



Baby Friendly Health Initiative  
Australia



BFHI Handbook  
for Maternity Facilities



Australian College  
of Midwives

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Baby Friendly Health Initiative, Australia.

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World Health Organisation (WHO) & UNICEF Global Standards for BFHI.

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## Introduction - Why 'Baby Friendly'?

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

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

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

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

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

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

In a *Baby Friendly* facility, breastfeeding mothers are given consistent, accurate information and support. In many cases the duration of breastfeeding is extended.

Mothers who choose to artificially feed their babies, or who are required to supplement with or switch to infant formula, are given individual support and information to help them correctly prepare feeds and to ensure that they know how to feed their babies safely.

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

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

BFHI accreditation, with its focus on education and training, also aids recruitment and retention of staff through increased professional development opportunities and increased job satisfaction.

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## Achieving BFHI Accreditation

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### Ten Steps to Successful Breastfeeding

Review the standards for Implementation of the *Ten Steps to Successful Breastfeeding*.

### Coordination

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

### Support

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

### Self-Appraisal

Complete the BFHI self-appraisal tool.

### Policies for BFHI

Thoroughly review the facility's breastfeeding/infant feeding policy against requirements listed for step 1. Review any clinical pathways/ guidelines that support the breastfeeding policy to ensure they also meet BFHI requirements and reflect contemporary lactation management practices. Review the facility's breastfeeding and supplementation statistics over the previous 12 months.

### Observations

Walk through the facility, looking at it from a BFHI perspective. Refer to Appendix 4 for guidance on internal auditing for implementation of the *WHO International Code* in a BFHI facility.

### Self-audit

Conduct an audit of common problem areas, for example step 5 (show mothers how to breastfeed using 'hands off' techniques, show mothers how to hand-express), step 6 (*Acceptable Medical Reasons for Use of Breastmilk Substitutes*, required documentation and informed consent), step 7 (rooming in, including required documentation regarding separation), step 8 (breastfeeding on demand), or others as needed. The results of these internal audits are not required as part of the accreditation process, however it is a useful tool for the facility to gauge how it measures against *Baby Friendly* standards.

### Action Plan

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

### Staff Education

Allocate all relevant staff to a staff group. Refer to step 2. Establish a database of relevant BFHI education for each staff member (an electronic database is best, using a spreadsheet or similar). Determine whether any further staff education is needed and if so ensure that it is completed.

## Further Self-Appraisal

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

## Assessment Type

Determine if a multi-facility or cluster assessment is appropriate.

### Multi-Facility Assessment

A multi-facility assessment is designed for two or more facilities in an area under the same governance to be assessed together. It is primarily designed to provide financial advantage as there is a fee reduction for the second and subsequent facilities.

The facilities must meet the following criteria:

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

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

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

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

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

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

### Cluster Assessment

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

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

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

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

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

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

### **Applying for Assessment**

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

- Request for assessment form
- Financial agreement form
- BFHI self-appraisal
- BFHI data for the most recent 12 months (Jan-Jun & Jul-Dec or Jul-Dec & Jan-Jun) using the BFHI Excel spreadsheet. Required for facilities applying for accreditation for the first time. (Already accredited facilities are required to submit data bi-annually).
- Copy of the facility's breastfeeding policy

### **Human Subject Research Clearance**

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

### **Police Checks/Working with Children and/or Vulnerable People Checks**

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

### **Confirming the Assessment**

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

### **Conflict of Interest**

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

## **The Assessment Team**

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

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

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

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

## **During Assessment**

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

On the day the assessment commences, the Assessors should be provided with a suitable workplace, appropriate identification, access to relevant areas, and be introduced to relevant staff. Facilities are encouraged to provide meals for the assessment team such as lunch, morning and afternoon tea, though this is not a requirement. If there are satellite sites, the facility is responsible for the assessors' travel to and from the primary site.

## **Interviews**

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

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

## **Interpreters**

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

## **Conclusion of the assessment**

On completion of the assessment a suitable time will be arranged with the BFHI Coordinator so the Assessors can formally conclude the assessment. This is usually on the afternoon of the second day. This informal session will allow the BFHI Coordinator and any other relevant key



maternity staff to ask questions and/or add any further information. The assessment team will provide general results including achievements and steps still needing further work; however, it is important to note that the assessment team cannot provide the outcome of the assessment.

### **The Assessment Report**

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

### **Assessment Outcomes**

#### ***Ten Steps to Successful Breastfeeding Met***

If the assessment and review indicates the facility has met all the standards for each of the *Ten Steps to Successful Breastfeeding*, the BFHI Manager will email the BFHI Coordinator at the facility. A copy of the assessment report and scoring booklet will be provided with a letter of outcome as well as an electronic copy of the accreditation certificate.

#### ***Ten Steps to Successful Breastfeeding Not Met***

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

### **Final Decision**

Accreditation is awarded by the Chief Executive Officer, Australian College of Midwives. The facility will be advised of the decision by email, and this is followed by an A3 accreditation certificate for display. Once accredited, the facility will be included on a list of Baby Friendly facilities in Australia on the ACM website. News of the accreditation will also be published in the Australian Midwifery News magazine, on the ACM's Facebook page and other social media. Photographs and stories of *Baby Friendly* celebrations or achievements help to further promote the facility, and can be submitted to the BFHI Manager.

### **Facility Feedback**

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

### **Appeals Process**

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

### **Accreditation period**

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

### **Maintaining Accreditation**

Once accredited, it is the facility's responsibility to ensure BFHI standards are maintained for the three-year period of accreditation. The facility will be required to submit BFHI data on a bi-annual basis to the BFHI Manager. Facilities will also be encouraged to complete an annual BFHI self-appraisal to track standards and should also conduct regular internal audits, although these documents will not be required to be submitted annually.

### **Re-Accreditation**

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

For Further information on BFHI please visit [www.midwives.org.au](http://www.midwives.org.au) or contact

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

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**Policies for BFHI**

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

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

There are options for how this can be achieved:

- The facility may have a breastfeeding policy and several other 'policies for BFHI' that complement and refer to each other to support step 1.
- Alternatively, facilities may integrate all the policy requirements of step 1 into a comprehensive infant feeding policy.

Each policy must include:

- a statement regarding who the policy relates to
- a statement regarding the fact that it is mandatory to adhere to it
- who it has been endorsed by
- the date of effect
- the date when it is due for review

Most policies are supported by detailed clinical protocols/guidelines which do not belong in a policy. The policy is 'what we will do', whilst the protocols/guidelines are 'how will we do it'. Some facilities have alternate names for policies and clinical protocols; this is acceptable as long as they fulfil the criteria.

Protocols must be:

- consistent with BFHI standards
- evidence-based
- reflective of contemporary information and practices.

**Responsibilities**

All personnel<sup>1</sup> who have contact with mothers and babies are familiar with 'policies for BFHI', and understand their responsibility to adhere to them. They are able to locate the policies and/or protocols/guidelines in the areas where they work.

**Review**

The policies and protocols are reviewed and updated at least every 3 years. Where policies and protocols are national or state-wide and have a review cycle of up to 5 years, there is evidence (memo, minutes of meetings etc.) that demonstrates that the policies and protocols have at least been reviewed at the facility level within the last 3 years to ensure that they are still consistent with current evidence and best practice.

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<sup>1</sup> Personnel refers to all persons engaged in relevant activities, not just those who the facility defines as "staff".

## Reassessment

At reassessment, facilities can satisfactorily report on how recommendations made at the last assessment have been addressed. They may also report on any internal monitoring, new services, programs or facilities supportive of breastfeeding which have resulted from a continuous improvement process since the last assessment.

## The Breastfeeding Policy

At a minimum, the breastfeeding policy addresses the principles and practices that enable implementation of each of the *Ten Steps to Successful Breastfeeding*. The breastfeeding policy is accessible to mothers and their families on request, and an easily visible summary is displayed in each area of the facility which potentially serves pregnant women, mothers, infants and/or young children (see breastfeeding policy summary below). It is important to note that a list of the *Ten Steps to Successful Breastfeeding* on its own does not meet the requirements of the breastfeeding policy as it does not adequately address what the facility commits to do to implement each step.

## Breastfeeding Policy Summary

The breastfeeding policy summary covers the key points of the policy, and is displayed in each area of the facility which potentially serves pregnant women, mothers, infants and/or young children. It is presented in an easy-to-read format, which may be low literacy or pictorial. The summary must be displayed in each language used by 10% or more of mothers who use the facility's maternity services and facilities are encouraged to have it available in other languages used by mothers. The *Ten Steps to Successful Breastfeeding* may be used if appropriately presented as a summary of the facility's breastfeeding policy. The summary must include a statement that the full policy may be viewed on request.

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

## Implementation of the WHO International Code

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

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

any association with artificial feeding or potential promotion of brand/product recognition in relation to infant feeding.

- There is careful scrutiny at the institutional level of any research which involves mothers and babies for potential implications on infant feeding or interference with the full implementation of the policy.

### **Support for staff to continue to breastfeed when they return to work**

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

### **Standards of care for the mother who is artificially feeding her baby**

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

- Relevant personnel<sup>1</sup> have received education to ensure that their knowledge about artificial feeding is current.
- Relevant personnel have the skills to teach mothers correct preparation, storage and handling of powdered infant formula<sup>2</sup>.
- Mothers who are considering artificial feeding are supported to make a fully informed choice, appropriate to their circumstances.
- All mothers who will be leaving the facility using infant formula are given:
  - information and instruction on the safe preparation, storage and handling of reconstituted powdered infant formula, using NHMRC Guidelines<sup>3</sup> ;
  - information on the risks to the baby if the preparation and handling instructions are not followed carefully;
  - a demonstration and supervised practice in making up a bottle-feed using powdered infant formula;
  - information on where to get help with infant feeding after discharge from the facility.
- Instruction on artificial feeding is given only to parents who require it. The instruction is not given in a group situation. The instruction is conducted privately, away from breastfeeding mothers.
- Instructional materials on artificial feeding shown or given to parents are free from advertising, do not refer to or contain images of an identifiable product, and comply with the *WHO International Code*.

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<sup>1</sup> Personnel refers to all persons engaged in relevant activities, not just those who the facility defines as "staff".

<sup>2</sup> Infant Feeding Guidelines for Health Workers, Section 8. *National Health and Medical Research Council (NHMRC) 2012*.

<sup>3</sup> The NHMRC Infant Feeding Guidelines outline the standard of care for artificial feeding in Australia and are recommended for use in BFHI facilities. However, facilities may elect to use "WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization 2007*", especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

### **Mother-friendly labour and birthing practices**

There is a policy which addresses mother-friendly labour and birthing practices. The policy is supported by written protocols which foster mother-friendly labour and birthing practices that are helpful for the mothers' psychological and physical health and enhance the babies' start in life, including breastfeeding. The policy includes each of the following points:

- Women are encouraged to have a support person of their choice with them throughout labour and birth.
- There is support for practices that can help with comfort and non-pharmacological pain relief during labour.
- Women are encouraged to move about as they need to during labour, and to assume birthing positions of their choice, unless a restriction is medically indicated.
- Invasive procedures are not used routinely, unless specifically required for a complication. Invasive procedures include rupture of the membranes, episiotomy, acceleration or induction of labour, instrumental delivery, or caesarean birth. If these are required for a medical reason, the reason is explained to the mother.

NB. All personnel are aware that care involving restrictions on drinking and eating light foods, and invasive procedures during labour and birth may impact on the mother's condition and on the establishment of exclusive breastfeeding.

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

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All facility personnel<sup>1</sup> who have contact with pregnant women, mothers and infants in the facility have received orientation to and education on the 'policies for BFHI' outlined in step 1 and have the skills necessary to implement these policies.

Personnel are divided into three groups, based on what they do in their role in the facility rather than on their position title. Allocation to the various groups can be determined by the facility, but needs to meet the following criteria:

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

**Group 2:** Those who may provide general breastfeeding advice but do not assist mothers with breastfeeding. For example, obstetricians, paediatricians, other medical personnel, most paediatric unit personnel (unless they frequently assist mothers with breastfeeding or breast expression), speech pathologists, physiotherapists and dieticians who advise or provide care related to infant feeding or lactation to mothers and/or their babies.

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

Facility Personnel Education Database
<p><b>Facility Records</b> The facility maintains electronic or hard copy central records which show the number of hours of education completed by each person who has contact with pregnant women, mothers and infants. For BFHI purposes, this is referred to as the facility personnel education database.</p>
<p><b>Completion of Education and Documentation</b> For all groups, completion of education must be documented in the facility personnel education database.</p>
<p><b>At assessment, the facility personnel education database must indicate that</b></p> <ul style="list-style-type: none"><li>• at least 80% of personnel from each group have completed the relevant education requirements.</li></ul>

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<sup>1</sup> Personnel refers to all persons engaged in relevant activities, not just those who the facility defines as "staff".

## Education requirements for new personnel, casual personnel, students, locums and others who assist mothers with breastfeeding

There is an education schedule for new and casual/agency personnel whose role may involve educating, advising or assisting mothers with breastfeeding.

### Orientation

The education schedule includes orientation to 'policies for BFHI' and protocols at commencement of their first shift/placement/visit. Orientation should include:

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

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

### New personnel

New personnel from groups 1, 2 and 3 should be scheduled for appropriate education as per relevant group within 6 months of commencing and complete the education within 12 months. For groups 1 & 2, relevant BFHI education from another BFHI accredited facility can be credited towards the required education if it was documented and was within the last 3 years. Recognised prior learning (RPL) if applicable – see below for definition - can be credited towards the education required.

### Casual/agency personnel

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

The facility personnel education database must indicate that at least 80% of new and casual/agency personnel have completed the education requirements.

## Group 1 BFHI Education Requirements

- **First assessment:** All group 1 personnel at the facility
- **Reassessment:** All group 1 personnel who commenced work since the last assessment
- **Reassessment:** All group 1 personnel working at the facility at the time of the last assessment

Group 1 personnel must have a minimum of 20 hours of education which covers the BFHI curriculum. Up to 12 hours of the 20 hours can be by RPL.

The education must include:

- at least 8 hours theoretical education in the previous 3 years; and
- at least 3 hours relevant supervised clinical experience (see below).

The content delivery of the 20 hours is flexible: there must be a minimum of 8 hours theoretical education covering the BFHI curriculum (see below); the balance can be further theoretical education or supervised clinical experience in the BFHI skills relevant to the area of work. The education program may include various delivery options such as face-to-face education (e.g. study days); orientation session, online education or self-directed learning that has been validated by the facility.



### **Supervised Clinical Experience**

Supervision should be by someone who is experienced and knowledgeable about evidence-based, contemporary breastfeeding practices consistent with BFHI standards.

The supervised clinical experience must be documented and can be acquired in a single session or cumulatively through direct or indirect supervised experience during a normal working day or simulated activities. It may include observation and or assisting with a particular practice e.g. breast expression, assisting with a breastfeed, discussing breastfeeding with a pregnant woman (antenatal clinic or booking-in), facilitation of skin to skin contact at birth and early initiation of breastfeeding, or support provided to a mother who is artificially feeding her baby. This definition is based on the *WHO 20-hour course: Breastfeeding Promotion and Support in a Baby Friendly Hospital*.

### **Recognition of Prior Learning (RPL)**

RPL (up to 12 hours) can include theoretical education in breastfeeding and supervised clinical experience in breastfeeding skills. RPL can be granted for breastfeeding education/supervised clinical experience acquired from any source in the 10-year period prior to the BFHI assessment. This refers to breastfeeding education from any appropriate source not necessarily directly BFHI related.

Each group 1 member who needs to use RPL as a component of their 20 hours education is required to have a personal record of their prior learning. This record should show completed breastfeeding education programs or sessions and supervised clinical experience, including the number of hours for each item listed. Before assessment, the facility must review the personal record and record the number of RPL hours (up to 12) in the facility personnel education database.

Those personnel, who can show evidence of being a currently certified International Board of Certified Lactation Consultants (IBCLC) or a current Australian Breastfeeding Association (ABA) counsellor with a Cert IV in Breastfeeding Education, may be deemed to have 12 hours RPL.

Relevant BFHI education from another BFHI accredited facility can be credited towards the required education if it was documented and was within the last 3 years.

Refer to section "Facility Personnel Education Database" earlier in this step for further requirements.

### **Group 1 education requirements for reassessment (at facility at time of last assessment)**

For reassessment, group 1 personnel who were working at the facility at the time of the last assessment must have a further 8 hours of relevant BFHI education, including a re-orientation to the 'policies for BFHI'. It is recommended the education is spread over the 3 years.

Education may include: participation in relevant breastfeeding sessions or workshops, face-to-face or online; self-directed learning that has been validated by the facility; reporting on breastfeeding research and articles; conducting breastfeeding education sessions for personnel; repeat or update of original education, etc. It is not a requirement for these personnel to complete supervised clinical experience for reassessment.

### **Group 2 BFHI Education Requirements**

- **First assessment:** All group 2 personnel at the facility's first assessment
- **Reassessment:** All group 2 personnel who commenced work since the last assessment
- **Reassessment:** All group 2 personnel working at the facility at the time of the last assessment

Group 2 personnel must have a minimum of 2 hours of education. The delivery of the 2 hours is flexible. It may be face-to-face sessions individually or group, online sessions, a series of short handouts, or a combination of these. Relevant BFHI education from another facility can be

credited towards the required education if it was documented and was within the last 3 years.

Refer to section “Facility Personnel Education Database” earlier in this step for further requirements.

### **Group 2 BFHI education requirements for reassessment (at facility at time of last assessment)**

For reassessment, Group 2 personnel who were working at the facility at the time of the last assessment must have had a refresher on the above requirements. No time is specified.

### **Group 3 BFHI Education Requirements**

- **First assessment:** all group 3 personnel at the facility's first assessment
- **Reassessment:** all group 3 personnel who commenced work since the last assessment
- **Reassessment:** All group 3 personnel working at the facility at the time of the last assessment

No time is specified for group 3 education, but it is usually around one hour and can be delivered face-to-face individually or in a group. Refer to section “Facility Personnel Education Database” earlier in this step for further requirements.

### **Group 3 BFHI education requirements for reassessment (at facility at time of last assessment)**

For reassessment, group 3 personnel who were working at the facility at the time of the last assessment must have a refresher on the above requirements. No time is specified.

## **BFHI Education Curriculum**

### **Group 1 personnel**

There is a curriculum for BFHI education for group 1 personnel which covers:

- the facility's 'policies for BFHI' and the implementation of each of the *Ten Steps to Successful Breastfeeding*.
- the *Acceptable Medical Reasons for the Use of Breastmilk Substitutes* (see Appendix 2).
- the facility's and health workers' responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.
- the facility's protocols and information on breastfeeding and lactation management in a *Baby Friendly* facility, with a focus on empowering the women and using “hands-off” techniques.
- clinical skills such as positioning and attachment, recognising good attachment, hand expression, alternative ways in which a supplementary feed may be offered to a breastfeeding baby.
- mother-friendly labour and birthing practices and how they relate to breastfeeding.
- culturally sensitive care in response to women's beliefs, customs or ethnicity.
- how to assist the mother to make a fully informed and appropriate decision about infant feeding, suitable to her circumstances.
- providing optimal support to all mothers who will be leaving the facility using infant formula. At a minimum, group 1 personnel should be familiar with the information in Section 8 (pages 73-83) in *Infant Feeding Guidelines. National Health and Medical Research Council (NHMRC) 2012*. (See Appendix 4)

## **BFHI Education Curriculum Group 2 personnel**

There is a curriculum for BFHI education for group 2 personnel which covers:

- the facility's 'policies for BFHI' and the implementation of each of the *Ten Steps to Successful Breastfeeding*.
- the *Acceptable Medical Reasons for the Use of Breastmilk Substitutes*.
- the facility's and health workers' responsibilities under the *WHO International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.
- mother-friendly labour and birthing practices and how they relate to breastfeeding.
- culturally sensitive care in response to women's beliefs, customs or ethnicity.
- protocols related to step 4, skin to skin.
- why breastfeeding is important
- ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
- how to assist the mother to make a fully informed and appropriate decision about infant feeding, suitable to her circumstances.

## **BFHI Education Curriculum Group 3 personnel**

There is a curriculum for the group 3 BFHI education which briefly covers:

- why breastfeeding is important.
- the *Ten Steps to Successful Breastfeeding*.
- the facility's breastfeeding policy and the location/s of the summary.

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

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If the facility provides any antenatal services (including booking-in, antenatal clinics, antenatal classes or antenatal inpatient care), these services are used to inform pregnant women about birthing and about the importance and early management of breastfeeding. Written information is supported by individual discussion and/or antenatal classes and there are procedures in place to ensure that the required information is given to all women by the beginning of the third trimester (28 weeks).

Written antenatal information about birthing and breastfeeding is available for pregnant women in each language used by 10% or more of the women who use the facility's maternity services, though it is encouraged to have this information available in other languages. It is presented in an easy-to-read format, which may be low literacy or pictorial.

The antenatal service does not promote artificial feeding or products used for this purpose. All educational materials, handouts or sample bags available and/or distributed to antenatal women are made available for the Assessors to review and are free of promotion of artificial feeding.

#### **Antenatal information for women**

A written description of the information in the antenatal education/discussion about breastfeeding is made available to the Assessors. The antenatal education/discussion covers at least the following key points:

- the facility's breastfeeding policy including the *Ten Steps to Successful Breastfeeding*.
- why breastfeeding is important and the risks associated with not breastfeeding.
- the benefits of having a support person of the mother's choice with her throughout labour and birth.
- ways to help with comfort and non-pharmacological pain relief during labour.
- the importance of early uninterrupted skin-to-skin contact (the importance of the first hour).
- how to recognise when the baby is ready to attach to the breast for the first feed.
- basic breastfeeding and lactation management, including positioning and attachment, feeding cues and frequency of feeding.
- why 24-hour rooming-in (staying close to baby) is important.
- why bottle teats and dummies are discouraged while breastfeeding is being established.
- exclusive (full) breastfeeding for around six months and that breastfeeding continues to be important after other foods are introduced and may be continued for up to two years and beyond as per WHO guidelines.
- breastfeeding support groups and services in the community.

#### **Staff Interviews**

##### **The Senior Midwife Antenatal Services can:**

- confirm pregnant women are provided with information or education on breastfeeding and on mother-friendly labour and birthing.
- confirm that all pregnant women are asked about their breastfeeding knowledge and previous experience with infant feeding.

- confirm that pregnant women who did not breastfeed a previous child or had problems with breastfeeding are offered antenatal breastfeeding counselling and can describe how this counselling is facilitated.
- describe the community-based breastfeeding and pregnancy support groups and/or classes in the local area and how pregnant women are encouraged to access these.
- describe the support, resources and materials available for pregnant women from other cultures and/or those who use or understand a language other than English.

### **Pregnant women interviews**

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

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

### **At least 70% of the pregnant women interviewed can:**

- confirm that that they were asked about their previous knowledge and experience with baby feeding.
- confirm they have been given the opportunity to discuss breastfeeding with a staff member.
- state at least two reasons why breastfeeding is important.
- confirm they have been informed they can have a support person of their choice with them during labour.
- state at least two ways which help with comfort and non-pharmacological pain relief during labour. *(This item is excluded from scoring if the woman cannot answer and she is less than 36 weeks gestation or having a planned caesarean birth).*
- answer questions about
  - skin-to-skin contact immediately after birth; and
  - how to recognise when her baby is ready to attach for the first breastfeed
- state why rooming-in 24 hours per day is important.
- state why avoiding early dummy use is important.
- confirm that they have been given information on breastfeeding support groups and services available in the community and how to contact them.
- confirm that they have not received from the facility any group education on artificial feeding.

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**Step 4 Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed**

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The facility has procedures which facilitate immediate skin-to-skin contact on the mother's chest after birth and the baby is allowed to remain there without interruption or separation. When the mother is intending to breastfeed, the baby stays there until after the first breastfeed or for at least an hour if the baby feeds sooner. The mother is encouraged to support her baby to breastfeed when the baby show signs of readiness and the staff do not intervene to attach the baby, especially in the first hour. The baby is allowed to finish the feed when he/she is ready.

If the mother is not planning to breastfeed, the baby stays skin-to-skin for at least an hour after birth.

***Skin-to-skin immediately after a vaginal or caesarean birth***

***After a vaginal birth***

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

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

***After a caesarean birth***

Optimum practice:

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

BFHI minimum requirements:

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

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

*Skin-to-skin contact with another adult, such as the father, is an alternative when skin-to-skin is not possible with the mother or has to be interrupted e.g. for medical reasons. It will help stabilise the baby's temperature and respiration, and has other benefits. However, skin-to-skin on the mother's chest remains the optimal practice for babies who have had a vaginal or caesarean birth and is important for the optimal establishment of breastfeeding. Skin-to-skin contact with another adult does not meet step 4 requirements.*

### **Skin-to-skin contact “continues uninterrupted”**

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

#### **When the mother is intending to breastfeed**

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

*Although this step specifies that skin-to-skin contact should continue “for at least an hour”, it has been shown that most healthy term babies will follow a sequence of pre-feeding behaviours for more than an hour before they are ready to self-attach and initiate the first breastfeed – in one study the median was 80 minutes after an un-medicated birth; it may be longer if there have been interventions.*

The staff provides assistance by keeping the mother and baby together and ensuring procedures are in place for appropriate vigilance of the infant, including assessment of airway, breathing and colour. Staff care should be hands-off, encouraging the mother to recognise and respond to her baby’s innate feeding behaviours and allowing the baby to self-attach to the breast. The midwife may help the mother into a more comfortable position. The mother may give the baby assistance if required, but only at the mother’s request should a staff member help her position the baby; all hands-on assistance must be documented.

*In some uncommon situations, with mother’s permission, it may be acceptable for a staff member to use hands-on to attach the baby. e.g. baby having difficulty self-attaching after being given sufficient time and mother sedated or unwell. To meet BFHI standards, it must be more than an hour after birth, with the mother’s permission, and it must be documented.*

*Where there is the potential for the baby to have low blood sugar levels, e.g. mother with diabetes, and she is unable to assist her baby to initiate feeding, it may be necessary for the midwife to use hands-on assistance, with an explanation and the mother’s permission, to help the baby attach to the breast sooner than one hour after birth. It must be documented.*

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

#### **‘Without interruption’**

*Weighing, measuring and bathing the baby, and cuddles by others, are delayed; most required medical procedures can be carried out with the baby on the mother’s abdomen. A brief interruption may be necessary e.g. transfer from a theatre bed to a recovery bed, however transfer procedures will generally respect the importance of keeping the baby skin-to-skin with the mother. If the mother’s condition necessitates a toilet break before the baby has breastfed, then the interruption should be as brief as possible, before resuming skin-to-skin contact.*

*If skin-to-skin has to be interrupted or terminated for maternal medical reasons, skin-to-skin with another adult, such as the father, is the next best option. See above.*

#### **When the mother is not planning to initiate breastfeeding**

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

## Staff Interviews

### The Senior Midwife Birthing Services can:

- outline practices and procedures used in the facility that can help a mother be more comfortable and in control during labour and birth.
- describe at least two labour and birthing practices and procedures that make it more likely that breastfeeding will get off to a good start.
- give at least one example of ways in which the staff provide culturally sensitive care in response to a woman's beliefs, customs or ethnicity.
- outline the procedures used in this facility for keeping mothers and babies together after a vaginal birth, and after a caesarean birth, and what the staff do to support the optimal initiation of breastfeeding.

### The Senior Midwife Postnatal can:

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

### At least 80% of the group 1 and group 2 personnel interviewed can:

- describe at least two labour and birthing practices and procedures that make it more likely that breastfeeding will get off to a good start

## Mother Interviews<sup>1</sup>

### At least 80% of mothers interviewed, unless a medically indicated procedure was required can:

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

### Of those who intended to breastfeed, at least 80% of mothers interviewed, unless a medically indicated procedure was required can:

- confirm the baby stayed skin-to-skin without interruption for at least an hour (even if the baby breastfed early).
- describe how they could recognise that their baby was ready to attach to the breast for the first feed.
- confirm that the baby was allowed to follow the normal sequence of innate feeding behaviours, seek the breast and initiate the first breastfeed, without staff hands-on intervention, as per the standards for this step.
- confirm that the baby was allowed to finish the feed when he/she was ready.

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

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

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

### At least 60% of mothers with babies in Special Care<sup>2</sup> can:

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

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<sup>1</sup> The relative number of mothers interviewed who have had a vaginal vs. caesarean birth will be determined by the annual percentage of vaginal vs. caesarean births at that facility.

<sup>2</sup> For the purpose of interviewing mothers for BFHI assessments, NICU can be included in the definition of special care.



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

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All mothers who plan to breastfeed are taught the necessary skills and provided with appropriate support and information to initiate and maintain lactation and to breastfeed their babies.

All breastfeeding mothers are taught:

- how to position and attach their babies for breastfeeding, and how to recognise that the baby is well attached on the breast and breastfeeding effectively.
- how to stimulate the milk ejection reflex and how to hand express their breastmilk.
- the supply and demand principles behind maintaining optimal milk supply.
- how to recognise when their baby is ready to feed.
- how to maintain lactation if they are separated from their baby.

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

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

**Staff interviews****The Divisional Director of Nursing/Midwifery can:**

- confirm that support is provided if a breastfeeding mother or a breastfed baby/child is admitted to any part of the facility.

**The Senior Midwife Postnatal can:**

- describe the support, resources and materials available for pregnant women from other cultures and/or those who use or understand a language other than English.
- give at least one example of ways in which the staff provide culturally sensitive care in response to a woman's beliefs, customs or ethnicity.

**At least 80% of the group 1 personnel interviewed can:**

- demonstrate correct teaching of both positioning and attachment, preferably using a baby-led-attachment, biological nurturing or "hands-off" technique.
- explain how to instruct a mother to recognise if her baby is well attached and feeding effectively.
- demonstrate an acceptable technique for teaching mothers how to hand express their breasts.
- outline correct information for storage and use of expressed breastmilk.
- outline key safety and hygiene points that should be covered when instructing reconstitution of powdered infant formula.

**At least 66% of the group 2 personnel interviewed can:**

- state who they would refer mothers to for skilled assistance on breastfeeding.

## **Mother Interviews (breastfeeding)**

**At least 80% of breastfeeding mothers who are interviewed can:**

- report that staff gave further assistance with breastfeeding as required.
- demonstrate or describe correct positioning and attachment.
- describe how to recognise their babies are well attached on the breast and breastfeeding effectively.
- describe cues, other than crying, that indicate their baby is ready to feed.
- describe when they should feed their baby.
- explain the potential risks associated with using supplements in the first six months.

**The mothers who are more than 24 hours after birth (48 hours if caesarean birth, or there is a documented maternal medical reason) can:**

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

**At least 60% of mothers with babies who are in Special Care (including NICU) and who are breastfeeding or expressing their milk can:**

- confirm they have been supported to initiate lactation as soon as possible (within six hours of birth unless the mother was severely medically compromised).
- confirm they have been shown by staff how to express their breastmilk and have been provided with assistance as required.
- confirm they have been informed by staff how to maintain lactation by frequent expression of breastmilk.
- confirm they have been informed by staff and provided with written information on how to store, transport and use their expressed breastmilk (if their babies are 24 or more hours old).

## **Care of mothers who are artificial feeding**

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

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

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

- information and instruction on the safe preparation, storage and handling of reconstituted powdered infant formula, using NHMRC Guidelines<sup>1</sup>.
- information on the risks to the baby if the preparation and handling instructions are not followed carefully.

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<sup>1</sup> Infant Feeding Guidelines, Section 8. *National Health and Medical Research Council (NHMRC) 2012*. See appendix 3.

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

- a demonstration and supervised practice in making up a bottle-feed using powdered infant formula<sup>1</sup>;
- information on the importance of ensuring the correct concentration by following the instructions on the can exactly, regarding water volume and scoops of powder, and are made aware that these will be different for each brand of formula.
- information on best practice for feeding their babies with a bottle.
- information on where to get help with infant feeding after discharge from the facility.

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

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

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

#### **The Senior Midwife Postnatal and group 1 personnel can:**

- confirm that mothers who will be leaving the facility using infant formula are given instruction and supervised practice on the reconstitution of powdered infant formula and how to bottle-feed.
- describe briefly:
  - what should be considered when organising where and how instruction on the preparation of infant formula should be given.
  - the key safety and hygiene points that should be covered when instructing reconstitution of powdered infant formula.
  - the key issues to be covered when instructing a mother on how to feed her baby with a bottle.

#### **Mother Interviews (artificial feeding)**

**At least 66% of mothers who have been feeding their babies with infant formula for at least 24 hours (or whose babies are at least 48 hours old if caesarean birth or there is a documented maternal medical reason) can:**

- confirm they have been given individual education about making up a bottle-feed using powdered infant formula.
- confirm they have made up a bottle-feed using powdered infant formula under supervision, or been offered the opportunity to do so.
- adequately answer questions about:
  - making up and using powdered infant formula to feed their babies.
  - the risks to the baby if the preparation and handling instructions are not carefully adhered to.
  - how to feed a baby with a bottle.

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<sup>1</sup> If liquid infant formula (ready-to-feed) is used in the facility, arrangements must be made to have powdered formula available for teaching reconstitution, even if it is discarded after preparation. The NHMRC Guidelines are clear that health workers must know how to demonstrate the preparation of infant formula and have a responsibility to check that it is being prepared according to instructions.

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**Step 6 Give newborn infants no food or drink other than breastmilk, unless medically indicated**

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Babies are exclusively breastfed or breastmilk-fed from birth. The baby is given no infant formula, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines. Breastmilk-fed includes mother's expressed milk or donor milk.

Parents are made aware of the importance of exclusive breastfeeding to around 6 months and the risks associated with giving formula or other supplements to a breastfed baby.

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

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

If a supplement is given to a breastfed baby:

- it is for an acceptable medical reason (Appendix 2), which has been documented, or
- it is at the mother's request, after she has made an informed decision which has been documented.

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

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

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

### **Exclusive breastfeeding rates**

BFHI accredited facilities are required to achieve and maintain at least a 75% exclusive breastfeeding or breastmilk-feeding rate for mothers and their babies discharged from inpatient care.

For the purposes of this data collection, facilities are not required to include babies who have been in NICU or Special Care for 24 hours or more or have been transferred from another facility. However, if a facility has difficulty excluding these babies from their statistics, it is acceptable to include these babies in the data.

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

## Staff interviews

**The Senior Midwife Postnatal and at least 80% of personnel from groups 1 and 2 can:**

- state at least three of the *Acceptable Medical Reasons for the Use of Breastmilk Substitutes* (see Appendix 2).
- outline ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother.
- briefly describe what should be discussed with a breastfeeding mother who is considering feeding her baby with infant formula, including the potential risks.

## Mother interviews

**Of the breastfeeding mothers interviewed, at least 80% can:**

- confirm their babies have not been fed food or drink other than breastmilk. If a supplement was given, there is documented evidence in the case notes that there was an acceptable medical reason (Appendix 2) or it was at the mother's request, having made an informed decision which was documented.

## Observations and Reviews

Materials which are unsupportive of breastfeeding, or contradict exclusive breastfeeding for around 6 months as the norm, are not used, displayed or distributed by staff to parents, except informational materials given individually to parents who are artificially feeding. No materials or literature which picture or refer to a proprietary product that is within the scope of the *WHO International Code* are used, displayed or distributed.

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

### Observations confirm that:

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

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

### Review of these materials confirms that they are free of:

- promotion of artificial feeding, bottles, teats and dummies and contain no samples or redeemable vouchers for these products.
- information or articles which normalise artificial feeding.
- advertisements or promotion of infant, follow-on or toddler formula.

- advertisements or promotion of equipment for artificial feeding including bottles and teats.
- samples or coupons for products within the scope of the WHO International Code.
- samples or coupons for baby foods.
- information which contradicts exclusive breastfeeding for around 6 months as the norm.
- recommendations for scheduled feeds.
- advertisements for dummies.

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

### **Purchase of breastmilk substitutes by the facility**

The facility and its staff do not accept or distribute to mothers free or subsidised (low cost) samples or supplies of breastmilk substitutes, teats, bottles or dummies. Records and receipts indicate that breastmilk substitutes including special formula and other supplies required for artificial feeding are purchased wholesale by the facility through a pharmaceutical distributor or government tender or similar contact, or at a retail outlet, or are brought in by parents for feeding their own infants.

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## Step 7 Practise rooming-in - allow mothers and infants to remain together 24 hours a day

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Babies are with their mothers<sup>1</sup> 24 hours per day from birth to discharge except when there is a justifiable reason<sup>2</sup> that necessitates separation, such as a mother or baby medical reason or a mother whose condition means that she is not able to respond to and/or be responsible for her baby and there is not an alternative carer, such as her partner, who is able to do this.

The time, duration and the reason/circumstances of all separations are documented.

Every effort should be made to support the mother to have her baby close to her at all times. Her partner or support person, if available, can assist with this. Mother's request or staff suggestion, without a justifiable reason that necessitates separation, is not acceptable.

There are many evidence-based reasons why mothers and their babies should be together; any separations should be uncommon, only when necessary, and fully documented.

The facility has suitable provision to ensure direct supervision of babies for any period that they are not with their mothers.

### Staff interviews

#### The Senior Midwife Postnatal can:

- outline provisions that ensure direct supervision of babies on the postnatal unit if they are separated from their mothers

#### At least 80% of group 1 personnel interviewed can:

- outline the circumstances when an exception can be made to mothers and babies rooming-in 24 hours a day in the postnatal unit.
- outline what must be documented for every mother/baby separation on the postnatal unit.

### Mother interviews

#### At least 70% of mothers interviewed, whose babies are not in Special Care, whether they are breastfeeding or not, can:

- report that since birth their babies have been with them day and night. If any of these mothers report that their babies have been separated from them, the separation was necessary for a justifiable reason, which was adequately documented.

#### At least 80% of the same mothers can:

- state one reason why rooming-in (staying close to their babies 24 hours a day) is important.

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<sup>1</sup> For the purposes of this step, this can include the mother's partner or support person.

<sup>2</sup> Mother's request or staff suggestion, without a justifiable reason, is not acceptable in the BFHI Global Standards which have been implemented in Australia.

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## Step 8 Encourage breastfeeding on demand

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

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

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

Some babies will have a medical indication that necessitates a feeding regime that differs from the above. The reasons for this intervention should be explained to the mother and documented.

### Staff interviews

**The Senior Midwife Postnatal and at least 80% of group 1 personnel interviewed can:**

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

### Mother interviews

**At least 80% of mothers interviewed who are breastfeeding and whose babies are not in Special Care can:**

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



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## Step 9 Give no artificial teats or dummies to breastfeeding infants

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The use of artificial teats and dummies is not recommended by the facility while breastfeeding is being established. Artificial teats are not used to feed babies when the mother is breastfeeding or intending to breastfeed, except where there is a legitimate clinical indication<sup>1</sup> for an individual baby, which has been documented. Dummies are not provided by the facility, except where there is a legitimate clinical indication<sup>2</sup> for an individual baby, which is documented.

When a mother is breastfeeding or planning to breastfeed and expressed breastmilk (EBM) or a supplement is given, the method of feeding other than from the breast is documented. If a baby has been fed by bottle/teat there should be a legitimate clinical indication or mother's informed request documented.

Staff members have the clinical skills to assist mothers to use alternative feeding methods, other than artificial teats and bottles, when they are required.

Pregnant women and mothers are informed of the following reasons why dummies are not recommended in the early weeks of breastfeeding:

- different type of suck so there is the potential for suck confusion.
- harder to recognise feeding cues.
- babies tend to feed less often.
- can reduce the time at the breast and decrease milk supply.

### Staff Interviews

#### The Senior Midwife Postnatal can:

- confirm that breastfeeding babies are not given any feeds, including EBM, using a bottle and teat, except where there is a legitimate clinical indication or mother's request having made an informed decision.
- confirm the facility does not provide dummies to mothers who request them for use in the postnatal unit.

### Antenatal Interviews

#### At least 70% of pregnant women interviewed can:

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

### Mother Interviews

#### At least 80% of mothers interviewed who are breastfeeding and whose babies are not in Special Care can:

- report that, to the best of their knowledge, their babies have not been provided with a dummy by staff or the facility, unless there was a clinical indication<sup>2</sup> which was explained to the mother.
- can explain why dummy use is not recommended while breastfeeding is being established.
- report that, to the best of their knowledge, their babies have only fed while attached to the breast and have not been fed using a bottle and artificial teat. If an artificial teat was used, there is documentation to show that there was a legitimate clinical indication<sup>1</sup> or it was at mother's documented request.

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<sup>1</sup> For example, a baby with an orofacial disorder, or a baby going home not yet able to feed from the breast and where alternative feeding methods are not indicated or not appropriate.

<sup>2</sup> For example, if promotion of suck development is indicated for a preterm baby.

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**Step 10 Foster the establishment of breastfeeding support and refer mothers on discharge from the facility**

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

The facility works with and includes the local breastfeeding support groups and services.

After-discharge, care is discussed with the mother and written information is provided about both health services and mother/peer support. Where appropriate, mothers are referred to services at the facility or in the community for ongoing management after discharge from inpatient care.

Breastfeeding mothers are encouraged to be seen with their babies soon after discharge (preferably 2-4 days after discharge from inpatient care and again in the second week) at the facility or in the community by a skilled breastfeeding support person who can assess feeding and give the support needed.

Mothers who are artificially feeding are similarly encouraged to be seen with their babies by an appropriately skilled support person who can assess feeding and give the support needed.

**Staff interviews****The Senior Midwife Postnatal can:**

- describe the infant feeding support groups and follow-up services available in the local area or from the hospital and explain how mothers are encouraged to access these.
- describe how the facility works with and includes the local breastfeeding support groups and services.

**Mother interviews**

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

**At least 80% of mothers interviewed can:**

- confirm they have been given information on infant feeding services and support groups that they can access after they leave inpatient care.
- report at least two infant feeding support groups and services they could access.

**Observations**

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

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## Appendix 1: Definitions

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### **Artificial feeding**

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

### **Assessors**

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

### **Bottle feeding**

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

### **Breastfeeding at discharge**

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

### **Breastfeeding initiated**

Baby received at least one feed of colostrum or breastmilk.

### **Breastfeeding mothers**

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

### **Breastfeeding support and services**

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

### **Breastmilk substitute**

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

### **Complementary feeding**

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

### **Data collection**

For the purposes of BFHI data collection on infant feeding, facilities are not required to include babies who have been in NICU or Special Care for 24 hours or more.

## **Discharged**

For hospital assessment purposes, including interviews with mothers, as well as BFHI data collection for the requirement of step 6, women are deemed to be “discharged” when they are discharged from inpatient care.

## **Domiciliary Care**

For BFHI purposes, this definition includes ongoing care provided by the facility’s staff in the mother’s home, a hotel or similar setting, to a maximum of 14 days. For example, “Midcall”, “Hospital in the Home”, “Midwifery in the Home”, “Extended Midwifery Service” or “Domiciliary Midwifery Care”. Re-admissions, outpatient breastfeeding clinics and domiciliary services contracted to other providers are not included. Facilities that provide this type of service are asked to record data in the BFHI data collection sheet from the period when mothers and babies are discharged from inpatient care and transferred to domiciliary care.

## **Exclusive breastfeeding**

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

## **Facility**

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

## **Hands-off Techniques**

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

## **Non-pharmacological pain relief**

Non-pharmacological pain relief is any method used to relieve pain that does not involve medications.

## **Nursery (Well Baby Nursery)**

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

## **Rooming-in**

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

## **Samples/Supplies**

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

immediate use within the facility. **Supplies** are quantities of a product provided for use over an extended period.

### **Skin-to-skin contact**

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

### **Special Care**

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

### **Supervised Clinical Experience**

Supervision should be undertaken by someone who is experienced and knowledgeable about evidenced based, contemporary breastfeeding practices consistent with BFHI standards. The supervised clinical experience must be documented and can be acquired in a single session or cumulatively through direct or indirect supervised experience during a normal working day or simulated activities. It may include observation and or assisting with a particular practice e.g. breast expression, assisting with a breastfeed, discussing breastfeeding with pregnant women (antenatal clinic or booking-in), facilitation of skin to skin contact at birth and early initiation of breastfeeding as well as support provided to a non-breastfeeding mother. This definition is based on the WHO 20-hour course: *Breastfeeding Promotion and Support in a Baby Friendly Hospital*.

### **Supplementary feeding**

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

### **Supplement rate**

The percentage of babies who have been given infant formula or other fluids by mouth at least once.

### **WHO International Code**

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

### **WHO Global Criteria**

The BFHI Australia standards for hospital assessment are based closely on, and incorporate, the revised WHO/UNICEF global standards for BFHI. These include *The Ten Steps to Successful Breastfeeding*, *Compliance with the International Code of Marketing of Breast-milk Substitutes*, *Mother-Friendly Labour and Birthing* and *Support for Non-Breastfeeding Mothers*. Hospitals accredited by BFHI Australia are accredited to the standards of the Global Criteria.

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## Appendix 2: WHO Acceptable Medical Reasons for Use of Breastmilk Substitutes<sup>1</sup>

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### Introduction

Almost all mothers can breastfeed successfully, that is initiating breastfeeding within the first hour of life, breastfeeding exclusively for the first 6 months and the continuation of 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.

The 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<sup>1</sup>. It also protects against chronic conditions in the future such as type-1 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.<sup>2</sup> Breastfeeding delays the return of a woman's fertility and reduces the risks of post-partum haemorrhage, pre-menopausal breast cancer and ovarian cancer.<sup>3</sup>

Nevertheless, a small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently<sup>4</sup>. 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.

When the discontinuation of breastfeeding is being considered, the benefits of breastfeeding should be weighed against the risks posed by the presence of the specific conditions listed.

### Infant Conditions

**Infants with the following conditions should not receive breast milk or any other milk except specialised formula:**

- Classic galactosemia: a special galactose-free formula is needed.
- Maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed.
- Phenylketonuria: a special phenylalanine-free formula is needed though some breastfeeding is possible, under careful monitoring.

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

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

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<sup>1</sup> Reproduced unamended by BFHI Australia, Australian College of Midwives, with permission. Updated "Addendum for Australia" has been added.

## Maternal Conditions

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

### Mothers with the following condition may need to avoid breastfeeding

- HIV infection: if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS)<sup>6</sup>

The most appropriate infant feeding option for a HIV-infected mother depends on the individual circumstances of mother and baby, including the mother's health status, but should also take into consideration the health services available and the counselling and support the mother is likely to receive. When replacement feeding is acceptable, feasible, affordable, sustainable and safe (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.

### Mothers with the following conditions may need to avoid breastfeeding temporarily:

- 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 including:
  - 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<sup>7</sup>;
  - 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.

### Mothers with the following conditions can continue breastfeeding, 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<sup>8</sup>.
- Hepatitis B: infants should be given hepatitis B vaccine within the first 48 hours or as soon as possible thereafter<sup>9</sup>
- Hepatitis C.
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition<sup>8</sup>.
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines<sup>10</sup>.
- Substance use<sup>11</sup>: Mothers should be encouraged not to use these substances and given opportunities and support to abstain. 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.
  - nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants have been demonstrated to have harmful effects on breastfed babies.
  - alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

## Addendum for Australia

The list above was developed by the World Health Organization for global use. There are some situations and more recent recommendations which are not included above, but are listed below that are considered by BFHI to be acceptable medical reasons for the use of breastmilk substitutes in Australia.

### Primary Inadequate Breastmilk Supply

- Breast surgery: Women who have had breast surgery such as breast reduction with nipple relocation may find it necessary to use a breastmilk substitute to supplement their baby's intake and ensure adequate nutrition.
- Bilateral breast hypoplasia: Every attempt should be made to stimulate an adequate milk supply, but if unsuccessful, the baby may need a breastmilk substitute to supplement intake and ensure adequate nutrition.

### HIV Infection

The World Health Organization (WHO) have released updated guidelines; Guidelines on HIV and Infant Feeding, 2010, Principles and recommendations for infant feeding in the context of HIV and a summary of Evidence, Geneva WHO; 2010. If a decision is made to use replacement feeding it must be acceptable, feasible, affordable, sustainable and safe (AFASS). An individual decision should be made in consultation with each mother, taking into account her circumstances and viral load.

### Hepatitis B

Under the current Hepatitis B recommended prophylaxis, breastfeeding is not a risk factor for mother-to-child transmission<sup>12</sup>.

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12. National Centre for Immunisation Research and Surveillance. *Hepatitis B vaccines for Australians | NCIRS Factsheet.* [http://www.ncirs.edu.au/assets/provider\\_resources/fact-sheets/hepatitis-B-fact-sheet.pdf](http://www.ncirs.edu.au/assets/provider_resources/fact-sheets/hepatitis-B-fact-sheet.pdf) accessed 19 July 2016



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

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The following appendices are simply extracted parts of Steps 1 to 10, grouped together under a theme for convenience.

### Support for mothers who are using breastmilk substitutes

The revised version of the *WHO Global Criteria* for BFHI (see Appendix 1) now includes more specific criteria related to the care given to the mother who is artificially feeding her baby. The inclusion of these criteria does not mean that BFHI is promoting artificial feeding but, rather, that BFHI wants to help ensure that **all** mothers, regardless of feeding method, get the feeding support they need.

The criteria are integrated into the relevant Steps in the *Standards for Implementation of the Ten Steps to Successful Breastfeeding*, but for convenience are also copied in this Appendix so they can be reviewed as a whole.

Section 8 of the NHMRC Infant Feeding Guidelines<sup>1</sup> outlines the standard of care for artificial feeding in Australia and these standards are recommended for use in BFHI facilities. However, facilities may elect to use the WHO Guidelines<sup>2</sup>, especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

It should be noted that many of the requirements relating to the care of the mother who is artificially feeding her baby are applicable to **all mothers who will be leaving the facility using infant formula**. Babies, who are not breastfed, or not fully breastfed, are at increased risk and it is just as important that their mothers are fully informed.

### Step 1

#### Policy Requirements and Options

The facility has a written policy or policies that support the implementation of BFHI. There are options for how this can be achieved:

- The facility may have a breastfeeding policy and several other 'policies for BFHI' that complement and refer to each other to support step 1.
- Alternatively, facilities may integrate all the policy requirements of step 1 into a comprehensive infant feeding policy.

#### The Breastfeeding Policy

At a minimum, the breastfeeding policy addresses the principles and practices that enable implementation of each of the *Ten Steps to Successful Breastfeeding*. The facility is also required to have policy statements which address:

- Implementation of the *WHO International Code*
- Support for staff to continue to breastfeed when they return to work
- Standards of care for the mother who is artificially feeding her baby
- Mother-friendly labour and birthing practices

Some facilities have alternate names for policies and clinical protocols; this is acceptable as long as they fulfil the criteria.

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<sup>1</sup> Infant Feeding Guidelines, Section 8. *National Health and Medical Research Council (NHMRC) 2012*

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

## Standards of care for the mother who is artificially feeding her baby

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

- Relevant personnel<sup>1</sup> have received education to ensure that their knowledge about artificial feeding is current.
- Relevant personnel have the skills to teach mothers correct preparation, storage and handling of powdered infant formula<sup>2</sup>.
- Mothers who are considering artificial feeding are supported to make a fully informed choice, appropriate to their circumstances.
- All mothers who will be leaving the facility using infant formula are given:
  - information and instruction on the safe preparation, storage and handling of reconstituted powdered infant formula, using NHMRC Guidelines<sup>3</sup> ;
  - information on the risks to the baby if the preparation and handling instructions are not followed carefully;
  - a demonstration and supervised practice in making up a bottle-feed using powdered infant formula;
  - information on where to get help with infant feeding after discharge from the facility.
- Instruction on artificial feeding is given only to parents who require it. The instruction is not given in a group situation. The instruction is conducted privately, away from breastfeeding mothers.
- Materials on artificial feeding shown or given to parents are free from advertising, do not refer to or contain images of an identifiable product, and comply with the *WHO International Code*.

## Step 2

### Group 1 BFHI Education Requirements and Curriculum

Group 1 personnel must have a minimum of 20 hours of education. There is a curriculum for the group 1 BFHI education which includes:

- how to assist the mother to make a fully informed and appropriate decision about infant feeding, suitable to her circumstances; and
- provision of optimal support to all mothers who will be leaving the facility using infant formula.

At a minimum, group 1 personnel should be familiar with the information in Section 8 (pages 73-83) in Infant Feeding Guidelines. National Health and Medical Research Council (NHMRC) 2012.

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<sup>1</sup> Personnel refers to all persons engaged in relevant activities, not just those who the facility defines as "staff".

<sup>2</sup> Infant Feeding Guidelines for Health Workers, Section 8. *National Health and Medical Research Council (NHMRC) 2012.*

<sup>3</sup> The NHMRC Infant Feeding Guidelines outline the standard of care for artificial feeding in Australia and are recommended for use in BFHI facilities. However, facilities may elect to use "WHO Safe Preparation, storage and handling of powdered infant formula: guidelines. *World Health Organization 2007*", especially if they are already in use. The WHO Guidelines also meet the standard of care for BFHI purposes.

## Group 2 BFHI Education Requirements and Curriculum

Group 2 personnel must have a minimum of 2 hours of education. There is a curriculum for the group 2 which includes:

- ways in which a supplementary feed of infant formula can affect the breastfeeding baby and mother;
- how to assist the mother to make a fully informed and appropriate decision about infant feeding, suitable to her circumstances.
- providing optimal support to all mothers who will be leaving the facility using infant formula.

### Step 4

#### When the mother is not planning to initiate breastfeeding

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

#### Mother interviews

Unless a medically indicated procedure was required:

- at least 80% of the mothers who are interviewed, whether or not they intended to breastfeed, confirm that the baby was immediately placed skin-to-skin as per the standards for this step.
- at least 80% of those who did not intend to breastfeed confirm the baby stayed skin-to-skin without interruption for at least an hour, unless earlier separation was at mother's request, which was documented.

### Step 5

#### Care of the Mother who is Artificially Feeding her Baby

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

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

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

- information and instruction on the safe preparation, storage and handling of reconstituted powdered infant formula, using NHMRC Guidelines<sup>1</sup>.
- information on the risks to the baby if the preparation and handling instructions are not followed carefully.
- a demonstration and supervised practice in making up a bottle-feed using powdered infant formula<sup>2</sup>.

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

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

- information on the importance of ensuring the correct concentration by following the instructions on the can exactly; regarding water volume and scoops of powder; and are made aware that these will be different for each brand of formula.
- information on best practice for feeding their babies with a bottle.
- information on where to get help with infant feeding after discharge from the facility.

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

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

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

### **Mother interviews (artificial feeding)**

At least 66% of mothers who have been feeding their babies with infant formula for at least 24 hours (or whose babies are at least 48 hours old if caesarean birth or there is a documented maternal medical reason) can:

- confirm they have been given individual education about making up a bottle-feed using powdered infant formula.
- confirm they have made up a bottle-feed using powdered infant formula under supervision, or been offered the opportunity to do so.
- adequately answer questions about:
  - making up and using powdered infant formula to feed their babies.
  - the risks to the baby if the preparation and handling instructions are not carefully adhered to.
  - how to feed a baby with a bottle.

### **The Senior Midwife Postnatal can:**

- confirm that mothers who will be leaving the facility using infant formula are given instruction and supervised practice on the reconstitution of powdered infant formula and how to bottle-feed.
- describe briefly:
  - what should be considered when organising where and how instruction on the preparation of infant formula should be given.
  - the key safety and hygiene points that should be covered when instructing reconstitution of powdered infant formula.
  - the key issues to be covered when instructing a mother on how to feed her baby with a bottle.

## NHMRC Infant Feeding Guidelines

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

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

### 8.2 NHMRC Health workers and infant formula

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

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

Under the *WHO International Code*:

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

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

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

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

### 8.3 NHMRC Preparing infant formula

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

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

<b>Table 8.1: NHMRC Preparation of infant formula</b>
<ul style="list-style-type: none"> <li>• Always wash hands before preparing formula and ensure that formula is prepared in a clean area.</li> </ul>
<ul style="list-style-type: none"> <li>• Wash bottles, teats, caps and knives – careful attention to washing is essential – and sterilise by boiling for 5 minutes or using an approved sterilising agent (see Section 8.3.3).</li> </ul>
<ul style="list-style-type: none"> <li>• Boil fresh water and allow it to cool until lukewarm. To cool to a safe temperature, allow the water to sit for at least 30 minutes. In places with clean water supply which meets Australian standards, hot water urns such as hydro boils are safe to use for formula reconstitution, provided the supply of very hot water has not been depleted.</li> </ul>
<ul style="list-style-type: none"> <li>• Ideally prepare only one bottle of formula at a time, just before feeding.</li> </ul>
<ul style="list-style-type: none"> <li>• Always read the instructions to check the correct amount of water and powder as shown on the feeding table on the back of the pack. This may vary between different formulas.</li> </ul>
<ul style="list-style-type: none"> <li>• Add water to the bottle first, and then powder.</li> </ul>
<ul style="list-style-type: none"> <li>• Pour the correct amount of previously boiled (now cooled) water into a sterilised bottle.</li> </ul>
<ul style="list-style-type: none"> <li>• Always measure the amount of powder using the scoop provided in the can, as scoop sizes vary between different formulas.</li> </ul>
<ul style="list-style-type: none"> <li>• Fill the measuring scoop with formula powder and level off using the levelling device provided or the back of a sterilised knife. The scoop should be lightly tapped to remove any air bubbles.</li> </ul>
<ul style="list-style-type: none"> <li>• Take care to add the correct number of scoops to the water in the bottle. Do not add half scoops or more scoops than stated in the instructions.</li> </ul>
<ul style="list-style-type: none"> <li>• Keep the scoop in the can when not in use. Do not wash the scoop as this can introduce moisture into the tin if not dried adequately.</li> </ul>
<ul style="list-style-type: none"> <li>• Place the teat and cap on the bottle and shake it until the powder dissolves.</li> </ul>
<ul style="list-style-type: none"> <li>• Test the temperature of the milk with a few drops on the inside of your wrist. It should feel just warm, but cool is better than too hot.</li> </ul>
<ul style="list-style-type: none"> <li>• Feed infant. Any formula left at the end of the feed must be discarded.</li> </ul>
<ul style="list-style-type: none"> <li>• A feed should take no longer than 1 hour. Any formula that has been at room temperature for longer than 1 hour should be discarded.</li> </ul>
<ul style="list-style-type: none"> <li>• Formula that has been at room temperature for less than 1 hour may be stored in a refrigerator for up to 24 hours (in a sterile container). Discard any refrigerated feed that has not been used within 24 hours.</li> </ul>
<ul style="list-style-type: none"> <li>• When a container of formula is finished, throw away the scoop with the container, to ensure that the correct scoop is used next time.</li> </ul>

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## Appendix 4: Summary of WHO International Code Compliance Standards

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

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

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

### Step 1

At a minimum, the breastfeeding policy addresses the principles and practices that enable implementation of each of the Ten Steps to Successful Breastfeeding. The facility is also required to have policy statements which address:

- Implementation of the *WHO International Code*.
- Support for staff to continue to breastfeed when they return to work.
- Standards of care for the mother who is artificially feeding her baby.
- Mother-friendly labour and birthing practices.

### Policy statements on the WHO International Code

This can be a stand-alone policy that the breastfeeding policy refers to, or can be an integrated part of the breastfeeding policy.

There is a policy which protects breastfeeding by addressing implementation of the *WHO International Code*. It includes the following points:

- Adherence by the facility and its staff to the relevant provisions of the *WHO International Code* and subsequent WHA resolutions.
- All promotion of artificial feeding and materials which promote the use of infant formula, feeding bottles and teats is prohibited.
- The facility is not permitted to receive or distribute free and subsidised (low cost) products within the scope of the *WHO International Code*.
- The distribution to parents of take home samples and supplies of infant formula, bottles and teats is not permitted.
- There are restrictions on access to the facility and staff by representatives from companies in relation to marketing or distributing infant formula products or equipment used for artificial feeding.
- There is no direct or indirect contact of these representatives with pregnant women or mothers and their families.
- The facility does not accept free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events from these companies if there is

any association with artificial feeding or potential promotion of brand/product recognition in relation to infant feeding<sup>1</sup>.

- There is careful scrutiny at the institutional level of any research which involves mothers and babies for potential implications on infant feeding or interference with the full implementation of the policy.

## Step 2

### Group 1 and group 2 BFHI education curriculum

A copy of the curricula or course outlines for each group is made available to the assessors. For groups 1 and 2, this includes education in:

- the facility's and health workers' responsibilities under the *International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.

## Step 3

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

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

### Pregnant women interviews

At least 70% of the pregnant women who are interviewed can:

- confirm that they have not received from the facility any group education on artificial feeding.

## Step 5

Instruction on making up powdered infant formula is given individually and only to parents who need it; there is no group instruction; it is done privately, away from breastfeeding mothers.

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

## Step 6

Materials which are unsupportive of breastfeeding, or contradict exclusive breastfeeding for around 6 months as the norm, are not used, displayed or distributed by staff to parents, except informational materials given individually to parents who are artificially feeding. No materials or literature which picture or refer to a proprietary product that is within the scope of the *WHO International Code* are used, displayed or distributed.

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

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<sup>1</sup> In maternity facilities, promotion of brand/product recognition is likely to occur, for example, when a logo on a donated item or printed materials, or the brand on a product which may be unrelated to infant feeding (such as baby care items), is the same as an infant formula product name or manufacturer.



**Observations confirm that:**

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

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

**Review of these materials confirms that they are free of:**

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

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

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

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

If sample bags are distributed by the facility, it is recommended that they are checked monthly and that completion of this monthly audit is documented. Try to review the contents

through the eyes of new parents and ask how their infant feeding decisions and practises might be influenced. For example:

- A sample of baby food labelled 4-6 months, given to parents of a newborn in a hospital sample bag, may undermine exclusive breastfeeding to 6 months. It also serves to advertise the company that also happens to produce infant formula.
- A poster on baby massage featuring the logo of a company that manufactures bottles and teats. The poster has lots of photos of beautiful and healthy mothers and babies and may associate the company or brand with 'good health' and the company's benevolence, creating a subconscious positive association with that company.
- Breastfeeding information which focuses only on the negatives may affect the confidence of a pregnant woman or new mother.
- Advertisements for 'breastfeeding equipment' (such as breast pumps) that over-emphasise the need for various products are inappropriate and may promote brand association with a company that also produces bottles and teats.
- Direct advertising of artificial feeding equipment assists in portraying bottle-feeding as a normal activity.

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

#### **Purchase of breastmilk substitutes by the facility**

The facility and its staff do not accept or distribute to mothers free or subsidised (low cost) samples or supplies of breastmilk substitutes, teats, bottles or dummies. Records and receipts indicate that breastmilk substitutes including special formula and other supplies needed for artificial feeding are purchased wholesale by the facility through a pharmaceutical distributor or government tender or similar contact, or at a retail outlet, or are brought in by parents for feeding their own infants.

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## Appendix 5: Summary of Mother-Friendly Labour and Birthing

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### Mother-friendly care

New criteria have been added to the *WHO Global Criteria* for BFHI to ensure that practices are in place for mother-friendly labour and delivery, in support of an optimal “continuum of care” for both mother and child from the antenatal to postnatal period. These practices are important for the physical and psychological health of mothers, and have also been shown to enhance infants’ start in life, including breastfeeding.

BFHI Australia is committed to implementing the standards of the *WHO Global Criteria*, so the new criteria for mother-friendly labour and birthing have been included in this revision of the documents. The criteria are integrated into the relevant steps in the standards for implementation of the *Ten Steps to Successful Breastfeeding*, but for convenience are also copied in this Appendix so they can all be reviewed as a whole.

### Step 1

#### Policy Requirements and Options

The facility has a written policy or policies that support the implementation of BFHI. There are options for how this is can be achieved:

- The facility may have a breastfeeding policy and several other ‘policies for BFHI’ that complement and refer to each other to support step 1.
- Alternatively, facilities may integrate all the policy requirements of step 1 into a comprehensive infant feeding policy.

Some facilities have alternate names for policies and clinical protocols; this is acceptable as long as they fulfil the criteria.

#### Mother-friendly labour and birthing practices

There is a policy which addresses mother-friendly labour and birthing practices. The policy is supported by written protocols which foster mother-friendly labour and birthing practices that are helpful for the mothers’ psychological and physical health and enhance the babies’ start in life including breastfeeding. The policy includes each of the following points:

- Women are encouraged to have a support person of their choice with them throughout labour and birth.
- There is support for practices that can help with comfort and non-pharmacological pain relief during labour.
- Women are encouraged to move about as they need to during labour, and to assume birthing positions of their choice, unless a restriction is medically indicated.
- Invasive procedures are not used routinely, unless specifically required for a complication. Invasive procedures include rupture of the membranes, episiotomy, acceleration or induction of labour, instrumental delivery, or caesarean birth. If these are required for a medical reason, the reason is explained to the mother.

NB. All personnel are aware that care involving restrictions on drinking and eating light foods, and invasive procedures during labour and birth may impact on the mother’s condition and on the establishment of exclusive breastfeeding.

## Step 2

### Group 1 BFHI education requirements and curriculum

Group 1 personnel must have a minimum of 20 hours of education. There is a curriculum for the group 1 BFHI education which includes:

- mother-friendly labour and birthing practices and how they relate to breastfeeding.
- culturally sensitive care in response to women's beliefs, customs or ethnicity.

### Group 2 BFHI education requirements and curriculum

Group 2 personnel must have a minimum of 2 hours of education. There is a curriculum for the group 2 BFHI education which includes:

- mother-friendly labour and birthing practices and how they relate to breastfeeding.
- culturally sensitive care in response to women's beliefs, customs or ethnicity.

## Step 3

If the facility provides any antenatal services (including booking-in, antenatal clinics, antenatal classes or antenatal inpatient care), these services are used to inform pregnant women about birthing and about the importance and early management of breastfeeding. Written information is supported by individual discussion and/or antenatal classes and there are procedures in place to ensure that the required information is given to all women by the beginning of the third trimester (28 weeks).

Written antenatal information about birthing and breastfeeding is available for pregnant women in each language used by 10% or more of the women who use the facility's maternity services, though it is encouraged to have this information available in other languages. It is presented in an easy-to-read format, which may be low literacy or pictorial.

### The Senior Midwife Antenatal Services can:

- confirm pregnant women are provided with information or education on breastfeeding and on mother-friendly labour and birthing.
- describe the support, resources and materials available for pregnant women from other cultures and/or those who use or understand a language other than English.

### Antenatal information for women

A written description of the information in the antenatal education/discussion about breastfeeding is made available to the assessors. The antenatal education/discussion covers at least the following key points:

- the benefits of having a support person of the mother's choice with her throughout labour and birth.
- ways to help with comfort and non-pharmacological pain relief during labour.

### Pregnant women interviews

#### At least 70% of the pregnant women interviewed can:

- confirm they have been informed they can have a support person of their choice with them during labour.
- state at least two ways which help with comfort and non-pharmacological pain relief during labour.

## Step 4

### The Senior Midwife Birthing Services can:

- outline practices and procedures used in the facility that can help a mother be more comfortable and in control during labour and birth.
- describe at least three labour and birthing practices and procedures that make it more likely that breastfeeding will get off to a good start.
- give at least one example of ways in which the staff provide culturally sensitive care in response to a woman's beliefs, customs or ethnicity.
- outline the procedures used in this facility for keeping mothers and babies together after a vaginal birth, and after a caesarean birth, and what the staff do to support the optimal initiation of breastfeeding.