiful milk secretion. Early and frequent milk expression is critical to stimulating milk production and secretion for preterm infants who are not yet able to suckle. Transition to direct and exclusive breastfeeding should be the aim whenever possible[35]and is facilitated by prolonged skin-to-skin contact.

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

Facilities are encouraged to review the "American Academy of Pediatrics' Clinical Report: Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns"[25] and the WHO/UNICEF "Competency Verification Tool Kit Examiners Resource[3"] for suggested safe skin-to-skin care practices.

REFER TO APPENDIX A: PATIENT EDUCATION TOPICS for the comprehensive list of all required education topics for postpartum mothers.

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. **(**All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)**

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 4	VERIFICATION METHOD
*18. **Explain** at least 3 reasons why immediate and uninterrupted skin-to-skin is important for the mother.	**Question or case study**
*19. **Explain** at least 3 reasons why immediate and uninterrupted skin-to-skin is important for the infant.	**Question or case study**
20. **Demonstrate** at least 3 points of how to routinely implement immediate, uninterrupted and safe skin-to-skin between mother and infant, regardless of method of birth.	**Observation**
*21. **Demonstrate** at least 3 safety aspects to assess when mother and baby are skin-to-skin during the first 2 hours postpartum, regardless of method of birth.	**Observation**
*22. **List** at least 3 reasons why skin-to-skin should NOT be *delayed or* interrupted.	**Question or case study**
*23. **Explain** at least 2 reasons when skin-to-skin could be *delayed or* interrupted for medically justifiable reasons.	**Question or case study**
24. "WHERE APPLICABLE" **Explain** how to maintain skin-to-skin during transfer of mother and infant to another room or other recovery area.	**Question or case study**
*25. **Engage** in a conversation with a mother including at least 3 reasons why suckling at the breast in the first hour is important, when the baby is ready.	**Observation**
26. **Demonstrate** at least 3 aspects of safe care of the newborn in the first 2 hours post-birth.	**Observation**
27. **Describe** to a mother at least 3 pre-feeding behaviors babies show before actively sucking at the breast.	**Observation**

STEP 4

THE FOLLOWING STANDARDS APPLY:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
4.1 Mothers report that their babies were placed in skin-to-skin contact with them immediately after birth and that this contact lasted 1 hour or more, unless there were documented medically justifiable reasons for delayed contact.	**Interviews with mothers will confirm:** ***Criterion 4.1.1*** *Following a vaginal birth, at least 80% of mothers will confirm:* *A. That their infants were placed in skin-to-skin contact with them immediately after birth, unless there were documented medically justifiable reasons for delayed contact, AND* *B. The initial period of skin-to-skin contact continued uninterrupted for at least 1 hour [longer, if needed, to allow a breastfeeding infant to complete a feeding], unless there were documented medically justifiable reasons to interrupt contact.* ***Criterion 4.1.2*** *Following a cesarean birth, at least 80% of mothers will confirm:* *A. That their infants were placed in skin-to-skin contact with them when safe and feasible [minimally, following a cesarean delivery, skin-to-skin should begin in the recovery area as soon as mother is responsive and alert], unless there were documented medically justifiable reasons for delayed contact, AND* *B. The initial period of skin-to-skin contact continued uninterrupted for at least 1 hour [longer, if needed, to allow a breastfeeding infant to complete a feeding], unless there were documented medically justifiable reasons to interrupt contact.* ***Criterion 4.1.3*** *At least 80% of mothers will confirm that in the event of delayed or interrupted skin-to-skin contact for medically justifiable reasons, skin-to-skin was initiated/re-established when safe and medically feasible.* **Documentation:** ***Criterion 4.1.4*** *If necessary, a review of the medical record will provide documentation of skin-to-skin contact including:* *A. Time of delivery,* *B. Time skin-to-skin was implemented,* *C. Time of completion/duration of skin-to-skin contact, and* *D. Any reasons for delay/interruption of skin-to-skin contact* **Observations of births will confirm:** ***Criterion 4.1.5*** *Observations of vaginal births, if necessary and/or available, show:* *A. That infants are placed skin-to-skin with their mothers immediately after birth, unless there were medically justifiable reasons for delayed contact, AND* *B. The initial period of skin-to-skin contact continued uninterrupted for at least 1 hour [longer, if needed, to allow a breast¬-feeding infant to complete a feeding], unless there were medically justifiable reasons to interrupt contact.* *continued*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
4.1 Mothers report that their babies were placed in skin-to-skin contact with them immediately after birth and that this contact lasted 1 hour or more, unless there were documented medically justifiable reasons for delayed contact.	**Observations of birth will confirm:** ***Criterion 4.1.6*** *Observations of cesarean births, if necessary and/or available, show:* *A. That infants are placed in skin-to-skin contact with their mothers when safe and feasible [minimally, following a cesarean delivery, skin-to-skin should begin in the recovery area as soon as mother is responsive and alert], unless there were medically justifiable reasons for delayed contact, AND* *B. The initial period of skin-to-skin contact continued uninterrupted for at least 1 hour [longer, if needed, to allow a breastfeeding infant to complete a feeding], unless there were medically justifiable reasons to interrupt contact.*

U.S. CLARIFICATION: MEDICALLY JUSTIFIABLE REASONS FOR-DELAYED/INTERRUPTED SKIN-TO-SKIN CONTACT

Healthcare Professionals must use their clinical judgement. *Mothers or infants that are not stable may require that immediate skin-to-skin contact be postponed. Interruptions may be necessary to address any procedure that cannot be postponed until the completion of the first feeding. In the event that a mother and/or infant are separated for medical reasons, skin-to-skin contact will be initiated as soon as the mother and infant are stabilized/reunited. Any delays or interruptions of skin-to-skin contact should be clearly documented in the medical record.*

To be clear, routine procedures (e.g., assessment, vital signs, security steps, APGAR scoring) should be done with the infant skin-to-skin with the mother. Procedures that are painful or may require separation from skin-to-skin (e.g. eye ointment, weights, vitamin K, bathing) should be delayed until the completion of first feeding or after the initial first hour of skin-to-skin contact [if formula feeding].

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
4.2 Mothers report that their babies were put *[supported or self-attached]* to the breast within 1 hour after birth, unless there were documented medically justifiable reasons. ***NOTE:*** *Early Initiation of Breastfeeding: According to WHO, infants should be put to the breast within 1 hour of birth. This practice gives infants the opportunity to feed at the mother's breast. Early initiation of breastfeeding does not require that the infant attached/suckled at the breast or that milk was transferred from breast to infant. It represents the practice of putting an infant in skin-to-skin contact and allowing an infant to slowly crawl toward the breast or supporting mothers to help the baby to the breast, if desired. Putting the baby to breast within the first hour is related to a number of positive outcomes including reduced mortality and exclusive breastfeeding.*[36]	**Interviews with breastfeeding mothers will confirm:** ***Criterion 4.2.1*** *At least 80% of breastfeeding mothers will report that they were supported to initiate breastfeeding with their babies as soon as possible after birth, within the first one to two hours after delivery, unless there were documented medically justifiable reasons.* ***NOTE:*** *Supporting the initiation of breastfeeding is defined as placing the baby on the mother's chest (skin-to-skin) for breastfeeding, pointing out infant feeding readiness cues and gently coaching the mother to allow baby to move and attach to the breast.* ***Criterion 4.2.2*** *At least 80% of breastfeeding mothers will confirm that they were encouraged to look for signs that their infants were ready to feed during this first one to two hours of contact.* *BFUSA CLARIFICATION/INTERPRETATION: BFUSA supports the practice of "putting infants to the breast" within 1 hour of birth. Due to the effect of various birth medications, some infants do not show readiness to feed until the end of the first hour and/or well into the second hour, even though they have been in uninterrupted skin-to-skin contact with their mothers. Therefore, for the purposes of evaluating the initiation of breastfeeding with a latch or attempts to latch, criterion 4.2.1 will focus on the initiation of the first feeding within the first 2 hours after birth.* **Documentation:** ***Criterion 4.2.3*** *If necessary, a review of the medical record will provide documentation of the initiation of breastfeeding including:* *A. Time of delivery* *B. Time of initiation of breastfeeding* *C. Any medically justifiable reasons for delay of initiation of breastfeeding* **Observations of breastfeeding infants will confirm:** ***Criterion 4.2.4*** *Observations, if necessary and/or available, confirm that breastfeeding mothers are supported to initiate breastfeeding with their infants as soon as possible after birth, within the first one to two hours after delivery, unless there are medically justifiable reasons.* **NOTE:** *Supporting the initiation of breastfeeding is defined as placing the baby on the mother's chest (immediate and uninterrupted skin-to-skin) for breastfeeding, pointing out infant feeding readiness and gently coaching the mother to allow baby to move and attach to the breast.* ***Criterion 4.2.5*** *Observations, if necessary and/or available, show that at least 80% of breastfeeding mothers are shown how to recognize the signs that infants are ready to feed during this first hour of contact.*

COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
4.3 Health professionals who provide labor & delivery and/or immediate newborn care will be competent to safely implement immediate and uninterrupted skin-to-skin contact and facilitate breastfeeding within the first hour, according to cues.	**Interviews with direct care nursing staff and direct care providers will confirm:** DIRECT CARE NURSING STAFF ***Criterion 4.3.1*** *At least 80% of* ***direct care nursing staff who provide labor & delivery and/or immediate newborn care*** *will be able to demonstrate or explain at least 3 points of how to routinely implement immediate, uninterrupted and safe skin-to-skin between a mother and infant regardless of method of birth. [PI 20]* ***Criterion 4.3.2*** *At least 80% of* ***direct care nursing staff who provide labor & delivery and/or immediate newborn care*** *will correctly respond to 1 of the randomly selected performance indicators listed below:* *A. Demonstrating or explaining at least 3 safety aspects to assess when a mother and baby are skin-to-skin during the first 2 hours postpartum, regardless of method of birth. [PI 21]* *B. Demonstrating or explaining at least 3 aspects of safe care of the newborn in the first 2 hours post-birth. [PI 26]* ***Criterion 4.3.3*** *At least 80% of* ***direct care nursing staff who provide labor & delivery and/or immediate newborn care*** *will correctly respond to 1 of the randomly selected performance indicators listed below:* *A. Describing at least 2 pre-feeding behaviors babies show before actively sucking at the breast. [PI 27]* *B. Describing at least 2 reasons why suckling at the breast in the first hour is important, when the baby is ready. [PI 25]* DIRECT CARE PROVIDERS ***Criterion 4.3.4*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery and/or immediate newborn care*** *will be able to list at least 2 reasons why skin-to-skin should not be delayed or interrupted. [PI 22]* ***Criterion 4.3.5*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery and/or immediate newborn care*** *will be able to explain at least 2 reasons when skin-to-skin could be delayed or interrupted for medically justifiable reasons. [PI 23]* ***Criterion 4.3.6*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery and/or immediate newborn care*** *will be able to describe at least 2 points to include in a conversation with a mother concerning why suckling at the breast in the first hour is important, when the baby is ready. [PI 25]*

STEP 5

Support mothers to initiate and maintain breastfeeding and manage common difficulties.

RATIONALE:

While breastfeeding is a natural human behavior, most mothers need practical help in learning how to breastfeed. Even experienced mothers encounter new challenges with breastfeeding a newborn. Postnatal breastfeeding counseling and support has been shown to increase rates of breastfeeding up to 6 months of age.[37] Early adjustments to positioning and attachment can prevent breastfeeding problems at a *future* time. Frequent coaching and support helps build maternal confidence.[1]

IMPLEMENTATION GUIDANCE:

Mothers should receive practical support to enable them to initiate and maintain breastfeeding and manage common breastfeeding difficulties.[2] Practical support includes providing emotional and motivational support, imparting information and teaching concrete skills to enable mothers to breastfeed successfully. The stay in the facility providing maternity and newborn services is a unique opportunity to discuss and assist the mother with questions or problems related to breastfeeding and to build confidence in her ability to breastfeed.[1]

All mothers should receive individualized attention, but first-time mothers and mothers who have not breastfed before will require extra support. However, even mothers who have had another child might have had a negative breastfeeding experience and need support to avoid previous problems. Mothers delivering by cesarean section and obese mothers should be given additional help with positioning and attachment.[1]

A number of topics should be included in teaching mothers to breastfeed. It is essential to demonstrate good positioning and attachment at the breast, which are crucial for stimulating the production of breast-milk and ensuring that the infant receives enough milk. Direct observation of a feed is necessary to ensure that the infant is able to attach to and suckle at the breast and that milk transfer is happening. *Competent direct care staff will observe at least one feed every shift.*[38] Additionally, facility direct care staff need to educate mothers on the *importance of direct breastfeeding*, *prevention of pathologically* engorged breasts, ways to ensure and maintain a good milk supply, prevention of cracked and sore nipples, and evaluation of milk intake.[1]

Mothers should be coached on how to express breast-milk as a means of maintaining lactation in the event of their being separated temporarily from their infants.[2] There is not sufficient evidence that one method of expression (hand expression, manual pump or electric pump) is more effective than another,[39] and thus any method(s) may be taught, depending on the mother's context. However, hand expression does have the advantage of being available no matter where the mother is and of allowing the mother to relieve pressure or express milk when a pump is not available *or during an emergency where there may be power outages. It is reasonable for all mothers to be taught hand expression during the birth hospitalization.* Pumps can potentially have more microbial contamination if they cannot easily be cleaned. Mothers also need to be supported for collection and storage of expressed milk.[1]

Practical support for preterm, including late preterm newborns is particularly critical, in order to establish and maintain the production of breast-milk. Many mothers of preterm infants have health problems of their own and need motivation and extra support for milk expression. *Robust and older* late preterm infants are generally able to exclusively breastfeed at the breast, but are at greater risk of jaundice, hypoglycemia and feeding difficulties than full-term infants, and thus require increased vigilance.[40] Mothers of twins (multiples) also need extra support, especially for positioning and attachment.[1]

Conversations with mothers should include information on the importance of direct breastfeeding. However, some mothers will make an informed decision to exclusively pump and feed their expressed breast-milk to their infants. If this is the case, they should be advised to pump and feed their infants expressed breast-milk at least 8 times in 24 hours.

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

*General guidance regarding facilitating milk production and maintaining milk supply may include (**NOTE:** This guidance must be individualized.)*

- *Direct breastfeeding: Ensure good positioning and correct attachment with observable efficient suckling patterns at the breast. Practice responsive feeding with no limits on frequency and duration of feedings. Avoid non-medically indicated supplemental feeds, pacifiers, and artificial nipples.*

- *Breastfeeding and formula feeding combined [Mixed-feeding - Maternal request]: Establish exclusive direct breastfeeding for several weeks with supplementation introduced at a later date. The mother must be knowledgeable regarding the importance of expressing breast-milk after formula is introduced.*

- *Temporary medically-indicated supplementation: Supplement, when possible, at the breast. Avoid pacifiers and artificial nipples. Establish expression of breast-milk when supplements are offered.*

- *Exclusively breast-milk feeding, preterm infants, and infants that cannot breastfeed due to illness or separation: Express breast-milk regularly, at least 8 times in 24 hours, with stretches not longer than 4 hours. Mothers may describe hand expression, manual pumping or electric pumping.*

- *Preterm infants, particularly those being cared for on the regular postpartum unit must receive individualized care, including close observation, due to their immaturity. These infants are less alert, have less stamina, are often hypotonic, and have greater difficulty with latch, suck and swallow.[41] Mothers of late preterm infants are at a greater risk of delayed lactogenesis.[40]Management strategies to support these couplets include developing an adequate milk volume and ensuring that these infants are adequately fed.[40] Mothers should be assisted to start expressing their milk within the first 6 hours after birth [preferably within 1-2 hours after birth and completion of initial skin-to-skin contact]. In order to initiate and establish the mother's milk supply, regular expression using hand expression may be necessary to stimulate the breasts.[40] Many of these infants may not effectively transfer milk during breastfeeding, so supplementation with the mother's own milk, pasteurized donor human milk or infant formula may be necessary following attempted breastfeeds with appropriate lactation support.[41]*

REFER TO APPENDIX A: PATIENT EDUCATION TOPICS for the comprehensive list of all required education topics for postpartum mothers.

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 5	VERIFICATION METHOD
28. **Describe** at least 6 essential issues that every breastfeeding mother should know or demonstrate.	**Question or case study**
*30. **Engage** in a conversation with a mother regarding 2 elements related to infant feeding patterns in the first 36 hours of life.	**Observation**
*31. **Describe** to a mother at least 4 signs of adequate transfer of milk in the first few days.	**Observation**
32. **Evaluate** a full breastfeeding session observing at least 5 points.	**Observation**
*33. **Demonstrate** at least 3 aspects of how to help a mother achieve a comfortable and safe position for breastfeeding within the first 6 hours after birth and later as needed during the hospital stay.	**Observation**
*34. **Demonstrate** how to help a mother achieve an effective and comfortable latch, noting at least 5 points.	**Observation**
40. **Demonstrate** to a mother how to hand express breast-milk, noting 8 points.	**Observation**
43. **Help** a mother achieve a comfortable and safe position for breastfeeding with her preterm, late preterm, or weak infant at the breast, noting at least 4 points.	**Observation**
*44. **Engage** in a conversation with a mother of a preterm, late preterm, or low-birth-weight infant not sucking effectively at the breast, including at least 5 points.	**Observation**
57. **Engage** in a conversation with a mother regarding at least 4 different ways to facilitate breastfeeding in order to prevent or resolve most common conditions of the lactating breasts (sore nipples, engorgement, mother who thinks she doesn't have enough milk, infants who have difficulty sucking).	**Observation**
*65. ***Describe*** *at least 2 maternal and 2 infant risk factors associated with delayed lactogenesis II.*	**Question or case study**

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE POSTPARTUM UNIT:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
5.1 Breastfeeding mothers report that someone on the *direct care* staff offered assistance with breastfeeding within 6 hours after birth.	**Interviews with breastfeeding [including breast-milk feeding] mothers will confirm:** ***Criterion 5.1.1*** *At least 80% of breastfeeding [including breast-milk feeding] mothers will report that:* *A. Term infants/Direct Breastfeeding: direct care staff provided additional guidance and support as needed with breastfeeding within 6 hours of birth. OR* *B. Exclusively expressing/Breast-milk feeding: direct care staff provided additional guidance and support with expressing their breast-milk within the first 6 hours after birth [preferably within 1-2 hours after birth and completion of initial skin-to-skin contact], unless there is a justifiable reason to delay initiation of expression. OR* *C. Late preterm infants/Direct Breastfeeding on the postpartum unit: direct care staff provided additional guidance and support as needed with breastfeeding and expressing their breast-milk within the first 6 hours after birth [preferable within 1-2 hours after birth and completion of the initial skin-to-skin contact], unless there is a justifiable reason to delay initiation of expression.* **NOTE:** *Early adjustments to positioning and attachment within the first 6 hours following the initial breastfeeding after delivery can prevent breastfeeding problems at a future time.*
5.2 Breastfeeding mothers are able to demonstrate how to position their babies for breastfeeding and that the babies can suckle and transfer milk.	**Interviews with breastfeeding mothers will confirm:** ***Criterion 5.2.1*** *At least 80% of breastfeeding mothers are able to demonstrate or describe:* *A. Correct positioning with their babies, AND* *B. Correct attachment (latch) with their babies, AND* *C. Observable efficient suckling patterns with their babies, AND* *D. Audible sounds associated with the transfer of breast-milk with their babies.*
5.3 Breastfeeding mothers can describe at least two ways to facilitate milk production for their infants.	**Interviews with breastfeeding [including breast-milk feeding] mothers will confirm:** ***Criterion 5.3.1*** *At least 80% of breastfeeding [including breast-milk feeding] mothers can describe at least two ways to facilitate milk production and to keep up the supply for their babies.*
5.4 Breastfeeding mothers can describe at least two indicators of whether a breastfed baby consumes adequate milk. *continued*	**Interviews with breastfeeding mothers will confirm:** ***Criterion 5.4.1*** *At least 80% of breastfeeding mothers can describe at least two indicators of whether a breastfed baby has consumed adequate milk.*

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE POSTPARTUM UNIT: continued

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
5.5 Mothers of breastfed infants can correctly demonstrate or describe how to express breast-milk.	**Interviews with breastfeeding mothers will confirm:** ***Criterion 5.5.1*** *At least 80% of breastfeeding mothers can correctly demonstrate or describe how to hand express breast-milk.*

THE FOLLOWING STANDARD APPLIES TO MOTHERS WITH INFANTS THAT ARE BEING CARED FOR IN THE NICU:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
5.6 Mothers of preterm or sick infants report having been helped to express milk within 1—2 hours after birth.	**Interviews with mothers who are breastfeeding or intending to do so with infants in the NICU will confirm:** ***Criterion 5.6.1*** *At least 80% of mothers with infants in the NICU, who are breastfeeding or intending to do so, will report that they have been provided guidance and support with expressing their breast-milk within the first 6 hours after birth [preferably within 1-2 hours after birth and completion of initial skin-to-skin contact - if safe and medically feasible], unless there is a justifiable reason to delay initiation of expression.* ***Criterion 5.6.2*** *At least 80% of mothers with infants in the NICU, who are breastfeeding or intending to do so will report that they have been provided guidance that they need to breastfeed or express their milk at least 8 times every 24 hours, with stretches not longer than 4 hours, to establish and maintain their milk supply.*

COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
5.9 Health professionals who provide labor & delivery, postpartum and/or newborn care will be competent in: · ***How to assist a mother in the steps to getting her baby to latch*** · ***How to discuss with a mother how breastfeeding works*** · ***In helping a mother to breastfeed a late-preterm baby*** · ***In helping a mother prevent or resolve difficulties with breastfeeding*** · ***In helping a mother manage milk expression*** · ***In helping a mother who is not feeding her baby directly at the breast***	**Interviews with direct care nursing staff and direct care providers will confirm:** DIRECT CARE NURSING STAFF ***Criterion 5.9.1*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will be able to describe at least 3 essential issues that every breastfeeding mother should know or demonstrate. [PI 28]* ***Criterion 5.9.2*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will be able to describe to a mother at least 2 signs of adequate transfer of milk in the first few days. [PI 31]* ***Criterion 5.9.3*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will be able to describe how they evaluate a full breastfeeding session observing at least 5 points. [PI 32]* ***Criterion 5.9.4*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will be able to describe how they engage in a conversation with a mother of a late preterm infant rooming-in on the postpartum unit that is not sucking effectively at the breast, including at least 3 points. [PI 44]* ***Criterion 5.9.5*** *At least 80% of direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care will correctly respond to 1 of the randomly selected performance indicators listed below:* *A. Demonstrate at least 3 aspects of how to help a mother achieve a comfortable and safe position for breastfeeding within the first 6 hours after birth and later as needed during the hospital stay. [PI 33]* *B. Help a mother achieve a comfortable and safe position for breastfeeding with her preterm, late preterm or weak infant at the breast, noting at least 3 points. [PI 43]* ***Criterion 5.9.6*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will correctly respond to 1 of the randomly selected performance indicators listed below:* *A. Demonstrate how to help a mother achieve an effective and comfortable latch, noting at least 3 points. [PI 34]* *B. Demonstrate to a mother how to hand express breast-milk to a mother, noting at least 3 points. [PI 40]* ***Criterion 5.9.7*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will correctly respond to 1 of the randomly selected performance indicators listed below:* *A. Engage in a conversation with a mother regarding 2 elements related to infant feeding patterns in the first 36 hours of life. [PI 30]* *B. Engage in a conversation with a mother regarding at least 4 different ways to facilitate breastfeeding in order to prevent or resolve most common conditions of the lactating breasts (sore nipples, engorgement, mother who thinks she doesn't have enough milk, infants who have difficulty sucking). [PI 57]*

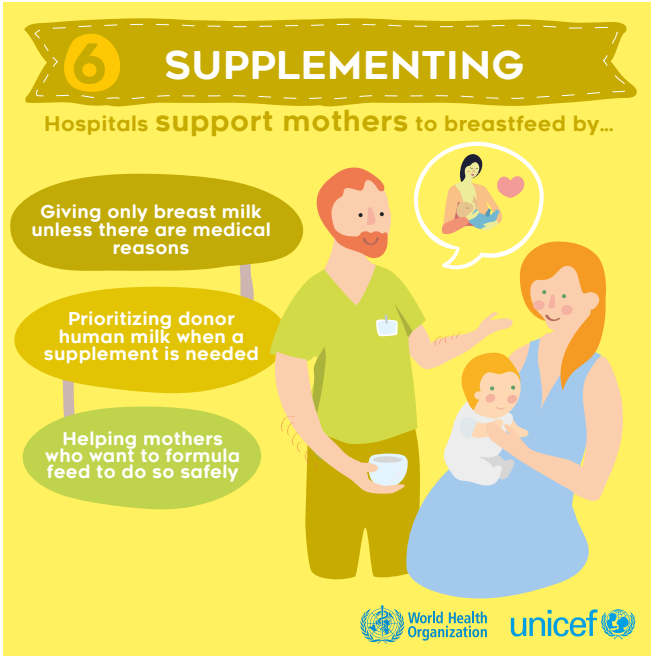
COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
5.9 Health professionals who provide labor & delivery, postpartum and/or newborn care will be competent in: **· How to assist a mother in the steps to getting her baby to latch** **· How to discuss with a mother how breastfeeding works** **· In helping a mother to breastfeed a late-preterm baby** **· In helping a mother prevent or resolve difficulties with breastfeeding** **· In helping a mother manage milk expression** **· In helping a mother who is not feeding her baby directly at the breast**	**Interviews with direct care nursing staff and direct care providers will confirm:** DIRECT CARE PROVIDERS ***Criterion 5.9.8*** *At least 80% of* **direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care** *will be able to describe how they engage in a conversation with a mother regarding 2 elements related to infant feeding patterns in the first 36 hours of life. [PI 30]* ***Criterion 5.9.9*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care*** *will be able to describe to a mother at least 2 signs of adequate transfer of milk in the first few days. [PI 31]* ***Criterion 5.9.10*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care*** *will be able to describe at least 2 maternal and 2 infant risk factors associated with delayed lactogenesis II. [PI 65]* ***Criterion 5.9.11*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care*** *will be able to explain how they would engage in a conversation with a mother of a preterm, late preterm, or low-birth weight infant not sucking effectively at the breast, including at least 3 points. [PI 44]*

STEP 6

Do not provide breastfed newborns any food or fluids other than breast-milk, unless medically indicated.

RATIONALE:

Giving newborns any foods or fluids other than breast-milk in the first few days after birth interferes with the establishment of breast-milk production. Newborns' stomachs are very small and easily filled. Newborns who are fed other foods or fluids will suckle less vigorously at the breast and thus inefficiently stimulate milk production, creating a cycle of insufficient milk and supplementation that leads to breastfeeding failure. Babies who are supplemented prior to facility discharge have been found to be twice as likely to stop breastfeeding altogether in the first 6 weeks of life.[13] In addition, foods and liquids may contain harmful bacteria and carry a risk of disease. Supplementation with artificial milk significantly alters the intestinal microflora. *Breastfeeding exclusively is necessary to establish a healthy normal microbiome.*[1, 6]



IMPLEMENTATION GUIDANCE:

Exclusive breastfeeding for 6 months provides the nurturing, nutrients, immune factors and energy needed for physical and neurological growth and development. Beyond 6 months, breastfeeding continues to provide energy, immune factors and high-quality nutrients that, jointly with safe and adequate complementary feeding, help prevent hunger, undernutrition and obesity. Inadequate breastfeeding practices significantly impair health, development and survival of infants, children and mothers.[1]

Mothers should be discouraged from giving any food or fluids other than breast-milk, unless medically indicated.[2] Very few conditions of the infant or mother preclude the

feeding of breast-milk and necessitate the use of breast-milk substitutes. The WHO/UNICEF document on "Acceptable medical reasons for use of breast-milk substitutes" describes conditions for which breastfeeding is contraindicated.[42] In addition, some breastfed infants will require supplementation. The Academy of Breastfeeding Medicine (ABM) has laid out a clinical protocol for managing situations in which supplementation of the mother's own milk would become necessary.[43] Infants should be assessed for signs of inadequate milk intake and supplemented when indicated, but routine supplementation is rarely necessary in the first few days of life. Lack of resources, staff time or knowledge is not justification for the use of early additional foods or fluids.[1] *In addition to the WHO and ABM documents, facilities are encouraged to utilize the recommendations from the Centers for Disease Control and Prevention and the American Academy of Pediatrics to develop a policy/protocol that describes the current, evidence-based medical indications for supplementation and contraindications to breastfeeding.*[44-46]

Mothers who intend to "mixed-feed" (a combination of both breastfeeding and feeding with breast-milk substitutes) should be counseled *(using meaningful conversation techniques- see Step 2)* on the importance of exclusive breastfeeding in the first few weeks of life, how to establish a milk supply and to ensure that the infant is able to suckle and transfer milk from the breast. Supplementation can be introduced at a later date if the mother chooses. Mothers who report they have chosen not to breastfeed should be counseled *(using meaningful conversations techniques-see Step 2)* on the importance of breastfeeding. However, if they still do not wish to breastfeed, feeding with breast-milk substitutes will be necessary. Mothers who are feeding breast-milk substitutes, by necessity or by choice, must be taught about safe preparation and storage of formula[47, 55, 56] and how to respond adequately to their child's feeding cues.[1]

If a breastfeeding mother requests that her infant be supplemented, direct care staff and/or direct care providers should gently engage in an appropriate meaningful conversation [see Step 2] that carefully listens to her reasons. If the mother expresses any challenges, staff/providers should provide responsive care to evaluate/assess her concerns. It is possible that she is experiencing some breastfeeding difficulties that staff may be able to support her to overcome with additional guidance. If she still wishes to supplement with infant formula, staff should empower her understanding of evidence-based information that emphasizes the protections provided by breastfeeding, the possible impact of this decision to her health, the health of her infant and to the potential success of breastfeeding. Her informed decision should be confirmed and documented in the medical record. This education is only required to be provided once during the hospital stay.

STEP 6

FOR INFANTS WHO ARE UNABLE TO BE FED THEIR MOTHER'S OWN MILK.

IMPLEMENTATION GUIDANCE:

Infants who cannot be fed their mother's own milk, or who need to be supplemented, especially low-birth-weight infants, including those with very low birthweight[48, 49] and other vulnerable infants, should be fed *pasteurized* donor *human* milk. If *pasteurized* donor human milk is unavailable or culturally unacceptable, breast-milk substitutes are required. In most cases, supplementation is temporary, until the newborn is capable of breastfeeding and/or the mother is available and able to breastfeed. Mothers must also be supported and encouraged to express their milk to continue stimulating production of breast-milk, and to prioritize use of their own milk, even if direct breastfeeding is challenging for a period of time.[1]

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

If a mother expresses concern about the sufficiency of her breast-milk, an infant feeding assessment is warranted.

When mothers have decided not to breastfeed their infant or supplementation is needed/requested, direct care staff should discuss various options suitable to their situation such as the choice of supplement, volume of supplemental feeding, and methods of providing supplementary feedings.

In the case of supplementation for medical reasons, the decision to supplement is a delicate one. Practitioners must carefully weigh the risks and benefits of this decision.

When a mother decides to feed formula and/or it is determined that the benefits of supplementation outweigh the risks, the recommendation should be communicated in a respectful manner that is mindful of the sense of guilt, concerns and failure the mother may experience regarding such a recommendation.

REFER TO APPENDIX A: PATIENT EDUCATION TOPICS for the comprehensive list of all required education topics for postpartum mothers.

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

US CLARIFICATION: BABY-FRIENDLY USA EXCLUSIVE BREASTFEEDING STANDARDS

The WHO/UNICEF BFHI Implementation Guidance standards call for a minimum of 80% exclusive breastfeeding (either milk from their own mothers or from a human milk bank) throughout the stay at the facility.[1] It is recognized by WHO and UNICEF that lower standards may need to be set at the national or local level, with the expectation that they should be raised over time, as other aspects of breastfeeding support in the community improve.

The US Designation is NOT based on an exclusive breastfeeding rate of greater than 80%.

It is expected that the facility will regularly monitor exclusive breast-feeding rates and that rates less than 80% will show improvement over time. Designated facilities with exclusive breastfeeding rates less than 50% will be required to submit quarterly reports to BFUSA.

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 6	VERIFICATION METHOD
*29. **Engage** in a conversation with a mother regarding at least 3 reasons why effective exclusive breastfeeding is important.	**Observation**
41. **Explain** at least 3 aspects of appropriate storage of breast-milk.	**Question or case study**
42. **Explain** at least 3 aspects of handling of expressed breast-milk.	**Question or case study**
*47. **List** at least 2 potential contraindications to breastfeeding for a baby and 2 for a mother.	**Question or case study**
*48. **Describe** at least 4 medical indications for supplementing breastfed newborns: 2 maternal indications and 2 newborn indications, when breastfeeding is not improved following skilled assessment and management.	**Question or case study**
*49. **Describe** at least 3 risks of giving a breastfed newborn any food or fluids other than breast-milk, in the absence of medical indication.	**Question or case study**
*66. ***Describe*** *at least 1 professional medical reference or resource for identifying medications that are safe/compatible for use during lactation.*	**Question or case study**
*50. For those few health situations where infants cannot, or should not, be fed at the breast, **describe**, in order of preference, the alternatives to use.	**Question or case study**
*51. **Engage** in a conversation with a mother who intends to feed her baby formula, noting at least 3 actions to take.	**Observation**
52. **Demonstrate** at least 3 important items of safe preparation of infant formula to a mother who needs that information.	**Observation**
*67. ***Identify*** *3 high-risk infant populations that may warrant extra precautions to protect against severe infections associated with powdered infant formula.*	**Question or case study**

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE POSTPARTUM UNIT:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
6.1 Infants receive only breast-milk (either from their own mother or from a human milk bank) throughout their stay at the facility, *unless medically indicated or informed parental decision*.	**Interviews with mothers will confirm:** ***Criterion 6.1.1*** *At least 80% of mothers will report that:* *A. Their babies have received no food or drink other than human milk (direct breastfeeding, expressed breast-milk, or pasteurized donor human milk) while in the facility, OR* *B. Formula has been given for a medically acceptable reason, OR* *C. Formula has been given in response to an informed parental request/decision.* ***Criterion 6.1.2*** *Of breastfeeding mothers whose infants have been given food or drink other than breast-milk, at least 80% of those who have no acceptable medical reason will report that a health professional:* *A. **Listened** to her reasons/concerns, AND* *B. **Responded** by assessing potential and/or existing challenges specific to her concerns, and/or providing additional guidance with workable solutions, AND* *C. If the mother still requests a breast-milk substitutes, health professionals **empowered her with an understanding** of evidence-based information [scientific, unbiased, factual] that allowed her to make an informed decision for her baby including:* ▪ *Importance of exclusive breastfeeding* ▪ *Possible risk factors that could influence health outcomes* ▪ *Possible impacts to the success of breastfeeding* ***Clarification:*** *The counseling conversation only needs to be **provided once at first request**.*

U.S. CLARIFICATION: INFORMED DECISIONS - MEANINGFUL CONVERSATIONS *Mothers should feel involved in all decisions regarding their selves and their babies. Empowering mothers to make informed decisions for their selves and their babies requires that they have up-to-date evidence-based [scientific, factual, unbiased] information that emphasized the protections provided by breastfeeding along with an understanding of risk factors that could influence health outcomes. The "Guideline: Counselling of Women to Improve Breastfeeding Practices" states that the "aim of breastfeeding counseling is to empower women to breastfeed, while respecting their personal situations and wishes."[50] As you work with families, consider incorporating appropriate components of the acronym E.N.C.O.U.R.A.G.E.S. so that you enter into meaningful conversations with them [see Step 2]*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
6.2 Breastfed babies who received supplemental feeds have a documented medical indication for supplementation in their medical records.	**Documentation:** ***Criterion 6.2.1:*** *Of breastfeeding infants who have been given food or drink other than breast-milk for medical indications, at least 80% will have the reasons for supplementation clearly documented in their medical records.* ***Criterion 6.2.2:*** *Of breastfeeding infants who have been given food or drink other than breast-milk for parental request, at least 80% will have the reasons for supplementation and evidence of parental counseling clearly documented in their medical records.*
6.3 Mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situations.	**Interviews with mothers who have decided not to breastfeed:** ***Criterion 6.3.1*** *Of mothers who have decided not to breastfeed [requesting to feed their babies with breast-milk substitutes], at least 80% of those who have no acceptable medical reason will report that the health care staff:* *A.* ***Listened*** *to their reasons/concerns, AND* *B.* ***Responded*** *by assessing potential and/or existing challenges specific to her concerns, and/or providing additional guidance with workable solutions including various feeding options, AND* *C. If the mothers still requested to feed their babies with breast-milk substitutes, health care staff* ***empowered them with an understanding*** *of evidence-based information [scientific, unbiased, factual] that allowed them to make an informed decision for their babies including:* ▪ *Importance of breastfeeding* ▪ *Possible risk factors that could influence health outcomes when feeding breast-milk substitutes* ***Clarification:*** *The counseling conversation only needs to be* ***provided once at first request.***
6.4 Mothers who *cannot*, or have decided not to breastfeed, will report that the staff discussed with them the safe preparation, feeding and storage of breast-milk substitutes.	**Interviews with mothers who are feeding their infants any formula and/or plan to continue post-discharge will be able to:** ***Criterion 6.4.1*** *At least 80% of mothers who are feeding their infants any formula and plan to continue post-discharge, will be able to describe 2 appropriate steps that staff discussed with them about safe preparation, feeding and storage of formula.*

U.S. CLARIFICATION: SAFE PREPARATION, STORAGE AND FEEDING OF INFANT FORMULA *Mothers who have decided not to breastfeed, decided to "mixed-feed", or will require supplementation with formula for their infants at the time of discharge must receive written instruction and verbal information about safe preparation, storage and feeding of formula. Staff should document completion of formula preparation instruction and feeding in the medical record. The information should be given on an individual basis only.*

Safe preparation, feeding, and storage of formula instruction must follow the recommendations of leading national and international authorities and must include:

1. *Appropriate hand hygiene*
2. *Cleaning infant feeding items [bottles, nipples, rings, caps, syringes, cups, spoons, etc.] and workspace surfaces*
3. *Appropriate and safe reconstitution of concentrated and powdered infant formulas*
4. *Accuracy of measurement of ingredients*
5. *Safe handling of formula*
6. *Proper storage of formula*
7. *Appropriate feeding methods which may include feeding on cue, frequent low volume feeds, paced bottle techniques, eye-to-eye contact, and holding the infant closely*
8. *Powdered infant formula is not sterile and may contain pathogens that can cause serious illness in infants younger than 3 months*

National and international authorities include:

- *American Academy of Pediatrics*
- *Centers for Disease Control and Prevention*
- *Food and Drug Administration*
- *United States Department of Agriculture*
- *World Health Organization*

COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
6.5 Health professionals who provide labor & delivery, postpartum and/or newborn care will be competent in: ***In helping a mother whose baby needs fluids other than breast-milk.***	**Interviews with Direct Care Nursing Staff and Direct Care Providers will confirm:** **DIRECT CARE NURSING STAFF** ***Criterion 6.5.1*** *At least 80% of direct care nursing staff* ***who provide labor & delivery, postpartum, and/or newborn care*** *will correctly respond to 1 of the randomly selected performance indicators listed below:* *A. List at least 1 potential contraindication to breastfeeding for a baby and 1 for a mother. [PI 47]* *B. Describe at least 2 medical indications for supplementing breastfed newborns: 1 maternal indication and 1 newborn indication, when breastfeeding is not improved following skilled assessment and management. [PI 48]* ***Criterion 6.5.2*** *At least 80% of direct care nursing staff* ***who provide labor & delivery, postpartum, and/or newborn care*** *will correctly respond to 1 of the randomly selected performance indicators listed below:* *A. Engage in a conversation with a mother regarding at least 2 reasons why effective exclusive breastfeeding is important. [PI 29]* *B. Describe at least 2 risks of giving a breastfed newborn food or fluids other than breast-milk, in the absence of medical indications. [PI 49]* ***Criterion 6.5.3*** *At least 80% of direct care nursing staff* ***who provide labor & delivery, postpartum, and/or newborn care*** *will correctly respond to 1 of the randomly selected performance indicators listed below:* *A. Engage in a conversation with a mother who intends to feed her baby formula, noting at least 3 actions. [PI 51]* *B. Identify 2 high-risk infant populations that may warrant extra precautions to protect against severe infections associated with powdered infant formula. [PI 67]*

COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
6.6 Health professionals who provide labor & delivery, postpartum and/or newborn care will be competent in: ***In helping a mother whose baby needs fluids other than breast-milk.***	**DIRECT CARE PROVIDERS** ***Criterion 6.6.4*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care*** *will describe how they engage in a conversation with a mother regarding at least 2 reasons why effective exclusive breastfeeding is important. [PI 29]* ***Criterion 6.6.5*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care*** *will list at least 2 potential contraindications to breastfeeding for a baby and 2 for a mother. [PI 47]* ***Criterion 6.6.6*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care*** *will describe at least 4 medical indications for supplementing breastfed newborns: 2 maternal indications and 2 newborn indications, when breastfeeding is not improved following skilled assessment and management. [PI 48]* ***Criterion 6.6.7*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care*** *will describe at least 1 professional medical reference or resource for identifying medications that are safe/compatible for use during lactation. [PI 66]* ***Criterion 6.6.8*** *At least 80% of* ***direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care*** *will identify 2 high-risk infant populations that may warrant extra precautions to protect against severe infections associated with powdered infant formula. [PI 67]*

STEP 7

Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.

RATIONALE:

Rooming-in is necessary to enable mothers to practice responsive feeding, as mothers cannot learn to recognize and respond to their infants' cues for feeding if they are separated from them. When the mother and infant are together throughout the day and night, it is easy for the mother to learn to recognize feeding cues and respond to them. This, along with the close presence of the mother to her infant, will facilitate the establishment of breastfeeding.[1]

IMPLEMENTATION GUIDANCE:

Facilities providing maternity and newborn services should enable mothers and their infants to remain together and to practice rooming-in throughout the day and night.[2] Rooming-in involves keeping mothers and infants together in the same room, immediately after vaginal birth or cesarean section, or from the time when mothers are able to respond to their infants, until discharge. This means that mothers and infants are together throughout the day and night.[1]

Postpartum units need to be designed so that there is enough space for mothers and their newborns to be together. Facility staff need to visit the *hospital room* regularly to ensure the babies are safe. Babies should only be separated from their mothers for justifiable medical and safety reasons. Minimizing disruption to breastfeeding during the stay in the facility will require health-care practices that enable a mother to breastfeed for as much, as frequently and for as long as her baby needs it.[1]

When a mother is placed in a dedicated unit *[recovery area and/or postpartum room]* to recover from a cesarean section, the baby should be accommodated in the same room with her, close by. She will need practical support to position her baby to breastfeed, *and will need help with lifting the baby from a bassinet.*[1]

Rooming-in may not be possible in circumstances when infants need to be moved for specialized medical care.[1] If preterm or sick infants need to be in a separate room to allow for adequate treatment and observation, efforts must be made for the mother to recuperate postpartum with her infant, or to have no restrictions for visiting her infant. Mothers should have adequate space to express milk adjacent to their infants.[1]

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

There are several factors that must be understood when mothers and infants are rooming-in together:

- *Mothers will be naturally exhausted and/or only sleep in short bursts following childbirth.*[25]
- *Sleepiness is a normal, hormonally-driven, physiological response to breastfeeding for both mothers and infants. Unintentionally, this can lead to mothers falling asleep while breastfeeding their infants.*[51]
- *Following cesarean births, mothers have limited mobility and are likely to feel the effects of medications, which may cause them to be less responsive.*[25]

Facilities are encouraged to develop processes that support staff in the safe implementation of rooming-in practices.[25, 26, 51]

The hospital setting is the perfect place to role model safe rooming-in and to help families plan for a safe breastfeeding and sleep environment for home. It is a prime opportunity to educate mothers and families about the components of a safe environment which includes but is not limited to:

- *Mothers and infants have close but separate sleep surfaces.*[27]
- *Infants are placed on their backs to sleep, for naps and at night.*[27]
- *Firm flat sleep surface is used in a safety-approved crib, covered by a fitted sheet.*[27]
- *Soft bedding and objects are avoided. Do not put pillows, blankets, sheepskins in baby's sleep area.*[27]
- *Baby is dressed in sleep clothing. Loose blankets are not used, and baby is not over bundled.*[27]

Mothers (and families) should be given anticipatory guidance about considering how tired they are before and during their infant's feeding so that steps can be taken to reduce risks to their infant.[52] *Facilities and staff should consider implementing the following safe rooming-in practices:*

- *Monitor mothers according to their risk assessment.*[25]
- *Review equipment, such as call bells, with mothers*[25] *and instruct them to call for help when feeling tired or sleepy.*[51]
- *Conduct hourly rounding to provide assistance placing infants in bassinets when mothers or caregivers appear to be drowsy or after mothers have received pain medications.*[51]
- *Educate families and support persons to transition newborn to the bassinet when mother is falling asleep.*
- *Promote maternal rest*[51] *by limiting staff and visitor interruptions.*

REFER TO APPENDIX A: PATIENT EDUCATION TOPICS for the comprehensive list of all required education topics for postpartum mothers.

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 7	VERIFICATION METHOD
*35. **Engage** in a conversation with a mother regarding 2 aspects related to the importance of rooming-in 24h/day.	**Observation**
*68. **Describe** 2 aspects involved in creating a safe environment for rooming-in during the hospital stay.*	**Question or case study**
69. **Demonstrate at least 3 safety aspects to assess when mother and baby are skin-to-skin during the postpartum hospitalization, regardless of method of birth.*	**Observation**
*36. **Explain** 2 situations: 1 for the mother and 1 for the infant, when it is acceptable to separate mother and baby while in hospital.	**Question or case study**
45. **Engage** in a conversation with a mother separated from her preterm or sick infant regarding at least 2 reasons to be with her infant in the intensive care unit.	**Observation**

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE POSTPARTUM UNIT:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
7.1 Mothers report that their babies stayed with them since birth, without separation lasting for more than 1 hour.	**Interviews with mothers will confirm:** ***Criterion 7.1.1** At least 80% of mothers will report that their infants have stayed with them in the same room day and night, without separation of more than 1 hour per 24-hour period unless:* *A. Medically justifiable reason for a longer separation, OR* *B. Safety-related reason for a longer separation, OR* *C. Informed decision for a longer separation [maternal request]*

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE POSTPARTUM UNIT:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
7.1 Mothers report that their babies stayed with them since birth, without separation lasting for more than 1 hour.	**Interviews with mothers will confirm:** ***Criterion 7.1.2*** *At least 80% of mothers who requested their infant to be removed from the room will report the facility staff:* *A.* ***Listened*** *to her reasons/concerns AND* *B.* ***Responded*** *by assessing potential and/or existing challenges specific to her concerns, and/or providing additional guidance with workable solutions to safely avoid the separation AND* *C. If the mother still requested separation, health professionals* ***empowered her with an understanding*** *of evidence-based information [scientific, unbiased, factual] that allowed her to make an informed decision for her baby including:* ▪ *Importance of rooming-in,* ▪ *If breastfeeding, a plan for reuniting the mother and infant as soon as the infant displays feeding cues.* **Documentation:** ***Criterion 7.1.3*** *Of mothers and babies that have been separated, at least 80% will have the following documented in the medical record:* *A. Reason for the separation* *B. Location of infant* *C. Length of separation* *D. Infant feedings during separation* *E. Counseled on the importance of rooming-in including a plan for reuniting the mother and infant, and infant feeding.* **NOTE:** *Facilities must make every effort to minimize any disruptions to breastfeeding by reuniting a mother and infant as frequently and for as long as her baby needs it.* ***Criterion 7.1.4*** *Quality improvement question for informational purposes (not a designation criterion): Mothers will report that they felt supported with rooming and caring for her baby.* *A. They received practical information AND* *B. Received help when needed.*
7.2 Observations in the postpartum wards and well-baby observation areas confirm that mothers and babies are together or, if not, have medically justifiable reasons for being separated.	**Observations in the postpartum unit and newborn units will confirm:** ***Criterion 7.2.1*** *Observations in the postpartum unit and any well-baby observation areas confirm that at least 80% of the mothers and infants are rooming-in or have a documented:* *A. Medically justifiable reason for separation, OR* *B. Safety-related reason for separation, OR* *C. Informed decision for separation [maternal request]*

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE NICU UNIT:

US STANDARD	US CRITERION FOR EVALUATION
7.3 Mothers of preterm or sick infants report having no restrictions and had access to their infants in the NICU whenever they wanted.	**Interviews with mothers who are breastfeeding or intending to do so with infants in the NICU will confirm:** ***Criterion 7.3.1*** *At least 80% of mothers with infants in the NICU report that they have had access to their infants in the NICU whenever they wanted.*

COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
7.4 Health professionals who provide postpartum and/or newborn care will be competent in helping a mother to respond to her baby's feeding cues [by enabling a mother and infant to rooming-in 24 hours a day].	**DIRECT CARE NURSING STAFF** ***Criterion 7.4.1*** *At least 80% of* ***direct care nursing staff who provide postpartum, and/or newborn care*** *will describe or demonstrate how they engage in a conversation with a mother regarding 2 aspects related to the importance of rooming-in 24h/day. [PI 35]* ***Criterion 7.4.2*** *At least 80% of* ***direct care nursing staff who provide postpartum, and/or newborn care*** *will describe or demonstrate at least 2 safety aspects to assess when mother and baby are skin-to-skin during the postpartum hospitalization regardless of method of birth. [PI 69]* ***Criterion 7.4.3*** *At least 80% of* ***direct care nursing staff who provide postpartum, and/or newborn care*** *will explain 2 situations: 1 for the mother and 1 for the infant, when it is acceptable to separate mother and baby while in the hospital. [PI 36]* **DIRECT CARE PROVIDER** ***Criterion 7.4.4*** *At least 80% of* ***direct care providers with privileges to provide postpartum and/or newborn care*** *will describe how they engage in a conversation with a mother regarding 2 aspects related to the importance of rooming-in 24h/day. [PI 35]* ***Criterion 7.4.5*** *At least 80% of* ***direct care providers with privileges to provide postpartum and/or newborn care*** *will explain 2 situations: 1 for the mother and 1 for the infant, when it is acceptable to separate mother and baby while in the hospital. [PI 36]*

U.S. CLARIFICATION: MEDICALLY JUSTIFIABLE OR SAFETY-RELATED REASONS FOR SEPARATION ***Healthcare Professionals must use their clinical judgement****. While it is true that rooming-in is the expected practice in Baby-Friendly designated facilities, we recognize some circumstances necessitate mother-baby separation. The decision that leads to a separation is often complex involving observations, assessments, and an understanding of the individual mother-baby dyad. It is imperative in these situations that care and decisions are individualized and include the mother's participation, if possible. Facilities should have a dedicated area to provide care to infants who have a justifiable reason for separation. As a reminder, BFUSA does NOT require that facilities close their nursery.*

To be clear, infants must not be separated for routine facility procedures that could be performed in the mother's room.

STEP 8

Support mothers to recognize and respond to their infants' cues for feeding.

RATIONALE:

Breastfeeding involves recognizing and responding to the infant's display of hunger and feeding cues and readiness to feed, as part of a nurturing relationship between the mother and infant. Responsive feeding (also called on-demand or baby-led feeding) puts no restrictions on the frequency or length of the infant's feeds, and mothers are advised to breastfeed whenever the infant is hungry or as often as the infant wants. Scheduled feeding, which prescribes a predetermined, and usually time-restricted, frequency and schedule of feeds is not recommended. It is important that mothers know that crying is a late *feeding* cue and that it is better to feed the baby earlier, since optimal positioning and attachment are more difficult when an infant is in distress.[1]

IMPLEMENTATION GUIDANCE:

Mothers should be supported to practice responsive feeding as part of nurturing care.[1] Regardless of whether they breastfeed or not, mothers should be supported to recognize and respond to their infants' cues for feeding, closeness and comfort, and enabled to respond accordingly to these cues with a variety of options, during their stay at the facility providing maternity and newborn services.[2] Supporting mothers to respond in a variety of ways to behavioral cues for feeding, comfort or closeness enables them to build a caring, nurturing relationship with their infants and increases their confidence in themselves, in breastfeeding and in their infants' growth and development.[1]

When the mother and baby are not in the same room for medical *or other justifiable reasons*, the facility staff need to *bring the mother and infant together* as often as possible, so that she can recognize feeding cues. When staff notice feeding cues, they should also bring the mother and baby together.[1]

New mothers believe that it is important that they respond to their infant's feeding cues. However, mothers have reported being stressed and anxious about how to interpret their infant's needs. Postpartum conversations support families to develop an understanding of an infant's cues for feeding, comfort, or closeness. Education provided to families should increase a mother's confidence in interpreting these cues and responding in a variety of ways which might include breastfeeding, rocking, holding, walking, singing, and skin-to-skin contact.[2]

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

ABM Protocol #10 recommends that mothers of late preterm and early term infants on the postpartum unit should be taught to respond to their infants' cues for feeding. However, it may be necessary for mothers to wake their infants when they do not demonstrate hunger cues within 4 hours of the previous feeding. Preterm infants should be breastfed (or breast-milk fed) 8-12 times in a 24-hour period.[41]

REFER TO APPENDIX A: PATIENT EDUCATION TOPICS for the comprehensive list of all required education topics for postpartum mothers.

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 8	VERIFICATION METHOD
*37. **Describe** at least 2 early feeding cues and 1 late feeding cue.	**Question or case study**
38. **Describe** at least 4 reasons why responsive feeding (also called on-demand or baby-led feeding) is important.	**Question or case study**
39. **Describe** at least 2 aspects of responsive feeding (also called on-demand or baby-led feeding) independent of feeding method.	**Question or case study**
46. **Engage** in a conversation with a mother of a preterm, late preterm or vulnerable infant (including multiple births) regarding the importance of observing at least 2 subtle signs and behavioral state shifts to determine when it is appropriate to breast-feed.	**Observation**
*58. **Describe** at least 4 elements to assess when a mother says that her infant is crying frequently.	**Question or case study**

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE POSTPARTUM UNIT:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
8.1 Breastfeeding mothers can describe at least two feeding cues.	**Interviews with breastfeeding mothers will confirm:** ***Criterion 8.1.1*** *At least 80% of breastfeeding mothers can describe at least 2 early feeding cues.*
8.2 Breastfeeding mothers report that they have been advised to feed their babies as often and for as long as the infant wants.	**Interviews with breastfeeding mothers will confirm:** ***Criterion 8.2.1*** *At least 80% of breastfeeding mothers will report that they have been advised to feed their infants as often and as long as the infants want.* ***Criterion 8.2.2*** *Quality improvement question for informational purposes (not a designation criterion): At least 80% of breastfeeding mothers can provide 2 acceptable responses to describe normal infant feeding patterns after the first 24 hours of life including:* ▪ *The average feeding frequency is at least 8-12 times in 24 hours,* ▪ *Infants feeding through the night and/or* ▪ *That cluster feeding is common.*

COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
8.3 Health professionals who provide labor & delivery, postpartum and/or newborn care will be competent in helping a mother to respond to her baby's feeding cues.	**Interviews with direct care nursing staff and direct care providers will confirm:** **DIRECT CARE NURSING STAFF** ***Criterion 8.3.1*** *At least 80% of direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care will describe at least 2 early feeding cues and 1 late feeding cue. [PI 37]* ***Criterion 8.3.2*** *At least 80% of direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care will describe at least 2 reasons why responsive feeding (also called on-demand feeding) is important [PI 38]* ***Criterion 8.3.3*** *3 At least 80% of direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care will describe at least 2 elements to assess when a mother says her infant is crying frequently. [PI 58]* **DIRECT CARE PROVIDER** ***Criterion 8.3.4*** *At least 80% of direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care will describe at least 2 early feeding cues and 1 late feeding cue. [PI 37]* ***Criterion 8.3.4*** *At least 80% of direct care providers with privileges to provide labor & delivery, postpartum and/or newborn care will describe at least 2 elements to assess when a mother says her infant is crying frequently. [PI 58]*

STEP 9

Counsel mothers on the use and risks of feeding bottles, artificial nipples, and pacifiers.

RATIONALE:

Proper guidance and counseling of mothers and other family members enables them to make informed decisions on the use or avoidance of pacifiers and/or feeding bottles and *artificial nipples* until the successful establishment of breastfeeding. While WHO guidelines[2] do not call for absolute avoidance of feeding bottles, *artificial nipples* and pacifiers for term infants, there are a number of reasons for caution about their use, including hygiene, oral formation and recognition of feeding cues.[1]

IMPLEMENTATION GUIDANCE:

If expressed milk or other feeds are medically indicated for term infants, feeding methods (*devices*) such as cups, spoons or feeding bottles and *artificial nipples* can be used during their stay at the facility.[2] However, it is important that staff do not become reliant on *artificial nipples* as an easy response to suckling difficulties instead of counseling mothers and enabling babies to attach babies properly and suckle effectively.[1]

It is important that the facility staff ensure appropriate hygiene in the cleaning of these utensils, since they can be a breeding ground for bacteria. Facility staff should also inform mothers and family members of the hygiene risks related to inadequate cleaning of feeding utensils, so that they can make informed *decisions* on the feeding method.

The physiology of suckling at the breast is different from the physiology of suckling from a feeding bottle and *an artificial nipple*.[53] It is possible that the use of the feeding bottle and an *artificial nipple* could lead to breastfeeding difficulties, particularly if use is prolonged.

However, the only study on this did not demonstrate a specific carry-over effect from suckling at a feeding bottle and *an artificial nipple* to suckling at the breast.[1, 15]

Pacifiers have long been used to soothe an upset infant. In some cases, they serve a therapeutic purpose, such as reducing pain during procedures when breastfeeding or skin-to-skin contact are not possible. *Pacifiers have also been shown to reduce the risk of SIDS, even among breastfeeding infants.* However, if pacifiers replace suckling and thus reduce the number of times an infant stimulates the mother's breast physiologically, this can lead to a reduction of maternal milk production. The use of *artificial nipples* or pacifiers may interfere with the mother's ability to recognize feeding cues. If the use of a pacifier prevents the mother from observing the infant's smacking of the lips or rooting towards the breast, she may delay feeding until the infant is crying and agitated.[1] *Therefore, recommending to parents that they delay pacifier introduction until breastfeeding is well established supports breastfeeding while reducing the risk of SIDS and helps parents understand appropriate timeframes for introducing pacifiers.*[26, 27]

For preterm infants, evidence does demonstrate that use of feeding bottles with *artificial nipples* interferes with learning to suckle at the breast. If expressed breast-milk or other feeds are medically indicated for preterm infants, feeding methods such as cups or spoons are preferable to feeding bottles and *artificial nipples.*[2] On the other hand, for preterm infants who are unable to breastfeed directly, non-nutritive sucking and oral stimulation may be beneficial until breastfeeding is established.[2] Non-nutritive sucking or oral stimulation involves the use of pacifiers, a gloved finger or a breast that is not yet producing milk.[1] **NOTE**: *If a preterm infant is in the room with the mother, oral stimulation should always be done by placing baby at the breast.*

There should be no promotion of feeding bottles or *artificial nipples* in any part of facilities providing maternity and newborn services, or by any of the staff. As is the case with breast-milk substitutes, these products fall within the scope of the *International* Code.[1, 15, 16, 54] *[SEE STANDARD 9.2 FOR ADDITIONAL GUIDANCE on the promotion of pacifiers as a SIDS risk reduction measure.]*

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

Hygiene is an important consideration for safe implementation of the use of bottles, nipples and pacifiers and other infant feeding items. The Centers for Disease Control and Prevention (CDC) and World Health Organization provide the steps that families should follow to clean, sanitize, and store infant feeding items. The CDC also provides steps to ensure that breast pump and breast pump parts are clean and sanitized.[55, 56]

Pacifiers are also recognized as a risk reduction measure for Sudden Infant Death Syndrome (SIDS). To reduce the risk of SIDS, the AAP recommends exclusive breastfeeding, breastfeeding for at least 6 months, and offering a pacifier at naptime and bedtime, once breastfeeding is well established. Infants who are not being directly breastfed can begin pacifier use as soon as desired.[26]

REFER TO APPENDIX A: PATIENT EDUCATION TOPICS for the comprehensive list of all required education topics for postpartum mothers.

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 9	VERIFICATION METHOD
28. **Describe** at least 6 essential issues that every breastfeeding mother should know or demonstrate.	**Question or case study**
53. **Demonstrate** to a mother how to safely cup-feed her infant when needed, showing at least 4 points.	**Observation**
54. **Describe** to a mother at least 4 steps to feed an infant a supplement in a safe manner.	**Observation**
*55. **Describe** at least 2 alternative feeding methods other than feeding bottles.	**Question or case study**
56. **Engage** in a conversation with a mother who requests feeding bottles, *artificial nipples*, and pacifiers [soothers] without medical indication, including at least 3 points.	**Observation**
*59. **Describe** at least 4 elements of anticipatory guidance to give to a mother on calming or soothing techniques before or as alternatives to pacifiers.	**Question or case study**
*70. ***Describe*** *when the acceptable time is for introducing a pacifier with a breast-feeding infant, with regards to SUID/SIDS reduction strategies.*	**Question or case study**

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE POSTPARTUM UNIT:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
9.1 Breastfeeding mothers report that they have been taught about the risks of using feeding bottles, *artificial nipples* and pacifiers.[2]	**Interviews with breastfeeding mothers will confirm:** ***Criterion 9.1.1*** *At least 80% of breastfeeding mothers can describe:* *A. One possible impact that pacifiers might have on breastfeeding, AND* *B. When the acceptable time is for introducing the pacifier.* ***Criterion 9.1.2*** *At least 80% of breastfeeding mothers can describe one possible impact that bottles and artificial nipples might have on breastfeeding.* ***Criterion 9.1.3*** *At least 80% of breastfeeding mothers that are unable to feed their baby directly at the breast or needed/chose additional supplementation will report:* *A. Alternative feeding devices other than bottles were offered, AND* *B. They were informed of the potential impacts of feeding bottles on breastfeeding AND* *C. Will be able to describe 2 feeding techniques appropriate for the use of selected feeding device.* ***Criterion 9.1.4*** *At least 80% of breastfeeding mothers [including breast-milk feeding] utilizing infant feeding items [bottles, artificial nipples, rings, caps, syringes, cups, spoons, breast pump equipment, etc.] can provide 1 acceptable response about proper hygiene when cleaning these infant feeding items.*

STEP 9

SAFE SLEEP AND SIDS REDUCTION MESSAGES SHOULD BE DISTRIBUTED BY THE FACILITY AND THE FOLLOWING STANDARDS AND CRITERIA FOR EVALUATION APPLY:

RATIONALE:

BFUSA acknowledges the evidence pertaining to pacifier use related to SIDS risk reduction.[25] Safe sleep and SIDS risk reduction information is important for parents to receive during the birth hospital stay.[26, 27] This education may be compatibly provided to parents by using safe sleep materials that also promote breastfeeding.

US STANDARD	US CRITERION FOR EVALUATION
9.2 Facilities distributing safe sleep materials must also provide additional verbal and written education related to breastfeeding and pacifier use to mothers.	**A review of education materials will confirm:** ***Criterion 9.2.1*** *A review of materials will confirm that safe sleep and SIDS risk reduction materials that are provided to mothers also provide additional written education that includes the all of the following:* *A. Pacifier use in the breastfed infant should be delayed until breastfeeding is firmly established.[26, 27] AND* *B. How mothers can know that breastfeeding is firmly established (For example, milk supply has increased, infant is breastfeeding 8-12 times in 24 hours, infant is satisfied after feedings, infant is gaining weight, mother can hear baby swallowing during feeding, adequate voiding and stooling according to expected norms).AND* *C. Breastfeeding is associated with a reduced risk of SIDS, and the protective effect increases with breastfeeding duration and exclusivity, with the greatest protection offered by breastfeeding for at least 6 months.[27, 57]* ***Criterion 9.2.2*** *Quality improvement question for informational purposes (not a designation criterion):* *At least 80% of mothers should be able to recall at least 2 of the following key safe sleep messages:* ▪ *Baby should always be placed on back to sleep.* ▪ *Baby should sleep in an empty, approved (CPSC) crib.* ▪ *Baby should sleep in the same room as parents for at least 6 and preferably to 12 months.* ▪ *Parents should refrain from smoking during and after pregnancy and baby should sleep in a smoke-free environment.* ▪ *Breastfeeding reduces the risk of SIDS.* ▪ *Pacifier use at bedtime reduces the risk of SIDS.*

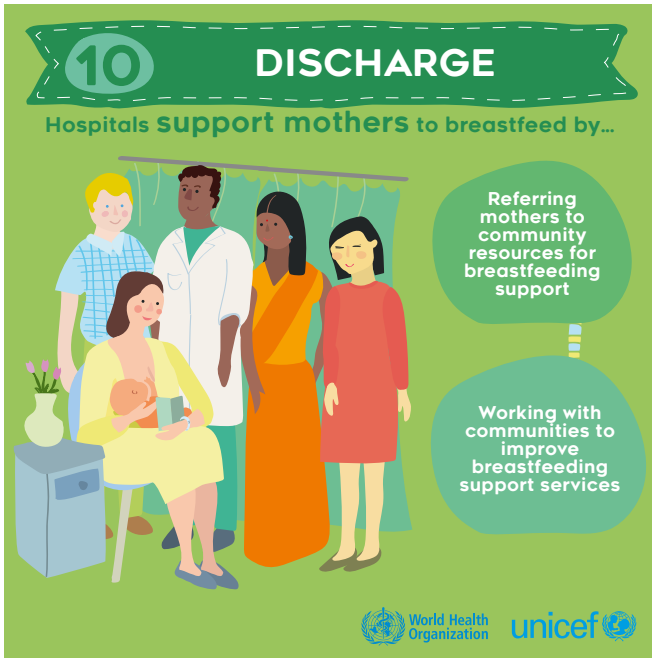
COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
9.3 Health professionals who provide labor and delivery, postpartum and/or newborn care will be competent in: • ***How to discuss with a mother how breastfeeding works,*** • ***Helping a mother who is not feeding her baby directly at the breast.***	**Interviews with direct care nursing staff and direct care providers will confirm:** **DIRECT CARE NURSING STAFF** ***Criterion 9.3.1*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will describe to a mother at least 4 steps to feed an infant a supplement in a safe manner. [PI 54]* ***Criterion 9.3.2*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will describe at least 2 elements of anticipatory guidance to give to a mother on calming or soothing techniques before or as alternatives to pacifiers. [PI 59]* ***Criterion 9.3.3*** *At least 80% of* ***direct care nursing staff who provide labor & delivery, postpartum, and/or newborn care*** *will describe when the acceptable time is for introducing a pacifier with a breastfeeding infant with regards to SUID/SIDS reduction strategies. [PI 70]* **DIRECT CARE PROVIDER** ***Criterion 9.3.4*** *At least 80% of direct care providers with privileges to* ***provide labor & delivery, postpartum and/or newborn care*** *will describe at least 2 elements of anticipatory guidance to give to a mother on calming or soothing techniques before or as alternatives to pacifiers. [PI 59]* ***Criterion 9.3.5*** *At least 80% of direct care providers with privileges to* ***provide labor & delivery, postpartum and/or newborn care*** *will describe when the acceptable time is for introducing a pacifier with a breastfeeding infant with regards to SUID/SIDS reduction strategies. [PI 70]*

STEP
10

Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

RATIONALE:

Mothers need sustained support to continue breastfeeding. While the time in the facility providing maternity and newborn services should provide a mother with basic breastfeeding skills, it is very possible her milk supply has not been fully established until after discharge. Breastfeeding support is especially critical in the succeeding days and weeks after discharge, to identify and address early breastfeeding challenges that occur. She 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 skills in a different way and additional support will be needed. Receiving timely support after discharge is instrumental in maintaining breastfeeding rates. Maternity facilities must know about and refer mothers to the variety of resources that exist in the community.[1]



IMPLEMENTATION GUIDANCE:

As part of protecting, promoting and supporting breastfeeding, discharge from facilities providing maternity and newborn services should be planned for and coordinated, so that parents and their infants have access to ongoing support and receive appropriate care.[2] Each mother should be linked to lactation-support resources in the community upon discharge. Facilities need to provide appropriate referrals to ensure that mothers and babies are seen by a health worker to assess the feeding situation. *The AAP recommends that every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital that includes an evaluation for feeding and jaundice. Breastfeeding newborns*

should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction. Printed and/or online information could be useful to provide contacts for support, in case of questions, doubts or difficulties, but this should not substitute for active follow-up care by a skilled professional.[1]

Facilities providing maternity and newborn services need to identify appropriate community resources for continued and consistent breastfeeding support that is culturally and socially sensitive to their needs. The facilities have a responsibility to engage with the surrounding community to enhance such resources. Community resources include primary health-care centers, community health workers, home visitors, breastfeeding clinics, nurses/midwives, lactation consultants, peer counsellors, mother-to-mother support groups, or phone lines ("hot lines"). The facility should maintain contact with the groups and individuals providing the support as much as possible and invite them to the facility where feasible.[1]

Follow-up care is especially crucial for preterm and low-birth-weight babies. In these cases, the lack of a clear follow-up plan could lead to significant health hazards. Ongoing support from skilled professionals is needed.[1]

US CONSIDERATIONS FOR SAFE IMPLEMENTATION:

Vulnerable Populations: Breastfeeding can be extremely challenging, especially if a mother is in a community at risk for not breastfeeding. Equity will be increased if competently skilled professionals and evidence-based breastfeeding counseling is accessible to all mothers. Populations at risk for lower rates of breastfeeding duration may include African American/Black mothers, mothers who are young, return early to work; lack social support; mothers with mental or medical concerns; parents with social and cultural considerations; late preterm and early term infants.[50, 58]

Knowledge of the existence of post discharge support can be instrumental in a mother's willingness to give breastfeeding a try. While breastfeeding mothers may have some particular concerns, it is critically important that support be provided to all mothers.

Continuum of care: The Academy of Breastfeeding Medicine's "Clinical Protocol #7: Model Maternity Policy Supportive of Breastfeeding" provides the following guidance:

- *Before discharge, the health care team will ensure that there is effective breastfeeding, that breastfeeding mothers are able to efficiently breastfeed their infants and that continuity of care is guaranteed, either by follow-up visits or by arranging qualified primary care providers and/or lactation specialists visits and/or support groups or peer counseling contacts.*[38]

- *If the infant is still not latching or feeding well at the time of discharge, an individualized feeding plan will be devised and, depending on the dyad's clinical situation and resources, the infant's discharge may be delayed.*[38]

- *Mothers identified prenatally or soon after delivery as at risk of delayed lactogenesis II will be assigned to special help as deemed appropriate. A feeding plan and close follow-up of the infant (for adequate hydration and nutrition besides help with expression) will be offered. At discharge, continuum of care will be ensured with a feeding plan and close follow-up.*[38]

REFER TO APPENDIX A: PATIENT EDUCATION TOPICS for the comprehensive list of all required education topics for postpartum mothers.

REFER TO APPENDIX C: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY for the comprehensive list of required knowledge, skills, and attitudes. (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)

WHO/UNICEF PERFORMANCE INDICATORS DEMONSTRATING COMPETENCY TO IMPLEMENT STEP 10	VERIFICATION METHOD
57. **Engage** in a conversation with a mother regarding at least 4 different ways to facilitate breastfeeding in order to prevent or resolve most common conditions of the lactating breasts (sore nipples, engorgement, mother who thinks she doesn't have enough milk, infants who have difficulty sucking).	**Observation**
60. **Describe** at least 2 locally available sources for timely infant feeding information and problem management.	**Question or case study**
61. **Describe** at least 2 ways the healthcare facility engages with community-based programs to coordinate breastfeeding messages and offer continuity of care.	**Question or case study**
*62. **Develop** individualized discharge feeding plans with a mother that includes at least 6 points.	**Observation**
*63. **Describe** to a mother at least 4 warning signs of infant undernourishment or dehydration for a mother to contact a health care professional after discharge.	**Observation**
*64. **Describe** at least 3 warning maternal signs for a mother to contact a health care professional after discharge.	**Question or case study**

THE FOLLOWING STANDARDS APPLY TO MOTHERS AND INFANTS BEING CARED FOR ON THE POSTPARTUM UNIT:

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
10.1 Mothers report that a staff member has informed them where they can access breastfeeding support/*infant formula feeding support* in their community.	**Interviews with mothers will confirm:** ***Criterion 10.1.1*** *At least 80% of breastfeeding mothers [including breast-milk feeding] will report that they have been given verbal and written information on:* A. ***How*** *to access breastfeeding support [support groups, peer counselors, providers, or other skilled community health services] after discharge from the facility, AND* B. ***When*** *to follow-up for a newborn evaluation for jaundice and feeding, AND* C. *Maternal/infant warning signs/symptoms of breastfeeding problems that must receive urgent evaluation and whom they should call for assistance.* ***Criterion 10.1.2*** *At least 80% of mothers choosing to feed their babies formula will report that they have been given verbal and written information on:* A. ***How*** *to access infant formula feeding support [support groups, peer counselors, providers, or other skilled community health services] after discharge from the facility, AND* B. ***When*** *to follow-up for a newborn evaluation for jaundice and feeding, AND* C. *Maternal/infant warning signs/symptoms of breast problems and/or formula feeding concerns that must receive urgent evaluation and whom they should call for assistance.* ***NOTE:*** *Mothers who are "mixed-feeding" their babies should receive verbal and written information appropriate to support optimal, safe infant feeding individualized to their feeding intentions.*

WHO/UNICEF STANDARD	US CRITERION FOR EVALUATION
10.2 The facility can demonstrate that it coordinates with community services that provide breastfeeding/infant feeding support, including clinical management and mother-to-mother support.	**A review of documents indicates:** ***Criterion 10.2.1*** *A review of documents indicates that written (printed or electronic) information is distributed to mothers before discharge on how and where mothers, regardless of feeding method, can find help on feeding their infants after returning home and includes information on what type of help is available from each source of support.* ***Criterion 10.2.2*** *The facility provides a written description of how it fosters the establishment of and/or coordinates with mother support groups and other community services that provide breastfeeding/infant feeding support to mothers. The description includes a specific list of programs and services they fostered/coordinated with.*

COMPETENCY ASSESSMENT-SELECTED PERFORMANCE INDICATORS	US CRITERION FOR EVALUATION
10.3 Health professionals who provide postpartum and/or newborn care will be competent to ensure a seamless transition after discharge.	**Interviews with direct care nursing staff and direct care providers will confirm:** **DIRECT CARE NURSING STAFF** ***Criterion 10.3.1*** *At least 80% of* ***direct care nursing staff who provide postpartum and/or newborn care*** *will describe the components of an individualized discharge feeding plans with a mother that includes at least 4 points. [PI 62]* ***Criterion 10.3.2*** *At least 80% of* ***direct care nursing staff who provide postpartum and/or newborn care*** *will describe to a mother at least 3 warning signs of infant undernourishment or dehydration for a mother to contact a health professional after discharge. [PI 63]* ***Criterion 10.3.3*** *At least 80% of* ***direct care nursing staff who provide postpartum and/or newborn care*** *will describe at least 2 maternal warning signs for a mother to contact a health care professional after discharge. [PI 64]* **DIRECT CARE PROVIDER** ***Criterion 10.3.4*** *At least 80% of direct care providers with privileges to* ***provide postpartum and/or newborn care*** *will describe to a mother at least 3 warning signs of infant undernourishment or dehydration for a mother to contact a health professional after discharge. [PI 63]* ***Criterion 10.3.5*** *At least 80% of direct care providers with privileges to* ***provide postpartum and/or newborn care*** *will describe at least 2 maternal warning signs for a mother to contact a health care professional after discharge. [PI 64]*

APPENDICES:

APPENDIX A: PATIENT EDUCATION TOPICS

PRENATAL CONVERSATION TOPICS INCLUDE:	POSTPARTUM BREASTFEEDING EDUCATION TOPICS INCLUDE:	POSTPARTUM INFANT FORMULA FEEDING EDUCATION TOPICS INCLUDE:
WHO/UNICEF Required Prenatal Conversation Topics Include at a Minimum: **Breastfeeding** ▪ the importance of breastfeeding *[including a discussion on the importance of direct breastfeeding, as needed]* ▪ global recommendations for breastfeeding including: o exclusive breastfeeding for the first 6 months o the risks of giving formula or other breast-milk substitutes o breastfeeding continues to be important after 6 months when other foods are given ▪ the basics of good positioning and attachment ▪ recognition of feeding cues **Birth Practices** ▪ the importance of immediate and sustained skin-to-skin contact ▪ the importance of early initiation of breastfeeding ▪ the importance of rooming-in ***US Recommended Prenatal Discussion Topics for Anticipatory Guidance include:*** ▪ *non pharmacologic pain relief during labor* ▪ *creating a safe sleep environment:* o *along with the importance of rooming-in, staff should discuss how to create a safe sleep environment while rooming-in at the hospital. Narcotic-induced sleepiness, hormonally driven sleepiness [physiology of lactation and its effects on mothers] and fatigue are all factors that mothers should be aware of while rooming-in at the hospital.* o *risk reduction strategies for SIDS after leaving the hospital including the importance of removing suffocation hazards (e.g., soft bedding/pillows) from the breastfeeding environment and defining hazardous circumstances* ▪ *how to have an abundant milk supply* ▪ *how to prevent nipple soreness* ▪ *how to prevent or minimize engorgement after birth* ▪ *availability of community resources with staff properly trained to assist with breastfeeding assessment and management* ▪ *a brief conversation to discuss details about feeding a premature, low birthweight or sick baby that might need to be admitted to the NICU*	▪ *proper positioning, correct attachment, efficient suckling, and milk transfer* ▪ *ensuring a good milk supply* ▪ *criteria to assess if the infant is getting enough breast-milk including adequate intake and output for day of life* ▪ *preventative management of common problems such as engorgement, sore and cracked nipples*[5] ▪ *hand expression of breast-milk* ▪ *the importance of exclusive breastfeeding* ▪ *how to maintain exclusive breastfeeding for about 6 months* ▪ *signs/symptoms of infant feeding issues requiring referral to a qualified provider* ▪ *early feeding cues and a reminder that crying is a late cue* ▪ *no limits on how often or how long infants should be fed* ▪ *the effects of pacifiers and artificial nipples on breastfeeding and why to avoid them until lactation is established* ▪ *normal newborn feeding patterns* ▪ *collection and storage of breast-milk* ▪ *creating a safe sleep environment for breastfeeding including:* o *the physiology of lactation and its effects on the mother leading to hormonally driven sleepiness* o *the importance of removing suffocation hazards (e.g., soft bedding/pillows) from the breastfeeding environment* ▪ *community breastfeeding support services [including how to access support and when to follow-up for formal evaluation]* ▪ *maternal/infant warning signs/symptoms of breast problems and breastfeeding problems that must receive urgent evaluation [including who they should call for assistance]*	▪ *safe preparation, feeding, and storage of infant formula including:* o *appropriate hand hygiene* o *cleaning infant feeding items [bottles, nipples, rings, caps, syringes, cups, spoons, etc.] and workspace surfaces* o *appropriate and safe reconstitution of concentrated and powdered infant formulas* o *accuracy of measurement of ingredients* o *safe handling of formula* o *proper storage of formula* o *appropriate feeding methods which may include feeding on cue, frequent low volume feeds, paced bottle techniques, eye-to-eye contact, and holding the infant closely* o *powdered infant formula is not sterile and may contain pathogens that can cause serious illness in infants younger than 3 months* ▪ *preventative steps to minimize engorgement [if mother plans to exclusively formula feed]* ▪ *signs/symptoms of infant feeding issues requiring referral to a qualified provider* ▪ *normal newborn feeding patterns* ▪ *creating a safe sleep environment for feeding your baby including:* o *the importance of removing suffocation hazards (e.g., soft bedding/pillows) from the environment* ▪ *community infant formula feeding services [including how to access support and when to follow-up for formal evaluation]* ▪ *maternal/infant warning signs/symptoms of breast problems and/or formula feeding concerns that must receive urgent evaluation and who they should call for assistance*

APPENDIX B: INDICATORS FOR FACILITY MONITORING OF KEY CLINICAL PRACTICES

KEY CLINICAL PRACTICES	INDICATOR DEFINITION NOTE: More detailed and specific guidance on numerator/denominator inclusions/ exclusions is described on the Facility Data Sheet.	TARGET	PRIMARY SOURCE	OTHER SOURCES	SUBMIT METHOD
Step 3: Discuss the importance and management of breastfeeding with pregnant women and their families.	**Affiliated Prenatal Services:** The percentage of mothers who received prenatal care at an affiliated prenatal service who received prenatal counseling on breastfeeding.	≥80%	Mothers Survey	Audits	Mothers Survey Report form or Link
Step 4: Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.	***Vaginal Delivery:*** *The percentage of infants that were placed in skin-to-skin contact with their mothers immediately after a vaginal birth and remained there uninterrupted for at least 1 hour (longer, if needed, to allow a breastfeeding infant to complete a feeding).*	≥80%	Clinical records	Mothers Survey and/or Audits	Facility Data Sheet Mothers Survey Report Form or Link
	Cesarean Delivery: *The percentage of infants born by cesarean delivery that were placed in skin-to-skin contact with their mothers, when safe and feasible [mother is responsive and alert] and remained there uninterrupted for at least 1 hour (longer, if needed, to allow a breastfeeding infant to complete a feeding).*	≥80%	Clinical records	Mothers Survey and/or Audits	Facility Data Sheet Mothers Survey Report Form or Link
	All Deliveries: *The percentage of infants who were supported to breastfeed as soon as possible after birth, within the first **one to two hours** after delivery.* **NOTE:** *Supporting the initiation of breastfeeding is defined as placing the baby on the mother's chest (skin-to-skin) for breastfeeding, pointing out infant feeding readiness cues and gently coaching the mother to allow baby to move and attach to the breast.*	≥80%	Clinical records	Mothers Survey and/or Audits	Facility Data Sheet Mothers Survey Report Form or Link
Step 5: Support mothers to initiate and maintain breastfeeding and manage common difficulties.	*The percentage of breastfeeding mothers who report being taught how to position their baby for breastfeeding.*	≥80%	Mothers Survey	Audits	Mothers Survey Report form or Link
	The percentage of breastfeeding mothers who report being taught how to attach their baby for breastfeeding.	≥80%	Mothers Survey	Audits	Mothers Survey Report form or Link
	The percentage of breastfeeding mothers who report being taught how to observe for expected suckling patterns.	≥80%	Mothers Survey	Audits	Mothers Survey Report form or Link

APPENDIX B: INDICATORS FOR FACILITY MONITORING OF KEY CLINICAL PRACTICES

KEY CLINICAL PRACTICES	INDICATOR DEFINITION NOTE: More detailed and specific guidance on numerator/denominator inclusions/ exclusions is described on the Facility Data Sheet.	TARGET	PRIMARY SOURCE	OTHER SOURCES	SUBMIT METHOD
Step 5: Support mothers to initiate and maintain breastfeeding and manage common difficulties.	*The percentage of breastfeeding mothers who report being taught how to listen for swallowing sounds.*	›80%	Mothers Survey	Audits	Mothers Survey Report form or Link
	The percentage of breastfeeding mothers who report being taught how to express their breast-milk by hand.	›80%	Mothers Survey	Audits	Mothers Survey Report form or Link
Step 6: Do not provide breastfed newborns any food or fluids other than breast-milk, unless medically indicated.	*The percentage of infants who received only breast-milk throughout their stay at the facility.* ***Reminder: The US BFHI Designation Is based on implementation of clinical practices, NOT on an exclusive breastfeeding rate of ›80%.***	›80%	Clinical records	Mothers Survey and/or Audits	Facility Data Sheet Mothers Survey Report Form or Link
	The percentage of breast-milk fed infants who received formula supplementation during their stay at the facility.	‹ 14.2%	Clinical records	Mothers Survey and/or Audits	Facility Data Sheet Mothers Survey Report Form or Link
	The percentage of mixed-feeding and formula feeding mothers who report being taught how to safely prepare, feed and store infant formula.	›80%	Mothers Survey	Audits	Mothers Survey Report form or Link
Step 7: Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.	*The percent of infants who stayed with their mothers both day and night, without separation of more than 1 hour per 24-hour period.*	›80%	Clinical records	Mothers Survey and/or Audits	Facility Data Sheet Mothers Survey Report Form or Link
Step 8: Support mothers to recognize and respond to their infants' cues for feeding.	*The percentage of mothers [regardless of feeding method] who report being taught that salivating or rooting is an early feeding cue.*	›80%	Mothers Survey	Audits	Mothers Survey Report form or Link
	The percentage of mothers [regardless of feeding method] who report being taught that the baby putting fingers or fist in or around his/her mouth is an early feeding cue.	›80%	Mothers Survey	Audits	Mothers Survey Report form or Link
	The percentage of mothers [regardless of feeding method] who report being taught that the baby becoming more active and alert is an early feeding cue.	›80%	Mothers Survey	Audits	Mothers Survey Report form or Link

APPENDIX B: INDICATORS FOR FACILITY MONITORING OF KEY CLINICAL PRACTICES

KEY CLINICAL PRACTICES	INDICATOR DEFINITION NOTE: More detailed and specific guidance on numerator/denominator inclusions/ exclusions is described on the Facility Data Sheet.	TARGET	PRIMARY SOURCE	OTHER SOURCES	SUBMIT METHOD
Step 9: Counsel mothers on the use and risks of feeding bottles, artificial nipples and pacifiers.	*The percentage of breastfeeding mothers who report being taught about the risks of using feeding bottles, artificial nipples and pacifiers.*	≥80%	Mothers Survey	Audits	Mothers Survey Report form or Link
	The percentage of breastfeeding mothers who report being taught when an acceptable time is to introduce a pacifier.	≥80%	Mothers Survey	Audits	Mothers Survey Report form or Link
Step 10: Coordinate discharge so that parents and their infants have timely access to ongoing support and care.	*The percentage mothers [regardless of feeding method] who report being taught how to tell if their babies are getting enough.*	≥80%	Mothers Survey	Audits	Mothers Survey Report form or Link
	The percentage of mothers [regardless of feeding method] who report being taught where they can access infant feeding support in the community.	≥80%	Mothers Survey	Audits	Mothers Survey Report form or Link

APPENDIX C1: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY – SORTED BY DOMAIN/COMPETENCY

DOMAINS, COMPETENCIES AND PERFORMANCE INDICATORS (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	VERIFICATION METHOD
DOMAIN 1: CRITICAL MANAGEMENT PROCEDURES TO SUPPORT THE TEN STEPS	
Competency 01. Implement the Code in a health facility (Step 1A)	
*1. **List** at least 3 products that are covered by the Code.	**Question or case study**
*2. **Describe** at least 3 ways a direct care provider/direct care staff protects breastfeeding in practice.	**Question or case study**
*3. **Describe** at least 1 way a direct care provider/direct care staff should respond if offered information provided by manufacturers and/or distributors of products within the scope of the Code.	**Question or case study**
*4. **Describe** at least 1 type of financial or material inducement that might be offered to a direct care provider/direct care staff by a manufacturer and/or distributor of products within the scope of the Code.	**Question or case study**
*5. **Describe** at least 1 harm of a direct care provider/direct care staff accepting financial or material inducements.	**Question or case study**
*6. **Explain** at least 2 ways that the facility ensures that there is no promotion of infant formula, feeding bottles, or teats in any part of facilities providing maternity and new-born services, or by any of the direct care staff/direct care providers.	**Question or case study**

APPENDIX C1: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY – SORTED BY DOMAIN/COMPETENCY	
DOMAINS, COMPETENCIES AND PERFORMANCE INDICATORS (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	**VERIFICATION METHOD**
DOMAIN 1: CRITICAL MANAGEMENT PROCEDURES TO SUPPORT THE TEN STEPS continued	
Competency 02. Explain a facility's infant feeding policies and monitoring systems (Step 1B and 1C)	
*7. **Describe** at least 2 elements that are in the facility's infant feeding policy.	**Question or case study**
*8. **Explain** at least 3 ways that the infant feeding policy affects a direct care provider's/direct care staff member's work in *providing safe, equitable and appropriate care*.	**Question or case study**
*9. **Explain** at least 2 reasons why monitoring of hospital practices is important to ensure quality of care.	**Question or case study**
*10. **Explain** at least 2 ways practices are monitored in this facility.	**Question or case study**
DOMAIN 2: FOUNDATIONAL SKILLS: COMMUNICATING IN A CREDIBLE AND EFFECTIVE WAY	
Competency 03. Use listening and learning skills whenever engaging in a conversation with a mother (All Steps)	
*11. **Demonstrate** at least 3 aspects of listening and learning skills when talking with a mother.	**Observation**
*12. **Demonstrate** at least 3 ways to adapt communication style and content when talking with a mother.	**Observation**
Competency 04. Use skills for building confidence and giving support whenever engaging in a conversation with a mother (All Steps)	
*13. **Demonstrate** at least 2 ways to encourage a mother to share her views, taking time to understand and consider these views.	**Observation**
*14. **Demonstrate** at least 3 aspects of building confidence and giving support when talking with a mother.	**Observation**
DOMAIN 3: PRENATAL PERIOD	
Competency 05. Engage in antenatal conversation about breastfeeding (Step 3)	
*15. **Engage** in a conversation with a pregnant woman on 3 aspects of the importance of breastfeeding.	**Observation**
*16. **Assess** at least 3 aspects of a pregnant woman's knowledge about breastfeeding in order to fill the gaps and correct inaccuracies.	**Observation**
*17. **Engage** in a conversation with a pregnant woman about at least 4 care practices a mother/infant dyad will experience at the birthing facility that will support breastfeeding.	**Observation**

APPENDIX C1: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY – SORTED BY DOMAIN/COMPETENCY	
DOMAINS, COMPETENCIES AND PERFORMANCE INDICATORS (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	**VERIFICATION METHOD**
DOMAIN 4: BIRTH AND IMMEDIATE POSTPARTUM	
Competency 06. Implement immediate and uninterrupted skin-to-skin (Step 4)	
*18. **Explain** at least 3 reasons why immediate and uninterrupted skin-to-skin is important for the mother.	**Question or case study**
*19. **Explain** at least 3 reasons why immediate and uninterrupted skin-to-skin is important for the infant.	**Question or case study**
20. **Demonstrate** at least 3 points of how to routinely implement immediate, uninterrupted and safe skin-to-skin between mother and infant, regardless of method of birth.	**Observation**
*21. **Demonstrate** at least 3 safety aspects to assess when mother and baby are skin-to-skin during the first 2 hours postpartum, regardless of method of birth.	**Observation**
*22. **List** at least 3 reasons why skin-to-skin should NOT be interrupted.	**Question or case study**
*23. **Explain** at least 2 reasons when skin-to-skin could be interrupted for medically justifiable reasons.	**Question or case study**
24. "WHERE APPLICABLE" **Explain** how to maintain skin-to-skin during transfer of mother and infant to another room or other recovery area.	**Question or case study**
DOMAIN 5: ESSENTIAL ISSUES FOR A BREASTFEEDING MOTHER	
Competency 07. Facilitate breastfeeding within the first hour, according to cues (Step 4)	
*25. **Engage** in a conversation with a mother including at least 3 reasons why suckling at the breast in the first hour is important, when the baby is ready.	**Observation**
26. **Demonstrate** at least 3 aspects of safe care of the newborn in the first 2 hours post-birth.	**Observation**
27. **Describe** to a mother at least 3 pre-feeding behaviours babies show before actively sucking at the breast.	**Observation**
Competency 08. Discuss with a mother how breastfeeding works (Steps 3, 5, 6 and 9)	
28. **Describe** at least 6 essential issues that every breastfeeding mother should know or demonstrate.	**Question or case study**
*29. **Engage** in a conversation with a mother regarding at least 3 reasons why effective exclusive breastfeeding is important.	**Observation**
*30. **Engage** in a conversation with a mother regarding 2 elements related to infant feeding patterns in the first 36 hours of life.	**Observation**
*31. **Describe** to a mother at least 4 signs of adequate transfer of milk in the first few days.	**Observation**
*66. ***Describe*** *at least 1 professional medical reference or resource for identifying medications that are safe/compatible for use during lactation.*	**Question or case study**

APPENDIX C1: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY – SORTED BY DOMAIN/COMPETENCY	
DOMAINS, COMPETENCIES AND PERFORMANCE INDICATORS (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	**VERIFICATION METHOD**
DOMAIN 5: ESSENTIAL ISSUES FOR A BREASTFEEDING MOTHER continued	
Competency 09. Assist mother getting her baby to latch (Step 5)	
32. **Evaluate** a full breastfeeding session observing at least 5 points.	**Observation**
*33. **Demonstrate** at least 3 aspects of how to help a mother achieve a comfortable and safe position for breastfeeding within the first 6 hours after birth and later as needed during the hospital stay.	**Observation**
*34. **Demonstrate** how to help a mother achieve an effective and comfortable latch, noting at least 5 points.	**Observation**
Competency 10. Help a mother respond to feeding cues (Steps 7 and 8)	
*35. **Engage** in a conversation with a mother regarding 2 aspects related to the importance of rooming-in 24h/day.	**Observation**
*36. **Explain** 2 situations: 1 for the mother and 1 for the infant, when it is acceptable to separate mother and baby while in hospital.	**Question or case study**
*37. **Describe** at least 2 early feeding cues and 1 late feeding cue.	**Question or case study**
38. **Describe** at least 4 reasons why responsive feeding is important (also called on-demand or baby-led feeding) independent of feeding method.	**Question or case study**
39. **Describe** at least 2 aspects of responsive feeding (also called on-demand or baby-led feeding) independent of feeding method.	**Question or case study**
*68. **Describe** 2 aspects involved in creating a safe environment for rooming-in during the hospital stay.*	**Question or case study**
69. **Demonstrate at least 3 safety aspects to assess when mother and baby are skin-to-skin during the postpartum hospitalization, regardless of method of birth.*	**Observation**
Competency 11. Help a mother manage milk expression (Steps 5 and 6)	
40. **Demonstrate** to a mother how to hand express breast milk, noting 8 points.	**Observation**
41. **Explain** at least 3 aspects of appropriate storage of breast-milk.	**Question or case study**
42. **Explain** at least 3 aspects of handling of expressed breast-milk.	**Question or case study**

APPENDIX C1: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY – SORTED BY DOMAIN/COMPETENCY

DOMAINS, COMPETENCIES AND PERFORMANCE INDICATORS (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	VERIFICATION METHOD
DOMAIN 6: HELPING MOTHERS AND BABIES WITH SPECIAL NEEDS	
Competency 12. Help a mother to breastfeed a low-birth-weight or sick baby (Steps 5, 7 and 8)	
43. **Help** a mother achieve a comfortable and safe position for breastfeeding with her preterm, late preterm, or weak infant at the breast, noting at least 4 points.	**Observation**
*44. **Engage** in a conversation with a mother of a preterm, late preterm, or low-birth-weight infant not sucking effectively at the breast, including at least 5 points.	**Observation**
45. **Engage** in a conversation with a mother separated from her preterm or sick infant regarding at least 2 reasons to be with her infant in the intensive care unit.	**Observation**
46. **Engage** in a conversation with a mother of a preterm, late preterm or vulnerable infant (including multiple births) regarding the importance of observing at least 2 sub-tle signs and behavioural state shifts to determine when it is appropriate to breastfeed.	**Observation**
Competency 13. Help a mother whose baby needs fluids other than breast milk (Step 6)	
*47. **List** at least 2 potential contraindications to breastfeeding for a baby and 2 for a mother.	**Question or case study**
*48. **Describe** at least 4 medical indications for supplementing breastfed newborns: 2 maternal indications and 2 newborn indications, when breastfeeding is not improved following skilled assessment and management.	**Question or case study**
*49. **Describe** at least 3 risks of giving a breastfed newborn any food or fluids other than breast milk, in the absence of medical indication.	**Question or case study**
*50. For those few health situations where infants cannot, or should not, be fed at the breast, **describe**, in order of preference, the alternatives to use.	**Question or case study**
*51. **Engage** in a conversation with a mother who intends to feed her baby formula, noting at least 3 actions to take.	**Observation**
52. **Demonstrate** at least 3 important items of safe preparation of infant formula to a mother who needs that information.	**Observation**
*67. ***Identify*** *3 high-risk infant populations that may warrant extra precautions to protect against severe infections associated with powdered infant formula.*	**Question or case study**
Competency 14. Help a mother who is not feeding her baby directly at the breast (Step 9)	
53. **Demonstrate** to a mother how to safely cup-feed her infant when needed, showing at least 4 points.	**Observation**
54. **Describe** to a mother at least 4 steps to feed an infant a supplement in a safe manner.	**Observation**
*55. **Describe** at least 2 alternative feeding methods other than feeding bottles.	**Question or case study**
56. **Engage** in a conversation with a mother who requests feeding bottles, teats, pacifiers and soothers without medical indication, including at least 3 points.	**Observation**

APPENDIX C1: PERFORMANCE INDICATORS TO MEASURE EACH COMPETENCY – SORTED BY DOMAIN/COMPETENCY	
DOMAINS, COMPETENCIES AND PERFORMANCE INDICATORS (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	**VERIFICATION METHOD**
DOMAIN 6: HELPING MOTHERS AND BABIES WITH SPECIAL NEEDS continued	
Competency 15. Help a mother prevent or resolve difficulties with breastfeeding (Steps 5, 8, 9 and 10)	
57. **Engage** in a conversation with a mother regarding at least 4 different ways to facilitate breastfeeding in order to prevent or resolve most common conditions of the lactating breasts (sore nipples, engorgement, mother who thinks she doesn't have enough milk, infants who have difficulty sucking).	**Observation**
*58. **Describe** at least 4 elements to assess when a mother says that her infant is crying frequently.	**Question or case study**
*59. **Describe** at least 4 elements of anticipatory guidance to give to a mother on calming or soothing techniques before or as alternatives to pacifiers.	**Question or case study**
*70. ***Describe*** *when the acceptable time is for introducing a pacifier with a breastfeeding infant, with regards to SUID/SIDS reduction strategies.*	**Question or case study**
*65. ***Describe*** *at least 2 maternal and 2 infant risk factors associated with delayed lactogenesis II.*	**Question or case study**
DOMAIN 7: CARE AT DISCHARGE	
Competency 16. Ensure seamless transition after discharge (Step 10)	
60. **Describe** at least 2 locally available sources for timely infant feeding information and problem management.	**Question or case study**
61. **Describe** at least 2 ways the healthcare facility engages with community-based programs to coordinate breastfeeding messages and offer continuity of care.	**Question or case study**
*62. **Develop** individualized discharge feeding plans with a mother that includes at least 6 points.	**Observation**
*63. **Describe** to a mother at least 4 warning signs of infant undernourishment or dehydration for a mother to contact a health care professional after discharge.	**Observation**
*64. **Describe** at least 3 warning maternal signs for a mother to contact a health care professional after discharge.	**Question or case study**

APPENDIX C2: PERFORMANCE INDICATORS TO MEASURE COMPETENCY - SORTED BY STEP

TEN STEPS TO SUCCESSFUL BREASTFEEDING (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	VERIFICATION METHOD
STEP 1A. COMPLY FULLY WITH THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES AND RELEVANT WORLD HEALTH ASSEMBLY RESOLUTIONS. (COMPETENCY 01)	
*1. **List** at least 3 products that are covered by the Code.	**Question or case study**
*2. **Describe** at least 3 ways a direct care provider/direct care staff protects breastfeeding in practice.	**Question or case study**
*3. **Describe** at least 1 way a direct care provider/direct care staff should respond if offered information provided by manufacturers and/or distributors of products within the scope of the Code.	**Question or case study**
*4. **Describe** at least 1 type of financial or material inducement that might be offered to a direct care provider/direct care staff by a manufacturer and/or distributor of products within the scope of the Code.	**Question or case study**
*5. **Describe** at least 1 harm of a direct care provider/direct care staff accepting financial or material inducements.	**Question or case study**
*6. **Explain** at least 2 ways that the facility ensures that there is no promotion of infant formula, feeding bottles, or teats in any part of facilities providing maternity and newborn services, or by any of the direct care providers.	**Question or case study**
STEP 1B. HAVE A WRITTEN INFANT FEEDING POLICY THAT IS ROUTINELY COMMUNICATED TO STAFF AND PARENTS. (COMPETENCY 02)	
*7. **Describe** at least 2 elements that are in the facility's infant feeding policy.	**Question or case study**
*8. **Explain** at least 3 ways that the infant feeding policy affects a direct care provider's/direct care staff member's work in *providing safe, equitable and appropriate care*.	**Question or case study**
STEP 1C. ESTABLISH ONGOING MONITORING AND DATA-MANAGEMENT SYSTEMS. (COMPETENCY 02)	
*9. **Explain** at least 2 reasons why monitoring of hospital practices is important to ensure quality of care.	**Question or case study**
*10. **Explain** at least 2 ways practices are monitored in this facility.	**Question or case study**
STEP 2. ENSURE THAT STAFF HAVE SUFFICIENT KNOWLEDGE, COMPETENCE AND SKILLS TO SUPPORT BREASTFEEDING. (FOUNDATIONAL SKILLS APPLYING TO ALL STEPS. (COMPETENCY 03 AND 04)	
*11. **Demonstrate** at least 3 aspects of listening and learning skills when talking with a mother.	**Observation**
*12. **Demonstrate** at least 3 ways to adapt communication style and content when talking with a mother.	**Observation**
*13. **Demonstrate** at least 2 ways to encourage a mother to share her views, taking time to understand and consider these views.	**Observation**
*14. **Demonstrate** at least 3 aspects of building confidence and giving support when talking with a mother.	**Observation**

APPENDIX C2: PERFORMANCE INDICATORS TO MEASURE COMPETENCY - SORTED BY STEP

TEN STEPS TO SUCCESSFUL BREASTFEEDING (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	VERIFICATION METHOD
STEP 3. DISCUSS THE IMPORTANCE AND MANAGEMENT OF BREASTFEEDING WITH PREGNANT WOMEN AND THEIR FAMILIES. (COMPETENCY 05 AND 08)	
*15. **Engage** in a conversation with a pregnant woman on 3 aspects of the importance of breastfeeding.	**Observation**
*16. **Assess** at least 3 aspects of a pregnant woman's knowledge about breastfeeding in order to fill the gaps and correct inaccuracies.	**Observation**
*17. **Engage** in a conversation with a pregnant woman about at least 4 care practices a mother/infant dyad will experience at the birthing facility that will support breastfeeding.	**Observation**
*29. **Engage** in a conversation with a mother regarding at least 3 reasons why effective exclusive breastfeeding is important.	**Observation**
STEP 4. FACILITATE IMMEDIATE AND UNINTERRUPTED SKIN-TO-SKIN CONTACT AND SUPPORT MOTHERS TO INITIATE BREASTFEEDING AS SOON AS POSSIBLE AFTER BIRTH. (COMPETENCY 06 AND 07)	
*18. **Explain** at least 3 reasons why immediate and uninterrupted skin-to-skin is important for the mother.	**Question or case study**
*19. **Explain** at least 3 reasons why immediate and uninterrupted skin-to-skin is important for the infant.	**Question or case study**
20. **Demonstrate** at least 3 points of how to routinely implement immediate, uninterrupted and safe skin-to-skin between mother and infant, regardless of method of birth.	**Observation**
*21. **Demonstrate** at least 3 safety aspects to assess when mother and baby are skin-to-skin during the first 2 hours postpartum, regardless of method of birth.	**Observation**
*22. **List** at least 3 reasons why skin-to-skin should NOT be interrupted.	**Question or case study**
*23. **Explain** at least 2 reasons when skin-to-skin could be interrupted for medically justifiable reasons.	**Question or case study**
24. "WHERE APPLICABLE" **Explain** how to maintain skin-to-skin during transfer of mother and infant to another room or other recovery area.	**Question or case study**
*25. **Engage** in a conversation with a mother including at least 3 reasons why suckling at the breast in the first hour is important, when the baby is ready.	**Observation**
26. **Demonstrate** at least 3 aspects of safe care of the newborn in the first 2 hours post-birth.	**Observation**
27. **Describe** to a mother at least 3 prefeeding behaviors babies show before actively sucking at the breast.	**Observation**

APPENDIX C2: PERFORMANCE INDICATORS TO MEASURE COMPETENCY - SORTED BY STEP

TEN STEPS TO SUCCESSFUL BREASTFEEDING (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	VERIFICATION METHOD
STEP 5. SUPPORT MOTHERS TO INITIATE AND MAINTAIN BREASTFEEDING AND MANAGE COMMON DIFFICULTIES. (COMPETENCY 08, 09, 11, 12 AND 15)	
28. **Describe** at least 6 essential issues that every breastfeeding mother should know or demonstrate.	**Question or case study**
*30. **Engage** in a conversation with a mother regarding 2 elements related to infant feeding patterns in the first 36 hours of life.	**Observation**
*31. **Describe** to a mother at least 4 signs of adequate transfer of milk in the first few days.	**Observation**
32. **Evaluate** a full breastfeeding session observing at least 5 points.	**Observation**
*33. **Demonstrate** at least 3 aspects of how to help a mother achieve a comfortable and safe position for breastfeeding within the first 6 hours after birth and later as needed during the hospital stay.	**Observation**
*34. **Demonstrate** how to help a mother achieve an effective and comfortable latch, noting at least 5 points.	**Observation**
40. **Demonstrate** to a mother how to hand express breast milk, noting 8 points.	**Observation**
43. **Help** a mother achieve a comfortable and safe position for breastfeeding with her preterm, late preterm, or weak infant at the breast, noting at least 4 points.	**Observation**
*44. **Engage** in a conversation with a mother of a preterm, late preterm, or low-birth-weight infant not sucking effectively at the breast, including at least 5 points.	**Observation**
57. **Engage** in a conversation with a mother regarding at least 4 different ways to facilitate breastfeeding in order to prevent or resolve most common conditions of the lactating breasts (sore nipples, engorgement, mother who thinks she doesn't have enough milk, infants who have difficulty sucking).	**Observation**
*65. **Describe** *at least 2 maternal and 2 infant risk factors associated with delayed lactogenesis II.*	**Question or case study**
STEP 6. DO NOT PROVIDE BREASTFED NEWBORNS ANY FOOD OR FLUIDS OTHER THAN BREAST-MILK, UNLESS MEDICALLY INDICATED. (COMPETENCY 08, 11, 13.)	
*29. **Engage** in a conversation with a mother regarding at least 3 reasons why effective exclusive breastfeeding is important.	**Observation**
41. **Explain** at least 3 aspects of appropriate storage of breast-milk.	**Question or case study**
42. **Explain** at least 3 aspects of handling of expressed breast-milk.	**Question or case study**
*47. **List** at least 2 potential contraindications to breastfeeding for a baby and 2 for a mother.	**Question or case study**
*48. **Describe** at least 4 medical indications for supplementing breastfed newborns: 2 maternal indications and 2 newborn indications, when breastfeeding is not improved following skilled assessment and management.	**Question or case study**
*49. **Describe** at least 3 risks of giving a breastfed newborn any food or fluids other than breast milk, in the absence of medical indication.	**Question or case study**

APPENDIX C2: PERFORMANCE INDICATORS TO MEASURE COMPETENCY - SORTED BY STEP

TEN STEPS TO SUCCESSFUL BREASTFEEDING (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	VERIFICATION METHOD
STEP 6. DO NOT PROVIDE BREASTFED NEWBORNS ANY FOOD OR FLUIDS OTHER THAN BREAST-MILK, UNLESS MEDICALLY INDICATED. (COMPETENCY 08, 09, 11, 13.) continued	
*66. **Describe** at least 1 professional medical reference or resource for identifying medications that are safe/compatible for use during lactation.*	**Question or case study**
*50. For those few health situations where infants cannot, or should not, be fed at the breast, **describe**, in order of preference, the alternatives to use.	**Question or case study**
*51. **Engage** in a conversation with a mother who intends to feed her baby formula, noting at least 3 actions to take.	**Observation**
52. **Demonstrate** at least 3 important items of safe preparation of infant formula to a mother who needs that information.	**Observation**
*67. ***Identify** 3 high-risk infant populations that may warrant extra precautions to protect against severe infections associated with powdered infant formula.*	**Question or case study**
STEP 7. ENABLE MOTHERS AND THEIR INFANTS TO REMAIN TOGETHER AND TO PRACTICE ROOMING-IN 24 HOURS A DAY. (COMPETENCY 10 AND 12)	
*35. **Engage** in a conversation with a mother regarding 2 aspects related to the importance of rooming-in 24h/day.	**Observation**
*68. **Describe** 2 aspects involved in creating a safe environment for rooming-in during the hospital stay.*	**Question or case study**
*69. ***Demonstrate** at least 3 safety aspects to assess when mother and baby are skin-to-skin during the postpartum hospitalization, regardless of method of birth.*	**Observation**
*36. **Explain** 2 situations: 1 for the mother and 1 for the infant, when it is acceptable to separate mother and baby while in hospital.	**Question or case study**
45. **Engage** in a conversation with a mother separated from her preterm or sick infant regarding at least 2 reasons to be with her infant in the intensive care unit.	**Observation**
STEP 8. SUPPORT MOTHERS TO RECOGNIZE AND RESPOND TO THEIR INFANTS' CUES FOR FEEDING. (COMPETENCY 10, 12 AND 15)	
*37. **Describe** at least 2 early feeding cues and 1 late feeding cue.	**Question or case study**
38. **Describe** at least 4 reasons why responsive feeding is important (also called on-demand or baby-led feeding) independent of feeding method.	**Question or case study**
39. **Describe** at least 2 aspects of responsive feeding (also called on-demand or baby-led feeding) independent of feeding method.	**Question or case study**
46. **Engage** in a conversation with a mother of a preterm, late preterm or vulnerable infant (including multiple births) regarding the importance of observing at least 2 subtle signs and behavioral state shifts to determine when it is appropriate to breastfeed.	**Observation**
*58. **Describe** at least 4 elements to assess when a mother says that her infant is crying frequently.	**Question or case study**

APPENDIX C2: PERFORMANCE INDICATORS TO MEASURE COMPETENCY - SORTED BY STEP

TEN STEPS TO SUCCESSFUL BREASTFEEDING (All performance indicators apply to direct care staff. Specific performance indicators for which knowledge competency applies to direct care providers are marked with an *)	VERIFICATION METHOD
STEP 9. COUNSEL MOTHERS ON THE USE AND RISKS OF FEEDING BOTTLES, ARTIFICIAL NIPPLES (TEATS) AND PACIFIERS. (COMPETENCY 14 AND 15)	
53. **Demonstrate** to a mother how to safely cup-feed her infant when needed, showing at least 4 points.	**Observation**
54. **Describe** to a mother at least 4 steps to feed an infant a supplement in a safe manner.	**Observation**
*55. **Describe** at least 2 alternative feeding methods other than feeding bottles.	**Question or case study**
56. **Engage** in a conversation with a mother who requests feeding bottles, teats, pacifiers and soothers without medical indication, including at least 3 points.	**Observation**
*59. **Describe** at least 4 elements of anticipatory guidance to give to a mother on calming or soothing techniques before or as alternatives to pacifiers.	**Question or case study**
*70. ***Describe*** *when the acceptable time is for introducing a pacifier with a breastfeeding infant, with regards to SUID/SIDS reduction strategies.*	**Question or case study**
STEP 10. COORDINATE DISCHARGE SO THAT PARENTS AND THEIR INFANTS HAVE TIMELY ACCESS TO ONGOING SUPPORT AND CARE. (COMPETENCY 15 AND 16)	
57. **Engage** in a conversation with a mother regarding at least 4 different ways to facilitate breastfeeding in order to prevent or resolve most common conditions of the lactating breasts (sore nipples, engorgement, mother who thinks she doesn't have enough milk, infants who have difficulty sucking).	**Observation**
60. **Describe** at least 2 locally available sources for timely infant feeding information and problem management.	**Question or case study**
61. **Describe** at least 2 ways the healthcare facility engages with community-based programs to coordinate breastfeeding messages and offer continuity of care	**Question or case study**
*62. **Develop** individualized discharge feeding plans with a mother that includes at least 6 points.	**Observation**
*63. **Describe** to a mother at least 4 warning signs of infant undernourishment or dehydration for a mother to contact a health care professional after discharge.	**Observation**
*64. **Describe** at least 3 warning maternal signs for a mother to contact a health care professional after discharge.	**Question or case study**

APPENDIX D: DETERMINING AFFILIATED PRENATAL SERVICES

AFFILIATED PRENATAL SERVICES

INTRODUCTION: It is important to accurately determine your facility's status regarding affiliation with prenatal services early in your Baby-Friendly journey.

INSTRUCTIONS: The questions below describe various situations in which BFUSA considers facilities to have affiliated prenatal services. If any of the situations below is true for your facility, you are considered to have affiliated prenatal services. Carefully consider each of the questions with your multi-disciplinary team. It is also important to consider these questions again any time your facility has a change. **The questions should be applied to all primary prenatal services that have patients who deliver at your facility.** Providers who do not provide primary prenatal services, but rather are specialists who provide consultation for the patient's primary prenatal care provider, should not be included. For example, a Maternal Fetal Medicine provider who is consulted when needed but never becomes the primary provider for a woman or her infant would not be considered to be an affiliated prenatal service. A Maternal Fetal Medicine provider who acts as the patient's primary provider would be considered to be an affiliated prenatal service if one of the scenarios described in the questions below also applies.

EVOLVING STATE OF HEALTH CARE: Health care in the United States is dynamic. Facilities are merging into systems as well as buying and selling service lines. In large institutions, some structural changes may not be known by the facility's Baby-Friendly multi-disciplinary committee, yet they have a significant impact on the Baby-Friendly process. Therefore, **it is recommended that this questionnaire be completed annually by the facility and discussed with leadership by the multi-disciplinary committee.** The committee should then consider how the results will impact the implementation of Steps 1, 2, and 3, and the International Code of Marketing of Breast-milk Substitutes.

QUESTIONS:

Your facility is considered to have affiliated prenatal services if you answer "yes" to any of the following questions:

1. Are providers who deliver primary prenatal care at the prenatal service employed by the facility?

2. Are providers who deliver primary prenatal care at the prenatal service employed by the same system that employs staff at the facility?

3. Are providers who deliver primary prenatal care at the prenatal service contracted (or in another type of agreement, such as an MOU) by the facility or system to provide prenatal services on behalf of the facility?

4. Are staff who provide care or education at the prenatal service employed by the facility?

5. Are staff who provide care or education at the prenatal service employed by the same system that employs staff at the facility?

6. Are staff who provide care or education at the prenatal service contracted (or in another type of agreement, such as an MOU) by the facility or system to provide prenatal services on behalf of the facility?

7. Are prenatal services offering primary prenatal care owned by the facility or the system that owns the facility?

8. Do marketing or patient information materials imply that primary prenatal care is offered by the facility? (Consider the facility or system website, brochures and media marketing campaigns.)

APPENDIX E: ACCEPTABLE MEDICAL REASONS FOR USE OF BREAST-MILK SUBSTITUTES

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

The facility should develop a protocol/procedure that describes the current, evidence-based contraindications to breastfeeding and medical indications for supplementation. Staff and care providers should be trained to utilize the protocol/procedure as guidance in the case of supplementation. A facility may utilize the recommendations of national and international authorities [e.g., Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), and Academy of Breastfeeding Medicine (ABM), American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG)] in developing this protocol/procedure. However, the facility is responsible for ensuring that its medical indications for supplementation are supported by current evidence.

APPENDIX F: DEFINITION OF TERMS AND ABBREVIATIONS USED IN THIS DOCUMENT

AFFILIATED PRENATAL SERVICES — Primary prenatal care delivered through a close formal or informal association with a birthing facility. For Baby-Friendly purposes, the affiliation is determined through completion of a questionnaire regarding specific aspects of the relationship, such as business relationship, personnel relationship, and marketing of services. *(See Appendix D)*

CAMPUS — The institution's main buildings and the physical area immediately adjacent to them, other areas and structures that are not strictly contiguous to the main buildings but are located on the same property or within 250 yards of the main buildings, and any other areas determined, on an individual case basis, to be part of the provider's campus.

CLINICAL STAFF — Includes all individuals providing direct patient care. Clinical roles often require certification or licensing. Examples include: RN, LPN, Technicians, CNA, MA, etc.

CRITERIA FOR EVALUATION — The minimum standards which must be met to achieve Baby Friendly designation.

COMPETENCY — The capability to use a set of related knowledge, skills and behaviors to successfully perform identified jobs, roles or responsibilities.[3]

COMPETENCY ASSESSMENT — An evaluation of an individual's ability to use a set of related knowledge, skills and behaviors to successfully perform identified jobs, roles or responsibilities.[3]

COMPETENCY VERIFICATION — The confirmation of an individual's ability to use a set of related knowledge, skills and behaviors to successfully perform identified jobs, roles or responsibilities.

CONFLICT OF INTEREST — Any situation where an individual or organization is in a position to derive a benefit which is at odds with the interests / purpose of their position or organization. In this context, it is most usually seen when individual members of staff enter a relationship with companies falling within the scope of the Code (the companies) in order to gain some advantage for themselves or their service.

COUNSELING — Professional guidance, advice and/or assistance provided by an individual trained in the specific topic area of concern.

CUE-BASED FEEDING — Feeding practices that are based on infant readiness indicators such as alertness, rooting, orienting toward own or caregivers' hands, pacifier, breast or bottle nipple; sucking on own hands or other objects; pacing as well as pausing when an infant's stress cues are observed.

DIRECT CARE PROVIDERS — Physicians, midwives, physician assistants, and advanced practice registered nurses who provide education, assessment, support, intervention, assistance and/or follow-up with regards to infant feeding [Including the following units: Affiliated Prenatal Services, Labor and Delivery Unit, Postpartum Unit, Newborn Unit]. Interviews with direct care providers will include providers granted privileges to provide care in labor & delivery, postpartum and well newborn units.

DIRECT CARE STAFF — All other non-Direct Care Provider health professionals who provide education, assessment, support, intervention, assistance and/or follow-up with regards to infant feeding [Including the following units: Affiliated Prenatal Services, Labor and Delivery Unit, Postpartum Unit, Newborn Unit]. Interviews with direct care staff will include facility-based direct care nursing staff providing care in labor & delivery, postpartum and well newborn units.

EDUCATION — Information about what to do and why; didactic knowledge; may be provided in classroom or electronically, individually or in group settings.

EDUCATIONAL MATERIALS — Information provided through written or electronic sources including brochures, pamphlets, posters, websites, videos, texting programs, social media, education channels, applications, and other evolving technologies.

EXCLUSIVE BREAST-MILK FEEDING — The infant receives only human milk (including direct breastfeeding, expressed breast-milk or donor human milk) and is allowed to receive vitamins, minerals, and medicines.

FACILITY — A building or area that is used for the provision of health care services. Some health care facilities have multiple campuses. BFUSA policies require individual assessment and designation of each individual campus.

FAIR MARKET PRICE — The International Code of Marketing of Breast-milk Substitutes, and subsequently, the BFHI call for health systems to purchase infant foods and feeding supplies at a fair market value. Fair market pricing can be determined by calculating the margin of retail price the facility pays on other items available on the retail market or by using the minimum threshold price method as described in BFUSA materials.

FEEDING OPTIONS — The type of food (mother's own milk, pasteurized donor human milk, infant formula) and method of feeding (direct breast feeding, expression of milk, cup, syringe, supplemental nursing system, bottle) an infant. Feeding options may consist of a combination of foods and methods. For example, a mother may directly breastfeed sometimes and occasionally pump and feed her own milk though a cup.

GESTATIONAL AGE (INCLUDING DEFINITIONS OF PRETERM AND TERM INFANTS) — Time elapsed between the first day of the last menstrual period and the day of delivery.

Preterm infants are defined as born alive before 37 weeks of pregnancy are completed. There are sub-categories of preterm birth defined by the WHO.[59] Related groups of infants defined by ACOG[60] may be admitted to the NICU based on gestational age:

- Extremely preterm (<28 weeks)
- Very preterm (28 to <31 6/7 weeks)
- Moderate preterm (32 to 33 6/7 weeks)
- Late preterm (34 to 36 6/7 weeks)

Additionally, infants' size in relation to gestational age may relate to risk categories:

AGA = Appropriate for gestational age (> 10 and < 90 percentile birth weight)
LGA = large for gestational age (>90 percentile birth weight)
IUGR = intrauterine growth restriction
SGA = small for gestational age (<10 percentile birthweight)

"Corrected Gestational Age": post-menstrual age calculated as gestational age at birth + chronological (calendar) age since birth; also sometimes called "adjusted age".

GUIDELINES — The standards of care which facilities strive to achieve for all patients.

HEALTH PROFESSIONAL — A health worker with a professional / degree, certification, diploma or license, such as but not limited to a medical practitioner, a registered nurse or midwife. Health professionals include all providers and clinical staff with policy making, supervisory, education and/or patient care responsibilities. Interviews with health professionals will include direct care nursing staff and privileged direct care providers.

HEALTH PROVIDER — A doctor, advanced practice nurse, physician assistant or midwife.

INFANT FEEDING SUPPLIES — Products used to nourish and/or deliver nourishment to a baby.

IN-SERVICE EDUCATION — Instruction provided to individuals already employed in a profession.

ITEM — An individual object or article. Examples include:

- Written educational materials, brochures/pamphlets, etc.
- Electronic sources including websites, videos, texting programs, social media, education channels, applications, and other evolving technologies.
- Posters, calendars, notepads, pens, cups, gift packs, growth charts, bassinet cards, etc.

KANGAROO MOTHER CARE (KMC) — Kangaroo Care or Kangaroo Mother Care are often used interchangeably to refer to skin-to-skin care provided by a parent of a preterm infant (or any infant in NICU). The infant is placed against the parent's naked chest in such a fashion that the infant is held upright and/or prone to maximize contact between ventral skin surfaces. The dyad is then wrapped in a blanket or other clothing to secure the infant against the parent's chest. Ideally, the infant may be held continuously (or almost continuously) in this fashion for multiple hours. Optimally, KMC begins as soon as the infant is judged ready for skin-to-skin contact or holding; sometimes part of stabilization immediately after birth.

When provided by the mother, it may allow for access to the breast for non-nutritive sucking or pre-feeding practice (nuzzling, licking, tasting drops of expressed milk) as well as direct feeding from the breast. Whether or not it includes breastfeeding, it offers benefits such as warmth/temperature regulation, respiratory support/improved oxygenation, cardiovascular stabilization, glucose homeostasis and immune support through colonization with normal flora. Maximal benefits are obtained with continuous or sustained KMC.

LOGO — An emblem, picture or symbol by means of which a company or product is identified.

MOU — Memorandum of Understanding is a formal written agreement between two or more parties.

NEONATAL UNIT (NICU) — Space designated and used for specialized patient care and consultation, monitoring and medical/nursing interventions. May include designated areas in maternity/postpartum units or pediatric units where infants are admitted. *Levels of neonatal care are designated:*[61]

LEVEL I: Well newborn nursery: for term or stable late-preterm (35-37 week gestation) infants, or for stabilization of ill or more preterm infants

LEVEL II: Special care nursery: Level I capabilities plus care for ›/=32 week gestation, ›/=1500 gram, moderately ill or convalescing infants, possibly requiring brief respiratory support, and/or stabilization of more preterm or ill infants

LEVEL III: NICU: Level II capabilities plus comprehensive care for infants ‹32 weeks and ‹1500 grams, including sustained life support, full range of respiratory support and advanced imaging services

LEVEL IV: Regional NICU: Level III capabilities plus surgical services, medical and surgical subspecialists, pediatric anesthesiologists, transport and outreach education.

NON-CLINICAL STAFF — Facility employees and/or contractors who interact with patients but provide no medical care. Examples: Administrative Assistants, Unit Secretaries, etc.

PACIFIER — An artificial nipple/teat-shaped device for non-nutritive sucking, also called a dummy or soother. (Limited use to decrease pain during procedures when the infant cannot be safely held or breastfed is acceptable.)

PERFORMANCE INDICATOR — Measures of a direct care provider and direct care staff's competence to protect, promote and support breastfeeding in a facility providing maternity and newborn services.

POLICY — An enforceable document that guides staff in the delivery of care. At the facility level, this may include policies, practice guidelines and protocols.

PRE-SERVICE EDUCATION — Instruction designed to enable individuals to acquire the knowledge and skills required to enter a profession.

PROMOTE — To employ any method of directly or indirectly encouraging a person, a health facility, or any other entity to purchase or use a designated product whether or not there is reference to a brand name.

SAMPLE — A small part or quantity intended to show what the whole is like.

SKILLED PROFESSIONAL — an individual with specialized training and a demonstrated ability to provide assessment, education, intervention, and follow-up in a specific field.

SKIN-TO-SKIN CONTACT (STS) — Contact between the newborn infant and its mother. (In the case of incapacitation of the mother, another adult, such as the infant's father or grandparent, may hold the infant skin-to-skin.) After birth, the infant is placed naked against the mother's naked ventral surface. The infant and mother are then covered with a warm blanket, keeping the infant's head uncovered. The infant may wear a diaper and/or a hat, but no other clothing should be between the mother's and infant's bodies. STS should continue, uninterrupted, until completion of the first feeding, or at least one hour if the mother is not breastfeeding. STS should be encouraged beyond the first hours and into the first days after birth and beyond.

SPONSOR — An individual or organization that pays some or all of the costs involved in staging an event in return for advertising.

STANDARD — The established requirement for delivery of evidenced-based care.

SUPPLEMENTATION — Additional feeding(s) provided to a breastfed infant. Options for supplementation include expressed breast-milk, pasteurized donor human milk, and appropriate breast-milk substitutes. The method of providing supplementary feedings may include supplemental nursing systems at the breast, cup feeding, spoon or dropper feeding, finger feeding, syringe feeding or bottle feeding.

TRAINING — Applying and/or acquiring knowledge and learning how to perform a specific skill, task, or behavior: typically requires simulation, clinical skills practice, counseling, role play and/or competency verification.

AAP	American Academy of Pediatrics
AAFP	American Academy of Family Physicians
ABM	Academy of Breastfeeding Medicine
ACNM	American College of Nurse Midwives
ACOG	American College of Obstetricians and Gynecologists
AWHONN	Association of Women's Health Obstetrical and Neonatal Nurses
BFHI	Baby-Friendly Hospital Initiative
BFUSA	Baby-Friendly USA Inc.
CDC	Centers for Disease Control and Prevention
KMC	Kangaroo Mother Care
NICU	Neonatal Intensive Care Unit
STS	Skin-to-skin contact
UNICEF	United Nations Children's Fund
USLCA	United States Lactation Consultant Association
WHA	World Health Assembly
WHO	World Health Organization

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APPENDIX H: GUIDELINES AND EVALUATION CRITERIA CLARIFICATION STATEMENTS

None at this time. We use this section to address issues that emerge between planned updates to the GEC.

APPENDIX I: REFERENCES

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