BABY-FRIENDLY HOSPITAL INITIATIVE

Revised, Updated and Expanded
for Integrated Care

SECTION 1
BACKGROUND AND IMPLEMENTATION

2009

Original BFHI Guidelines developed 1992

unicef

World Health Organization

WHO Library Cataloguing-in-Publication Data

Baby-friendly hospital initiative : revised, updated and expanded for integrated care. Section 1, Background and implementation.

Produced by the World Health Organization, UNICEF and Wellstart International.

1.Breast feeding. 2.Hospitals. 3.Maternal welfare. 4.Maternal health services. I.World Health Organization. II.UNICEF. III.Wellstart International. IV.Title: Background and implementation.

ISBN 978 92 4 159496 7 (v. 1) (NLM classification: WQ 27.1)
ISBN 978 92 4 159495 0 (set)

Printed by the WHO Document Production Services, Geneva, Switzerland

Cover image "Maternity", 1963.

Acknowledgements

The original 1992 BFHI guidelines were prepared by the staff of the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), with assistance from Wellstart International in developing The Global Criteria. Ann Brownlee prepared sections 1, 2, 4 and 5 of this set of materials, and Genevieve Becker prepared section 3. Both have declared no conflict of interest.

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Acknowledgement is given to all the UNICEF and WHO Regional and Country offices, BFHI coordinators, health professionals, and field workers, who, through their diligence and caring, have implemented and improved the Baby-friendly Hospital Initiative through the years, and thus contributed to the content of these revised guidelines.

The extensive comments provided by Genevieve Becker and Ann Brownlee of *BEST Services*; Rufaro Madzima, MOH Zimbabwe; Mwate Chintu, LINKAGES Project; Miriam Labbok, Center for Infant and Young Child Feeding and Care, School of Public Health, University of North Carolina; Moazzem Hossain, UNICEF; and Randa Jarudi Saadeh, WHO were of particular value.

Review and additional inputs were provided by: Azza Abul-Fadl Egypt; Carmen Casanovas, Bolivia and WHO; Elizabeth Hormann, Germany; Elizabeth (Betty) Zisovska, Macedonia; Ngozi Niepuome, Nigeria; and Sangeeta Saxena, India.

Acknowledgements for all those who assisted with reviewing the Global Criteria and other components of the BFHI package that relate to self-appraisal and assessment are listed in Sections 4 and 5 of the set of materials.

Special thanks to the many government and NGO staff, members of National Authorities, and BFHI national co-coordinators around the world who responded to the user needs survey and gave further input concerning revisions to the assessment tools and generously shared various BFHI self-appraisal and assessment tools developed at country level.

These multi-country and multi-organizational contributions were invaluable in helping to fashion a set of tools and guidelines designed to address the current needs of countries and their mothers and babies, facing a wide range of challenges in many differing situations.

Preface for the 2009 BFHI materials: Revised, Updated and Expanded for Integrated Care

Since the Baby-friendly Hospital Initiative (BFHI) was launched by UNICEF and WHO in 1991-1992, the Initiative has grown, with more than 20,000 hospitals having been designated in 156 countries around the world over the last 15 years. During this time, a number of regional meetings offered guidance and provided opportunities for networking and feedback from dedicated country professionals involved in implementing BFHI. Two of the most recent were held in Spain, for the European region, and Botswana, for the Eastern and Southern African region. Both meetings offered recommendations for updating the Global Criteria, related assessment tools, as well as the "18-hour course", in light of experience with BFHI since the Initiative began, the guidance provided by the new Global Strategy for Infant and Young Child Feeding, and the challenges posed by the HIV pandemic. The importance of addressing "mother-friendly care" within the Initiative was raised by a number of groups as well.

As a result of the interest and strong request for updating the BFHI package, UNICEF, in close coordination with WHO, undertook the revision of the materials in 2004-2005, with various people assisting in the process (Genevieve Becker, Ann Brownlee, Miriam Labbok, David Clark, and Randa Saadeh). The process included an extensive "user survey" with colleagues from many countries responding. Once the revised course and tools were drafted they were reviewed by experts worldwide and then field-tested in industrialized and developing country settings. The full first draft of the materials was posted on the UNICEF and WHO websites as the "Preliminary Version for Country Implementation" in 2006. After more than a year's trial, presentations in a series of regional multi-country workshops, and feedback from dedicated users, UNICEF and WHO[1] met with the co-authors above[2] and resolved the final technical issues that had been raised. The final version was completed in late 2007. It is expected to update these materials no later than 2018.

The revised BFHI package includes:

Section 1: Background and Implementation, which provides guidance on the revised processes and expansion options at the country, health facility, and community level, recognizing that the Initiative has expanded and must be mainstreamed to some extent for sustainability, and includes:

1.1 Country Level Implementation
1.2 Hospital Level Implementation
1.3 The Global Criteria for BFHI
1.4 Compliance with the International Code of Marketing of Breast-milk Substitutes
1.5 Baby-friendly Expansion and Integration Options
1.6 Resources, references and websites

Section 2: Strengthening and sustaining the Baby-friendly Hospital Initiative: A course for decision-makers was adapted from the WHO course "Promoting breast-feeding in health facilities: A short course for administrators and policy-makers". This can be used to orient hospital decisions-makers (directors, administrators, key managers, etc.) and policy-makers to the Initiative and the

[1] Moazzem Hossain, UNICEF NY, played a key role in organizing the multi-country workshops, launching the use of the revised materials. He, Randa Saadeh and Carmen Casanovas of WHO worked together with the co-authors to resolve the final technical issues.

[2] Miriam Labbok is currently Professor and Director, Center for Infant and Young Child Feeding and Care, Department. of Maternal and Child, University of North Carolina School of Public Health.

positive impacts it can have and to gain their commitment to promoting and sustaining "Baby-friendly". There is a Course Guide and eight Session Plans with handouts and PowerPoint slides. Two alternative session plans and materials for use in settings with high HIV prevalence have been included.

Section 3: Breastfeeding Promotion and Support in a Baby-friendly Hospital, a 20-hour course for maternity staff, which can be used by facilities to strengthen the knowledge and skills of their staff towards successful implementation of the Ten Steps to Successful Breastfeeding. This section includes:

3.1 Guidelines for Course Facilitators including a Course Planning Checklist
3.2 Outlines of Course Sessions
3.3 PowerPoint slides for the Course

Section 4: Hospital Self-Appraisal and Monitoring, which provides tools that can be used by managers and staff initially, to help determine whether their facilities are ready to apply for external assessment, and, once their facilities are designated Baby-friendly, to monitor continued adherence to the Ten Steps. This section includes:

4.1 Hospital Self-Appraisal Tool
4.2 Guidelines and Tools for Monitoring

Section 5: External Assessment and Reassessment, which provides guidelines and tools for external assessors to use both initially, to assess whether hospitals meet the Global Criteria and thus fully comply with the Ten Steps, and then to reassess, on a regular basis, whether they continue to maintain the required standards. This section includes:

5.1 Guide for Assessors, including PowerPoint slides for assessor training
5.2 Hospital External Assessment Tool
5.3 Guidelines and Tool for External Reassessment
5.4 The BFHI Assessment Computer Tool

Sections 1 through 4 are available on the UNICEF website at http://www.unicef.org/nutrition/index_24850.html or by searching the UNICEF website at http://www.unicef.org/ and, on the WHO website at http://www.who.int/nutrition/publications/infantfeeding/9789241594950/en/index.html or by searching the WHO website at www.who.int/nutrition.

Section 5: External Assessment and Reassessment, is not available for general distribution. It is only provided to the national authorities for BFHI who provide it to the assessors who are conducting the BFHI assessments and reassessments. A computer tool for tallying, scoring and presenting the results is also available for national authorities and assessors. Section 5 can be obtained, on request, from the country or regional offices or headquarters of UNICEF Nutrition Section and WHO, Department of Nutrition for Health and Development.

SECTION 1
BACKGROUND AND IMPLEMENTATION

SECTION 1.1
COUNTRY LEVEL IMPLEMENTATION

Background Rationale for Revisions

When the Baby-friendly Hospital Initiative was conceived in the early 1990s in response to the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding call for action, there were very few countries that had dedicated Authorities or Committees to oversee and regulate infant feeding standards. Today, after nearly 15 years of work in support of optimal infant and young child feeding, 156 countries have, at one time or another, assessed hospitals and designated at least one facility "Baby-friendly." The BFHI has measurable and proven impact,[3] however, it is clear that only a comprehensive, multi-sector, multi-level effort to protect, promote and support optimal infant and young child feeding, including legislative protection, social promotion and health worker and health system support via BFHI and additional approaches, can hope to achieve and sustain the behaviours and practices necessary to enable every mother and family to give every child the best start in life.

The 2002 WHO/UNICEF *Global Strategy for Infant and Young Child Feeding* (GSIYCF) calls for renewed support - with urgency - for exclusive breastfeeding from birth for 6 months, and continued breastfeeding with timely and appropriate complementary feeding for two years or longer. This Strategy and the associated "Planning Framework for Implementation" being prepared by WHO and UNICEF reconfirm the importance of the Innocenti Declaration goals, while adding attention to support for complementary feeding, maternal nutrition, and community action.

The nine operational areas of the Global Strategy are:

1. Appoint a national breastfeeding co-ordinator, and establish a breastfeeding committee.
2. Ensure that every maternity facility practices the *Ten Steps to Successful Breastfeeding.*
3. Take action to give effect to the International Code of Marketing of Breast-milk Substitutes and subsequent relevant resolutions of the World Health Assembly.
4. Enact imaginative legislation protecting the breastfeeding rights of working women.
5. Develop, implement, monitor and evaluate a comprehensive policy covering all aspects of infant and young child feeding.
6. Ensure that the health care system and other relevant sectors protect, promote and support exclusive breastfeeding for six months and continued breastfeeding for up to two years of age or beyond, while providing women with the support that they require to achieve this goal, in the family, community and workplace.
7. Promote timely, adequate, safe and appropriate complementary feeding with continued breastfeeding.
8. Provide guidance on feeding of infants and young children in exceptionally difficult circumstances, which include emergencies and parental HIV infection.

[3] Kramer MS, Chalmers B, Hodnett ED, et al: PROBIT Study Group (Promotion of Breastfeeding Intervention Trial) Promotion of Breastfeeding Intervention Trial (PROBIT): a randomized trial in the Republic of Belarus. JAMA. 2001;285:413-420, and Merten S, Dratva J, Ackermann-Liebrich U. Do baby-friendly hospitals influence breastfeeding duration on a national level? Pediatrics. 2005;116(5):e702-e708.

9. Consider what new legislation or other suitable measures may be required to give effect to the principles and aim of the International Code of Marketing of Breast-milk Substitutes and to subsequent relevant World Health Assembly resolutions.

This implementation plan encourages all countries to revitalize action programmes according to the Global Strategy, including the Baby-friendly Hospital Initiative (BFHI). The original BFHI addresses targets 1 and 2 and 8, above, and this version adds some clarity to 1, 2, 6, 7 and 8.

In 2003, nine UN agencies joined in the development and launching of "HIV and Infant Feeding - Framework for Priority Action". This document recommends key actions to governments related to infant and young child feeding, and covers the special circumstances associated with HIV/AIDS. The aim of these actions is to create and sustain an environment that encourages appropriate feeding practices for all infants while scaling-up interventions to reduce HIV transmission.

The five recommended actions include the need for ensuring support for optimal infant and young child feeding for all, including the need for BFHI, as requisites to successful counselling of the HIV-positive mother:

1. Develop or revise (as appropriate) a comprehensive national infant and young child feeding policy that includes HIV and infant feeding.
2. Implement and enforce the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly Resolutions.
3. Intensify efforts to protect, promote and support appropriate infant and young child feeding practices in general, while recognizing HIV as one of a number of exceptionally difficult circumstances.

   This action specifically includes a call for revitalization and scale-up of coverage of the Baby-friendly Hospital Initiative and to extend it beyond hospitals, including through the establishment of breastfeeding support groups. It also encourages making provision for expansion of activities to prevent HIV transmission to infants and young children hand-in-hand with promotion of BFHI principles. HIV/Infant Feeding counselling training recommendations from WHO/UNICEF note that BFHI or other breastfeeding support training should precede training on infant feeding counselling for the HIV-positive mother.
4. Provide adequate support to HIV-positive women to enable them to select the best feeding option for themselves and their babies, to successfully carry out their infant feeding decisions.
5. Support research on HIV and infant feeding, including operations research, learning, monitoring and evaluation at all levels, and disseminate findings.

In 2005, the fifteenth anniversary of the Innocenti Declaration, an assessment of progress and challenges was carried out, culminating in a second Innocenti Declaration 2005 on Infant and Young Child Feeding, highlighting the importance of early initiation of breastfeeding, suggesting ways to strengthen action on breastfeeding and outlining urgent activities for the nine operational areas of the Global Strategy.

BFHI Section 1, Background and Implementation, presents a methodology for encouraging nations to reinvigorate, restore or launch the BFHI in today's realities, facilitating the changes needed in maternity facilities, practices, and health worker training in those facilities, in accordance with the WHO and UNICEF "Ten Steps to Successful Breastfeeding." The original documents written during the 1990s have been

revised to take into account the current global context, with consideration given to HIV/AIDS, to address obstacles to the processes that have been encountered over the years, and include recent evidence-based findings related to infant and young child feeding. The Annexes to Section 1.1 include Annex 1: a summary framework for implementation at the national level, Annex 2: suggested questions for a self-assessment, Annex 3: excerpts from recent publications that may be helpful in sensitisation of decision-makers regarding the importance of early and exclusive breastfeeding and Annex 4: an illustration of how breastfeeding is essential for the achievement of the Millennium Development Goals (MDGs).

Getting Started

Most countries have taken steps to start national Baby-friendly campaigns, including vigorous steps towards improved support to breastfeeding in hospitals, actions to protect breastfeeding by national policy implementation, and public promotion campaigns. The recommendations and steps below are presented to help re-invigorate, restore, modify or strengthen such national initiatives, or to help launch such activities where none exist.

The Ten Steps to Successful Breastfeeding, a summary of the guidelines for maternity care facilities presented in the Joint WHO/UNICEF Statement Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services, (WHO, 1989) have been accepted as the minimum global criteria for attaining the status of a Baby-friendly Hospital.

TEN STEPS TO SUCCESSFUL BREASTFEEDING

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk unless *medically* indicated.
7. Practise rooming in - allow mothers and infants to remain together - 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

The process of becoming a baby-friendly hospital is outlined in Section 1.2. In brief, it is a process that starts with self-appraisal by the facility. This initial self-assessment includes an analysis of the practices that encourage or hinder breastfeeding, and then helps identify the actions that will help to make the necessary changes. It follows the accepted triple-A sequence (Assessment, Analysis and Action), which characterises much of UNICEF Programme development. After a facility is satisfied that it meets a high standard, this achievement is confirmed objectively by an external assessment of whether the facility has achieved, or nearly achieved, the "Global Criteria" for BFHI and thus can be awarded the Global Baby-friendly Hospital designation and plaque.

The key documents that serve to guide the Baby-friendly Hospital Initiative are Section 1: Background and Implementation - the guidelines for implementation of the Initiative that include initiation at the country and hospital levels, compliance with the International Code of Marketing of Breast-milk Substitutes, and approaches to expansion, integration and sustainability; Section 2: Strengthening and sustaining the Baby-friendly Hospital Initiative - a course for decision-makers adapted from "Promoting breast-feeding in health facilities a short course for administrators and policy-makers"; Section 3: the BFHI Training Course - with updated content for HIV, maternity practices and emergencies; Sections 4: Self- Appraisal and Monitoring; and Section 5: External Assessment and Reassessment.

Five Steps in Implementing BFHI at the Country Level (also see Section 1.1, Annex 1)

Today many countries' BFHI programmes are well underway. Therefore, this section will offer a five-step approach, based on what has been used for more than a decade with modifications for today's circumstances. This section addresses both those settings where there is no BFHI or it has become quiescent, as well as those where the BFHI effort is ongoing. Each step includes suggested activities. These five essential steps are summarised on page 13, including the process, the inputs and outputs associated with them.

Step 1:
Establish, re-energize, or plan a meeting of the National Breastfeeding, Infant and Young Child Feeding, or Nutrition Authority, to establish or assess its functions related to BFHI.

If your country has an established national authority, ensure that it is up to the current standards as outlined in the Global Strategy for Infant and Young Child Feeding. If not, the following provides guidance for its membership and functions.

- *1A. Who are the members of a National Authority?*

According to the Global Strategy, the national authority should be multi-sectoral. The National Authority should not be confined to the medical of health sector. Possible composition would include:

- Representative(s) of the national government's health and nutrition sector that supports women and children's health outcomes,
- Representative(s) of the national government's financial planning,
- Representative(s) of the national government's social sector,
- Technical representative(s) from the academic sector,
- Community action leadership, such as NGOs, and
- Representative(s) from committee(s) that supports BFHI and/or Code implementation,

- Communications specialist,
- Monitoring and evaluation specialist.

- *1B. What is the role of the National Authority in relation to BFHI?*

The national authority will have government endorsement to have oversight of all nine Global Strategy targets, as operationalised in the four major action areas: 1) national policy and legislation, 2) health system and health worker standards, reform and related actions, 3) multi-sectoral mobilisation and community action, and 4) special circumstances. As such the primary roles are to:

- strategise and plan national IYCF activities;
- oversee implementation of specific activity areas such as BFHI and the Code; and
- monitor and evaluate the status of programmes and activities as well as the outcomes in terms of changes in feeding behaviours.

These activities demand ongoing assessment and feedback. Therefore, the national authority must also:

- advocate for data collection, both ongoing in health systems as well as periodic surveys,
- be mandated by the national or regional government, and
- have support and funding in the national or regional financial plan and budget.

The specific roles and responsibilities of the national authority include:

- Coordinating and fostering collaboration across Ministries, stipulating a process for sustainable reassessment, e.g., via insurance, taxes.
- Incorporating support for breastfeeding and complementary feeding into ongoing mechanisms.
- Setting goals based on international standards. In general:
  - The goal for early initiation should be that newborns are placed skin-to-skin within minutes of birth, remaining for 60 minutes or longer, with all mothers encouraged to support the infant to breastfeed when their babies show signs of readiness.
  - The goal for exclusive breastfeeding, as determined at the UN Standing Committee on Nutrition, 2004, should be to increase exclusive breastfeeding to 6 months of age to a minimum of 60% by 2015, with the ultimate goal of approaching 100%.
    Note: in countries where women receive voluntary counselling for HIV/AIDS, a proportion of these women will choose replacement feeding. Even though some of the HIV-positive women will choose exclusive breastfeeding, in such settings, the ultimate goal will remain less than 100%.
  - The goal for complementary feeding, as determined at the UN Standing Committee on Nutrition, 2004, from 6 months to 23 months or longer, is that breastfeeding continue to supply 350-500 calories a day, and an additional 3-5 feedings of nutrient rich complementary foods is needed, as described under "optimal feeding".
- Achieving stated IYCF goals. <u>Therefore, a regular budget and budget line must be identified by the government from governmental sources to support these functions.</u>
- Overseeing standards for health worker training and legislation to protect optimal infant and young child feeding, such as undergraduate health worker

curricula, working with professional organizations to upgrade standards of practice, and legislation to implement the Code of Marketing and maternity protection.
- Adapting criteria for baby-friendly expansion into the community and other expansion approaches (see section 1.5).
- Incorporating baby-friendly principles into any and all related health (e.g., Saving Newborn Lives, C-IMCI), nutrition (e.g., Ending Child Hunger and Undernutrition Initiative, work on MDGs) or social programmes (e.g., Early Child Development).
- Providing technical oversight and review as necessary of the BFHI Coordination Group's assessments – including how it administers self-appraisals, assessments and re-assessment at least once every 3-5 years.
- Overseeing ethics of the designation processes and insure avoidance of conflict of interest, whether with a manufacturer, training programme, or other, that may bias assessments and designations.
- Carrying out, at least annually, an assessment and evaluation of health service data on breastfeeding and complementary feeding for baby-friendly-designated facilities and other settings.

In addition, the National Authority will develop a multi-year plan of action and associated budget for government support and consideration, and will meet regularly to assess progress against each goal, as well as to assess progress on agreed upon objectives.

Step 2:
Identify – or re-establish – national BFHI goals and approaches.

Many countries have BFHI committees and goals in place, but they may or may not be part of current comprehensive or integrated health system and health worker training policies and plans. The first step is to ensure that these goals are currently part of national or regional programming. If there has not been recent action on these goals, consider conducting a rapid baseline survey or literature review of country-level breastfeeding and complementary feeding practices, support activities, number and location of facilities previously designated, and status of those facilities to assess current standards of practice. (see the sample questionnaire for rapid assessment in Annex 2 of this Section 1.1.).

The concept of BFHI is no longer limited to the Ten Steps in maternities, but has been adapted to include many possibilities for expansion into other parts of the health system, including maternal care, paediatrics, health clinics, and physicians' offices, and into other sectors and venues such as community, commercial sector, and agricultural or educational systems. Baby-friendly care concepts derived from the Ten Steps can also be provided in tandem with other international initiatives, such as Community IMCI or HIV/AIDS/PMTCT programming.

The National Authority may decide to include some of these new components and emphases in developing a new, greater picture of Baby-friendly care in the local context. Some examples of these options are presented later in the Section 1.5: Expansion and Integration Possibilities.

Step 3:
Identify, designate or develop a BFHI Coordination Group (BCG).

Coordinating the BFHI designation process may or may not be considered to be additional role for the National Breastfeeding, Infant and Young Child Feeding, or Nutrition Authority. However, it is highly recommended that these be at least two separate groups, both recognized by the government, so that the National Authority might provide oversight for the activities of the other, and so that there is a place that a facility might seek recourse if there is any question concerning the designation process.

- *3A. Who selects the BFHI Coordination Group?*

The National Authority, whether located in the Ministry of Health, another Ministry, or as a government-sanctioned NGO, will assist the government in the designation of a BFHI Coordination Group and maintain oversight with intent to ensure ongoing quality assurance and a code of ethics. The national government may choose to designate this group, with confirmation by the National Authority, or vice versa.

- *3B. What are the roles of this Group?*

The BFHI Coordination Group (BCG) is responsible for coordinating the process and procedures for facility designation. The BCG itself may or may not carry out the assessments for designation, depending on the number of facilities in the country, the structure of the group, and the resources available. Alternatively, the BCG could serve to ensure that all BFH Designating Committees or Designating Processes continue to use standardized procedures (see Step 5).

The BCG is responsible for acquiring the BFH designation posters from the UNICEF supply catalogue or through locally developed image creation, and for having the BFHI designation plaques printed in the local language, with specified dates of designation and end of designation period. Specifications for the plaques are available from UNICEF or WHO representatives.

The BFH Designating Committees (BDCs) may be considered arms of the BCG. These committees are qualified by the BCG to carry out assessments and recommend facilities for Designation. “Designation” means the formal recognition by the BCG that there is conformity with the BFHI Hospital Assessment Criteria (see Section 1.2).

There are at least eight models for development of the BCG and the approach to assessment and credentialing/designating hospitals and maternities as “Baby-friendly”:

1. *Develop, legislate and regulate standards for health facilities that include the components of BFHI.* In this model, there would be no BCG aside from the oversight by the National Authority. Legislating BFHI will support sustainability; however, without activities to ensure the quality of the activity, this model could result in superficial activities alone. Therefore this model would require ongoing monitoring and enforcement regulations in the legislation.
2. *Incorporate Baby-friendly assessment criteria into national health facility credentialing board procedures that are national standards for all hospitals and maternities.* In some countries, such credentialing is under the auspices of the professional societies, in others a separate association is established to provide quality assurance. In this case, the national board would serve the function of the BCG, and regular re-credentialing would be sustained. This probably is the most cost-efficient option, however, technical oversight by the national authority may be necessary.

3. *Encourage a professional organization or professional network to include BFHI in its mandate*. For example, in Australia, the professional society of nurse-midwifery is the BCG and is responsible for assessments. This could be with or without government support. BFHI could, logically, be the responsibility of any health profession that serves mothers and newborns and could designate, with National Authority oversight. This model would appear to offer enhanced quality control; however, some professional societies do not have the structural or fiscal base to take on this task.
4. *Establish a system whereby facilities assess each other and help each other to achieve designation status.* This model reduces the burden and the costs for the central authority, in that there only need be spot checks as to ongoing status, and would lessen the load for the BDC. However, with this reduced direct oversight, there may be a risk of collusion or other biases.
5. *Allow one professional organisation or other NGO, independent of the National Authority, to take responsibility for designation.* This approach, similar to 3, above, without oversight, reduces the costs for governments and allows independence in assessment, but it may lead to breeches in quality assurance and may result in conflict of interest, e.g., if the NGO also provides and charges for training, charges for preparation for assessment, and charges for helping the facility to improve if they fail the assessment may be practicing with inherent conflict of interest. In some settings, charges for the assessments may be prohibitive for smaller facilities or those in poorer settings. This last option is currently functioning in many countries. If selected, there are modifications (6 and 7, below) that could provide checks and balances for this approach.
6. *Allow any interested professional organization or NGO to apply to the National Authority for the right to coordinate the designation process (BCG) or to serve as a designating committee (BDC).* One or more NGOs could be approved by the National Authority to create a network of BDCs or carry out the assessments and designations themselves, depending on the number of facilities and the capacity of the NGO. The National Authority would be the organization that oversees this and grants the designations. There is a possibility of competition between NGOs that could be minimized by regional responsibility and careful oversight (see 7 below).
7. *Allow any interested professional organization or NGO to apply to the National Authority for the right to coordinate the designation process (BCG) or to serve as a designating committee (BDC) for a specific region of the country.* This approach is similar to 5 and 6 above, however, it includes aspects of oversight while reducing the possibility of inappropriate competitive activities. This approach may present a greater administrative burden for the National Authority.
8. While not ideal, *UNICEF country offices may assist* this function for a very limited period of time until the National Authority and BCG are established.

Many other constructs are possible, but each should be examined for sustainability, cost containment and insurance of oversight or checks and balances to ensure ongoing quality.

Regardless of the approach selected, it is essential that all necessary measures are taken to avoid a) any compromise to the high standards required for BFHI accreditation and b) any conflict of interest. Particular care should be taken where the national authority has given the BFHI designation group responsibility for delivering or monitoring standards of clinical care, or for delivering general health professional education and/or for

providing specific breastfeeding training. The National Authority (as described above) is essential for oversight or quality and ethical considerations.

Step 4:
The National Authority:

a) ensures that the BFHI Coordinating Group fulfils its responsibility to provide, directly or indirectly through BFHI Designating Committees, the initial or ongoing assessments of facilities,
b) helps plan training and curriculum revision,
c) ensures that the national health information system includes a record of feeding status on all contacts with children under 2 years of age, and
d) develops and implements a monitoring and evaluation plan.

Note: if the BFHI program is ongoing, it may not be necessary to carry out all parts of this step, as there may be an existing record of current status, a roster of trainers and assessors, and a training plan ongoing, with curriculum revisions being enacted. However, the BFHI may not as yet include health information system updates to ensure that feeding status of all children is recorded.

- *4A. Ensuring that the BFHI Coordinating Group fulfils its responsibility to provide, directly or indirectly through BDCs, the initial or ongoing assessments of facilities*

Once the National Authority has developed the BCG, initial assessments of current status of the BFHs should be the next activity. No matter which model of BCG is instituted, initial assessments should be carried out by specially trained local or external assessors. Following the assessment or review of current status, establishing if there is a roster of individuals with expertise to serve as 1) local assessors, 2) trainers for each level of training, 3) curriculum specialists, and 4) health information system specialists, plans may be developed to engage these individuals in these tasks. If there is not a sufficient number of individuals with each of these skill areas, consider holding further trainings or sending individuals to regional or global training courses.

Current regional and global training courses can be accessed at: http://www.unicef.org/nutrition/index_events.html or at http://www.who.int or on the Nutrition Quarterly, last section, found in the right hand column of: http://www.unicef.org/nutrition/index_bigpicture.html.

The National Authority has the authority to modify or change the BCG as needed to maintain the function of ongoing assessment and designation.

- *4B. Helps plan training and curriculum revision*

Once the needs and the rosters are available, the needed curriculum revisions and trainings should be planned. Based on the assessed needs, a plan should be developed for carrying out the 20-hour course in every facility as well as for periodically conducting curricula updates. In addition, special training should be ensured for those health workers who will serve as the referral expert lactation consultants. The trainings should be carried out by individuals with appropriate training and skills. It is reasonable to develop a phased plan, so that those trained in one facility may support trainings in a near-by site. It is important that there be on-site ongoing training by supervisors, as well. Therefore, each BFH facility must have on staff individuals with significantly more training, such as a Certified Lactation Consultant or other certified specialists on this issue.

If BFHI assessors are available and facilities are ready, assessment may begin immediately without waiting for the training plans to be implemented. If there is an insufficient number to carry out assessments, all levels of training, and/or curricula reform, the plan should address these needs.

Even where few births take place in facilities, training may be necessary to create a standard of care and to ensure that all health care personnel are skilled in breastfeeding protection, promotion and support. In addition, consideration should be given to development of "Baby-friendly" community designation (see Section 1.5), or other national programme approaches to ensure support for early, exclusive and continued breastfeeding with age-appropriate complementary feeding. These efforts can be linked to facilities directly, or through health or social systems, to ensure consistency in messages and support approaches.

Phased work should begin immediately, with all training materials and curricula updates developed, and sufficient resources identified to complete this work in a timely manner.

In addition to BFHI materials, National Authorities should consider providing handbooks such as "Protecting Infant Health: A Health Workers' Guide to the International Code of Marketing of Breast-milk Substitutes", a basic breastfeeding support manual, and a summary of local regulations, law and policy.

- *4C. Ensuring that national health information system includes a record of feeding status on all contacts with children under 2 years old*

This new responsibility, developed to address the operational objectives of the Global Strategy and other programme needs, dealing with the Ministry of Health, academia, Ministry of Education, Ministry of Plan, and Demographics, depending on which has the responsibility for data collection. Existing health information systems should be amended to include the new growth standards of WHO, notation on feeding pattern at each contact with mothers and children under age 2, and regular planned review by health practitioners.

In addition, the National Authority should review the summaries of these records, as well as periodic surveys, to assess progress and area where programme adjustment may be necessary.

- *4D. Monitoring and evaluation plan*

The National Authority is responsible for keeping records and supporting the planning necessary to ensure that all facilities are encouraged or mandated to follow the BFHI criteria. In addition, this body will review all available data and ensure that analyses are carried out, in collaboration with Health information system directorate and national statistics offices, and the information used to improve programming and further the IYCF goals.

Step 5:
BFHI Coordination Group coordinates facility-level assessments, re-assessments and designation of "Baby-friendly" status.

"Baby-friendly" assessments and designations may begin as soon as the BCG, with or without BDCs, is established by the National Authority, and after the facilities carry out the self-assessment and consider themselves compliant with the "Ten Steps". Designations should be based on an assessment as per national guidelines and should be monitored, and, where necessary, probationary periods established. Once designation is achieved, the designation must be for a pre-set number of months or years, based on in-

country experience with duration of compliance. The date of designation, as well as the end date of the period of designation, must be posted on the designation plaque. If this is a new programme, it is suggested that designation not be for a period greater than 3 years.

If facilities fail to be in compliance when re-assessed, they will be allowed one additional opportunity to achieve the necessary standards. If facilities only fail on a few steps or *Global Criteria*, they can be retested just on these specific components. If the areas in which they lack compliance are major, a full "reassessment" should be scheduled. The second reassessment (either partial or full) will determine if the "Baby-friendly" designation must be removed, or if a new plaque, with the new date of obsolescence, will be granted.

Re-assessment is necessary prior to the date when designation will elapse. Records should be kept by the National Authority of the status of every maternity facility in the country, and every effort should be made to achieve 100% designation. [N.B. criteria and assessment tools have been adapted to allow for settings where there is a high incidence of HIV- positive mothers].

If a facility has 1) a designation that has expired, or 2) been observed/reported as having experienced deterioration of its adherence to the Ten Steps, the BCG, or the BDC as its agent, should arrange for a reassessment. The expiration dates should be kept on record by the BCG/BDC and arrangements should be initiated in a timely manner for re-assessment. Between assessments, if a health professional or other observer reports deterioration, the facility should be notified and asked for response. If the BCG/BDC finds the response inadequate, an interim visit can be arranged.

If a designation has expired or a facility is found to be non-compliant during the term of its designation, the National Authority should remove any designation plaques and remove this hospital from the list of those facilities that are designated as "Baby-friendly" until such time as re-assessment and restoration of status occurs. A probationary period may be granted, with a quality assessment team sent to work with the facility if needed, and then reassessment arranged, before resorting to removal of the plaque. These steps will depend in part on which model has been established by the National Authority for assessment.

In most case the National Authority is responsible for the formal presentation of the designation, but may assign this role to the BCG, which is responsible for acquiring the designation posters from the UNICEF supply catalogue and for having the designation plaques printed in the local language. Specifications for the plaques are available on the UNICEF intranet.

The BCG should develop a plan, to be approved by the National Authority, to ensure designation of all public and private facilities nation-wide, and re-designation of those facilities that have failed to maintain standards, and whose designation has been rescinded.

Section 1.1, Annex 1 presents a simplified table with the basic inputs and outputs for each of these 5 steps.

National Criteria for Baby-friendly Community Designation

In order to ensure community support, as outlined in Step 10 of the BFHI, there is a need to more actively involve the community in support of optimal IYCF. The concept of "Baby-friendly Communities" emerged from the recognition that Step 10 was the least likely to be fully effective in practice. In some countries, there are established criteria for Baby-friendly Community Health Services. This approach is applicable where not all of the population has ready access to facilities, and may work best where community services fully reach all mothers and children.

In settings where the health system outreach may not be as comprehensive, a national effort to create Baby-friendly Communities may be necessary to achieve optimal feeding practices. The Model National Baby-friendly Community components presented here are provided as a basis for discussion with the community concerning its needs, reflecting on all applicable Global Criteria for the BFHI (the Ten Steps, the Code, mother-friendly care, and HIV and infant feeding). Locally developed criteria should be developed with the participation of community political and social leadership, both male and female, committed to making a change in support of optimal IYCF, and of all health facilities that are designated "Baby-friendly" and actively support both early and exclusive breastfeeding (0-6 months).

Baby-friendly Community planning might include:

1. community leadership;
2. representatives of healthcare facilities, especially those that are baby-friendly;
3. those who support in-home and community-based births.

Baby-friendly Community criteria might include:

1. All local health workers have appropriate breastfeeding support and maternity support training.
2. All workers know where and how to refer for additional care.
3. Support for mothers is available in the community to assist mothers in making appropriate choices and succeeding with them.
4. Mother-to-mother support system, or similar, is in place.
5. No practices, distributors, shops or services violate the International Code (as applicable) in the community.
6. Local government or civil society has convened, created and supports implementation of at least one political or social normative change and/or additional activity to support mothers and families.

It is also suggested that simplified job-aids for assisting and for assessing home deliveries (including those performed by skilled midwives and, if possible, traditional birth attendants) have been developed and are in use.

More detail on the development of the Baby-friendly Community approach, other expansion and mainstreaming approaches are available in Section 1.5.

Section 1.1 - Annex 1: Five Steps in Implementing BFHI at the Country Level: Suggested Inputs and Outputs

Step	Inputs	Outputs
1. Establish, re-energize, or plan a meeting of the National Authority (Breastfeeding, Infant and Young Child Feeding, or Nutrition Authority) to establish or assess its functions related to BFHI.	Government commitment to the Global Strategy for Infant and Young Child Feeding, including BFHI evidenced by willingness to incorporate support into national budget or national accrediting approach. Review of existing data on breastfeeding, and BFHI if already established, completed. (if data are not available), rapid baseline survey(s) of country-level breastfeeding practices, support, and status using short questionnaire or WHO implementation planning tool carried out and analysed.	Government supported or endorsed National Authority established, with commitment to developing/ strengthening BFHI. Analysis of current status on IYCF and BFHI completed, with listing of all national facilities and their BFHI status.
2. Identify - or re-establish - national BFHI goals and approaches.	Necessary meetings and functions convened by National Authority to identify national goals, specific and measurable objectives and indicators, and possible expansion/integration approaches to BFHI in the local context.	Five-year strategic plan with budget for the National Authority and BFHI-associated activities created.
3. Identify, designate or develop a BFHI Coordination Group (BCG), and, where appropriate, BFHI Designating Committees (BDCs).	Most appropriate BCG option identified by the National Authority for their setting and resources based on the decisions concerning BFHI and possible expansions areas. The BCG plan of action in response to the 5-year strategic plan presented to the National Authority for approval and support.	A sustainable approach has been selected. BCG and/or procedures and processes for designation that might include BDCs established and approved by National Authority and recognized by government. BCG activated.
4. Ensure: 1) that the BCG fulfils its responsibility to provide, directly or indirectly, the initial or ongoing assessments of facilities, 2) development of a plan for pre-and in-service curricula revision (if needed) and BFHI training, 3) that national health information system includes a record of feeding status on all contacts with children under 2 years of age, and 4) monitoring and evaluation plan.	Regular reports provided by BCG to the National Authority. Meetings/functions as necessary to review content of curricula of all health workers and auxiliary workers, convened by National Authority. Support for curricula revision identified, with National Authority assistance as necessary. Coverage and analyses discussed/ensured through meetings of the National Authority with Health information system directorate and national statistics offices.	Feedback is provided by the National Authority to the BCG, and to Government and civil society. Training and curricula are updated. HIS records of feeding pattern and growth for all children under age 2+ are available and analysed. Periodic surveys on feeding patterns are conducted. Analyses carried out to identify programme adjustments necessary.
5. Coordinate facility-level assessments, re-assessments and designation of “Baby-friendly” status.	BCG instituted plan of action, including the training of BDCs if determined necessary to meet national goals, with assistance as needed from National Authority.	BCG form and function, including the possibility of subsidiary BDC, is finalised and functioning. Facilities, communities, etc. are assessed and designations made in accordance with plan. Plan reviewed regularly for feasibility and adaptation if needed.

Section 1.1 - Annex 2

Suggested questions for a rapid baseline country assessment, to include literature review and key informant interviews

Where there is already an active National Authority or BFHI programme, ensure that data are available to fully answer:

1. What is the status of BFHI?
   How is assessment carried out?
   What group grants the designation?
   How is it funded?
   Is there any potential conflict of interest in its functions?
   How many and what percent of hospitals have ever been designated?
   What percentage of births take place in facilities currently designated as Baby Friendly?
   How many of these have been assessed or re-assessed in the last 3-5 years and found to be in compliance?
   What percentage of facilities continues to be in compliance?
2. Is there a list of the names and locations of all maternities, hospital-based or free-standing, in the country?
3. Is there a list of the names, locations, and contact individuals of all BFH-designated facilities, with date of initial designation and dates of re-assessments/re-designations?
4. What are the names and addresses of trained external assessors and BFHI trainers, as well as other national expertise, such as Certified Lactation Consultants or Fellows of the Academy of Breastfeeding Medicine?
5. What is the current status and enforcement of law related to the International Code of Marketing of Breast-milk Substitutes?
6. What are the current standards of practice promulgated by professional medical and healthcare organizations?
7. What are the trends and levels of immediate postpartum breastfeeding? Exclusive breastfeeding in the first 6 months? Continued breastfeeding at about 2 years?
8. What are the local complementary feeding practices? Have the 10 Principles of Complementary Feeding been adopted/initiated?
9. What are the names, descriptions and contacts for all IYCF-supportive programmes in country, including HIV/IF counselling, emergency preparedness agencies, extension workers in the agricultural or social arenas, etc.?
10. What additional related services and structures could help support IYCF?

Where there is not as yet an active BFHI programme, gather current baseline information.

Suggested approach: Interview 25 key informants, selected from among knowledgeable individuals in both public and private health sectors, non-governmental infant and young child feeding support, or other persons familiar with hospital activities, and request copies of any standards of practice, curricula, lists, laws or contacts mentioned.

1. Have any studies been carried out on feeding practices of infants and young children, whether by nutrition, health, reproductive health or other interest groups?
2. Have any surveys or other data collection instruments been used to assess:
   - immediate postpartum breastfeeding rates,
   - six months exclusive breastfeeding rates,
   - and/or
   - continued breastfeeding with complementary feeding?
   - are there any trend data for any of these patterns?
3. Are there government policies or laws that pertain to infant and young child feeding?
   - for hospitals/maternities?
   - for the commercial sector? Is there a national law implementing the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions?
   - for the workplace?
   - for emergencies?
   - for HIV/AIDS?
4. What training courses or curricula exist to train:
   - health workers in the “Breastfeeding Promotion and Support in a BFHI hospital” (20-hour course)?
   - trainers for facilitating the 20-hour course?
   - specialists in lactation support to act as referral/resource people?
   - assessors or credentialing boards?
   - health workers trained in "Infant and Young Child Feeding Counselling: an integrated course"?
   - other? Specify.
5. Do you know of any Academic Centres involved in supporting Infant and Young Child Feeding? (list all with contacts).
   Please explain whether this is training, research, and/or support of staff to breastfeed.
6. What Professional Societies are active in the area of Infant and Young Child Feeding and who are the contacts? Do they have standards of practice for their specialty?
7. What group certifies hospitals and maternities?
8. Do you know of any NGOs involved in supporting Infant and Young Child Feeding? (list all with contacts)

9. Do you know of any government, NGO or community entities involved in supporting and/or monitoring:
   - Infant and Young Child Feeding related activities?
   - BFHI?
   - International Code of Marketing of Breast-milk Substitutes?
   - Any other issue that relates to mothers or children, whether health, social, or other sector?
10. Do you know of any data bases that are maintained regularly on any aspect of IYCF? (list all with contacts).
11. Do you know any individuals, or rosters of individuals, with:
    - Experience of conducting BFHI assessments?
    - Specialist training and experience dealing with unusual or difficult breastfeeding situations?
    - Training in breastfeeding support skills?
    - Training in providing support for infant feeding in the context of HIV and support for the non-breastfed infant?
    - Training on Code-related issues such as development of legislation of the Code, monitoring and enforcement?
    - Training in emergency settings, including relactation and therapeutic feeding?
    - Experience in facilitating training in breastfeeding for health workers?

    (develop lists).
12. What resources are available to support BFHI? From what sources? Is this support sustainable?
13. Are there additional breastfeeding support activities in other health/nutrition /social/development programming?
14. Do you know of any government agency(ies) or individuals who are interested in supporting IYCF?

Section 1.1 - Annex 3

Excerpts from recent WHO, UNICEF, and other global publications and releases

Occasionally, those implementing BFHI in a country may need to call upon excerpts from globally recognized sources to support their actions and plans. This section is provided to address this need.

From UNICEF Press Release, September 2007

> "Much of the progress reflected [reduction in number of child deaths from 13 million in 1990 to 9.7 million] is due to widespread adoption of basic health interventions such as early and exclusive breastfeeding…"
>
> http://www.unicef.org/childsurvival/index_40850.html

From WHO Statement on Infant Feeding and HIV

> "Exclusive breastfeeding for 6 months is recommended for all women, and for HIV-infected women unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), in which case all breastfeeding should be avoided and infants should receive replacement feeding from birth".
>
> "After 6 months, breastfeeding should be continued unless AFASS replacement feeding is available".

From Innocenti +15

> "Current challenges only reinforce the need to act rapidly in support of infant and young child feeding".
>
> "Scientific evidence, the Global Strategy for Infant and Young Child Feeding, and demonstrated results from national and other large-scale programmes provide a sound foundation for moving forward. This requires government and donor commitment to: Increase resources for infant and young child feeding....Implement the Global Strategy for Infant and Young Child Feeding [and] Apply existing knowledge and experience".
>
> "Exclusive breastfeeding is the leading preventive child survival intervention. Nearly two million lives could be saved each year through six months of exclusive breastfeeding and continued breastfeeding with appropriate complementary feeding for up to two years or longer. The lasting impact of improved feeding practices is healthy children who can achieve their full potential for growth and development".
>
> "New scientific evidence and programmatic experience place child advocates in a better position now than in 1990 to protect, promote, and support improved infant and young child feeding practices. Yet the majority of health professionals and community workers have not been adequately educated or trained to put the knowledge and skills into practice. Appropriate materials and guidelines exist and should urgently be taken to scale for pre-service and in-service training and for

policy and program assessment, implementation, and monitoring. As forcefully stated by the executive heads of WHO and UNICEF in their forward to the Global Strategy for Infant and Young Child Feeding, There can be no delay in applying the accumulated knowledge and experience to help make our world a truly fit environment where all children can thrive and achieve their full potential".

From UNICEF Executive Director Ann M Veneman for World Breastfeeding Week, 2005:

"If we are to fulfill the promise of the Millennium Declaration and the Millennium Development Goals, we must renew our attention to those interventions that are effective, affordable and have significant impact. Improvements in breastfeeding and complementary feeding are essential for success in child survival, in reducing hunger, and to ensure that children develop in a manner that they may best benefit from education and opportunity".

"UNICEF applauds the commitment of all of those involved in support of child survival through optimal infant and young child feeding in the celebration of this year's World Breastfeeding Week".

From "Investing in Development: Practical Plan to Achieve the Millennium Development Goals". 2005, Millennium Project, New York, p. 26 "The Quick Wins needed to be embedded in the longer term investment policy framework of the MDG-based poverty reduction strategy".

"[In the design of] community nutrition programs that support breastfeeding, provide access to locally produced complementary foods, and, where needed, provide micronutrient…supplementation for pregnant and lactating women…".

From World Health Assembly 2004:

From: Global strategy on diet, physical activity and health A57/9 and WHA 57/17:

"11. Maternal health and nutrition before and during pregnancy, and early infant nutrition may be important in the prevention of non-communicable diseases throughout the life course. Exclusive breastfeeding for six months and appropriate complementary feeding contribute to optimal physical growth and mental development".

From: Family and health in the context of the tenth anniversary of the International Year of the Family A57/12:

"6. Almost 50% of all infant deaths in developing countries occur in the first 28 days after birth. As most infants in these countries are born at home, improvements in facility-based services will address only part of the problem and must be complemented by interventions in the home and community. A few simple interventions, such as aiding birth with skilled attendants, keeping the neonate warm, initiating breastfeeding early and recognizing and treating common infections, will greatly increase chances of neonatal survival".

From A57/18 Biennial Updates:
E. Infant and Young Child Nutrition: Biennial Progress Report 48.

"Despite overall improvements in exclusive breastfeeding …, practices fall far short of WHO's global public health recommendation: exclusive breastfeeding for six months followed by safe and appropriate complementary feeding with continued breastfeeding for up to two years of age or beyond (resolution WHA54.2)".

Fifty-Seventh World Health Assembly WHA57.14, Agenda item 12.1 22 May 2004:

"Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS
2. URGES Member States, as a matter of priority: (3) to pursue policies and practices that promote:
(h) integration of nutrition into a comprehensive response to HIV/AIDS;
(i) promotion of breastfeeding in the light of the United Nations Framework for Priority Action on HIV and Infant Feeding and the new WHO/UNICEF Guidelines for Policy-Makers and Health-Care Managers".

Section 1.1 - Annex 4
The contribution of Breastfeeding and Complementary Feeding to achieving the Millennium Development Goals[4]

Goal Number and Targets		Contribution of Infant and Young Child feeding[5]
1	**Eradicate extreme poverty and hunger** Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day, and who suffer from hunger.	Breastfeeding significantly reduces early childhood feeding costs, and exclusive breastfeeding halves the cost of breastfeeding[6]. Exclusive breastfeeding and continued breastfeeding for two years is associated with reduction in underweight[7] and is an excellent source of high quality calories for energy. By reducing fertility, exclusive breastfeeding reduces reproductive stress. Breastfeeding provides breast milk, serving as low-cost, high quality, locally produced food and sustainable food security for the child.
2	**Achieve universal primary education** Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education.	Breastfeeding and adequate complementary feeding are prerequisites for readiness to learn[8]. Breastfeeding and quality complementary foods significantly contribute to cognitive development and capacity. In addition to the balance of long chain fatty acids in breast milk, which support neurological development, initial exclusive breastfeeding and complementary feeding address micronutrient and iron deficiency needs and, hence, support appropriate neurological development and enhance later school performance.
3	**Promote gender equality and empower women** Eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015.	Breastfeeding is the great equalizer, giving every child a fair start on life. Most differences in growth between sexes begin as complementary foods are added into the diet, and gender preference begins to act on feeding decisions. Breastfeeding also empowers women: - increased birth spacing secondary to breastfeeding helps prevents maternal depletion from short birth intervals; - only women can provide it, enhancing women's capacity to feed children; - increases focus on need for women's nutrition to be considered.

[4] Developed by the UN Standing Committee on Nutrition Working Group on Breastfeeding and Complementary Feeding, 2003/4.
[5] Early and Exclusive Breastfeeding, continued breastfeeding with complementary feeding and related maternal nutrition.
[6] Bhatnagar, S, Jain, N. P. and Tiwari, V. K. Cost of infant feeding in exclusive and partially breastfed infants. *Indian Pediatrics.* 1996; 33:655-658.
[7] Dewey, K. G. Cross-cultural patterns of growth and nutritional status of breast-fed infants. *Am. J. Clin. Nutr*. 1998; 67:10-17.
[8] Anderson, J. W., Johnstone, B. M. and Remley, D. T. Breast-feeding and cognitive development: a meta-analysis. *Am. J. Clin. Nutr.* 1990; 70:525-535.

4	**Reduce child mortality** Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	By reducing infectious disease incidence and severity, breastfeeding could readily reduce child mortality by about 13%, and improved complementary feeding would reduce child mortality by about 6%.[9] In addition, about 50-60% of under-5 mortality is caused by mal-nutrition due to inadequate complementary foods and feeding following on poor breastfeeding practices[10] and, also, to low birth weight. The impact is increased in unhygienic settings. The micronutrient content of breast milk, especially during exclusive breastfeeding, and from complementary feeding can provide essential micronutrients in adequate quantities, as well as necessary levels of protein and carbohydrates.
5	**Improve maternal health** Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.	The activities called for in the Global Strategy include increased attention to support for the mother's nutritional and social needs. In addition, breastfeeding is associated with decreased maternal postpartum blood loss, breast cancer, ovarian cancer, and endometrial cancer, as well as the probability of decreased bone loss post-menopause. Breastfeeding also contributes to the duration of birth intervals, reducing maternal risks of pregnancy too close together, including lessening risk of maternal nutritional depletion from repeated, closely-spaced pregnancies. Breastfeeding promotes return of the mother's body to pre-pregnancy status, including more rapid involution of the uterus and postpartum weight loss (obesity prevention).
6	**Combat HIV/AIDS, malaria and other diseases** Have halted by 2015 and begun to reverse the spread of HIV/AIDS.	Based on extrapolation from the published literature on the impact of exclusive breastfeeding on MTCT, exclusive breastfeeding in a population of untested breastfeeding HIV-infected population could be associated with a significant and measurable reduction in MTCT.
7	**Ensure environmental sustainability**	Breastfeeding is associated with decreased milk industry waste, pharmaceutical waste, plastics and aluminium tin waste, and decreased use of firewood/fossil fuels for alternative feeding preparation,[11] less CO_2 emission as a result of fossil fuels, and less emissions from transport vehicles as breast milk is locally produced.
8	**Develop a global partnership for development**	The Global Strategy for Infant and Young Child Feeding fosters multi-sectoral collaboration, and can build upon the extant partnerships for support of development through breastfeeding and complementary feeding. In terms of future economic productivity, optimal infant feeding has major implications.

[9] Jones, G. et al. How many child deaths can we prevent this year? *Lancet* 2003; 362:65-71.
[10] Pelletier D.Frongillo, E. Changes in child survival are strongly associated with changes in malnutrition in developing countries. *Journal of Nutrition*. 2003;133:107-119.
[11] Labbok M. Breastfeeding as a women's issue: conclusions and consensus, complementary concerns, and next actions. *International Journal of Gynecology Obstetrics* 1994; 47(Suppl):S55-S61.

SECTION 1.2
HOSPITAL LEVEL IMPLEMENTATION

Breastfeeding rates

The Baby-friendly Hospital Initiative (BFHI) seeks to provide mothers and babies with a good start for breastfeeding, increasing the likelihood that babies will be breastfed exclusively for the first six months and then given appropriate complementary foods while breastfeeding continues for two years or beyond.

For purposes of assessing a maternity facility, the number of women breastfeeding exclusively from birth to discharge may serve as an approximate indicator of whether protection, promotion, and support for breastfeeding are adequate in that facility. The maternity facility's annual statistics should indicate that at least 75% of the mothers who delivered in the past year are either exclusively breastfeeding or exclusively feeding their babies human milk from birth to discharge or, if not, this is because of acceptable medical reasons. (in settings where HIV status is known, if mothers have made fully informed decisions to replacement feed, these can be considered "acceptable medical reasons", and thus counted towards the 75% exclusive breastfeeding goal). If fewer than 75% of women who deliver in a facility are breastfeeding exclusively from birth to discharge, the managers and staff may wish to study the results from the *Self Appraisal*, consider the *Global Criteria* carefully, and work, through the Triple A process of assessment, analysis, and action, to increase their exclusive breastfeeding rates. Once the 75% exclusive breastfeeding goal has been achieved, an external assessment visit should be arranged.

The BFHI cannot guarantee that women who start out breastfeeding exclusively will continue to do so for the recommended 6 months. However, research studies have shown that delay in initiation of breastfeeding and early supplemental feeding in hospital are associated with less exclusive breastfeeding thereafter. By establishing a pattern of exclusive breastfeeding during the maternity stay, hospitals are taking an essential step towards longer durations of exclusive breastfeeding after discharge.

If hospital staff believes that antenatal care provided elsewhere contributes to rates of less than 75% breastfeeding after the birth, or that community practices need to be more supportive of breastfeeding, they may consider how to work with the antenatal caregivers to improve antenatal education on breastfeeding and with breastfeeding advocates to improve community practices (see Section 1.5 for a discussion of strategies for fostering Baby-friendly Communities).

Supplies of breast-milk substitutes

Research has provided evidence that clearly shows that breast-milk substitute marketing practices influence health workers' and mothers' behaviours related to infant feeding. Marketing practices prohibited by *The International Code of Marketing of Breast-milk Substitutes* (the *Code)* have been shown to be harmful to infants, increasing the likelihood that they will be given formula and other items under the scope of *The Code* and decreasing optimal feeding practices. The 1991 UNICEF Executive Board called for the ending of free and low-cost supplies of formula to all hospitals and maternity wards by the end of 1992. Compliance with *The Code* is required for health facilities to achieve Baby-friendly status.

Questions have been added to the *Self-Appraisal Tool* that will help the national BFHI coordination groups and maternity facilities determine how well their maternity services are complying with *The Code* and subsequent WHA resolutions and what actions are needed to achieve full compliance.

Support for non-breastfeeding mothers

This revised version of the assessment includes specific questions related to the training staff has received on providing support for "non-breastfeeding mothers" and what actual support these mothers have received. The inclusion of these questions does NOT mean that the BFHI is promoting formula feeding but, rather, that the Initiative wants to help insure that ALL mothers, regardless of feeding method, get the feeding support they need.

Mother-friendly care

New *Global Criteria* and questions have been added to insure that practices are in place for mother-friendly labour and delivery. These practices are important, in their own right, for the physical and psychological health of the mothers themselves, and also have been shown to enhance infants' start in life, including breastfeeding. Many countries have explored options for including mother-friendly criteria within the Initiative, in some cases re-terming their national initiatives as "mother and baby friendly". Other countries have adopted full "mother-friendly" initiatives. New self-appraisal and assessment questions on this topic offer a way for countries that have not done so already to add a component focused on the key "mother-friendly" criteria needed for an optimal "continuum of care" for both mother and child from the antenatal to postpartum period.[12] These criteria should be required only after health facilities have had time to train their staff on policies and practices related to mother-friendly care.

HIV and infant feeding

The increasing prevalence of HIV among women of childbearing age in many countries has made it important to give guidance on how to offer appropriate information and support for women related to HIV within the BFHI. Thus, as mentioned earlier, components on HIV and infant feeding have been added to the *20-hour course* and to the *Global Criteria* and assessment tools.

The course material aims to raise the awareness of participants as to why BFHI continues to be important in areas of high HIV prevalence and ways to assist mothers who are HIV-positive as part of regular care in the health facility. This 20-hour course does not train participants to counsel women who are HIV-positive on infant feeding decisions. Another course and counselling aids are available from WHO for that specialized training and counselling.

It is recommended that the BFHI national authorities and coordination groups in each country work with other relevant national decision-makers to determine whether the HIV components of the assessment will be required and whether this requirement will be for all facilities or only those meeting specified criteria. The decision should be based on the prevalence of HIV among pregnant women and mothers and, therefore, the need for information and support on this issue. If this information is not available, surveys

[12] See the website for the Coalition for Improving Maternity Services (CIMS) http://www.motherfriendly.org/MFCI/ for a description of *The Mother-Friendly Childbirth Initiative.*

may be necessary to determine what percentages of pregnant women and mothers using the antenatal and delivery services in maternity facilities are HIV positive. It is suggested that if a maternity facility has a prevalence of more than 20% HIV positive clients, and/or has a PMTCT[13] programme, this component of the assessment should be required. If prevalence is over 10%, the use of this component is strongly advised. National decision-makers in countries with high HIV prevalence may decide to include additional HIV-related criteria and questions, depending on their needs.

The *Global Criteria*, *Self-Appraisal Tool* and *Hospital External Assessment Tool* all have HIV-related items added in such a way that they can be included or not, depending on the need. The HIV and Infant Feeding criteria are listed separately in the *Global Criteria*. The questions related to HIV in both the *Self-Appraisal* and the various interviews in the *Assessment Tool* are either presented in separate sections or at the end of the respective interviews. There is a separate Summary Sheet in the *Assessment Tool* to display the HIV-related results.

A handout that provides guidance for "Applying the Ten Steps in facilities with high HIV prevalence" is attached as Annex 1 of Section 1.2.

The Baby-friendly Hospital designation process

The BFHI is initiated at national level, with the BFHI national authority and coordination group, UNICEF, WHO, breastfeeding, nutrition and other health groups, and others interested parties as catalysts. The *Global Criteria* and *Self-Appraisal Tool* are available to all who are interested in accessing it on the UNICEF website. UNICEF and WHO will encourage the national authorities and BFHI coordination groups to access it and encourage health facilities to join or continue to participate in the Initiative. For details on country level implementation, please read Section 1.1 of this document.

At the facility level the assessment and designation process includes a number of steps, with facilities following differing paths, depending on the outcomes at various stages of the process. Once a facility has used the *Self-Appraisal Tool* to conduct a "self assessment" of whether it meets baby-friendly standards and has studied the *Global Criteria* to determine whether an external assessment is likely to give the same results, it will decide whether or not it is ready for external assessment.

If the facility determines that it is ready for external assessment in some countries the next step would be an optional or required pre-assessment visit during which an outside consultant explores the readiness of the hospital for a full assessment, using the *Self-Appraisal Tool* and *Global Criteria*. This could be done through an on site visit or by means of an extensive telephone interview/survey, if travel costs are prohibitive. This can be a quite useful intermediate step, as many hospitals overrate their compliance with the *Global Criteria* and this type of visit, followed by working on any further improvements needed, can save a lot of time, money, and anguish both for the hospital and the national BFHI coordination group.

If a facility has used the *Self-Appraisal Tool*, studied the *Global Criteria*, and received feedback during a pre-assessment visit or telephone interview, if scheduled, and determined that it does <u>not</u> yet meet the BFHI standards and recognizes its need for improvement, it should analyse its deficiencies and develop plans to address them. This may include scheduling the 20-hour course (presented in Section 3 of these BFHI

[13] Prevention of mother-to-child-transmission (of HIV/AIDS).

materials) for its maternity staff, if this training has not been given or was conducted very long ago.

The facility may also request a *Certificate of Commitment* while it is working to become baby-friendly, if the BFHI coordination group supplies this for facilities at this stage of the process. When it is ready, the facility should then request an external assessment, following the process described in the paragraph above.

The next step, as mentioned above, would be for a facility to request or invite an external assessment. The BFHI coordination group may review the *Self Appraisal* results, any supporting documents that it requires, and the results from a pre-assessment visit or telephone interview, if one has been made, to help determine if the facility is ready. The external assessment will determine whether the facility meets the *Global Criteria for a Baby-friendly Hospital*. If so, the BFHI coordination group should award the facility the Global BFH Award and Plaque for a specified period.

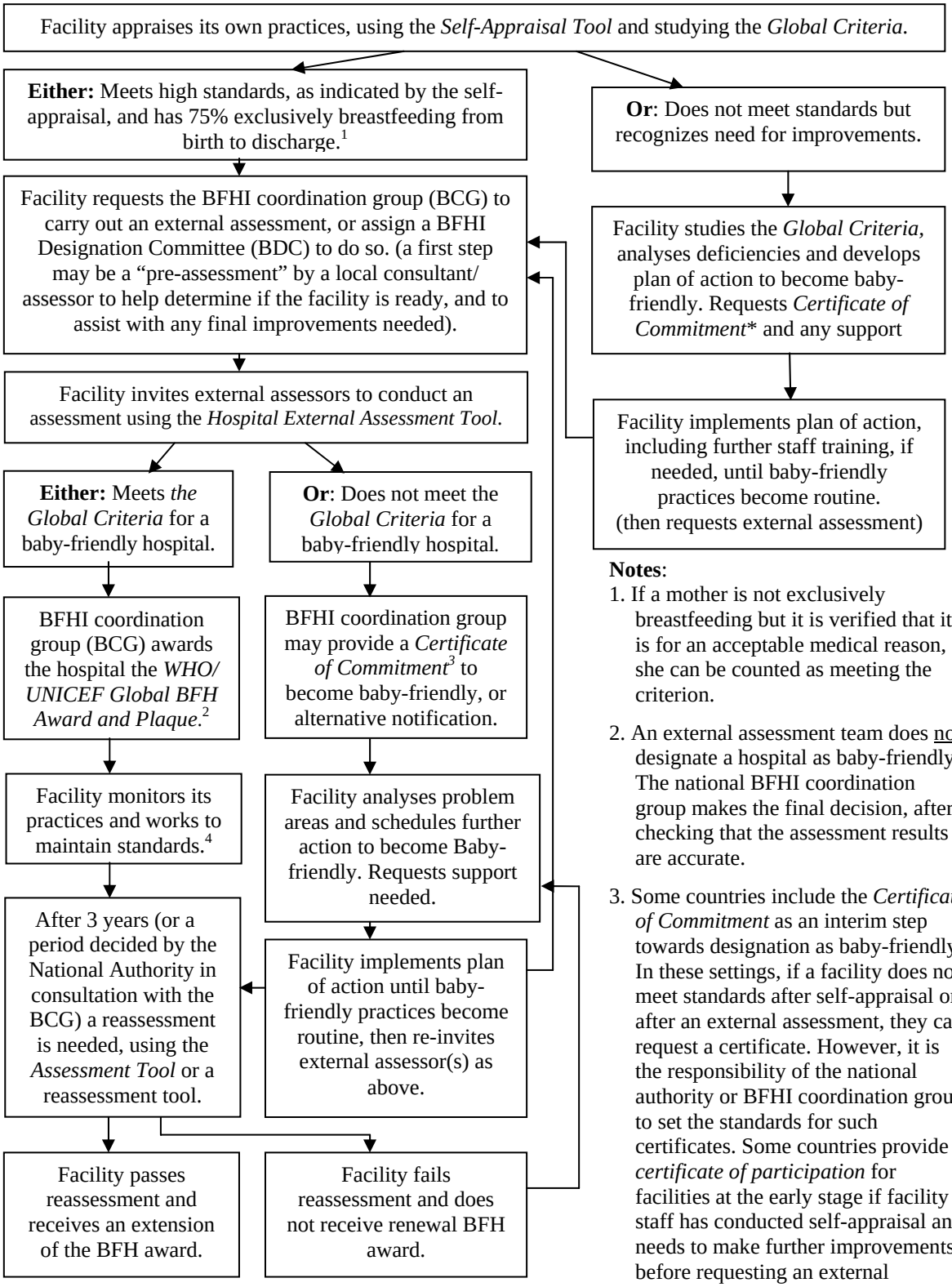
If the facility, on the other hand, does not meet the *Global Criteria*, it would be awarded a *Certificate of Commitment* to becoming baby-friendly and would be encouraged or supported to further analyse problem areas and take whatever actions are needed to comply, then inviting another assessment. Whether this second assessment would be a full one, or only partial, focusing on those criteria on which the facility did not originally comply, would depend on the decision made by the assessors and BFHI coordination group at the time of the original assessment.

If the national BFHI coordination group finds that hospitals that have been assessed as failing at times do not agree with the conclusions reached by the assessors, it might consider setting up an appeal process, when necessary, with a review of results by panels of assessors not involved in the original assessments.

Reassessments should be scheduled for baby-friendly hospitals, after the specified period for the Award. If the facility passes the reassessment, it should be given a renewal. If not, it needs to work to address any identified problems and then apply again for reassessment.

This process is illustrated in graphic form in the flow chart on the following page.

THE BABY-FRIENDLY HOSPITAL DESIGNATION PROCESS



Notes:

1. If a mother is not exclusively breastfeeding but it is verified that it is for an acceptable medical reason, she can be counted as meeting the criterion.
2. An external assessment team does <u>not</u> designate a hospital as baby-friendly. The national BFHI coordination group makes the final decision, after checking that the assessment results are accurate.
3. Some countries include the *Certificate of Commitment* as an interim step towards designation as baby-friendly. In these settings, if a facility does not meet standards after self-appraisal or after an external assessment, they can request a certificate. However, it is the responsibility of the national authority or BFHI coordination group to set the standards for such certificates. Some countries provide a *certificate of participation* for facilities at the early stage if facility staff has conducted self-appraisal and needs to make further improvements before requesting an external assessment.
4. A facility that attains baby-friendly status may consider immediate action to expand the Global Criteria based on needs of the community.

Section 1.2: Annex 1

Applying the Ten Steps in facilities settings with high HIV prevalence[14]

The "Ten Steps" for Successful Breastfeeding	Guidance on applying the "Ten Steps" in facilities with high HIV prevalence
Step 1: Have a written policy on breastfeeding that is routinely communicated to all health care staff.	Expand the policy to focus on infant feeding, including guidance on the provision of support for HIV positive mothers and their infants.
Step 2: Train all health care staff in skills necessary to implement this policy.	Ensure that the training includes information on infant feeding options for HIV-positive women and how to support them.
Step 3: Inform all pregnant women about the benefits and management of breastfeeding.	Where voluntary testing and counselling for HIV and PTMCT is available, counsel all pregnant women on the benefits of knowing their HIV status so that, if they are positive, they can make informed decisions about infant feeding, considering the risks and benefits of various options. Counsel HIV-positive mothers on the various feeding options available to them and how to select options that are acceptable, feasible, affordable, sustainable and safe**.** Promote breastfeeding for women who are HIV negative or of unknown status.
Step 4: Help mothers initiate breastfeeding within a half-hour of birth.	Place all babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers who have chosen to breastfeed to recognize when their babies are ready to breastfeed, offering help if needed. Offer mothers who are HIV positive and have chosen not to breastfeed help in keeping their infants from accessing their breasts.
Step 5: Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.	Show mothers who have chosen to replacement feed how to prepare and give other feeds, as well as how to maintain optimal feeding practices and dry up their breast milk while maintaining breast health.

[14] The application of the Steps for facilities with high HIV prevalence provided in this handout has been developed to provide additional guidance for health care managers and staff working in these settings. Guidance has been prepared, taking account of the: *Report of a meeting on BFHI in the context of HIV/AIDS, Gaborone, June 2nd – 4th 2003,* sample infant feeding policies for settings with high HIV prevalence, and the Consensus Statement for the WHO HIV and Infant Feeding Technical Consultation, Geneva, October 25-27, 2006.

The "Ten Steps" for Successful Breastfeeding	Guidance on applying the "Ten Steps" in facilities with high HIV prevalence
Step 6: Give newborn infants no food or drink other than breast milk, unless medically indicated.	Counsel HIV positive mothers on the importance of feeding their babies exclusively by the option they have chosen (breastfeeding or replacement feeding) and the risks of mixed feeding (that is, giving both the breast and replacement feeds).
Step 7: Practise rooming-in — allow mothers and infants to remain together — 24 hours a day.	Protect the privacy and confidentiality of mother' HIV status by providing the same routine care to all mothers and babies, including rooming-in.
Step 8: Encourage breastfeeding on demand.	Address the individual needs of mothers and infants who are not breastfeeding, encouraging replacement feeding at least 8 times a day.
Step 9: Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.	Apply this step for both breastfeeding and non-breastfeeding infants.
Step 10: Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.	Provide on-going support from the hospital or clinic and foster community support for HIV positive mothers to help them maintain the feeding method of their choice and avoid mixed feeding. Offer infant feeding counselling and support, particularly at key points when feeding decisions may be reconsidered, such as the time of early infant diagnosis and at six months of age. If HIV positive mothers are breastfeeding, counsel them to exclusively breastfeed for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.

SECTION 1.3
THE GLOBAL CRITERIA FOR THE BFHI

Criteria for the 10 Steps and other components

The Global Criteria for the Baby-friendly Hospital Initiative serve as the standard for measuring adherence to each of the Ten Steps for Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes. The criteria listed below for each of the Ten Steps and the Code are the minimum global criteria for baby-friendly designation. Additional criteria are provided for ”mother-friendly care” and “HIV and infant feeding”. It is recommended that the criteria for “mother-friendly care” be implemented gradually, after maternity staff has received necessary training on this topic. Relevant decision-makers in each country should decide whether the criteria on HIV and infant feeding should be required, depending on the prevalence of HIV among women using the maternity facilities.

The BFHI Self-Appraisal Tool, presented in Section 4 of this series, gives maternity facilities a tool for making a preliminary assessment of whether they are fully implementing the Ten Steps, adhering to the International Code of Marketing, and meeting criteria related to mother-friendly care and HIV and infant feeding. The Global Criteria actually describe how “baby-friendliness” will be judged during the external assessment, and thus can be very useful for maternity staff to study as they work to get ready for assessment. The Global Criteria are listed both here and after the respective sections of the Self Appraisal Tool, for easy reference during self-appraisal.

It is important that the hospital consider adding the collection of statistics on infant feeding and implementation of the Ten Steps into its maternity record-keeping system, if it has not done so already. It is best if this data collection process be integrated into whatever information gathering system is already in place. If the hospital needs guidance on how to gather this data and possible forms to use, responsible staff can refer to the sample data-gathering tools available in Section 4.2: Guidelines and Tools for Monitoring BFHI.

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

Global Criteria - Step One

The health facility has a written breastfeeding or infant feeding policy that addresses all 10 Steps and protects breastfeeding by adhering to the International Code of Marketing of Breast-milk Substitutes. It also requires that HIV-positive mothers receive counselling on infant feeding and guidance on selecting options likely to be suitable for their situations. The policy should include guidance for how each of the "Ten Steps" and other components should be implemented (see Section 4.1, Annex 1 for suggestions).

The policy is available so that all staff members who take care of mothers and babies can refer to it. Summaries of the policy covering, at minimum, the Ten Steps, the Code and subsequent WHA Resolutions, and support for HIV-positive mothers, are visibly posted in all areas of the health care facility which serve pregnant women, mothers, infants, and/or children. These areas include the labour and delivery area, antenatal care in-patient wards and clinic/consultation rooms, post partum wards and rooms, all infant care areas, including well baby observation areas (if there are any), and any special care baby units. The summaries are displayed in the language(s) and written with wording most commonly understood by mothers and staff.

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

Global Criteria - Step Two

The head of maternity services reports that all health care staff members who have any contact with pregnant women, mothers, and/or babies, have received orientation on the breastfeeding/infant feeding policy. The orientation that is provided is sufficient.

A copy of the curricula or course session outlines for training in breastfeeding promotion and support for various types of staff is available for review, and a training schedule for new employees is available.

Documentation of training indicates that 80% or more of the clinical staff members who have contact with mothers and/or infants and have been on the staff 6 months or more have received training at the hospital, prior to arrival, or though well-supervised self-study or on-line courses that covers all 10 Steps, the Code and subsequent WHA resolutions, mother-friendly care. It is likely that at least 20 hours of targeted training will be needed to develop the knowledge and skills necessary to adequately support mothers. At least three hours of supervised clinical experience are required.

Documentation of training also indicates that non-clinical staff members have received training that is adequate, given their roles, to provide them with the skills and knowledge needed to support mothers in successfully feeding their infants.

Training on how to provide support for non-breastfeeding mothers is also provided to staff. A copy of the course session outlines for training on supporting non-breastfeeding mothers is also available for review. The training covers key topics such as:

- the risks and benefits of various feeding options;
- helping the mother choose what is acceptable, feasible, affordable, sustainable and safe (AFASS) in her circumstances;
- the safe and hygienic preparation, feeding and storage of breast-milk substitutes;
- how to teach the preparation of various feeding options, and

Global Criteria - Step Two

(continued from previous page)

- how to minimize the likelihood that breastfeeding mothers will be influenced to use formula.

The type and percentage of staff receiving this training is adequate, given the facility's needs

Out of the randomly selected clinical staff members*:

- At least 80% confirm that they have received the described training or, if they have been working in the maternity services less than 6 months, have, at minimum, received orientation on the policy and their roles in implementing it.
- At least 80% are able to answer 4 out of 5 questions on breastfeeding support and promotion correctly.
- At least 80% can describe two issues that should be discussed with a pregnant woman if she indicates that she is considering giving her baby something other than breast milk.

Out of the randomly selected non-clinical staff members**:

- At least 70% confirm that they have received orientation and/or training concerning the promotion and support of breastfeeding since they started working at the facility.
- At least 70% are able to describe at least one reason why breastfeeding is important.
- At least 70% are able to mention one possible practice in maternity services that would support breastfeeding.
- At least 70% are able to mention at least one thing they can do to support women so they can feed their babies well.

**These include staff members providing clinical care for pregnant women, mothers and their babies.*

*** These include staff members providing non-clinical care for pregnant women, mother and their babies or having contact with them in some aspect of their work.*

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

Global Criteria - Step Three

If the hospital has an affiliated antenatal clinic or an in-patient antenatal ward:

A written description of the minimum content of the breastfeeding information and any printed materials provided to all pregnant women is available.

The antenatal discussion covers the importance of breastfeeding, the importance of immediate and sustained skin-to-skin contact, early initiation of breastfeeding, rooming-in on a 24 hour basis, feeding on cue or baby-led feeding, frequent feeding to help assure enough milk, good positioning and attachment, exclusive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other foods are given.

Out of the randomly selected pregnant women in their third trimester who have come for at least two antenatal visits:

- At least 70% confirm that a staff member has talked with them individually or offered a group talk that includes information on breastfeeding.
- At least 70% are able to adequately describe what was discussed about two of the following topics: importance of skin-to-skin contact, rooming-in, and risks of supplements while breastfeeding in the first 6 months.

STEP 4. Help mothers initiate breastfeeding within a half-hour of birth.

This Step is now interpreted as:

Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.

Global Criteria - Step Four

Out of the randomly selected mothers with vaginal births or caesarean sections without general anaesthesia in the maternity wards:

- At least 80% confirm that their babies were placed in skin-to-skin contact with them immediately or within five minutes after birth and that this contact continued without separation for an hour or more, unless there were medically justifiable reasons.

  (Note: It is preferable that babies be left even longer than an hour, if feasible, as they may take longer than 60 minutes to breastfeed).

- At least 80% also confirm that they were encouraged to look for signs for when their babies were ready to breastfeed during this first period of contact and offered help, if needed.

  (Note: The baby should not be forced to breastfeed but, rather, supported to do so when ready. If desired, the staff can assist the mother with placing her baby so it can move to her breast and latch when ready).

If any of the randomly selected mothers have had caesarean deliveries with general anaesthesia, at least 50% should report that their babies were placed in skin-to-skin contact with them as soon as the mothers were responsive and alert, with the same procedures followed.

At least 80% of the randomly selected mothers with babies in special care report that they have had a chance to hold their babies skin-to-skin or, if not, the staff could provide justifiable reasons why they could not.

Observations of vaginal deliveries, if necessary to confirm adherence to Step 4, show that in at least 75% of the cases babies are placed with their mothers and held skin-to-skin within five minutes after birth for at least 60 minutes without separation, and that the mothers are shown how to recognize the signs that their babies are ready to breastfeed and offered help, or there are justified reasons for not following these procedures.

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

Global Criteria - Step Five

The head of maternity services reports that mothers who have never breastfed or who have previously encountered problems with breastfeeding receive special attention and support both in the antenatal and postpartum periods.

Observations of staff demonstrating how to safely prepare and feed breast-milk substitutes confirm that in 75% of the cases, the demonstrations were accurate and complete, and the mothers were asked to give "return demonstrations".

Out of the randomly selected clinical staff members:

- At least 80% report that they teach mothers how to position and attach their babies for breastfeeding and are able to describe or demonstrate correct techniques for both or, if not, can describe to whom they refer mothers on their shifts for this advice.
- At least 80% report that they teach mothers how to hand express and can describe or demonstrate an acceptable technique for this, or, if not, can describe to whom they refer mothers on their shifts for this advice.
- At least 80% can describe how non-breastfeeding mothers can be assisted to safely prepare their feeds, or can describe to whom they refer mothers on their shifts for this advice.

Out of the randomly selected mothers (including caesarean):

- At least 80% of those who are breastfeeding report that someone on the staff offered further assistance with breastfeeding within six hours of birth.
- At least 80% of those who are breastfeeding report that someone on the staff offered them help with positioning and attaching their babies for breastfeeding.
- At least 80% of those who are breastfeeding are able to demonstrate or describe correct positioning of their babies for breastfeeding.
- At least 80% of those who are breastfeeding are able to describe what signs would indicate that their babies are attached and suckling well.
- At least 80% of those who are breastfeeding report that they were shown how to express their milk by hand or given written information and told where they could get help if needed.
- At least 80% of the mothers who have decided not to breastfeed report that they have been offered help in preparing and giving their babies feeds, can describe the advice they were given, and have been asked to prepare feeds themselves, after being shown how.

Out of the randomly selected mothers with babies in special care:

- At least 80% of those who are breastfeeding or intending to do so report that they have been offered help to start their breast milk coming and to keep up the supply within 6 hours of their babies' births.
- At least 80% of those breastfeeding or intending to do so report that they have been shown how to express their breast milk by hand.
- At least 80% of those breastfeeding or intending to do so can adequately describe and demonstrate how they were shown to express their breast milk by hand.
- At least 80% of those breastfeeding or intending to do so report that they have been told they need to breastfeed or express their milk 6 times or more every 24 hours to keep up their supply.

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

Global Criteria - Step Six

Hospital data indicate that at least 75% of the babies delivered in the last year have been exclusively breastfed or exclusively fed expressed breast milk from birth to discharge or, if not, that there were documented medical reasons.

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.

No materials that recommend feeding breast milk substitutes, scheduled feeds or other inappropriate practices are distributed to mothers.

The hospital has an adequate facility/space and the necessary equipment for giving demonstrations of how to prepare formula and other feeding options away from breastfeeding mothers.

Observations in the postpartum wards/rooms and any well baby observation areas show that at least 80% of the babies are being fed only breast milk or there are acceptable medical reasons for receiving something else.

At least 80% of the randomly selected mothers report that their babies had received only breast milk or expressed or banked human milk or, if they had received anything else, it was for acceptable medical reasons, described by the staff.

At least 80% of the randomly selected 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.

At least 80% of the randomly selected mothers with babies in special care who have decided not to breastfeed report that staff has talked with them about risks and benefits of various feeding options.

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

Global Criteria - Step Seven

Observations in the postpartum wards and any well-baby observation areas and discussions with mothers and staff confirm that at least 80% of the mothers and babies are together or, if not, have justifiable reasons for being separated.

At least 80% of the randomly selected mothers report that their babies have been in the same room with them without separation or, if not, there were justifiable reasons.

STEP 8. Encourage breastfeeding on demand.

Global Criteria - Step Eight

Out of the randomly selected breastfeeding mothers:

- At least 80% report that they have been told how to recognize when their babies are hungry and can describe at least two feeding cues.
- At least 80% report that they have been advised to feed their babies as often and for as long as the babies want or something similar.

STEP 9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

Global Criteria - Step Nine

Observations in the postpartum wards/rooms and any well baby observation areas indicate that at least 80% of the breastfeeding babies observed are not using bottles or teats or, if they are, their mothers have been informed of the risks.

Out of the randomly selected breastfeeding mothers:

- At least 80% report that, as far as they know, their infants have not been fed using bottles with artificial teats (nipples).
- At least 80% report that, as far as they know, their infants have not sucked on pacifiers.

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

Global Criteria - Step Ten

The head/director of maternity services reports that:

- Mothers are given information on where they can get support if they need help with feeding their babies after returning home, and the head/director can also mention at least one source of information.
- 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 can describe at least one way this is done.
- The staff encourages mothers and their babies to be seen soon after discharge (preferably 2-4 days after birth and again the second week) at the facility or in the community by a skilled breastfeeding support person who can assess feeding and give any support needed and can describe an appropriate referral system and adequate timing for the visits.

A review of documents indicates that printed information is distributed to mothers before discharge, if appropriate, on how and where mothers can find help on feeding their infants after returning home and includes information on at least one type of help available.

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

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

Global Criteria – Code compliance

The head/director of maternity services reports that:

- No employees of manufacturers or distributors of breast-milk substitutes, bottles, teats or pacifiers have any direct or indirect contact with pregnant women or mothers.
- The hospital does not receive free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events from manufacturers or distributors of breast-milk substitutes, bottles, teats or pacifiers.
- No pregnant women, mothers or their families are given marketing materials or samples or gift packs by the facility that include breast-milk substitutes, bottles/teats, pacifiers, other infant feeding equipment or coupons.

A review of the breastfeeding or infant feeding policy indicates that it uphold the Code and subsequent WHA resolutions by prohibiting:

- The display of posters or other materials provided by manufacturers or distributors of breast-milk substitutes, bottles, teats and dummies or any other materials that promote the use of these products.
- Any direct or indirect contact between employees of these manufacturers or distributors and pregnant women or mothers in the facility.
- Distribution of samples or gift packs with breast-milk substitutes, bottles or teats or of marketing materials for these products to pregnant women or mothers or members of their families.
- Acceptance of free gifts (including food), literature, materials or equipment, money or support for in-service education or events from these manufacturers or distributors by the hospital.
- Demonstrations of preparation of infant formula for anyone that does not need them.
- Acceptance of free or low cost breast-milk substitutes or supplies.

A review of records and receipts indicates that any breast-milk substitutes, including special formulas and other supplies, are purchased by the health care facility for the wholesale price or more.

Observations in the antenatal and maternity services and other areas where nutritionists and dieticians work indicate that no materials that promote breast-milk substitutes, bottles, teats or dummies, or other designated products as per national laws, are displayed or distributed to mothers, pregnant women, or staff.

Observations indicate that the hospital keeps infant formula cans and pre-prepared bottles of formula out of view unless in use.

At least 80% of the randomly selected clinical staff members can give two reasons why it is important not to give free samples from formula companies to mothers.

Mother-friendly care

Global Criteria – Mother-friendly care

(Note: These criteria should be required only after health facilities have trained their staff on policies and practices related to mother-friendly care).

A review of the hospital policies indicates that they require mother-friendly labour and birthing practices and procedures including:

- Encouraging women to have companions of their choice to provide continuous physical and/or emotional support during labour and birth, as desired.
- Allowing women to drink and eat light foods during labour, as desired.
- Encouraging women to consider the use of non-drug methods of pain relief unless analgesic or anaesthetic drugs are necessary because of complications, respecting the personal preferences of the women.
- Encouraging women to walk and move about during labour, if desired, and assume positions of their choice while giving birth, unless a restriction is specifically required for a complication and the reason is explained to the mother.
- Care that does not involve invasive procedures such as rupture of the membranes, episiotomies, acceleration or induction of labour, instrumental deliveries, or caesarean sections unless specifically required for a complication and the reason is explained to the mother.

Out of the randomly selected clinical staff members:

- At least 80% are able to describe at least two recommended practices and procedures that can help a mother be more comfortable and in control during labour and birth.
- At least 80% are able to list at least three labour or birth procedures that should not be used routinely, but only if required due to complications.
- At least 80% are able to describe at least two labour and birthing practices and procedures that make it more likely that breastfeeding will get off to a good start

Out of the randomly selected pregnant women:

- At least 70% report that the staff has told them women can have companions of their choice with them throughout labour and birth and at least one reason it could be helpful.
- At least 70% report that they were told at least one thing by the staff about ways to deal with pain and be more comfortable during labour, and what is better for mothers, babies and breastfeeding.

HIV and infant feeding (optional)

(Note: The national BFHI coordination group and/or other appropriate national decision-makers will determine whether or not maternity services should be assessed on whether they provide support related to HIV and infant feeding).

Global Criteria – HIV and infant feeding

The head/director of maternity services reports that:

- The hospital has policies and procedures that seem adequate concerning providing or referring pregnant women for testing and counselling for HIV, counselling women concerning PMTCT of HIV, providing individual, private counselling for pregnant women and mothers who are HIV positive on infant feeding options, and insuring confidentiality.
- Mothers who are HIV positive or concerned that they are at risk are referred to community support services for HIV testing and infant feeding counselling, if they exist.

A review of the infant feeding policy indicates that it requires that HIV-positive mothers receive counselling, including information about the risks and benefits of various infant feeding options and specific guidance in selecting the options for their situations, supporting them in their choices.

A review of the curriculum on HIV and infant feeding and training records indicates that training is provided for appropriate staff and is sufficient, given the percentage of HIV positive women and the staff needed to provide support for pregnant women and mothers related to HIV and infant feeding. The training covers basic facts on:

- the risks of HIV transmission during pregnancy, labour and delivery and breastfeeding and its prevention;
- the importance of testing and counselling for HIV;
- local availability of feeding options;
- the dangers of mixed feeding for HIV transmission;
- facilities/provision for counselling HIV positive women on advantages and disadvantages of different feeding options; assisting them in exclusive breastfeeding or formula feeding (note: may involve referrals to infant feeding counsellors);
- how to assist HIV positive mothers who have decided to breastfeed; including how to transition to replacement feeds at the appropriate time
- how to minimize the likelihood that a mother whose status is unknown or HIV negative will be influenced to replacement feed.

A review of the antenatal information indicates that it covers the important topics on this issue. (these include the routes by which HIV-infected women can pass the infection to their infants, the approximate proportion of infants that will (and will not) be infected by breastfeeding; the importance of counselling and testing for HIV and where to get it; and the importance of HIV positive women making informed infant feeding choices and where they can get the needed counselling).

A review of documents indicates that printed material is available, if appropriate, on how to implement various feeding options and is distributed to or discussed with HIV positive mothers before discharge. It includes information on how to exclusively replacement feed, how to exclusively breastfeed, how to stop breastfeeding when appropriate, and the dangers of mixed feeding.

Continued on next page

Global Criteria – HIV and infant feeding

(continued from previous page)

Out of the randomly selected clinical staff members:

- At least 80% can describe at least one measure that can be taken to maintain confidentiality and privacy of HIV positive pregnant women and mothers.
- At least 80% are able to mention at least two policies or procedures that help prevent transmission of HIV from an HIV positive mother to her infant during feeding within the first six months.
- At least 80% are able to describe two issues that should be discussed when counselling an HIV positive mother who is deciding how to feed her baby.

Out of the randomly selected pregnant women who are in their third trimester and have had at least two antenatal visits or are in the antenatal in-patient unit:

- At least 70% report that a staff member has talked with them or given a talk about HIV/AIDS and pregnancy.
- At least 70% report that the staff has told them that a woman who is HIV-positive can pass the HIV infection to her baby.
- At least 70% can describe at least one thing the staff told them about why testing and counselling for HIV is important for pregnant women.
- At least 70% can describe at least one thing the staff told them about what women who do not know their HIV status should consider when deciding how to feed their babies.

Section 1.3 - Annex 1

WHO/NMH/NHD/09.01
WHO/FCH/CAH/09.01

Acceptable medical reasons for use of breast-milk substitutes

Preface

A list of acceptable medical reasons for supplementation was originally developed by WHO and UNICEF as an annex to the Baby-friendly Hospital Initiative (BFHI) package of tools in 1992.

WHO and UNICEF agreed to update the list of medical reasons given that new scientific evidence had emerged since 1992, and that the BFHI package of tools was also being updated. The process was led by the departments of Child and Adolescent Health and Development (CAH) and Nutrition for Health and Development (NHD). In 2005, an updated draft list was shared with reviewers of the BFHI materials, and in September 2007 WHO invited a group of experts from a variety of fields and all WHO Regions to participate in a virtual network to review the draft list. The draft list was shared with all the experts who agreed to participate. Subsequent drafts were prepared based on three inter-related processes: a) several rounds of comments made by experts; b) a compilation of current and relevant WHO technical reviews and guidelines (see list of references); and c) comments from other WHO departments (Making Pregnancy Safer, Mental Health and Substance Abuse, and Essential Medicines) in general and for specific issues or queries raised by experts.

Technical reviews or guidelines were not available from WHO for a limited number of topics. In those cases, evidence was identified in consultation with the corresponding WHO department or the external experts in the specific area. In particular, the following additional evidence sources were used:
-*The Drugs and Lactation Database* (LactMed) hosted by the United States National Library of Medicine, which is a peer-reviewed and fully referenced database of drugs to which breastfeeding mothers may be exposed.
-*The National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*, review done by the New South Wales Department of Health, Australia, 2006.

The resulting final list was shared with external and internal reviewers for their agreement and is presented in this document.

The list of acceptable medical reasons for temporary or long-term use of breast-milk substitutes is made available both as an independent tool for health professionals working with mothers and newborn infants, and as part of the BFHI package. It is expected to be updated by 2012.

Acknowledgments

This list was developed by the WHO Departments of Child and Adolescent Health and Development and Nutrition for Health and Development, in close collaboration with UNICEF and the WHO Departments of Making Pregnancy Safer, Essential Medicines and Mental Health and Substance Abuse. The following experts provided key contributions for the updated list: Philip Anderson, Colin Binns, Riccardo Davanzo, Ros Escott, Carol Kolar, Ruth Lawrence, Lida Lhotska, Audrey Naylor, Jairo Osorno, Marina Rea, Felicity Savage, María Asunción Silvestre, Tereza Toma, Fernando Vallone, Nancy Wight, Anthony Williams and Elizabeta Zisovska. They completed a declaration of interest and none identified a conflicting interest.

Introduction

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

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

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

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

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

INFANT CONDITIONS

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

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

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

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

MATERNAL CONDITIONS

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

Maternal conditions that may justify permanent avoidance of breastfeeding

- HIV infection[15]: if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) (6). Otherwise, exclusive breastfeeding for the first six months is recommended.

Maternal conditions that may justify temporary avoidance of breastfeeding

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

Maternal conditions during which breastfeeding can still continue, although health problems may be of concern

- Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started (8).
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter (9).
- Hepatitis C.
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition(8).
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines (10).
- Substance use[16] (11):
  - maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
  - alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

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

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

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

References

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

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

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(6) *HIV and infant feeding: update based on the technical consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Infants, Geneva, 25–27 October 2006.* Geneva, World Health Organization, 2007 (http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf, accessed 23 June 2008).

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

(8) *Mastitis: causes and management.* Geneva, World Health Organization, 2000 (WHO/FCH/CAH/00.13; http://whqlibdoc.who.int/hq/2000/WHO_FCH_CAH_00.13.pdf, accessed 24 June 2008).

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

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

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

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

For further information, please contact:

Department of Nutrition for Health and Development
E-mail: nutrition@who.int
Web: www.who.int/nutrition

Department of Child and Adolescent Health and Development
E-mail: cah@who.int
Web: www.who.int/child_adolescent_health

Address: 20 Avenue Appia, 1211 Geneva 27, Switzerland

SECTION 1.4
COMPLIANCE WITH THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

What is the Code?

The Code was adopted in 1981 by the World Health Assembly to promote safe and adequate nutrition for infants, by the protection and promotion of breastfeeding and by ensuring the proper use of breast-milk substitutes, when these are necessary. One of the main principles of the Code is that health care facilities should not be used for the purpose of promoting breast milk substitutes, feeding bottles or teats. Subsequent WHA resolutions have clarified the Code and closed loopholes.

How is the Code relevant to the Baby-friendly Hospital Initiative?

In launching the BFHI in 1991, UNICEF and WHO were hoping to ensure that all maternities would become centres of breastfeeding support. In order to achieve this, hospitals must avoid being used for the promotion of breast milk substitutes, bottles or teats, or the distribution of free formula. The Code, together with the subsequent relevant Resolutions of the World Health Assembly, lays down the basic principles necessary for this. In addition, in adopting the Code in 1981, the World Health Assembly called upon health workers to encourage and protect breastfeeding, and to make themselves familiar with their responsibilities under the Code.

Which products fall under the scope of the Code?

The Code applies to breast milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk; feeding bottles and teats.

Since exclusive breastfeeding is to be encouraged for 6 months, any food or drink shown to be suitable for feeding a baby during this period is a breast milk substitute, and thus covered by the Code. This would include baby teas, juices and waters. Special formulas for infants with special medical or nutritional needs also fall under the scope of the Code.

Since continued breastfeeding is to be encouraged for two years or beyond, any milk product shown to be substituting for the breast milk part of the child's diet between six months and two years, such as follow-on formula, is a breast-milk substitute and is thus covered by the Code.

What does the Code say?

The main points in the Code include:

- no advertising of breast-milk substitutes and other products to the public;
- no free samples to mothers;
- no promotion in the health services;
- no donations of free or subsidized supplies of breast-milk substitutes or other products in any part of the health care system;
- no company personnel to contact or advise mothers;
- no gifts or personal samples to health workers;
- no pictures of infants, or other pictures or text idealizing artificial feeding, on the labels of the products;
- information to health workers should only be scientific and factual;

- information on artificial feeding should explain the benefits of breastfeeding and the costs and dangers associated with artificial feeding;
- unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

Who is a "health worker" for the purposes of the Code?

According to the Code, any person working in the health care system, whether professional or non-professional, including voluntary and unpaid workers, in public or private practice, is a health worker. Under this definition, ward assistants, sweepers, nurses, midwives, social workers, dieticians, counsellors, in-hospital pharmacists, obstetricians, administrators, clerks, etc. are all health workers.

What are a health worker's responsibilities under the Code?

1. Encourage and protect breast-feeding. Health workers involved in maternal and infant nutrition should make themselves familiar with their responsibilities under the Code, and be able to explain the following:

- the benefits and superiority of breastfeeding;
- maternal nutrition, and the preparation for and maintenance of breastfeeding;
- the negative effect on breastfeeding of introducing partial bottle-feeding;
- the difficulty of reversing the decision not to breastfeed; and
- where needed, the proper use of infant formula, whether manufactured industrially or home-prepared.

When providing information on the use of infant formula, health workers should be able to explain:

- the social and financial implications of its use;
- the health hazards of inappropriate foods or feeding methods; and
- the health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes.

2. Ensure that the health facility is not used for the display of products within the scope of the Code, for placards or posters concerning such products. Ensure that packages of breast-milk substitutes and other supplies purchased by the health facility are not on display or visible to mothers.

3. Refuse any gifts offered by manufacturers or distributors.

4. Refuse samples (meaning single or small quantities) of infant formula or other products within the scope of the Code, or of equipment or utensils for their preparation or use, unless necessary for the purpose of professional evaluation or research at the institutional level.

5. Never pass any samples to pregnant women, mothers of infants and young children, or members of their families.

6. Disclose any contribution made by a manufacturer or distributor for fellowships, study tours, research grants, attendance at professional conferences, or the like to management of the health facility.

7. Be aware that support and other incentives for programmes and health professionals working in infant and young-child health should not create conflicts of interests.

Does the Code ban all free and low-cost supplies of infant formula and other breast-milk substitutes (including follow-on formula) in health facilities?

Yes. Although there were some ambiguities in the wording of Articles 6.6 and 6.7 of the Code, these were clarified in 1994 by World Health Assembly Resolution (WHA 47.5) which urged Governments:

> "to ensure that there are no donations of free or subsidized supplies of breast-milk substitutes and any other products covered by the International Code of Marketing of Breast-milk Substitutes in any part of the health care system".

Breast-milk substitutes should be obtained through "normal procurement channels" so as not to interfere with the protection and promotion of breastfeeding. Procurement means purchase.

Should free supplies be donated for pre-term and low birth weight infants? Some argue that these infants need early supplementation, and therefore free supplies should be permitted.

No. The prohibition applies to all types of infant formula, including those for special medical purposes. In any case, breast milk is the medically indicated feeding of choice for almost all pre-term and low birth weight babies.[17] Obtaining free supplies for these babies encourages bottle (artificial) feeding, which further threatens their survival and healthy development.

Moreover, once free supplies are available in the maternities and nurseries, it is extremely difficult to control their distribution and misuse.

Should free supplies be donated for infants of HIV-positive mothers who have chosen to formula feed?

No. As stated above, once free supplies are available in the health care system it is virtually impossible to prevent their misuse and the undermining of breastfeeding. Governments should procure the formula needed through normal procurement channels.

Should the prohibition extend to Maternal Child Health, primary health, and rural clinics?

Yes. The Code defines the health care system as: "governmental, non-governmental or private institutions or organizations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or child-care institutions. It also includes health workers in private practice".

Why not permit free supplies in paediatric wards, since older infants may already be using feeding bottles?

Because free supplies to paediatric services or other special services for sick infants can seriously undermine breastfeeding. The WHO/UNICEF guidelines suggest, in paragraph 50:

> "There will, of course, always be a small number of infants in these services who will need to be fed on breast-milk substitutes. Suitable substitutes, procured and distributed as part of the regular inventory of foods and medicines of any such health care facility, should be provided for those infants".

[17] See WHO/UNICEF "Guidelines concerning the main health and socioeconomic circumstances in which infants have to be fed on breast-milk substitutes" (WHO, A39/8 Add. 1, 10 April 1986). The 1986 World Health Assembly based its adoption of WHA 39.28 on this document.

Is there a working definition for "low-cost" supplies?

Yes. There is a general agreement that ending "low-cost" or "low-price" sales means ending sales at prices below the wholesale price or lower that 80 percent of the retail price, in the absence of a standard wholesale price. The reason for stopping low price sales is that low prices lead to the overuse of breast-milk substitutes.

Is the Code still relevant in view of the HIV pandemic and the increased need for formula?

Yes. Indeed the Code is even more important in the context of HIV, since the Code and resolutions:

- encourage governments to regulate the distribution of free or subsidized supplies of breast-milk substitutes to prevent "spillover";
- protect children fed on replacement foods by ensuring that product labels carry necessary warnings and instructions for safe preparation and use; and
- ensure that a given product is chosen on the basis of independent medical advice.

The Code is relevant to, and fully covers the needs of, mothers who are HIV-positive. Even where the Code has not been implemented, its provisions still apply.

SECTION 1.5
BABY-FRIENDLY EXPANSION AND INTEGRATION POSSIBILITIES

Over the last 15 years of work on BFHI, many lessons have been learned. Perhaps the clearest lesson is the need for more attention to Step 10 and the community. A second pressing issue has been the need to rectify the misunderstandings concerning the appropriateness of BFHI in the context of the HIV pandemic. Other issues that have arisen and have been addressed in some countries include:

- the need to ensure mother-friendly care;
- breastfeeding supportive paediatric care;
- mother and baby-friendly NICUs;
- mother and baby-friendly physician's offices;
- and last, but by no means least, the need for the mother of the exclusively breastfed child to be supported to understand the need for the age-appropriate addition of complementary foods after 6 months.

Current trends in health system and related planning indicate the need for increased flexibility, integration, and complementarity among interventions. For this reason, and to aid countries in creating synergy in their programmes and in actively addressing identified issues, a variety of alternative approaches are now included in the BFHI materials. These expansion and integration options are intended to create the possibility for more creative and supportive mother and baby-friendly care.

Presented below are a few of the many variations that have been tried around the world in order to bring truly baby-friendly care to all.

Baby-friendly communities: Creating Step Ten

Step 10, of all of the Ten Steps, has not achieved full implementation in a wide variety of settings, although many options are suggested, including mother-to-mother or peer groups, organised support by certified lactation consultants, regular outreach by the maternity staff especially in the first days postpartum, referral to community-based primary health care centres with specialized training, hotlines, etc. Efforts to date have not been optimal due to a variety of factors, not the least of which is that facility-based personnel may simply not have the skills to create community mobilization. In addition, often there is reliance on volunteers to carry out ongoing activities, so it is necessary to have regular refreshers and support activities for ongoing motivation and communication.

Perhaps of most relevance to reaching the most vulnerable populations is the reality that most deliveries in developing countries occur in the communities and even the initial baby-friendly care may not be in place.

A new initiative – Baby-friendly Communities – has been developed in some countries, and can serve as a model

1. for expanding BFHI practices and criteria into community health services,
2. for expanding BFHI practices into delivery settings where there are no community health services, and

3. for strengthening the vital tenth step in ensuring best practices and support for every mother.

Suggestions for development and content of national criteria that could be applied in these three situations are presented below:

Suggested National Baby-friendly Community components: provided for community discussion, reflecting on all applicable Global Criteria for the BFHI (the Ten Steps)

The development of the criteria should include the participation and commitment of:

1. Community political and social leadership, both male and female, who are committed to making a change in support of optimal infant and young child feeding.
2. All health facilities that include maternity services, or local health care provision, especially those that are already designated "baby-friendly" and actively support both early and exclusive breastfeeding (0-6 months).
3. If home deliveries are the norm, all who assist in these deliveries.

Locally developed criteria should specify that :

1. All who assist in facility-based or home deliveries are informed concerning mother-friendly labour and birthing practices such as encouraging mothers to have companions to provide support, minimizing invasive procedures unless medically necessary, encouraging women to move about and assume positions of their choice during labour, etc. (see "mother-friendly" section) and are informed concerning the importance of delayed cord cutting, immediate skin-to-skin continued for at least 60 minutes, and no prelacteal feeds.
2. Community access to referral site(s) with skilled support for early, exclusive and continued breastfeeding is available.
3. Support is available in the community for age-appropriate, frequent, and responsive complementary feeding with continued breastfeeding. This will generally mean that there is availability of micronutrients or animal-based foods and adequate counselling to assist mothers in making appropriate choices.
4. Mother-to-mother support system, or similar, is in place.
5. No practices, distributors, shops or services violate the International Code (as applicable) in the community.
6. Local government or civil society has convened, created and supports implementation of at least one political or social normative change and/or additional activity that actively supports mothers and families to succeed with immediate and exclusive breastfeeding practices (e.g. time-sharing of tasks, granting authority to transport breastfeeding mothers for referral if needed, identification of "breastfeeding advocates/protectors" among community leaders, breastfeeding supportive workplaces, etc.).

In addition, simplified job-aids for assisting and for assessing home deliveries (including those performed by skilled midwives and, if possible, traditional birth attendants), should be developed, are available and are in use.

Example from Gambia

An excellent example of an innovative approach to this problem and its solution is found in the *"The Baby Friendly Community Initiative (BFCI) – An Expanded Vision for Integrated Early Childhood Development in the Gambia"*. The full text of this document will be available on the UNICEF website.

In summary, BFHI was used as the model for the development of the Baby-friendly Community Initiative (BFCI). The BFCI includes 10 steps to successful infant feeding incorporating maternal nutrition, infant nutrition, environmental sanitation and personal hygiene. In other settings, safe delivery or child and maternity protection might have greater relevance. In Gambia, communities identified 5 women and 2 men each, to be trained and certified "Village Support Groups on Infant Feeding". When the 10 steps developed by the community are implemented, the community is designated a "Baby- friendly Community".

Training of community representatives as Village Support Groups on infant feeding was considered the most important element of the BFCI. Men's involvement in the BFCI both as members of the Support Groups and as part of the target population may also be a crucial element for success and sustainability of the intervention. Their involvement in an area, which in the past targeted only women, sent out a clear and strong message that maternal and infant nutrition concerned both men (fathers) and women (mothers).

World Breastfeeding Week may be used as an entry point to bring together targeted politicians, Senior Government and NGO officials, as well as international Agencies for sensitization to create better understanding of the importance of breastfeeding, what has already occurred in country, and what may be possible, and create a cadre of high level support.

In Gambia, such a meeting led to recommendations:

1. intensified information, education and communication (IEC) activities to eradicate taboos and other traditional practices, which affect the practice of optimal breastfeeding;
2. inclusion of breastfeeding in the curricula of schools and training institutions;
3. setting up of support groups on breastfeeding;
4. extended maternity leave for working mothers;
5. development of breastfeeding policies;
6. similar seminars at the regional and community levels;
7. the implementation of the Baby-friendly Hospital Initiative; and
8. ensuring community involvement.

The results of this approach in Gambia were an increase from 60% to 100% in initiation of breastfeeding in the first day of life, and a decline in introduction of complementary feeding at four months of age from 90% to nearly 0%.

In Gambia, the BFHI also helped introduce other community based services that meet the needs of infants and young children are vital to many health, growth and development intervention approaches, including bed nets, HIV/AIDS awareness, immunization support, and reproductive health care. The approach promotes and protects the rights of the child to survival, growth and development.

The Ten Steps to Successful Breastfeeding in the Community: The Gambia's Baby-friendly Community Initiative

Every village should have an enabling environment for mothers to practice optimal breastfeeding. Therefore, a trained Village Support Group on infant feeding:

1. Informs and advises all pregnant and lactating women and their spouses on the importance of an adequate maternal diet using locally available foods by explaining the benefits to both maternal and infant health.
2. Informs all pregnant women and their spouses about the benefits of breast milk including colostrum.
3. Advises and encourages mothers to initiate breastfeeding within an hour after birth and not to give any prelacteal feeds unless on the advice of a medical personnel.
4. Informs both mothers and fathers about the benefits of exclusive breastfeeding and encourages all mothers of healthy newborns to breastfeed exclusively for six months.
5. Informs both mothers and fathers about the hazards and cost of bottle-feeding, the use of formula and the use of pacifiers (comforters).
6. Ensures that orphans get breast milk by encouraging the traditional practice of wet nursing for babies who have lost their mothers at birth.
7. Advises and encourages mothers to introduce locally available complementary foods when the infant is six months of age.
8. Advises and encourages all mothers to use fermented cereal in the preparation of the complementary feeding by telling them about the benefits.
9. Teaches all mothers and caregivers about the benefits of adequate personal hygiene and environmental sanitation to infant health, including the basic principles for the preparation of safe foods for infants and young children.
10. Encourages mothers to support each other to practice optimal breastfeeding by forming their own informal support groups on infant feeding.

BFHI and Prevention of Mother-to-Child Transmission (PMTCT) of HIV/AIDS

The WHO/UNICEF guidance on infant feeding support for HIV-positive mothers strongly suggest that training on support for exclusive breastfeeding precede training on feeding options for HIV-positive mothers. For this reason, Malawi, among other countries, has decided that BFHI must be in place at the same time as the initiation of counselling for the HIV-positive mothers.

The rationale is at least 3-fold:

1. Since exclusive breastfeeding is an option for all mothers, the establishment of excellence in support of exclusive breastfeeding will benefit all.
2. For HIV-positive mothers for whom replacement feeding in not acceptable, feasible, affordable, sustainable and safe, exclusive breastfeeding is the recommended option.
3. If all counsellors understand the importance of exclusive breastfeeding, spill over and over use of artificial foods will be reduced.
4. Recent research findings indicate that exclusive breastfeeding may reduce the passage of HIV via breast milk, when compared to mixed feeding.

If this last item is proven to be consistent in additional studies, then exclusive breastfeeding among the greater population of HIV-infected women who have not been diagnosed as yet will provide a double benefit.

Mother-baby-friendly facilities

The Mother-friendly Childbirth Initiative includes the *"Ten Steps of the Mother-friendly Childbirth Initiative for mother-friendly Hospitals, Birth Centres, and Home Birth Services"* and can be initiated in concert with baby-friendly initiatives and as an integrated mother-baby aspect of a maternal-child care continuum.

The Mother-friendly Childbirth Initiative was initially developed in 1996 by the Coalition for Improving Maternity Services (CIMS) with the First Consensus Initiative. CIMS is a coalition of individuals and national organizations with concern for the care and well-being of mothers, babies, and families. The mission is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. This evidence-based mother-, baby-, and family-friendly model focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs. The suggested "Ten steps" is based on the recognition that some current maternity and newborn practices both contribute to high costs and inferior outcomes, such as inappropriate application of technology and routine procedures that are not based on scientific evidence. The principles of this approach is respect for the normalcy (i.e., non-medical) of the birthing process, the autonomy and empowerment of the woman, caregiver responsibility and doing "no harm".

The Mother-baby-friendly Ten Steps presented here are modified to allow integration with current continuum of care approaches.

Suggested Mother-baby-friendly Ten Steps for consideration in developing national criteria in coordination with baby-friendly:

A mother-baby-friendly hospital, birth centre, or home birth:

1. Provides or refers for antenatal care, including vitamin/iron/folate supplementation, malaria prophylaxis, HIV-testing, monitoring for danger signs, and referral where appropriate.
2. Offers all birthing mothers:
   - Unrestricted access to the birth companions of her choice, including fathers, partners, children, family members, and friends.
   - Unrestricted access to continuous emotional and physical support from a skilled woman-for example, a doula or labour-support professional.
   - Access to the best available care, preferably skilled assistance and access to timely referral as needed.
   - The freedom to walk, move about, and assume the positions of her choice during labour and birth (unless restriction is specifically required to correct a complication), and discourages the use of the lithotomy[18] position.
3. Maintains records to allow for external and self-assessment and reporting purposes.
4. Provides culturally competent care - that is, care that is sensitive and responsive to the specific beliefs, values, and customs of the mother's ethnicity and religion.
5. Has clearly defined policies and procedures for:
   - Clean birthing techniques.
   - Delayed cord clamping.
   - Placenta removal and disposal.
   - Collaboration, consultation and referral with other maternity services, including maintaining communication with all caregivers when referral/transfer is necessary.
   - Linking the mother and baby to appropriate community resources, including prenatal and post-discharge follow-up and breastfeeding support.
6. Does not routinely employ practices and procedures that are unsupported by scientific evidence, including but not limited to the following:
   - Shaving; enemas; IVs (intravenous drip); withholding nourishment; early rupture of membranes; electronic fetal monitoring.

   Other interventions are limited as follows:
   - Has an induction rate of 10% or less.
   - Has an episiotomy rate of 20% or less, with a goal of 5% or less.
   - Has a total caesarean rate of 10% or less in community hospitals, and 15% or less in tertiary care (high-risk) hospitals.
   - Has a VBAC (vaginal birth after caesarean) rate of 60% or more with a goal of 75% or more.
7. Educates staff in non-drug methods of pain relief and does not promote the use of analgesic or anaesthetic drugs not specifically required to correct a complication.
8. Encourages all mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions.
9. Has training in haemorrhage control, both manual and medical.
10. Strives to achieve the WHO-UNICEF *Ten Steps of the Baby-friendly Hospital Initiative* to promote successful breastfeeding.

[18] To lie flat on back with legs elevated

Key aspects of "mother-friendly care" have been integrated into the revised 20-hour course, *Global Criteria* and assessment process for BFHI, as an optional module. This provides countries with an easy way to begin the process of integrating mother-friendly childbirth practices into their maternity services, if they do not yet have a full-fledged initiative of the type described above.

Baby-friendly neonatal intensive care and paediatric units

Whereas BFHI is maternity based, its impact in support of post-discharge breastfeeding is limited to its community outreach – Step Ten. Therefore, the concept of baby-friendly paediatrics was considered. The following 10 steps are derived from the suggested 11 Steps developed in Australia[19] and are built upon the BFHI:

10 Steps to Optimal Breastfeeding in Paediatrics

1. Have a written breastfeeding policy and train staff in necessary skills.
2. When an infant is seen, for either a well visit or due to illness, ascertain the mother's infant feeding practices, and assist in establishment or management of breastfeeding as needed.
3. Provide parents with written and verbal information about breastfeeding.
4. Facilitate unrestricted breastfeeding or, if necessary, milk expression for mothers regardless of the child's age.
5. Give breastfed children other food or drink only when age appropriate or when medically indicated, and if medically indicated, use only alternative feeding methods most conducive to return to breastfeeding.
6. If hospitalization is needed, ensure facility allows 24-hours mother/child rooming in.
7. Administer medications and schedule procedures so as to cause the least possible disturbance of feeding.
8. Maintain a human milk bank, according to standards.
9. Provide information and contacts concerning community support available.
10. Maintain appropriate monitoring and records/data collection procedures to permit quality assurance assessment, progress rounds or staff meetings, and feedback.

The issue of transitioning the baby from an NICU setting to home is also extremely important. Items to include in consideration of baby-friendly treatment of the premature or ill infant should include criteria or standards for care, discharge planning, post-discharge assessment, and special support for mothers.

[19] Donohue L, Minchin M and C Minogue, 11 Step approach to Optimal Breastfeeding in the Paediatric Unit *Breastfeeding Review*. 1996; 4(2):88.

The Academy for Breastfeeding Medicine, International, in cooperation with US Department of Health and Human Services, WHO and UNICEF, has developed many protocols that may serve as a basis for national development of criteria for Baby-friendly Paediatrics or Baby-friendly NICUs. These protocols are posted and updated regularly. ABM is dedicated to continuing the development and dissemination of these standards for practice on their website: http://www.bfmed.org/protocols.html.

Baby-friendly physician's office: Optimizing care for infants and children

This guidance is derived from the ABM draft protocol which is available in full on their website. This is presented for consideration in the development of criteria for Baby-friendly Physician Offices.

Issues to consider in developing criteria for Baby-friendly physician offices[20]

1. Establish a written breastfeeding friendly office policy and inform all new staff about the policy.
2. Encourage breastfeeding mothers to exclusively breastfeed. Instruct mother not to offer bottles or a pacifier till breastfeeding is well established.
3. Offer culturally and ethnically competent care.
4. Offer a prenatal visit and show your commitment to breastfeeding during this visit.
5. Collaborate with local hospitals and maternity care professionals in the community. Convey to delivery rooms and newborn units your office policies on breastfeeding initiation.
6. Schedule a first follow-up visit 48-72 hours after hospital discharge or earlier if breastfeeding related problems, such as excessive weight loss (>7%) or jaundice are present at the time of hospital discharge.
7. Ensure availability of appropriate educational resources for parents. Educational material should be non-commercial and not advertise breast milk substitutes, bottles and nipples.
8. Do not interrupt or discourage breastfeeding in the office. Allow and encourage breastfeeding in the waiting room. Ensure an office environment that demonstrates breastfeeding promotion and support.
9. Develop and follow triage protocols to address breastfeeding concerns and problems.
10. Commend breastfeeding mothers during each visit for choosing and continuing breastfeeding.
11. Encourage mothers to exclusively breastfeed for 6 months and continue breastfeeding with complementary foods until at least 24 months and thereafter as long as mutually desired. Discuss introduction of solid food at 6 months of age, emphasizing the need for high-iron solids and assess for need for vitamin D supplementation.
12. Have a written breastfeeding policy and provide a lactation room with supplies for your employees who breastfeed or express breast milk at work. Encourage community employers and day care providers to support breastfeeding.
13. Acquire or maintain a list of community resources and support local breastfeeding support groups.

[20] Modified from ABM Protocol.

14. Work with insurance companies to encourage coverage of breast pump costs and lactation support services.
15. All clinicians and physicians should receive education regarding breastfeeding. Volunteer to let medical students and residents rotate in your practice. Participate in medical student and resident physician education. Encourage establishment of formal training programs in lactation for future and current healthcare providers.
16. Monitor breastfeeding initiation and duration rates in your practice, and analyse what additional changes can be made to enhance your support for optimal infant and young child feeding.

Baby-friendly complementary feeding

Breastfeeding and complementary feeding are a continuum; consideration of one must include consideration of the other. As the name indicates, "complementary" feeding is a complement to breastfeeding. Complementary feeding is essential for continued growth after 6 months of age. New recommendations for the addition of first foods into the diet emphasize protein and micronutrients in addition to energy needs.

The *Ten Guiding Principles of Complementary Feeding* serve as a guide for feeding behaviours, and as BFHI is integrated with other programmes, there will be an increasing number of opportunities to build on its messages.

TEN GUIDING PRINCIPLES FOR COMPLEMENTARY FEEDING[21]

1. DURATION OF EXCLUSIVE BREASTFEEDING AND AGE OF INTRODUCTION OF COMPLEMENTARY FOODS. Practice exclusive breastfeeding from birth to 6 months of age, and introduce complementary foods at 6 months of age (180 days) while continuing to breastfeed.

2. MAINTENANCE OF BREASTFEEDING. Continue frequent, on-demand breastfeeding until 2 years of age or beyond.

3. RESPONSIVE FEEDING. Practice responsive feeding, applying the principles of psychosocial care. Specifically: a) feed infants directly and assist older children when they feed themselves, being sensitive to their hunger and satiety cues; b) feed slowly and patiently, and encourage children to eat, but do not force them; c) if children refuse many foods, experiment with different food combinations, tastes, textures and methods of encouragement; d) minimize distractions during meals if the child loses interest easily; e) remember that feeding times are periods of learning and love - talk to children during feeding, with eye to eye contact.

4. SAFE PREPARATION AND STORAGE OF COMPLEMENTARY FOODS. Practice good hygiene and proper food handling by a) washing caregivers' and children's hands before food preparation and eating, b) storing foods safely and serving foods immediately after preparation, c) using clean utensils to prepare and serve food, d) using clean cups and bowls when feeding children, and e) avoiding the use of feeding bottles, which are difficult to keep clean.

21 *Guiding principles for complementary feeding of the breastfed child.* Washington DC, Panamerican Health Organization, 2003. The whole document can be downloaded from http://www.who.int/nutrition/publications/infantfeeding/guiding_principles_compfeeding_breastfed.pdf

5. AMOUNT OF COMPLEMENTARY FOOD NEEDED. Start at 6 months of age with small amounts of food and increase the quantity as the child gets older, while maintaining frequent breastfeeding. The energy needs from complementary foods for infants with "average" breast milk intake in developing countries are approximately 200 kcal per day at 6-8 months of age, 300 kcal per day at 9-11 months of age, and 550 kcal per day at 12-23 months of age. In industrialized countries these estimates differ somewhat (130, 310 and 580 kcal/d at 6-8, 9-11 and 12-23 months, respectively) because of differences in average breast milk intake.

6. FOOD CONSISTENCY. Gradually increase food consistency and variety as the infant gets older, adapting to the infant's requirements and abilities. Infants can eat pureed, mashed and semi-solid foods beginning at six months. By 8 months most infants can also eat "finger foods" (snacks that can be eaten by children alone). By 12 months, most children can eat the same types of foods as consumed by the rest of the family (keeping in mind the need for nutrient-dense foods, as explained in #8 below). Avoid foods that may cause choking (i.e., items that have a shape and/or consistency that may cause them to become lodged in the trachea, such as nuts, grapes, raw carrots).

7. MEAL FREQUENCY AND ENERGY DENSITY. Increase the number of times that the child is fed complementary foods as he/she gets older. The appropriate number of feedings depends on the energy density of the local foods and the usual amounts consumed at each feeding. For the average healthy breastfed infant, meals of complementary foods should be provided 2-3 times per day at 6-8 months of age and 3-4 times per day at 9-11 and 12-24 months of age, with additional nutritious snacks (such as a piece of fruit or bread or chapatti with nut paste) offered 1-2 times per day, as desired. Snacks are defined as foods eaten between meals-usually self-fed, convenient and easy to prepare. If energy density or amount of food per meal is low, or the child is no longer breastfed, more frequent meals may be required.

8. NUTRIENT CONTENT OF COMPLEMENTARY FOODS. Feed a variety of foods to ensure that nutrient needs are met. Meat, poultry, fish or eggs should be eaten daily, or as often as possible. Vegetarian diets cannot meet nutrient needs at this age unless nutrient supplements or fortified products are used (see #9 below). Vitamin A-rich fruits and vegetables should be eaten daily. Provide diets with adequate fat content. Avoid giving drinks with low nutrient value, such as tea, coffee and sugary drinks such as soda. Limit the amount of juice offered so as to avoid displacing more nutrient-rich foods.

9. USE OF VITAMIN-MINERAL SUPPLEMENTS OR FORTIFIED PRODUCTS FOR INFANT AND MOTHER. Use fortified complementary foods or vitamin-mineral supplements for the infant, as needed. In some populations, breastfeeding mothers may also need vitamin mineral supplements or fortified products, both for their own health and to ensure normal concentrations of certain nutrients (particularly vitamins) in their breast milk. [Such products may also be beneficial for pre-pregnant and pregnant women].

10. FEEDING DURING AND AFTER ILLNESS. Increase fluid intake during illness, including more frequent breastfeeding, and encourage the child to eat soft, varied, appetizing, favourite foods. After illness, give food more often than usual and encourage the child to eat more.

The two figures that follow, emphasis the need to support continued breastfeeding from 6 months to 2 years or longer to meet the baby's growing needs in addition to suitable complementary foods.

Figure 1: [22]
Percentage of nutrients from 550cc of breast milk, and needs remaining to be supplied by complementary foods in the second year of life

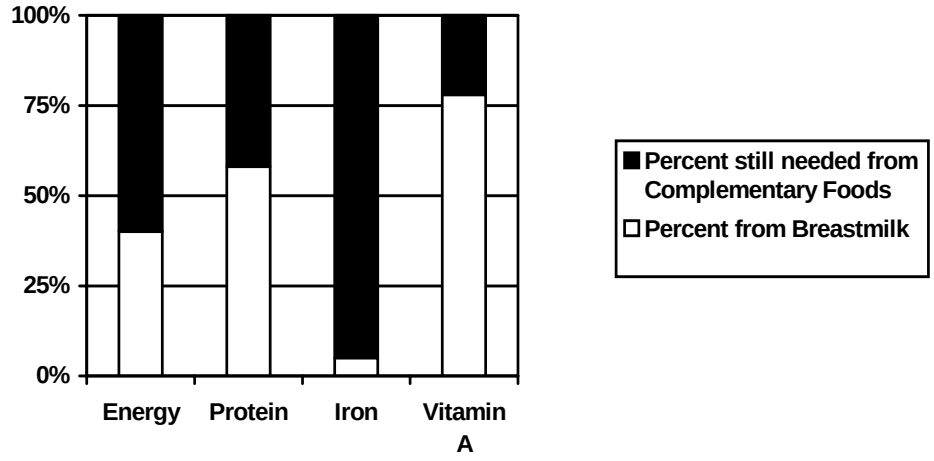

Figure 2:[23]
Minimum dietary energy density required to attain the level of energy needed from complementary foods in one to five meals per day, according to age group and level (low, average, or high) of breast milk energy intake (BME).

	6–8 mo			9–11 mo			12–23 mo		
Energy	Low BME	Average BME	High BME	Low BME	Average BME	High BME	Low BME	Average BME	High BME
Total energy required + 2SD (kcal/day)[b]	769	769	769	858	858	858	1,118	1,118	1,118
BME (kcal/day)	217	413	609	157	379	601	90	346	602
Energy required from complementary foods (kcal/day)	552	356	160	701	479	257	1,028	772	516
Minimum energy density (kcal/g)									
1 meal/day	2.22	1.43	0.64	2.46	1.68	0.90	2.98	2.24	1.50
2 meals/day	1.11	0.71	0.32	1.23	0.84	0.45	1.49	1.12	0.75
3 meals/day	0.74	0.48	0.21	0.82	0.56	0.30	0.99	0.75	0.50
4 meals/day	0.56	0.36	0.16	0.61	0.42	0.23	0.74	0.56	0.37
5 meals/day	0.44	0.29	0.13	0.49	0.34	0.18	0.60	0.45	0.30

a. Assumed functional gastric capacity (30 g/kg reference body weight) is 249 g/meal at 6–8 months, 285 g/meal at 9–11 months, and 345 g/meal at 12–23 months.
b. Total energy requirement is based on new US longitudinal data averages plus 25% (2SD).

This figure conveys the necessity of maintaining high volumes of milk for energy while adding a sufficient number of meals, dependent on their nutrient density.

[22] From the WHO/UNICEF Infant and Young Child Feeding Counselling: An Integrated Course.
[23] From Dewey K and K Brown, Update on technical issues concerning complementary feeding of young children in developing countries and implications for intervention programs. *Food and Nutrition Bulletin.* 2003; 24(1): 8, in Daelmans B, Martines J and R Saadeh (eds), Special Issue Based on a World Health Organization Expert Consultation on Complementary Feeding.

How might complementary feeding be addressed in baby-friendly care? There are many options.

- If BFHI has expanded into the paediatrics areas, it may include the "guiding principles" of complementary feeding and use of the new growth charts.
- If baby-friendly communities are in place, locally available foods may be identified for best feeding at this age.
- If BFHI Step Ten has reached out to community workers, whether from the health, agricultural, educational, or lay sectors, their training and efforts can include the "guiding principles".

In all cases, collection of data on feeding patterns and content by age of child, whether ongoing or periodic, will provide invaluable feedback for programme improvement.

Mother-baby friendly health care - everywhere!

The principles of mother-child centred care, protection of optimal mother and child conditions, and the recognition that maternal-child dyad deserves respect and support, are the underlying principles of all of these mother and baby-friendly expansion possibilities, and can be translated to a wide variety of environments, including:

- Hospitals, including all paediatric and women's health care units, as well as general medicine and surgery.
- Other health care facilities such as clinics, MCH centres, etc.
- Community outreach and mobilization programs.
- Faith based communities.
- Physician's offices.
- International initiatives, such as Community IMCI, partnership activities, Accelerated Child Survival and others.

The mother and baby-friendly activity may be added into one of these other efforts, or vice versa. The priority must be to ensure a comprehensive approach to support for Infant and Young Child Feeding, including legislating the International Code of Marketing, BFHI in the health system, and mother and baby-friendly community activities, as well as any of the above synergistic activities.

SECTION 1.6
RESOURCES, REFERENCES AND WEBSITES

Concerning the resources, references and websites listed below, please remember – web sites change frequently. Search for the key words 'BFHI', baby-friendly, and breastfeeding in the sites search engine, and look under Resources, Publications and Links within the web site.

UNICEF

For more information on UNICEF's work on infant and young child feeding support of country efforts to implement the targets of the Innocenti Declaration and the Global Strategy for Infant and Young Child Feeding, or on the Baby-friendly Hospital Initiative as a whole, and to download copies as materials are updated, please refer to http://www.unicef.org/nutrition/index_breastfeeding.html.

WHO

Department of Nutrition for Health and Development (NHD)
http://www.who.int/nutrition/topics/infantfeeding/en/index.html

Department of Child and Adolescent Health (CAH)
http://www.who.int/child_adolescent_health/topics/prevention_care/child/nutrition/en/index.html

WHO/UNICEF. *Global Strategy for Infant and Young Child Feeding.* Geneva, World Health Organization, 2003. Full text in PDF in English, Arabic, Chinese, French, Russian, Spanish.

WHO HIV and Infant Feeding Consensus Statement. Technical Consultation Held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants Geneva, October 25-27, 2006.

Edmond K, Bahl R. *Optimal feeding for the low birth weight infant: Technical review.* Geneva, World Health Organization, 2006.

WHO/UNICEF. *Implementing the Global Strategy for Infant and Young Child Feeding: Report of a technical meeting.* Geneva, World Health Organization, 2003.

WHO/UNICEF. *Breastfeeding and maternal medication: Recommendations for drugs in the eleventh WHO model list of essential drugs.* Geneva, World Health Organization, 2002.

Complementary feeding: Report of the Global Consultation, and Summary of Guiding Principles for complementary feeding of the breastfed child. Geneva, World Health Organization, 2001.

Guiding principles for complementary feeding of the breastfed child Washington DC, WHO/PAHO, 2003.

Butte N, Lopez-Alarcon M, Garza C. *Nutrient adequacy of exclusive breastfeeding for the term infant during the first six months of life.* Geneva, World Health Organization, 2002.

The optimal duration of exclusive breastfeeding, Report of an expert consultation WHO/FCH/CAH/01.24. Geneva, World Health Organization, 2001.

The optimal duration of exclusive breastfeeding, A systematic review WHO/FCH/CAH/01.23. Geneva, World Health Organization, 2001.

Statement on the effect of breastfeeding on mortality of HIV-infected women. Geneva, World Health Organization, 2001.

Evidence for the Ten Steps to Successful Breastfeeding WHO/CHD/98.9 Geneva, World Health Organization. 1998. Available in English, French and Spanish.

Complementary feeding of young children in developing countries: A review of current scientific knowledge WHO/NUT/98.1. Geneva, World Health Organization, 1998.

Health aspects of maternity leave and maternity protection. Statement to ILO, Geneva, 2001.

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

Breastfeeding and the use of water and teas Geneva, World Health Organization, 1997 (Update No 9).

Not enough milk Geneva, World Health Organization, 1996 (Update No 21).

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

WHO/UNICEF. *Breastfeeding counselling: A training course* . Geneva, World Health Organization, 1993.

UNAIDS/FAO/UNHCR/UNICEF/WHO/WFP/WB/UNFPA/IAEA. *HIV and Infant Feeding: Framework for Priority Action* Geneva, World Health Organization, 2003. Available in Chinese, English, French Portuguese and Spanish.

WHO/UNAIDS/UNFPA/UNICEF. *HIV transmission through breastfeeding. A review of available evidence* (Update) .Geneva, World Health Organization, 2007.

WHO/UNAIDS/UNFPA/UNICEF. *HIV and Infant Feeding. Guidelines for decision-makers* Geneva, World Health Organization, 2004. Available in English, French and Spanish..

WHO/UNAIDS/UNFPA/UNICEF. *HIV and Infant Feeding. A guide for health-care managers and supervisors* Geneva, World Health Organization, 2004. Available in English, French and Spanish.

Mastitis. Causes and management WHO/FCH/CAH/00.13. Geneva, World Health Organization, 2000.

HIV and infant feeding counselling: A training course WHO/FCH/CAH/00.2-4. Geneva, World Health Organization, 2000. Available in English and Spanish.

Relactation. A review of experience and recommendations for practice WHO/CHS/CAH/98.14. Geneva, World Health Organization, 1998.

Persistent diarrhoea and breastfeeding WHO/CHD/97.8.

Hypoglycaemia of the newborn. Review of the literature WHO/CHD/97.1. Geneva, World Health Organization, 1997.

Department of Reproductive Health and Research (RHR),
Email: reproductivehealth@who.int
www.who.int/reproductive-health/pages_resources/listing_maternal_newborn.en.html

Pregnancy, childbirth, postpartum and newborn care - a guide for essential practice. Geneva, World Health Organization, 2003.

Kangaroo Mother Care - a practical guide. Geneva, World Health Organization, 2003

OTHER ORGANIZATIONS: POLICIES, BACKGROUND AND PROTOCOLS

Academy for Breastfeeding Medicine, International: The Academy of Breastfeeding Medicine is a worldwide organization of physicians dedicated to the promotion, protection and support of breastfeeding and human lactation: http://www.bfmed.org

ABM Executive Office
191 Clarksville Road
Princeton Junction, NJ 08550
Toll free: 1 877-836-9947 ext. 25 Fax: 1 609-799-7032
Local/International: 1 609-799-6327
Email: ABM@bfmed.org http://www.bfmed.org

Selected protocols available:

1. Hypoglycemia
   Hypoglycemia (Japanese)
2. Going Home/Discharge (English)
   Alta (Spanish)
   Going Home (Chinese)
   Going Home (German)
3. Supplementation (English)
   Alimentación suplementaria (Spanish)
   Supplementation (Chinese)
   Supplementation (Japanese)
   Supplementation (German)
4. Mastitis (English)
   Mastitis (Spanish)
   Mastitis (Chinese)
   Mastitis (Japanese)
   Mastitis (German)
5. Peripartum BF Management (English)
   Manejo en el Periparto de la Lactancia (Spanish)
   Peripartum BF Management (Chinese)
   Peripartum BF Management (German)
6. Cosleeping and BF (English)
   Cosleeping and BF (Chinese)
   Cosleeping and BF (German)
7. Model Hospital Policy
8. Human Milk Storage (English)
   Human Milk Storage (German)
9. Galactogogues (English)
   Galactogogues (German)
10. Breastfeeding the Near-term Infant
    Breastfeeding the Near-term Infant (Japanese)
11. Neonatal Ankyloglossia
12. NICU Graduate Going Home
13. Contraception and Breastfeeding
14. Breastfeeding-Friendly Physicians' Office Part 1: Optimizing Care for Infants and Children
15. Analgesia and Anesthesia for the Breastfeeding Mother
16. Breastfeeding the Hypotonic Infant

Australian National Breastfeeding Strategy,
http://www.health.gov.au/pubhlth/strateg/brfeed/

Coalition for Improving Maternity Services (CIMS),
Coalition for Improving Maternity Services (CIMS)
National Office, PO Box 2346, Ponte Vedra Beach, FL 32004 USA
www.motherfriendly.org info@motherfriendly.org

Center for Infant and Young Child Feeding and Care, Department of Maternal and Child Health, University of North Carolina, USA http://www.sph.unc.edu/mch/ciycfc aims to create an enabling environment, at the community, state, national and global levels, in which every mother is supported to choose and to succeed in optimal infant and young child feeding and care, and every child will achieve his or her full potential through this best start on life. Its goal is to promote attention to the importance of the mother/child dyad in addressing breastfeeding-mediated health and survival, growth and development by:

- Developing and implementing breastfeeding-friendly health care;
- Educating and mobilizing major future leaders and influential groups;
- Creating the evidence base for action;
- Partnering and leveraging action at the state, national and international levels.

It fosters a network of like-minded organizations and individuals to further action to enable women to succeed in optimal infant feeding through attention to the family and the reproductive health continuum.

Emergency Nutrition Network (ENN): aims to improve the effectiveness of emergency food and nutrition interventions by providing a forum for the exchange of field level experiences between staff working in the food and nutrition sector in emergencies strengthening institutional memory amongst humanitarian aid agencies working in this sector helping field staff keep abreast of current research and evaluation findings relevant to their work better informing academics and researchers of current field level experiences, priorities and constraints thereby leading to more appropriate applied research agendas

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Tel: +44 (0)1865 722886 Fax: 44 (0)1865 722886
Email: office@ennonline.net http://www.ennonline.net/

IBFAN: the International Baby-Food Action Network - consists of public interest groups working around the world to reduce infant and young child morbidity and mortality. IBFAN aims to improve the health and well being of babies and young children, their mothers and their families through the protection, promotion and support of breastfeeding and optimal infant feeding practices.
http://www.ibfan.org/
Protecting Infant Health: A Health Workers' Guide to the International Code of Marketing of Breastmilk Substitutes (available in a variety of languages)
The Code Handbook: A Guide to Implementing the International Code of Marketing of Breastmilk Substitutes

Infant and Young Child Nutrition

Managed by PATH, the Infant and Young Child Nutrition Program (IYCN) is USAID's flagship project in this area – expanding upon 20 years of program experience to increase optimal feeding practices among mothers and their infants. This includes promoting breastfeeding, complementary feeding, infant feeding and HIV, and maternal nutrition.

International Lactation Consultant Association (ILCA), http://www.ilca.org

International Board of Lactation Consultant Examiners (IBLCE),
http://www.iblce.org/

La Leche League International (LLLI), http://www.lalecheleague.org/

LINKAGES was a USAID-funded program providing technical information, assistance, and training to organizations on breastfeeding, related complementary feeding and maternal dietary practices, and the lactational amenorrhea method - a modern postpartum method of contraception for women who breastfeed. Website includes publications to download: http://www.linkagesproject.org/

Exclusive Breastfeeding: The Only Water Source Young Infants Need - Frequently Asked Questions: Discusses the nutritional and health consequences of giving infants water during the first six months, and the role of breastfeeding in meeting an infant's water requirements. Languages Available: English (2004), French (2004), Spanish, Portuguese (2002).

Community-Based Strategies for Breastfeeding Promotion and Support in Developing Countries: WHO and LINKAGES examine the role of communities and community-based

resource persons in providing support to mothers who breastfeed. This report is based on a review of the literature and an analysis of three projects; it assesses the impact of interventions, the mechanisms through which behaviours can be changed, and the factors that are necessary to maximize and sustain the benefits of interventions. Author(s): A. Morrow, WHO Languages Available: English (2004).

Infant Feeding Options in the Context of HIV: This document identifies the specific behaviours required of a mother or caregiver to act upon the infant feeding recommendations and informed choice policy of WHO, UNICEF, UNAIDS, and UNFPA. Languages Available: English (2004).

Mother-to-Mother Support for Breastfeeding- Frequently Asked Questions: Focuses on a support group method where experienced breastfeeding mothers model optimal breastfeeding practices, share information and experiences, and offer support to other women in an atmosphere of trust and respect. Languages Available: English (2004), French (1999), Spanish (1999).

World Alliance for Breastfeeding Action (WABA), website includes publications to download: http://www.waba.org.my/

Wellstart, International: Wellstart International's mission is to advance the knowledge, skills, and ability of health care providers regarding the promotion, protection, and support of optimal infant and maternal health and nutrition from conception through the completion of weaning.

E-mail: info@wellstart.org www.wellstart.org

OTHER SOURCES

Kangaroo Mother Care This web site has downloadable resources on the research supporting Kangaroo Mother Care and experiences of implementing this practice. http://www.kangaroomothercare.com

EU Project on Promotion of Breastfeeding in Europe, Protection, promotion and support of breastfeeding in Europe: a blueprint for action. European Commission, Directorate Public Health and Risk Assessment, Luxembourg, 2004. http://europa.eu.int/comm/health/ph_projects/2002/promotion/promotion_2002_18_en.htm

JOURNAL REFERENCE SITES

Medline--National Library of Medicine http://www.ncbi.nlm.nih.gov/entrez/query.fcgi

Google are developing a free web searcher that searches research journals on open access. http://scholar.google.com/

The publishers of most of the journals have a searchable web site where the abstract and sometimes the full text of an article can be viewed or downloaded.

BFHI Committees willing to be listed in this edition:

Australia http://www.acmi.org.au/
Canada http://www.breastfeedingcanada.ca/
Ireland http://www.ihph.ie/babyfriendlyinitiative/
Netherlands http://www.zvb.borstvoeding.nl
Switzerland www.allaiter.ch
United Kingdom http://www.babyfriendly.org.uk/
USA www.babyfriendlyusa.org

There are more than 50 additional Committees and National Authorities that may be identified by a local UNICEF or WHO office.

If your committee would like to be listed in UNICEF's database, please let UNICEF know, by email: Subject line: Attn. Nutrition Section at: pdpimas@unicef.org

ADDITIONAL RESOURCES WILL BE MADE AVAILABLE AS RESOURCES PERMIT.

The Baby-friendly Hospital Initiative (BFHI) is a global effort launched by WHO and UNICEF to implement practices that protect, promote and support breastfeeding. It was launched in 1991 in response to the Innocenti Declaration. The global BFHI materials have been revised, updated and expanded for integrated care. The materials reflect new research and experience, reinforce the International Code of Marketing of Breast-milk Substitutes, support mothers who are not breastfeeding, provide modules on HIV and infant feeding and mother-friendly care, and give more guidance for monitoring and reassessment.

The revised package of BFHI materials includes five sections: 1. Background and Implementation, 2. Strengthening and Sustaining the BFHI: A course for decision-makers, 3. Breastfeeding Promotion and Support in a Baby-friendly Hospital: a 20-hour course for maternity staff, 4. Hospital Self-Appraisal and Monitoring, and 5. External Assessment and Reassessment. Sections 1 to 4 are widely available while section 5 is for limited distribution.

For further information please contact:

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World Health Organization
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Switzerland
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e-mail: nutrition@who.int
website: www.who.int/nutrition

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website: www.unicef.org

ISBN 978 92 4 159496 7