The Baby-Friendly Hospital Initiative

Interim

Guidelines and Evaluation Criteria for Facilities Seeking and Sustaining Baby-Friendly Designation

Baby-Friendly USA, Inc.

This document is an adaptation of the following documents:

- The UNICEF/WHO *Global Criteria for the Baby-Friendly Hospital Initiative*, developed in 1991
- The *Guidelines & Evaluation Criteria for the U.S. Baby-Friendly Hospital Initiative,* developed in 1996 by the United States Fund for UNICEF and Wellstart International
- The 2004 adaptation of the U.S. *Guidelines & Evaluation Criteria for the U.S. Baby-Friendly Hospital Initiative*
- The 2006 UNICEF/WHO *Global Criteria for the BFHI*
- The 2010 adaptation of the U.S. *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation*

Suggested citation:

Baby-Friendly USA. “Interim Guidelines and Evaluation Criteria for Facilities Seeking and Sustaining Baby-Friendly Designation.” Albany, NY: Baby-Friendly USA, 2019.

Acknowledgements

Grateful appreciation is extended to the following people for the update and review of this document:

Baby-Friendly USA (BFUSA) Program Committee members: Ann Brownlee, MA, PhD; Sarah Coulter Danner, RN, MSN, CNM, CPNP; Lawrence M. Gartner, MD; Theresa Landau, MS, RD; Kathie Marinelli, MD, IBCLC, FABM, FAAP; Heather Suzette Swanson, DNP, CNM, FNP, IBCLC; Marsha Walker, RN, IBCLC

BFUSA Staff: Sarah Avellino, BS; Susan Callaway, BSN, RN, IBCLC; Vanessa Dacey, MA; Rebecca Fallon, RN, MSN; Trish MacEnroe, BS, CDN, CLC; Elizabeth McIntosh BA, BSN, RN, IBCLC; Angela Pittman, RN, BSN, MBA; Tammy Titus, BSN, RN, IBCLC

Recognition is also due to the contributors, authors, and editors of the 2004, 2010 and 2016 updates to the *Guidelines and Evaluation Criteria*:

Jillian Carter, BS, RN, IBCLC; Karin Cadwell, PhD, RN, FAAN, ANLC, CLC, IBCLC; Lora L. Elston, BSN, RNC-NIC, IBCLC; Ruth Lawrence, MD; Jennifer Matranga, MS, BSN, RN, CCE, IBCLC; Sallie Page-Goertz, RN, BSN, MN, CPNP, IBCLC; Cindy Turner-Maffei, MA, ALC, IBCLC; Christie Ziegler, BA

Finally, our deepest appreciation goes to the contributors and authors of the original U.S. *Guidelines and Evaluation Criteria*:

U.S. Committee for UNICEF: Minda Lazarov

Wellstart International: Audrey Naylor, MD, DrPH; Ruth Wester, BA, RN; Ann Brownlee, MA, PhD; Janine Schooley, MPH

UNICEF: Helen Armstrong, Paula Donovan, Lida Lhotska

Dedication

Audrey J. Naylor, MD, DrPH

Baby-Friendly USA, Inc. dedicates the 2016 edition of the *Guidelines and Evaluation Criteria* to Audrey J. Naylor, MD, DrPH. Dr. Naylor was a visionary and passionate leader who devoted her career to improving maternity care practices throughout the world to support breastfeeding and mother-baby bonding. In 1985, she co-founded Wellstart International, a nonprofit organization established to educate health care providers on the importance and management of optimal infant and young child feeding. She was a driving force in both international and U.S. efforts to promote breastfeeding as the normal way to feed infants and young children. She was a staunch advocate for the Baby-Friendly Hospital Initiative, helping to shape both the Ten Steps to Successful Breastfeeding and the Initiative itself.

Dr. Naylor was a founding member of the World Alliance of Breastfeeding Action, the United States Breastfeeding Committee, the Academy of Breastfeeding Medicine, the Section on Breastfeeding of the American Academy of Pediatrics and helped to launch the U.S. Baby-Friendly Hospital Initiative. She was an experienced medical school educator and had been a member of several medical school faculties, including Ohio State University College of Medicine, the University of Southern California School of Medicine, The University of California San Diego School of Medicine and The University of Vermont College of Medicine where she was a Clinical Professor of Pediatrics (voluntary, part-time).

Dr. Naylor passed away on June 23, 2016. The field of lactation has lost one of its greatest leaders. Her legacy is substantial and will continue to live through our work.

Preamble to the U.S. Baby-Friendly Guidelines and Evaluation Criteria

Human milk provided by direct breastfeeding is the 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.[1] Women who breastfeed have a lower risk of Type 2 diabetes and breast and ovarian cancers.[2] Evidence suggests that reduction in the risk of cardiovascular and other related diseases may be added to the benefits of breastfeeding for women.[3] The American Academy of Pediatrics, the American Congress 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.

The U.S. Department of Health and Human Services has included breastfeeding among the national Healthy People (HP) objectives since their inception for the year 1990. The HP2020[4] objectives state:

MICH-21.1	Increase the proportion of infants who are ever breastfed	Target 81.9%
MICH-21.2	Increase the proportion of infants who are breastfed at 6 months	Target 60.6%
MICH-21.3	Increase the proportion of infants who are breastfed at 1 year	Target 34.1%
MICH-21.4	Increase the proportion of infants who are breastfed exclusively through 3 months	Target 46.2%
MICH-21.5	Increase the proportion of infants who are breastfed exclusively through 6 months	Target 25.5%
MICH-23	Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life	Target 14.2%

[1] Stanley Ip, et al. "Breastfeeding and maternal and infant health outcomes in developed countries," Evidence Report/Technology Assessment NO. 153 (Prepared by Tufts-New England Medical Center Evidence-Based Practice Center, under Contract No. 290-02-0022), AHRQ Publication No. 07-E007, (Rockville, MD: Agency for Healthcare Research and Quality, 2007).

[2] Ibid.

[3] E. B. Schwarz, et al. "Duration of lactation and risk factors for maternal cardiovascular disease," *Obstetrics & Gynecology* 113, 5 (2009): 97482.

[4] Healthy People 2020, *U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion* Accessed June 21, 2016, https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives

MICH-24	Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies	Target 8.1%

Despite the significant gains made during the past few years, the initiation, duration, and exclusivity of breastfeeding continue to lag behind the national objectives, particularly among the most vulnerable populations of African American and low income women. In 2012, approximately 80% of all women initiated breastfeeding; however, only 66% of non-Hispanic black women and 74% of women with incomes below the poverty line initiated breastfeeding.[5]

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.[6,7]

Numerous government and professional organizations actively encourage a strong program of information and support to promote the successful establishment and maintenance of breastfeeding, including:

- Academy of Breastfeeding Medicine
- Academy of Nutrition and Dietetics
- American Academy of Family Physicians
- American Academy of Nursing
- American Academy of Pediatrics
- American College of Nurse-Midwives
- American Congress of Obstetricians and Gynecologists
- American Nurses Association
- American Public Health Association
- Association of Women's Health, Obstetric and Neonatal Nurses
- Centers for Disease Control and Prevention
- National Academies of Science, Engineering and Medicine

[5] "Rates of Any and Exclusive Breastfeeding by Socio-demographics among Children Born in 2012," *National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services*, Accessed June 21, 2016, www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-socio-dem-2012.htm

[6] Ann M. DiGirolamo, Laurence M. Grummer-Strawn, Sara B. Fein, "Effect of maternity-care practices on breastfeeding," *Pediatrics* 122, 2 (2008)

[7] Rafael Perez-Escamilla, Josefa L. Martinez and Sofia Segura-Perez, "Impact of the Baby-friendly Hospital Initiative on breastfeeding and child health outcomes: a systematic review," *Maternal & Child Nutrition*, doi: 10.1111/mcn.12294.

- National WIC Association
- Office on Women's Health – United States Department of Health and Human Services
- United States Breastfeeding Committee
- United States Preventive Services Task Force
- United States Surgeon General

The diverse benefits of breastfeeding translate into hundreds of dollars of savings at the family level and billions of dollars at the national level through decreased hospitalizations and pediatric visits. Researchers have estimated that were the national initiation and 6 months goals (above) to be met, between 3.6 and 13 billion dollars would be saved on pediatric health care costs.[8,9] Consequently, activities to promote the national objectives are clearly among the best and most cost-effective health promotional strategies available.

The 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 encourage and recognize birthing facilities that offer an optimal level of care for infant feeding and mother-baby bonding. The core components of the BFHI are the UNICEF/WHO Ten Steps to Successful Breastfeeding, which are designed to facilitate the role of the birthing facility in providing women the information, care practices, and opportunity to breastfeed, regardless of the method of birth. More than 170 countries have undertaken implementation of the Ten Steps to Successful Breastfeeding, resulting in the designation of more than 20,000 birth facilities throughout both the developing and industrialized world. The BFHI has been endorsed by hundreds of organizations worldwide.

In the United States, Wellstart International, in cooperation with the U.S. Fund for UNICEF, piloted the development of tools for the assessment of the first U.S. Baby-Friendly hospitals, including the original *Guidelines and Evaluation Criteria*, which provided the basic guidance for birthing facility implementation of the program. In 1997, Baby-Friendly USA, Inc. was created at the request of the U.S. Fund for UNICEF to administer the BFHI program in U.S. birthing facilities.

[8] Jon Weimer, "The Economic Benefits of Breastfeeding: A Review and Analysis," *ERS Food Assistance and Nutrition Research Report* 13, (2001)

[9] M Bartick, A Reinhold, "The burden of suboptimal breastfeeding in the United States: a pediatric cost analysis," *Pediatrics* 125, 5 (2010): 104856.

The Guidelines and Evaluation Criteria for Hospital and Birthing Center Implementation of the U.S. Baby-Friendly Hospital Initiative

The *guidelines* in this document describe the standard of care which facilities should strive to achieve for all patients, while the accompanying *criteria* provide the specific quantifiable measures used by Baby Friendly USA (BFUSA) assessors to determine the birthing facility's conformity with the BFHI.

The U.S. BFHI *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 current, evidence-based care.
3. Monitoring of practice is required to assure adherence to policy.
4. Breastfeeding has been recognized by scientific authorities as the optimal method of infant feeding and should be promoted as the norm within all maternal and child health care facilities.
5. The most sound and effective procedural approaches to supporting breastfeeding and human lactation in the birthing environment that have been documented in the scientific literature to date should be followed by the health facility.
6. The health care delivery environment should be neither restrictive nor punitive and should facilitate informed health care decisions on the part of the mother and her family.
7. The health care delivery environment should be sensitive to cultural and social diversity.
8. 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 choices regarding infant health care practices.
9. When a mother has chosen not to breastfeed, when supplementation of breastfeeding is medically indicated, or when supplementation is chosen by the breastfeeding mother (after appropriate counseling and education), it is crucial that safe and appropriate methods of formula mixing, handling, storage, and feeding are taught to the parents.
10. 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.
11. Participation of any facility in the U.S. BFHI is entirely voluntary and is available to any institution providing birthing services. Each participating facility assumes full responsibility for assuring that its implementation of the BFHI is consistent with all of its safety protocols.

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

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

1.1.1 **Criterion for evaluation:** The facility will have written maternity care and infant feeding policies that address all Ten Steps, protect breastfeeding, and adhere to the International Code. All areas of the facility that potentially interact with childbearing women and infants will have language in their policies about the promotion, protection, and support of breastfeeding. Policies of all departments will not countermand the facility's breastfeeding policy. Review of all clinical protocols, standards, and educational materials related to breastfeeding and infant feeding used by the maternity services indicates that they are in line with the BFHI standards and current evidence-based guidelines.

1.1.2 **Criterion for evaluation:** The nursing director/manager will be able to identify the health care professional(s) who has ultimate responsibility for assuring implementation of the breastfeeding policy.

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

1.2.1 **Criterion for evaluation:** The nursing director/manager of the maternity unit and/or the designated health care professional within the facility will be able to locate the maternity care and infant feeding policies and describe how the other staff, including new employees, are made aware of the content.

1.2.2 **Criterion for evaluation:** Of randomly selected maternity staff members, at least 80% will confirm that they are aware of the facility's maternity care and infant feeding policies, know where the policies are kept or posted, and have received orientation regarding the policies.

1.2.3 **Criterion for evaluation:** The nursing director/manager of the maternity unit and/or the designated health care professional within the facility will be able to produce evidence of routine quality improvement procedures that have monitored the maternity care and infant feeding policies.

1.3 **Guideline:** The Ten Steps to Successful Breastfeeding (Ten Steps) and a statement indicating the facility's adherence to the WHO International Code requirements related to the purchase and promotion of breast milk substitutes, bottles, nipples, pacifiers, and other infant feeding supplies should be prominently displayed in all areas that serve mothers, infants, and young children. This information should be available in the language(s) most commonly understood by patients, and, if needed and possible, should be available in appropriate formats for illiterate and visually impaired patients.

1.3.1 **Criterion for evaluation:** The Ten Steps and the statement indicating the facility's adherence to the WHO International Code restricting the promotion of breast milk substitutes, bottles, nipples, and other infant feeding supplies will be prominently displayed in all areas of the health care facility which serve mothers, infants, and/or young children, including labor and delivery, the postpartum unit, all infant and child care areas, affiliated prenatal services, ultrasound, screening, antenatal testing, and the emergency room. This information will be displayed in the language(s) most commonly understood by patients.

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

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

Training for nursing staff on maternity should comprise a total of 20 hours, inclusive of the 15 sessions identified by UNICEF/WHO and 5 hours of supervised clinical experience. (See Appendix A.) Clinical competency verification will be a focus of all staff training. Maternity staff will receive training and mentorship necessary to attain competence in counseling the feeding decision, providing skin-to-skin contact in the immediate postpartum period and beyond, assisting and assessing the mother and infant in achieving comfortable and effective positioning and attachment at the breast, counseling mothers regarding maintaining exclusive breastfeeding, learning feeding cues, assuring rooming-in, teaching and assisting mothers with hand expression of milk, teaching formula preparation and feeding to parents when necessary, and assisting mothers in finding support upon discharge.

Health care providers (physicians, midwives, physician assistants, and advanced practice registered nurses) with privileges for labor, delivery, maternity, and nursery/newborn care

should have a minimum of 3 hours of breastfeeding management education pertinent to their role. At minimum, all health care providers must have a true understanding of the benefit of exclusive breastfeeding, physiology of lactation, how their specific field of practice impacts lactation, and how to find out about safe medications for use during lactation. If health care providers do not teach specific skills, it is not expected that they be able to describe or demonstrate them. However, it is expected that they will know to whom to refer a mother for help with matters for which they do not possess the skills.

The facility should determine the amount and content of training required by staff in other units and roles by their anticipated workplace exposure to mothers and infants. The content and number of hours of training for staff working outside maternity will be developed by each facility, based on job description and workplace exposure to breastfeeding couplets.

Examples of training for staff outside of maternity include, but are not limited to:

- Pharmacist - importance of exclusive breastfeeding, medications acceptable for breastfeeding
- Social worker, discharge planner - importance of exclusive breastfeeding, community resources that support breastfeeding
- Anesthesiologist - importance of exclusive breastfeeding, importance of immediate skin-to-skin contact
- Radiology - importance of exclusive breastfeeding, where to find out about safe medications for use during lactation, where to find appropriate information on use of radioisotopes during lactation
- Dietary - importance of exclusive breastfeeding, practices that support breastfeeding
- Housekeeping staff - importance of exclusive breastfeeding, practices that support breastfeeding, the facility's philosophy on infant nutrition, who to call when a mother needs help

2.1.1 **Criterion for evaluation:** The head of maternity services will report that all health care staff members who have any contact with pregnant women, mothers, and/or infants have received sufficient orientation on the infant feeding policies.

2.1.2 **Criterion for evaluation:** The head of maternity services will be able to identify the health care professional(s) responsible for all aspects of planning, implementing, and evaluating staff training in breastfeeding and parent teaching for formula preparation and feeding.

2.1.3 **Criterion for evaluation:** The designated health care professional(s) will provide documentation that training for breastfeeding and parent teaching for formula preparation and feeding is provided for all health care staff caring for mothers, infants and/or young children and that new staff are oriented on arrival and scheduled for the completion of training within 6 months (for example, by providing a list of new staff who are scheduled for training).

2.1.4 **Criterion for evaluation:** If training acquired prior to employment with this facility is accepted as a means of meeting the minimum competencies, the designated health care professional will be able to describe the process used to verify the previously acquired competencies.

2.1.5 **Criterion for evaluation:** The designated health care professional(s) will provide documentation of training offered to staff outside the maternity unit.

2.1.6 **Criterion for evaluation:** A copy of the curricula or course outlines for competency based training in breastfeeding, lactation management, and parent teaching for formula preparation and feeding will be available for review and a schedule for training all newly hired staff will exist. Maternity staff training will cover Steps 3 through 10 and include the topics and subtopics of all 15 sessions identified by the UNICEF/WHO 20 hour curriculum. (See Appendix A.) The training will include a minimum of five hours of supervised clinical experience.

2.1.7 **Criterion for evaluation:** Of randomly selected maternity staff members, including the nursery staff and health care providers with privileges, at least 80% will confirm that they have completed the described training and competency verification, or, if they have been on the unit less than 6 months, have at minimum been oriented.

2.1.8 **Criterion for evaluation:** Of health care providers with privileges, at least 80% will be able to correctly answer 4 out of 5 questions demonstrating they have a true understanding of the benefit of exclusive breastfeeding, physiology of lactation, how their specific field of practice impacts lactation, and how to find out about safe medications for use during lactation.

2.1.9 **Criterion for evaluation:** Of randomly selected maternity staff members, at least 80% will be able to answer 4 out of 5 questions on breastfeeding management correctly.

2.1.10 **Criterion for evaluation:** Of randomly selected maternity staff members and health care providers, at least 80% will be able to identify 2 topics to discuss with women who are considering feeding their infants something other than human milk.

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

Guidelines and criteria only for facilities with an affiliated prenatal clinic or services

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

3.1.1 **Criterion for evaluation:** If the facility has an affiliated prenatal clinic or services, the nursing director/manager will report that individual counseling or group education on breastfeeding is given to at least 80% of the pregnant women using those services.

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

3.2.1 **Criterion for evaluation:** A written description of the content of the prenatal education will be available and will cover, at minimum, the importance of breastfeeding, the importance of exclusive breastfeeding for about 6 months, and basic breastfeeding management.

3.2.2 **Criterion for evaluation:** At least 80% of pregnant women will report that a staff member at the affiliated prenatal services entered into a conversation with them on the necessary topics, either one-on-one or in small groups, or by following up to education provided through another learning mode [i.e. videos, podcasts, texts] based on their specific needs.

3.2.3 **Criterion for evaluation:** Of the randomly selected pregnant women in the third trimester who are using the facility prenatal services, at least 80% are able to adequately describe what was discussed concerning 2 of the following topics: importance of skin-to-skin contact, rooming-in, or risks of supplements while breastfeeding in the first 6 months.

Guidelines and criteria for all facilities with or without an affiliated prenatal clinic or services

3.3 **Guideline:** All facilities should foster the development of or coordinate services with programs that make education about breastfeeding available to pregnant women. All facilities should foster relationships with community-based programs that make available individual counseling or group education on breastfeeding and coordinate messages about breastfeeding with these programs. The education should begin in the first trimester whenever possible.

3.3.1 **Criterion for evaluation:** The nursing director/manager will report that the facility fosters relationships with community-based programs that make available individual counseling or group education on breastfeeding and coordinates messages about breastfeeding with these programs.

3.3.2 **Criterion for evaluation:** The nursing director/manager will report that the facility has fostered the development of or coordinated services with one or more of the following

programs: in-house breastfeeding education, childbirth education, hospital preregistration visits, hospital tours, in-patient services, etc.

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

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

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

This Step is now interpreted as:

Place infants in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their infants are ready to breastfeed, offering help if needed.

This Step applies to all infants, regardless of feeding method.

4.1 **Guideline:** All mothers should be given their infants to hold with uninterrupted and continuous skin-to-skin contact immediately after birth and until the completion of the first feeding, unless there are documented medically justifiable reasons for delayed contact or interruption. Routine procedures (e.g. assessments, Apgar scores, etc.) should be done with the infant skin-to-skin with the mother. 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 feasible, at the mother's bedside. Additionally, skin-to-skin contact should be encouraged throughout the hospital stay.

4.1.1 **Criterion for evaluation:** Of randomly selected mothers in the postpartum unit who have had normal vaginal births, at least 80% will confirm that their infants were placed in skin-to-skin contact with them immediately after birth and that skin-to-skin contact continued uninterrupted until the completion of the first feeding (or for at least one hour if not breastfeeding), unless there were documented medically justifiable reasons for delayed contact.

4.1.2 **Criterion for evaluation:** Of randomly selected mothers in the postpartum unit who have had normal vaginal births, at least 80% will confirm that they were encouraged to look for signs that their infants were ready to feed during this first period of contact and offered help if needed. (The infant should not be forced to feed, but rather, supported to do so when ready.)

4.1.3 **Criterion for evaluation:** Observations of vaginal births, if necessary to confirm adherence to Step 4, show that (regardless of the mother's feeding intentions) at least 80% of infants are placed skin-to-skin with their mothers within 5 minutes after birth and are held continuously skin-to-skin until completion of the first feeding, or for at least one hour if not breastfeeding, unless there were documented medically justifiable reasons for delayed contact.

4.1.4 **Criterion for evaluation:** Observations of vaginal births, if necessary to confirm adherence to Step 4, show that (regardless of the mother's feeding intentions) at least 80% of mothers are shown how to recognize the signs that their infants are ready to feed and offered help, or there are documented justifiable reasons for not following these procedures.

4.2 **Guideline:** After cesarean birth, mothers and their infants should be placed in continuous, uninterrupted skin-to-skin contact as soon as the mother is responsive and alert, with the same staff support identified above regarding feeding cues, unless separation is medically indicated.

4.2.1 **Criterion for evaluation:** Of randomly selected mothers in the postpartum unit who have had cesarean births of a healthy infant, at least 80% will confirm that their infants were placed in skin-to-skin contact with them as soon as the mother was responsive and alert and that skin-to-skin contact continued uninterrupted until completion of the first feeding (or at least one hour if not breastfeeding), unless there were documented medically justifiable reasons for delayed contact.

4.2.2 **Criterion for evaluation:** Of randomly selected mothers in the postpartum unit who have had cesarean births of a healthy infant, at least 80% will confirm that they were encouraged to look for signs that their infants were ready to feed during this first period of contact and offered help if needed. (The infant should not be forced to feed, but rather, supported to do so when ready.)

4.2.3 **Criterion for evaluation:** Observations of cesarean births and recovery, if necessary to confirm adherence to Step 4, show that (regardless of the mother's feeding intentions), at least 80% of infants are placed with their mothers and held continuously skin-to-skin as soon as the mother was responsive and alert and until completion of the first feeding.

4.2.4 **Criterion for evaluation:** Observations of cesarean births and recovery, if necessary to confirm adherence to Step 4, show that (regardless of the mother's feeding intentions), at least 80% of mothers are shown how to recognize the signs that their infants are

ready to feed and offered help, or there are documented justified reasons for not following these procedures.

4.3 **Guideline:** In the event that a mother and/or infant are separated for documented medical reasons, skin-to-skin contact will be initiated as soon as the mother and infant are reunited.

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

Recommendation for facilities with an affiliated special care nursery or neonatal intensive care unit

4.4 **Recommended guideline:** Mothers whose infants are being cared for in the special care nursery should be given the opportunity to practice Kangaroo Mother Care as soon as the infant is considered ready for such contact.

4.4.1 **Recommended criterion for evaluation:** The facility has a quality improvement goal and tracking method to assure that at least 80% of randomly selected mothers with infants in special care will have the opportunity to practice Kangaroo Mother Care, unless there are documented medically justifiable reasons why they could not.

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

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

5.1.1 **Criterion for evaluation:** Of randomly selected postpartum mothers, at least 80% will report that nursing staff offered further assistance with breastfeeding the next time they fed their infants or within 6 hours of birth, or of when they were able to respond.

5.1.2 **Criterion for evaluation:** Of randomly selected postpartum mothers, at least 80% of those who are breastfeeding will be able to demonstrate correct positioning and attachment with their own infants and will report that breastfeeding is comfortable for them.

5.1.3 **Criterion for evaluation:** Of randomly selected postpartum mothers, at least 80% of those who are breastfeeding will report that they were shown how to express their milk by hand.

5.1.4 **Criterion for evaluation:** Of randomly selected health care staff caring for postpartum mothers, at least 80% will report that they teach mothers how to position and attach their infants for breastfeeding and are able to describe or demonstrate correct techniques for both.

5.1.5 **Criterion for evaluation:** Of randomly selected health care staff caring for postpartum mothers, at least 80% will report that they teach mothers how to hand express breast milk and can describe or demonstrate an adequate technique for this.

5.2 **Guideline:** Additional individualized assistance should be provided to high risk and special needs mothers and infants and to mothers who have breastfeeding problems or must be separated from their infants. The routine standard of care should include procedures that assure that milk expression is begun as soon as possible, but no later than 6 hours after birth, expressed milk is given to the infant as soon as the infant is medically ready, and the mother's expressed milk is used before any supplementation with breast milk substitutes when medically appropriate. For high risk and special needs infants who cannot be skin-to-skin immediately or cannot suckle, beginning manual expression within one hour is recommended. Assistance should be provided as needed.

5.2.1 **Criterion for evaluation:** Of randomly selected mothers with infants in special care, at least 80% of those who are breastfeeding or intending to do so will report that they have been offered help to begin expressing and collecting milk as soon as possible, but no later than 6 hours after their infants' births, unless there is a medically justifiable reason to delay initiation of expression.

5.2.2 **Criterion for evaluation:** Of randomly selected mothers with infants in special care, at least 80% of those who are breastfeeding or intending to do so report that they have been shown how to express their milk by hand or other method.

5.2.3 **Criterion for evaluation:** Of randomly selected mothers with infants in special care, at least 80% of those who are breastfeeding or intending to do so can adequately describe and demonstrate how they were shown to express their milk.

5.2.4 **Criterion for evaluation:** Of randomly selected mothers with infants in special care, at least 80% of those who are breastfeeding or intending to do so will report that they have been told they need to breastfeed or express their milk 8 times or more every 24 hours to establish and maintain their milk supply.

5.3 **Guideline:** Mothers who feed formula should receive written instruction, not specific to a particular brand, and verbal information about safe preparation, handling, storage, and feeding of infant formula (See Appendix D **Formula: Safe Preparation, Storage and Feeding**). Staff

should document completion of formula preparation instruction and safe feeding in the medical record. This information should be given on an individual basis only to women who are feeding formula or mixed feeding their infants.

5.3.1 **Criterion for evaluation:** Of maternity staff members, at least 80% can describe how mothers who are feeding formula can be assisted to safely prepare and feed formula to their infants.

5.3.2 **Criterion for evaluation:** Of mothers who are feeding formula, at least 80% will report that someone discussed their feeding choice with them.

5.3.3 **Criterion for evaluation:** Of mothers who are feeding formula, at least 80% will report that they have been provided education about preparing and giving their infants feeds and can describe the advice they were given.

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

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

Each facility should track its rate of formula supplementation of breastfed infants. Facilities should strive to reach the Healthy People 2020 goal for exclusive breastfeeding. The rate of supplementation for nonmedical reasons should be analyzed and compared to the annual rate of supplementation of breastfed infants reported by the Centers for Disease Control and Prevention (CDC) National Immunization Survey data for the geographic region in which the facility is located. In addition, a year-by-year reduction in non-medically indicated supplementation is expected in Baby-Friendly designated facilities.

6.1 **Guideline:** When a mother specifically states that she has no plans to breastfeed or requests that her breastfeeding infant be given a breast milk substitute, the health care staff should first explore the reasons for this request, address the concerns raised, and educate her about the possible consequences to the health of her infant and the success of breastfeeding. If the mother still requests a breast milk substitute, her request should be granted and the process and the informed decision should be documented. Any other decisions to give breastfeeding infants food or drink other than breast milk should be for acceptable medical reasons and require a written order documenting when and why the supplement is indicated. (See Appendix B.)

6.1.1 **Criterion for evaluation:** Of randomly selected mothers who are breastfeeding, at least 80% will report that:

- to the best of their knowledge, their infants have received no food or drink other than breast milk while in the facility, or
- that formula has been given for a medically acceptable reason, or
- that formula has been given in response to a parental request.

6.1.2 **Criterion for evaluation:** 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 the health care staff explored the reasons for and the possible negative consequences of the mother's decisions.

6.1.3 **Criterion for evaluation:** Of infants who have been given food or drink other than breast milk, at least 80% will have the reasons for supplementation and evidence of parental counseling (in the event of parental choice) clearly documented in the medical record.

6.1.4 **Criterion for evaluation:** Of randomly selected mothers who have decided to feed formula, at least 80% will report that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situations.

6.1.5 **Criterion for evaluation:** Of mothers with infants in special care who have decided to feed formula, at least 80% will report that staff have talked with them about the risks and benefits of the various feeding options, including feeding expressed breast milk.

6.1.6 **Criterion for evaluation:** Observations in the postpartum unit/rooms and any well-baby observation areas show that at least 80% of breastfed infants are being fed only breast milk, or documentation indicates that there are acceptable medical reasons or fully informed choices for formula feeding.

Step 7: Practice rooming in - allow mothers and infants to remain together 24 hours a day.

7.1 **Guideline:** Rooming-in 24 hours a day is the expected standard for mother infant care for healthy term infants, regardless of feeding decision. The medical and nursing staff conduct newborn procedures at the mother's bedside whenever possible and avoid frequent separations or absences of the newborn from the mother for more than a total of one hour in a 24-hour period. When a mother requests that her infant be cared for in the nursery, the health care staff should sensitively engage her in a conversation to learn more about her understanding of the importance of rooming in and the reasons for the request. Staff should work to resolve any medical reasons, safety-related reasons, or maternal concerns. If the mother still requests or if it is determined that the infant is best cared for in the nursery, the process and informed decision should be documented. The mother should be provided access to feed her infant at any time and with a plan that she will be reunited with her infant as soon as her infant displays feeding cues.

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

7.1.2 **Criterion for evaluation:** Of randomly selected mothers with healthy term infants, at least 80% will report that since they came to their room after birth (or since they were able to respond to their infants in the case of cesarean birth), their infants have stayed

with them in the same room day and night except for up to one hour per 24-hour period, unless they report the following:

- medically justifiable reason for a longer separation or,
- safety-related reason for a longer separation or,
- an informed decision (maternal request for separation).

7.1.3 **Criterion for evaluation:** Of mothers and infants who have been separated for more than a total of one hour in a 24-hour period, at least 80% will have the medically justifiable, safety related reasons for the separation, or evidence of parental counseling (in the event of parental choice) clearly documented in the medical record.

7.1.4 **Criterion for evaluation:** Observations in the postpartum unit and any well-baby observation areas and discussions with mothers and staff confirm that at least 80% of the mothers and infants are rooming-in or have documented medically justifiable reasons, safety-related reasons, or informed maternal decision for separation.

Step 8: Encourage breastfeeding on demand.

This step applies to all infants, regardless of feeding method, and is now interpreted as:

Encourage feeding on cue.

8.1 **Guideline:** Health care professionals should help all mothers, regardless of feeding choice: 1) understand that no restrictions should be placed on the frequency or length of feeding, 2) understand that newborns usually feed a minimum of 8 times in 24 hours, 3) recognize cues that infants use to signal readiness to begin and end feeds, and 4) understand that physical contact and nourishment are both important.

8.1.1 **Criterion for evaluation:** Of randomly selected mothers of normal infants (including those of cesarean birth), at least 80% will report that they have been told how to recognize when their infants are hungry and can describe at least 2 feeding cues.

8.1.2 **Criterion for evaluation:** Of breastfeeding mothers, at least 80% will report that they have been advised to feed their infants as often and as long as the infants want.

8.1.3 **Criterion for evaluation:** Of mothers who are feeding their infants formula, at least 80% will report that they have been taught appropriate formula feeding techniques, including feeding on cue, eye-to-eye contact, and holding the infant closely.

8.1.4 **Criterion for evaluation:** The nursing director/manager on the maternity unit will confirm that no restrictions are placed on the frequency or length of feeds.

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

This Step is now interpreted as:

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

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

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

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

9.1.1 **Criterion for evaluation:** 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 methods were offered and,
B. If requesting bottles, mothers can describe one possible impact that bottles and artificial nipples might have on breastfeeding.

9.1.2 **Criterion for evaluation:** The nursing director/manager will confirm that breastfed infants are not routinely given bottles.

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

When a mother requests that her breastfeeding infant be given a pacifier, the health care staff should engage in a conversation with her about the reasons for this request, address the concerns raised, educate her on the possible consequences to the success of breastfeeding, help with any breastfeeding problems, discuss alternative methods for soothing her infant and the appropriate time to introduce a pacifier, once breastfeeding is well established.

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

9.2.1 **Criterion for evaluation:** At least 80% of breastfeeding mothers will describe one possible impact that pacifiers might have on breastfeeding.

9.2.2 **Quality improvement criterion for informational purposes (not a designation criterion):** At least 80% of breastfeeding mothers can describe when the appropriate time is for introducing a pacifier with a breastfeeding infant. (See Appendix D: **Exclusive Breastfeeding, Pacifiers, and Safe Sleep)**

9.2.3 **Quality improvement criterion for informational purposes (not a designation criterion):** At least 80% of health care professionals can describe when the appropriate time is for introducing a pacifier with a breastfeeding infant. (See Appendix D: **Exclusive Breastfeeding, Pacifiers, and Safe Sleep)**

9.2.4 **Criterion for evaluation:** The nursing director/manager will confirm that breastfeeding infants are not routinely given pacifiers and that use of pacifiers in term infants is restricted to cases where there is a medical indication.

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

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

10.1.1 **Criterion for evaluation:** The nursing director/manager on the maternity unit will report that mothers are given information on where they can find support if they need help with feeding their infants after returning home.

10.1.2 **Criterion for evaluation:** The nursing director/manager on the maternity unit will report that the facility fosters the establishment of and/or coordinates with mother support groups and other community services that provide breastfeeding/infant feeding support to mothers, and the designated staff member can describe at least one way this is done.

10.1.3 **Criterion for evaluation:** The nursing director/manager on the maternity unit will report that the staff assures that mothers and infants receive breastfeeding assessment and

support after discharge (preferably 2 to 4 days after discharge and again the second week) at the facility or in the community by a skilled breastfeeding support person who can assess feeding and give any support needed.

10.1.4 Criterion for evaluation: The nursing director/manager on the maternity unit will report that the staff can describe an appropriate referral system and adequate timing for the visits.

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

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

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

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

11.1.1 Criterion for evaluation: The nursing director/manager on the maternity unit will report that no employees of manufacturers or distributors of breast milk substitutes, bottles, nipples, pacifiers or other infant feeding supplies have any direct or indirect contact with pregnant women or mothers.

11.1.2 Criterion for evaluation: The nursing director/manager on the maternity unit will report that the facility and its staff members do not receive free gifts, non-scientific literature, materials or equipment, money, or support for breastfeeding education or events from manufacturers or distributors of breast milk substitutes, bottles, nipples, pacifiers or other infant feeding supplies. All other interactions with these manufacturers/distributors are in compliance with the facility's vendor/ethics policy.

11.1.3 Criterion for evaluation: The nursing director/manager on the maternity unit will report that pregnant women, mothers, and their families are not given marketing materials or samples or gift packs by the facility that include breast milk substitutes, bottles, nipples, pacifiers, or other infant feeding supplies, or coupons for any of the above items.

11.1.4 Criterion for evaluation: The nursing director/manager on the maternity unit will report that any educational materials distributed to breastfeeding mothers are free of messages that promote or advertise infant food or drinks other than breast milk.

11.1.5 Criterion for evaluation: The nursing director/manager on the maternity unit will report that no educational materials used refer to proprietary products or bear a product logo, unless specific to the mother's or infant's needs or condition. (For example, information about how to safely use a needed product such as a formula or breast pump would be acceptable to give to a mother or infant needing such a product. Marketing information for such products would not be acceptable.)

11.1.6 Criterion for evaluation: A review of records and receipts indicates that any breast milk substitutes, including special formulas, bottles, nipples, pacifiers and other infant feeding supplies are purchased by the health care facility at a fair market price. (See Appendix C for definition.)

11.1.7 Criterion for evaluation: Observations in the antenatal and maternity services and other areas where nutritionists and dietitians work indicate that no materials that promote breast milk substitutes, bottles, nipples, pacifiers* or other infant feeding supplies are displayed or distributed to mothers, pregnant women, or staff. (*See Appendix D: Exclusive Breastfeeding, Pacifiers, and Safe Sleep)

11.1.8 Criterion for evaluation: Infant formula cans and prepared bottles are kept out of view of patients and the general public.

11.1.9 Criterion for evaluation: Of randomly selected staff members, at least 80% can give 2 reasons why it is important not to give free samples or other items from formula companies to mothers.

Appendix A:

20-Hour Course Topic and Competency Skills List for the U.S.

Adapted for use in the United States from the WHO/UNICEF International Guidelines

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

Objectives	Content
Demonstrate the ability to identify the hallmarks of milk transfer and optimal breastfeeding.	**Session 6: Helping with a breastfeed** • Positioning for comfortable breastfeeding • How to assess a breastfeeding • Recognize signs of optimal positioning and attachment • Help a mother to learn to position and attach her baby • When to assist with breastfeeding • The baby who has difficulty attaching to the breast
Discuss hospital postpartum management policies and procedures that support exclusive breastfeeding.	**Session 7: Practices that assist breastfeeding** • Rooming-in • Skin-to-skin contact • Baby-led feeding • Dealing with sleepy babies and crying babies • Avoiding unnecessary supplements • Avoiding bottles and teats
Discuss methods that may increase milk production in a variety of circumstances.	**Session 8: Milk supply** • Concerns about “not enough milk” • Normal growth patterns of babies • Improving milk intake and milk production
Identify teaching points to include when educating or counseling parents who are using bottles and/or formula.	**Session 9: Supporting the non-breastfeeding mother and baby** • Counseling the formula choice: a pediatric responsibility • Teaching/assuring safe formula preparation in the postpartum • Safe bottle feeding; issues with overfeeding and underfeeding
Discuss contraindications to breastfeeding in the United States as well as commonly encountered areas of concern for breastfeeding mothers and their babies.	**Session 10: Infants and mothers with special needs** • Breastfeeding infants who are preterm, low birth weight or ill • Breastfeeding more than one baby • Prevention and management of common clinical concerns • Medical reasons for food other than breast milk • Nutritional needs of breastfeeding women • How breastfeeding helps space pregnancies • Breastfeeding management when the mother is ill • Medications and breastfeeding • Contraindications to breastfeeding
Describe management techniques for breast and nipple problems.	**Session 11: Breast and nipple concerns** • Examination of the mother’s breasts and nipples • Engorgement, blocked ducts, and mastitis • Sore nipples

Objectives	Content
Identify acceptable medical reasons for supplementation of breastfed babies according to national and international authorities.	**Session 12: If the baby cannot feed at the breast** • Learning to hand express • Use of milk from another mother • Feeding expressed breast milk to the baby
Describe essential components of support for mothers to continue breastfeeding beyond the early weeks.	**Session 13: Ongoing support for mothers** • Preparing a mother for discharge • Follow-up and support after discharge • Protecting breastfeeding for employed women • Sustaining continued breastfeeding for 2 years or longer
Describe strategies that protect breastfeeding as a public health goal.	**Session 14: Protecting breastfeeding** • The effect of marketing on infant feeding practices • The International Code of Marketing of Breast-milk Substitutes • How health workers can protect families from marketing • Donations in emergency situations • The role of breastfeeding in emergencies • How to respond to marketing practices
Identify barriers and solutions to implementation of the Ten Steps to Successful Breastfeeding that comprise the Baby-Friendly Hospital Initiative.	**Session 15: Making your hospital or birth center Baby-Friendly®** • The Ten Steps to Successful Breastfeeding • What "Baby-Friendly" Practices mean • The process of becoming a Baby-Friendly hospital or birth center

Skills Competencies for Maternity Staff:

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

Appendix B:
Acceptable Medical Reasons for Use of Breast Milk Substitutes

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

The facility should develop a protocol/procedure that describes the current, evidence-based 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)) in developing this protocol/procedure, however the facility is responsible for ensuring that its medical indications for supplementation are supported by current evidence.

Appendix C:

Definitions 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.

Criteria for evaluation – The minimum standards which must be achieved in order to achieve Baby Friendly designation.

Exclusive breast milk feeding – Refers to the optimal practice of feeding infants no food or drink other than human milk unless another food is determined to be medically necessary.

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.

Guidelines – The standards of care which facilities strive to achieve for all patients.

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

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

Skin-to-skin contact (STS) – Skin-to-skin contact or skin-to-skin care refers to 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 completely dried and placed naked against the mother's naked ventral surface. The infant may wear a diaper and/or a hat, but no other clothing should be between the mother's and infant's bodies. The infant and mother are then covered with a warm blanket, keeping the infant's head uncovered. 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.

ABM – Academy of Breastfeeding Medicine
BFHI – Baby-Friendly Hospital Initiative
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

WHO – World Health Organization

Appendix D:

Guidelines and Evaluation Criteria Clarification Statements

Safety of Baby-Friendly Practices

Safety is an important component of the Baby-Friendly Hospital Initiative (BFHI). This is addressed in the *Guidelines and Evaluation Criteria (GEC)*, which clearly state, "Each participating facility assumes full responsibility for assuring that its implementation of the BFHI is consistent with all of its safety protocols." It also indicates that all practices associated with the Ten Steps to Successful Breastfeeding be implemented in a sensitive manner that is responsive to the family's needs.

Immediate Skin-to-Skin Care

Skin-to-Skin Care has been shown to have numerous benefits for both mothers and infants. The ***AAP Neonatal Resuscitation Program (NRP)*** offers a Flow Diagram for assessing infant stability and care that is an excellent protocol for initiating skin-to-skin care immediately following birth. The NRP Flow Diagram for routine care starts with assessing if the infant is:

- Term Gestation
- Good Tone
- Breathing or Crying

If the answer is "yes" to all of those questions, the direction is to remain with the mother and provide routine care which includes maintaining normal temperature, positioning the airway, clearing secretions if needed, drying, and conducting ongoing evaluation.[10]

Rooming-in

Rooming-in has been recommended for infant health and safety for decades. It is an evidenced-based practice that is beneficial to both mothers and infants. The GEC call for rooming-in to be the routine standard of care. The BFHI does not call for newborn nurseries to be closed.

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 care practices.[11]

[10] American Academy of Pediatrics and American Heart Association, Textbook of Neonatal Resuscitation (NRP), 7th Ed, Edited by Gary M. Weiner and Jeanette Zaichkin, 2016.

[11] Lori Feldman-Winter, Jay P. Goldsmith, AAP Committee on Fetus and Newborn, and AAP Task Force on Sudden Infant Death Syndrome. "Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns." Pediatrics 138, no. 3 (2016): e20161889. doi: 10.1542/peds.2016-1889

Exclusive Breastfeeding, Pacifiers, and Safe Sleep

Baby-Friendly USA (BFUSA) promotes exclusive breastfeeding and the safe implementation of practices that support exclusive breastfeeding while also reinforcing safe sleep and Sudden Infant Death Syndrome (SIDS) reduction messages and practices. BFUSA believes strongly that the promotion of exclusive breastfeeding, safe sleep, and SIDS reduction are complementary initiatives. In fact, breastfeeding is recommended as a strategy for reducing SIDS and other sleep-related infant deaths.[12] The protective effect of breastfeeding increases with exclusivity.

BFUSA has received some questions from professionals working on safe sleep initiatives regarding the designation criteria related to pacifier use. The BFUSA *Guidelines and Evaluation Criteria* (*GEC*) related to Step 9 state that breastfed infants should not be given pacifiers by hospital staff and that mothers who request that their infants be given a pacifier be educated about how pacifier use could affect the success of breastfeeding. Early and frequent breastfeeding in the newborn period is essential to building up a mother's milk supply. Pacifier introduction too early in the breastfeeding relationship may interfere with this important biological process and mask potential breastfeeding problems. Furthermore, the *GEC* is also in alignment with the American Academy of Pediatrics' (AAP) recommendation for pacifier use found in the *2012 AAP Policy Statement: Breastfeeding and the Use of Human Milk*. The policy statement recommends that mothers of healthy term infants be instructed to use pacifiers at infant nap or sleep time after breastfeeding is well established, at approximately 3 to 4 weeks of age.[13] While it is acknowledged that the exact timeframe for the establishment of breastfeeding may vary from mother to mother, it rarely occurs during the first 2 days of life.

BFUSA acknowledges the evidence pertaining to pacifier education related to SIDS prevention. Safe sleep and SIDS prevention information is important for parents to receive during the birth hospital stay. This education may be compatibly provided to parents by using safe sleep materials that also promote breastfeeding. Since the *AAP SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment* continues to call for pacifiers to be delayed until breastfeeding is firmly established, BFUSA will require hospitals distributing safe sleep materials to provide additional verbal and written education to mothers that includes the following:

1. Pacifier use in the breastfed infant should be delayed until breastfeeding is well established, usually around 3-4 weeks of life.
2. How mothers can know that breastfeeding is well established.
3. Breastfeeding is associated with a reduced risk of SIDS, and the protective effect increases with breastfeeding exclusivity.

[12] American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome, SIDS, and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. *Pediatrics*. no. 138 (2016) 138(5). doi: 10.1542/peds.2016-2938.

[13] Lawrence M. Gartner, Arthur I. Eidelman, Jane Morton, Ruth A. Lawrence, Audrey J. Naylor, Donna O'Hare, and Richard J. Schanler. "Policy Statement, Section on Breastfeeding: Breastfeeding and the Use of Human Milk." Pediatrics 115, no. 2 (2005): 496–506. doi: 10.1542/peds.2004-2491.

FORMULA: SAFE PREPARATION, STORAGE AND FEEDING

Mothers that 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

Bibliography

Academy of Breastfeeding Medicine Protocol Committee. "ABM Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2009." Breastfeeding Medicine 4, no. 3 (2009): 175–182. doi: 10.1089/bfm.2009.9991

Academy of Breastfeeding Medicine. "ABM Clinical Protocol #10: Breastfeeding the Late Preterm Infant (34 0/7 to 36 6/7 Weeks Gestation) (First Revision June 2011)." Breastfeeding Medicine 6, no. 3 (2011): 151-156. doi: 10.1089/bfm.2011.9990.

Academy of Nutrition and Dietetics. "Practice Paper of the Academy of Nutrition and Dietetics: Promoting and Supporting Breastfeeding." Eatright.org (2015). Accessed 3/25/16. http://www.eatrightpro.org/~/media/eatrightpro%20files/practice/position%20and%20practice%20papers/practice%20papers/practicepaperpromotingandsupportingbreastfeeding.ashx .

Bartick, Melissa, and Arnold Reinhold. "The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis," Pediatrics 125, no. 5 (2010): 1048-1056. doi: 10.1542/peds.2009-1616.

Chantry, Caroline J., Anne Eglash, and Miriam Labbock. "ABM Position on Breastfeeding—Revised 2015." Breastfeeding Medicine 10, no. 9 (2015): 407-411. doi: 10.1089/bfm.2015.29012.cha.

Declercq, Eugene, Miriam H. Labbok, Carol Sakala, and MaryAnn O'Hara. "Hospital Practices and Women's Likelihood of Fulfilling Their Intention to Exclusively Breastfeed." American Journal of Public Health 99, no. 5 (2009): 929-935. doi: 10.2105/AJPH.2008.135236.

DiGirolamo, Ann M., Laurence M. Grummer-Strawn, and Sara B. Fein. "Effect of Maternity-Care Practices on Breastfeeding." Pediatrics 122, Suppl 2 (2008): S43–S49. doi: 10.1542/peds.2008-1315e.

Eidelman, Arthur I., and Richard J. Schanler, 2012. "Policy Statement: Breastfeeding and the Use of Human Milk, Section on Breastfeeding." Pediatrics 129, no. 3 (2012): e827-e841. doi: 10.1542/peds.2011-3552.

Evans, Amy, Kathleen A. Marinelli, Julie Scott Taylor, and The Academy of Breastfeeding Medicine. "ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: The Going Home Protocol, Revised 2014." Breastfeeding Medicine 9, no. 1 (2014): 3-8. doi: 10.1089/bfm.2014.9996.

Gagnon, Anita J., Guylaine Leduc, Kathy Waghorn, Hong Yang, and Robert W. Platt. "In-Hospital Formula Supplementation of Healthy Breastfeeding Newborns." Journal of Human Lactation 21, no. 4 (2005): 397–405. doi: 10.1177/0890334405280835.

Gartner, Lawrence M., Arthur I. Eidelman, Jane Morton, Ruth A. Lawrence, Audrey J. Naylor, Donna O'Hare, and Richard J. Schanler. "Policy Statement, Section on Breastfeeding: Breastfeeding and the Use of Human Milk." Pediatrics 115, no. 2 (2005): 496–506. doi: 10.1542/peds.2004-2491.

Hale, Thomas W., and Hilary E. Rowe. Medications and Mothers' Milk, 2014. Amarillo: Hale Publishing, 2014.

Holmes Allison V., Angela Yerdon McLeod, and Maya Bunik. "ABM Clinical Protocol #5: Peripartum Breastfeeding Management for the Healthy Mother and Infant at Term, Revision 2013." Breastfeeding Medicine 8, no. 6 (2013): 469-473. doi: 10.1089/bfm.2013.9979.

Howard, Cynthia, R., Fred M. Howard, Bruce Lanphear, Shirley Eberly, Elisabeth A. deBlieck, David Oakes, and Ruth A. Lawrence. "Randomized Clinical Trial of Pacifier Use and Bottle-feeding or Cupfeeding and Their Effect on Breastfeeding." Pediatrics 111, no. 3 (2003): 511–518. http://pediatrics.aappublications.org/content/111/3/511.

International Lactation Consultant Association. Clinical Guidelines for the Establishment of Exclusive Breastfeeding, Third Edition. 2014.

Ip, Stanley, Mei Chung, Gowri Raman, Priscilla Chew, Nombulelo Magula, Deirdre DeVine, Thomas Trikalinos, and Joseph Lau. "Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries." Evidence Report/Technology Assessment No. 153 prepared for Agency for Healthcare Research and Quality. Agency for Healthcare Research and Quality, Rockville, MD, April 2007. Accessed June 17, 2016. http://archive.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf.

Lawrence, Ruth A., and Robert M. Lawrence. Breastfeeding: A Guide for the Medical Profession, Seventh Edition. Philadelphia: Mosby, 2011.

Merten, Sonja, Julia Dratva, and Ursula Ackermann-Liebrich. "Do Baby-Friendly Hospitals Influence Breastfeeding Duration on a National Level?" Pediatrics 111, no. 5 (2005): e702–e708. Accessed June 17, 2016. http://www.ncbi.nlm.nih.gov/pubmed/16263985.

Mikiel-Kostyra, K., J. Mazur, and I. Boltruszko. "Effect of Early Skin-to-Skin Contact After Delivery on Duration of Breastfeeding: A Prospective Cohort Study." Acta Paediatricia 116, no. 5 (2002): 1301–1306. doi: 10.1111/j.1651-2227.2002.tb02824.x.

National Library of Medicine. "LactMed (Drugs and Lactation Database), A TOXNET Database." Updated monthly. http://toxnet.nlm.nih.gov/newtoxnet/lactmed.html.

Parker, L. A., S. Sullivan, C. Krueger, T. Kelechi, and M. Mueller. "Effect of Early Breast Milk Expression on Milk Volume and Timing of Lactogenesis Stage II Among Mothers of Very Low Birth Weight Infants: A Pilot Study." Journal of Perinatology 132, no. 3 (2012): 205-209. doi: 10.1038/jp.2011.78.

Pérez-Escamilla, Rafael, Josefa L. Martinez, and Sofia Segura-Pérez. "Impact of the Baby-friendly Hospital Initiative on Breastfeeding and Child Health Outcomes: A Systematic Review." Maternal Child Nutrition (2016). doi: 10.1111/mcn.12294.

Rosenberg, Kenneth D., John D. Stull, Michelle R. Adler, Laurin J. Kasehagen, and Andrea Crivelli-Kovach. "Impact of Hospital Policies on Breastfeeding Outcomes." Breastfeeding Medicine 110, no. 2 (2008): 110–116. doi: 10.1089/bfm.2007.0039.

Rosen-Carole, Casey, Scott Hartman, and The Academy of Breastfeeding Medicine. "Clinical Protocol Number #19: Breastfeeding Promotion in the Prenatal Setting, Revision 2015." Breastfeeding Medicine 10, no. 10 (2015): 451-457. doi: 10.1089/bfm.2015.29016.ros.

Schwarz, Eleanor Bimla, Roberta M. Ray, Alison M. Stuebe, Matthew A. Allison, Roberta B. Ness, Matthew S. Freiberg, and Jane A. Cauley. "Duration of Lactation and Risk Factors for Maternal Cardiovascular Disease." Obstetrics and Gynecology 113, no. 5 (2009): 974-982. doi: 10.1097/01.AOG.0000346884.67796.ca.

Stettler, Nicolas, Virginia A. Stallings, Andrea B. Troxel, Jing Zhao, Rita Schinnar, MPA; Steven E. Nelson, Ekhard E. Ziegler, and Brian L. Strom. "Weight Gain in the First Week of Life and Overweight in Adulthood: A Cohort Study of European American Subjects Fed Infant Formula." Circulation 111, no. 15 (2005): 1897–1903. doi: 10.1161/01.CIR.0000161797.67671.A7.

Su, Lin-Lin, Yap-Seng Chong, Yiong-Huak Chan, Yah-Shih Chan, Doris Fok, Kay-Thwe Tun, Faith S P Ng, and Mary Rauff. "Antenatal Education and Postnatal Support Strategies for Improving Rates of Exclusive Breast Feeding: Randomised Controlled Trial." BMJ 335 (2007): 596. doi: http://dx.doi.org/10.1136/bmj.39279.656343.55.

U.S. Department of Health and Human Services. "HHS Blueprint for Action on Breastfeeding." Washington, DC: Office on Women's Health, U.S. Department of Health and Human Services, 2000.

UNICEF. "Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding." New York: UNICEF, 1990.

Weimer, Jon. "The Economic Benefits of Breastfeeding: A Review and Analysis." Economic Research Service Food Assistance and Nutrition Research Report 13 (March 2001). Accessed June 28, 2016. http://www.ers.usda.gov/media/329098/fanrr13_1_.pdf.

Wight, Nancy, Kathleen A. Marinelli, and The Academy of Breastfeeding Medicine. "ABM Clinical

Protocol #1: Guidelines for Glucose Monitoring and Treatment of Hypoglycemia in Breastfed Neonates." Breastfeeding Medicine 9, no. 4 (2014) 173-179. doi: 10.1089/bfm.2014.998.

Williams, Anthony, and World Health Organization. "Hypoglycemia of the Newborn: Review of the Literature." Geneva: World Health Organization, 1997.

World Health Organization, and UNICEF. Global Strategy for Infant and Young Child Feeding. Geneva: Switzerland, 2003.

World Health Organization, and UNICEF. "Acceptable Medical Reasons for the Use of Breast-Milk Substitutes." Geneva: World Health Organization, 2009.

World Health Organization, and UNICEF. "Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services, A Joint WHO/UNICEF Statement." Geneva: World Health Organization, 1989.

World Health Organization, UNICEF, and Wellstart International. "Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care." Geneva: World Health Organization and UNICEF, 2009.

World Health Organization, UNICEF, UNAIDS, and UNFPA. "HIV and Infant Feeding: Update Based on the Technical Consultation Held on Behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women." Geneva: World Health Organization, 2006.

World Health Organization. "Technical Updates of the Guidelines on Integrated Management of Childhood Illness (IMCI): Evidence and Recommendations for Further Adaptations." Geneva: World Health Organization, Geneva, 2005.