The Global Criteria for Baby Friendly Community Health Services in Australia

Booklet 1

The Standards for implementation of the
7 Point Plan for the Protection, Promotion and Support of Breastfeeding

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The *7 Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services*

This Booklet contains the standards that a Community Health Service (CHS) must meet in order for accreditation as a Baby Friendly CHS to be awarded.

Point 1: Have a written breastfeeding policy that is routinely communicated to all staff and volunteers.

Point 2: Educate all staff in the knowledge and skills necessary to implement the breastfeeding policy.

Point 3: Inform women and their families about breastfeeding being the biologically normal way to feed a baby, and about the risks associated with not breastfeeding.

Point 4: Support mothers to establish and maintain exclusive breastfeeding for six months.

Point 5: Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

Point 6: Provide a supportive atmosphere for breastfeeding families, and for all users of the child health service.

Point 7: Promote collaboration between staff and volunteers, breastfeeding support groups and the local community in order to protect, promote and support breastfeeding.

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1 Have a written breastfeeding policy that is routinely communicated to all staff and volunteers

The Community Health Service (CHS) has a written breastfeeding policy that addresses the principles and practices that enable implementation of the *7 Point* Plan for the protection, promotion and support of breastfeeding. The 7 Points on their own do not meet the requirements of a policy and are also incomplete as a summary of the policy.

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

The **policy**:

- Has detailed protocols/procedures to support the policy, and the policy includes formal reference to the protocols/procedures which are evidence based and effective.
- In full, this is accessible to mothers/parents and their families, and a summary is visibly posted in each area of the CHS which mothers, infants and/or young children access, with a note that the full policy may be viewed on request.
- Supports staff to continue to breastfeeding when they return to work.
- Indicates a process for monitoring breastfeeding duration rates and initiatives to promote breastfeeding.
- Is reviewed on a regular basis and updated at least every 3 years.
- Includes reference of a system to ensure continuity of care between external services through effective communication between health care staff.

The CHS protects breastfeeding by adhering to the relevant provisions of the World Health Organization (WHO) International Code of Marketing of Breast-milk Substitutes (the "WHO Code") and subsequent World Health Assembly (WHA) resolutions.

The **policy:**

- prohibits all promotion of artificial feeding and materials which promote the use of infant formula, feeding bottles and teats
- does not permit the CHS to receive free and subsidised (low cost) products within the scope of the Code
- does not permit the distribution of samples and supplies of infant formula to parents
- addresses restrictions on access to the CHS and staff by representatives from companies which distribute or market products within the scope of the Code
- prohibits direct or indirect contact of these representatives with pregnant women or mothers and their families
- does not allow the CHS to accept free gifts, non scientific literature, materials or equipment, money, or support for in-service education or events from these companies
- ensures that instruction on preparation and feeding of infant formula is given individually and only to parents who need it; there is no group instruction
- supports 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

The Head of Service is able to:

- confirm that the CHS has a written policy/procedure and practices to enable and support staff to continue breastfeeding after returning to work
- identify relevant provisions of the WHO Code implementation in their breastfeeding policy

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- confirms that the CHS does not provide free or low cost infant formula including special formula or other supplies

Observations in the CHS**:**

- Indicate the policy summary is displayed in languages most commonly understood by mothers, families and staff.[1] The full policy can be reviewed on request.

Out of all selected staff interviewed who were breastfeeding at least 80% were able to confirm that they were supported to continue breastfeed their baby on return to work.

All staff and volunteers who support families where mothers are breastfeeding:

- receive orientation and continuing education about the breastfeeding policy and protocols
- are able to locate and refer to the breastfeeding policy and protocols

[1] "Languages most commonly understood" means each language used by 10% or more of mothers who use the services.

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2 Educate all staff in the knowledge and skills necessary to implement the breastfeeding policy

All staff who have contact with pregnant women, mothers and their families accessing the CHS receive orientation and education on the breastfeeding policy and the skills necessary to implement it. Staff can describe how they received this education. The CHS provides evidence showing the number of hours of education completed by each relevant staff member. An education schedule for new staff exists and is made available to the assessors.

Documentation of the education indicates that 80% or more of the staff members who have contact with pregnant women, babies, and/or young children have received the required education either at the CHS, or prior to employment. For initial assessment of existing staff and the new staff at reassessment, the education is scheduled within 6 months of commencement of employment and completed within 12 months.

Out of the randomly selected staff members from **Groups 1, 2, 3** and the **Antenatal Educator/Postnatal Educator, Breastfeeding Clinic/Day Service/Residential Service Coordinator** at least 80% confirm that they have received the required education. If staff have been working in the CHS for less than six months, they can confirm that they have received orientation to the policy, and are aware of their role in implementation.

Out of the randomly selected staff members from **Groups 1 and 2** and the **Antenatal Educator/Postnatal Educator, Breastfeeding Clinic/Day Service/Residential Service Coordinator**, at least 80% can outline three practices that can help promote breastfeeding within the CHS.

Out of the randomly selected staff members from **Group 3** at least 80% can state:

- At least one reason why breastfeeding is important
- How they comply with the WHO Code

Out of the randomly selected staff members from **Group 2** at least 80% can

- Identify one strategy they could implement which would support women to breastfeed their infants well.

A copy of the curricula or course outline for the each group is made available to the assessors.
Staff education curriculum should include:

Education	Group 1	Group 2	Group 3
The policy and implementation of the *Seven Point Plan*.	1	2	3
The CHS and health worker responsibilities under the WHO Code and subsequent WHA resolutions.	1	2	3
The CHS breastfeeding protocols to support the breastfeeding policy.	1	2	
Policy on 'welcoming breastfeeding' in the CHS.	1	2	3
Acceptable Medical Reasons for the use of Breastmilk Substitutes (see Appendix 2).	1	2	
How to assist a mother to breastfeed her baby using a hands off approach with emphasis on the empowerment of the mother.	1		
Reasons why exclusive breastfeeding for six months is recommended.	1	2	

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Breastfeeding management concerning challenges that may occur: Sore nipples, blocked ducts, mastitis, overfull breasts, oversupply/fast flow/overactive letdown, thrush/infection, delayed letdown, insufficient breastmilk supply, dummy use.	1		
How to support a mother who is considering feeding her baby infant formula to make a fully informed decision, including the risks of infant formula.	1	2	
How to educate mothers who are not breastfeeding about safe and hygienic preparation, storage and use of infant formula.	1		
How to support mothers to continue breastfeeding with the appropriate introduction of complementary foods.	1		
How to support mothers to successfully combine breastfeeding with returning to work.	1		
How to support a mother to hand express her breastmilk.	1		
Education on storage and use of expressed breastmilk.	1		
Education on the appropriate use of lactation aids: Breast pumps, supplementary feeding systems ('supply lines'), nipple shields, cup feeding.	1		
Referral pathways to support mothers requiring assistance with breastfeeding.	1	2	3
Appropriate professional information and support for mothers for on infant feeding.		2	3
How to support a mother to recognise her baby is breastfeeding well.	1		

Education records: The CHS is required to maintain central electronic or hard copy records which show the number of hours of education completed by each staff member, based on the requirements outlined in this Point.

Personal Records: All staff must be able to show evidence of how they received the relevant education. Group 1 staff must include at least 3 hours of supervised clinical experience[2].

Breastfeeding Education for each Staff group:

Initial Assessment*: Requirements are to be completed within the 3 years prior to the assessment*

Group 1: All staff who assist mothers with breastfeeding, or provide breastfeeding education, are required to have a minimum of 20 hours including at least 3 hours of supervised clinical experience[3] (the 20 hours is flexible: there must be a minimum of 8 hours theoretical education covering all aspects of the breastfeeding policy and supporting protocols; the balance can be further education or supervised clinical experience in the breastfeeding skills relevant to the area of work.

[3] See definition of 'supervised clinical experience' in Appendix 1

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Group 2: All staff who have contact with pregnant and breastfeeding mothers, and may provide breastfeeding advice but do not assist mothers with breastfeeding (e.g. most medical staff, some physiotherapists and dieticians, Aboriginal Health Workers and other cultural consultants) are required to have a minimum of 2 hours education including orientation to the policy, relevant skills, the WHO Code and *Acceptable Medical Reasons for use of Breastmilk Substitutes*.

Group 3: Staff who have contact with pregnant women and breastfeeding mothers but do not give assistance and do not provide advice as part of their role are required to have orientation on the policy (can answer relevant questions). This includes relevant administration, volunteer and domestic staff.

New Staff: New staff, including long term casual/agency staff, are scheduled to commence appropriate education as per relevant group within 6 months, to be completed within 12 months.

The following staff are made aware of the policy and protocols at commencement of placement/visit:

- New staff/agency/casual staff and students who are advising or assisting women with breastfeeding
- Mother support counsellors or peer counsellors who provide education or visit breastfeeding women
- Other personnel with visiting rights to breastfeeding women e.g. allied health, medical staff

Recognition of Prior Learning (RPL) – Group 1 only:
Currently certified IBCLC and current Australian Breastfeeding Association counsellors are deemed to have 12 hours RPL and no further RPL documentation is required.

Each Group 1 staff member who is using RPL as a component of their 20 hours education is required to maintain their own personal record of prior learning and to show this to the assessors on request.

Supervised Clinical Experience[4]
Currently certified IBCLC's and current Australian Breastfeeding Association Counsellors are exempt from the requirement of supervised clinical experience.

Reassessment: *Requirements for the 3 year period prior to re-assessment*

Group 1: Staff who assist mothers with breastfeeding who completed appropriate initial education as above must have a further 8 hours of relevant breastfeeding education over the three years between assessments, including a re-orientation to the policy. It is recommended this education is spread over the three years.

Group 2 & 3: staff who have contact with pregnant and breastfeeding mothers must receive reorientation to the policy.

New Staff: New staff, including long term casual/agency staff, are scheduled to commence appropriate education as per relevant group within 6 months, to be completed within 12 months.

[4] See definition of 'supervised clinical experience' in Appendix 1

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3 Inform women and their families about breastfeeding being the biologically normal way to feed a baby and about the risks associated with not breastfeeding

This point applies to:

- CHS offering antenatal clinics, antenatal education programs, co-location or outreach services,
- CHS with no antenatal services, but may have contact with pregnant women during postnatal home or clinic visits, breastfeeding clinics, day stay and residential services.

Where the CHS provides an antenatal service:

The **ante-natal educator:**

- reports that all pregnant women using the CHS are provided with breastfeeding information and are asked about their breastfeeding knowledge and previous experience with infant feeding,
- confirms that all pregnant women who did not breastfeed a previous child, or had problems with breastfeeding, are offered antenatal counselling for breastfeeding, and can describe how this counselling is facilitated.

The same **ante-natal educator** can outline:

- how breastfeeding education is provided to pregnant women and who provides it. (A written description of the minimum content of the antenatal breastfeeding education is available to assessors)
- how staff and mothers can access breastfeeding support groups in the local area, including mother to mother peer support groups
- how mothers are informed about them.

The **antenatal education** covers:

- why breastfeeding is important,
- the risks associated with not breastfeeding,
- the importance of early uninterrupted skin-to-skin contact in the first hour after a vaginal or caesarean birth (encouraging mothers to recognise when their babies are ready to breastfeed, offering help if needed),
- why 24-hour rooming-in (staying close to baby) is important,
- why exclusive breastfeeding for the first six months is recommended, and that breastfeeding continues to be important after six months when other foods are introduced,
- once at home, having baby near for 6 – 12 months (room sharing) to enable mother to respond to and feed her baby according to need,
- why bottle teats and dummies are not recommended while breastfeeding is being established,
- risks of using supplements while breastfeeding in the first six months,
- indications that a baby is adequately hydrated,
- basic breastfeeding and lactation management, including positioning and attachment, feeding cues and frequency of feeding,
- maintaining and increasing breastmilk supply,
- breastfeeding support groups and services in the community.

Out of the randomly selected **pregnant women** who are in their third trimester and have attended at least two antenatal visits at the CHS, 70% confirm that they:

- have been given the opportunity to discuss breastfeeding with a staff member,

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- were asked about their breastfeeding knowledge and previous experience with infant feeding,
- were offered continuing support for breastfeeding by the staff, especially if they had experienced previous breastfeeding difficulties or have not breastfed a previous child,
- were provided with information on breastfeeding support groups available in the local area,
- had not received any group education on the use of infant formula from staff at the CHS,
- had not seen displayed, or been given, any materials which picture or promote artificial feeding or a proprietary product that is within the scope of the WHO Code.

Out of the same **pregnant women** interviewed, at least 70% can state at least two of the following**:**

- breastfed babies are healthier than formula fed babies,
- breast-milk (including the role of colostrum and donor milk) is much better for the baby than infant formula,
- breastfeeding helps mothers and babies bond/feel closer to baby,
- there are health advantages for the mother who is breastfeeding,
- the importance of exclusive breastfeeding for six months and continued breastfeeding after six months when other foods are introduced ,
- breastfeeding can continue when working outside the home.

The same **pregnant women** can describe at least three of the following breastfeeding management topics:

- the importance of early undisturbed skin-to-skin contact,
- how to recognise the baby's innate sequence of feeding behaviours before the first feed,
- how to position and attach the baby for feeding,
- why breastfeeding on demand is important,
- why 24 hour rooming in (staying close to baby) is important,
- how frequent feeding helps ensure enough breastmilk,
- how to know if your baby is getting enough breastmilk,
- feeding cues other than crying,
- why bottles, teats and dummies are not recommended while breastfeeding is being established,
- the risks of supplementation while breastfeeding in the first six months.

Out of the randomly selected staff from **Groups 1 and 2,** at least 80% can describe two issues that should be discussed with a pregnant woman or mother if she indicates that she is considering feeding her baby with infant formula.

Where the CHS provides a postnatal service only:

Out of the randomly selected staff from **Group 1**, 80% were able to adequately describe information to offer breastfeeding mothers who are pregnant to support them to continue to breastfeed through pregnancy if they wish to.

Observations in the CHS (*for both antenatal and postnatal services)*

- All educational materials (including DVD's, posters, booklets and handouts) or sample bags available and/or distributed to women are free of promotion for artificial feeding bottles, teats or dummies and do not contain samples of infant formula, infants foods or drinks, teats, bottles or dummies, or redeemable vouchers for these products.
- written information is provided at the appropriate literacy level, and in languages commonly understood by pregnant women and mothers using the CHS

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- informational materials displayed or available or guidance provided to women using the CHS comply with the WHO Code and subsequent WHA resolutions

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4 Support mothers to establish and maintain exclusive breastfeeding for six months

All mothers are provided with appropriate support and information to breastfeed their babies exclusively for six months.

For BFHI assessment purposes a mother will need to have had at least 2 visits/contacts to the CHS to be included in the interviews.

The CHS must provide evidence of the following infant feeding statistics from those mothers enrolled/ registered in the CHS:

- If initial assessment – statistics are required for the most recent 3 months prior to assessment
- If re-assessment – statistics are required for the most recent 12 months prior to assessment

At registration/ enrolment/ or first contact – (see definition in Appendix 1)
% exclusively breastfeeding
% fully breastfeeding (exclusive + predominant)
% breastmilk + infant formula (supplementary breastfeeding)
% infant formula only (artificial feeding)

At 4 months[5]:
% exclusively breastfeeding
% fully breastfeeding (exclusive + predominant)
% breastmilk + infant formula (supplementary breastfeeding)
% infant formula only (artificial feeding)

To 6 months:
% exclusively breastfeeding
% fully breastfeeding (exclusive + predominant)
% breastmilk + infant formula (supplementary breastfeeding)
% infant formula only (artificial feeding)

At 12 months:
% Age appropriate breastfeeding (see definition in Appendix 1)

At 18 – 24 months:
% Age appropriate breastfeeding (see definition in Appendix 1)

The **Coordinator of the Assessment**:

- can provide evidence of ongoing data collection on breastfeeding duration (to establish breastfeeding trends over time)
- can report on any action plans for improving breastfeeding rates including any strategies for addressing any drop in statistics and/or practice issues
- can outline the education and support provided to a mother not breastfeeding on how to safely feed her baby with infant formula
- can describe how staff support mothers to access breastfeeding support groups in the local area

[5] Data is collected at 4 months in line with The Headline Indicators for Children's Health, Development and Wellbeing (Children's Headline Indicators). These are a set of 19 indicators endorsed by the Australian Health Ministers' Conference, Community and Disability Services Ministers' Conference and the Australian Education, Early Childhood Development and Youth Affairs Senior Officials Committee. Headline Indicator for Breastfeeding is "Proportion of infants exclusively breastfed at 4 months of age".

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Out of the **mothers who are breastfeeding**, at least 80% confirm that they have been given information on the following topics:

- why exclusive breastfeeding for six months is recommended,
- baby's feeding cues other than crying
- the importance of keeping their baby near (room sharing for 6 to 12 months - see definition in Appendix 1)
- how to recognise whether their baby is getting enough milk
- why using teats or dummies while breastfeeding is being established is not recommended
- the effects on breastfeeding of formula or solids before 6 months

Out of these **same mothers** at least 80% confirm that assistance was provided by staff of the CHS for the following if required:

- positioning and attachment of their babies for breastfeeding,
- management of the care of their breasts if they become uncomfortably full and the baby is asleep or separated from them

Out of the **mothers who are breastfeeding** and planning time away from their baby or returning to work, 80% confirm they were offered information or assistance as required about the following:

- how to maintain lactation
- how to express their breastmilk
- how to store, transport and feed their expressed breastmilk

Out of the **mothers who are not breastfeeding**, or have ceased breastfeeding, 80% confirm:

- that individual education and support was provided about the safe preparation and giving of infant formula feeds
- they were educated on the signs that their baby was adequately hydrated

Out of the **same mothers** at least 80% were able to correctly describe at least three of the important skills required for the safe preparation, storage and feeding of infant formula

- how to clean bottles and teats
- how to correctly boil, cool water and measure a scoop of powdered infant formula
- what to do with the remains of an unfinished feed
- how long reconstituted infant formula can be stored in the fridge
- how to test infant formula for correct temperature
- risks associated with using a microwave oven to warm bottles of formula
- how to position the baby for bottle feeding and the risks of prop feeding

Out of the randomly selected staff from **Group 1,** at least 80% can:

- explain why exclusive breastfeeding is recommended for the first six months with continued breastfeeding with the introduction of complementary foods for 2 years and beyond
- explain the importance of keeping baby near (room sharing for the first 6 to 12 months) including at home and in the residential service
- demonstrate how they show mothers to position and attach their babies for breastfeeding using hands off techniques (see definition in Appendix 1)
- describe the information given to mothers to ensure that they are able to recognise if their baby is attached and breastfeeding well
- describe feeding cues other than crying
- describe the information given to mothers about how often and long they should feed their babies

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- report they provide information to mothers about how to hand express breastmilk and can demonstrate an acceptable technique for this if required
- describe the information provided to a mother on how to increase her breastmilk supply
- correctly answer 6 out of 8 breast health/management questions concerning challenges that may occur:
    - *sore nipples*
    - *blocked ducts*
    - *mastitis*
    - *overfull breasts*
    - *oversupply/fast flow*
    - *delayed/overactive letdown*
    - *insufficient breastmilk supply*
    - *dummy use*
- explain the relevance of night feeds and breastfeeding
- provide correct information for storage, use and transport of expressed breastmilk including the risks associated with microwave oven use
- describe how they would provide information to a mother on the appropriate use of two of the following lactation aids:
    - *Breast pumps*
    - *Supplementary feeding systems ('supply lines')*
    - *Nipple shields*
    - *Cup feeding*

Out of the same randomly selected staff from **Group 1,** at least 80% can:

- state three ways in which a supplementary feed of infant formula can negatively effect the breastfeeding baby and mother
- describe how a mother not breastfeeding is assisted to safely prepare infant formula and feed her baby
- describe the information/support provided to help mothers planning to return to work to continue breastfeeding and maintain their breastmilk supply

The **Breastfeeding Clinic/Residential/Day Service Coordinator** can:

- explain the importance of keeping baby near (room sharing for the first 6 to 12 months) including at home and in the residential service
    - describe the information that staff provide to breastfeeding mothers about the appropriate use of dummies
    - describe how a mother not breastfeeding is assisted to safely prepare infant formula and feed her baby

Out of the randomly selected staff **from Group 1, 2** and the **Antenatal/Postnatal Educator, Breastfeeding Clinic/Day Service/Residential Service Coordinator** at least 80% can describe:

- at least three of the *Acceptable Medical Reasons for use of Breastmilk Substitutes* for breastfeeding babies in the first 6 months *(see Appendix 2)*.

Out of the randomly selected staff from **Group 2** at least 80% can confirm the recommended duration for exclusive breastfeeding.

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Observations in the CHS confirm that:

- infant formula and equipment for artificial feeding are stored discretely, out of sight
- adequate space and necessary equipment provided for giving individual demonstrations of infant formula preparation, out of sight from breastfeeding mothers
- a review of all records confirm that all infant formula and other supplies are purchased by the CHS at a wholesale price through a pharmaceutical distributor, by government tender or similar contract, or brought in by parents for feeding their own infants[6].

[6] The service using ready-to-feed infant formula should be particularly vigilant regarding the purchase price as these products are commonly sold to maternity facilities at a subsidised price.

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5 Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods

A partnership approach is used by staff when engaging with mothers and their families, which focuses on building relationships and acknowledging strengths.

The **Head of Service** reports that mothers and their families registered with the CHS, who do not regularly access or use the CHS, have access to information via community services or peer support groups, websites, printed information or publications.

Out of the randomly selected staff from **Group 1** at least 80% can adequately outline the guidance they provide on the following:

- contraception compatible with breastfeeding including LAM and/ or refer appropriately
- appropriate introduction of complementary foods

Out of the randomly selected interviewed **mothers who are breastfeeding,** at least 80% confirm that they have been provided with information on the following:

- introduction of appropriate complementary foods
- how to maintain their breastmilk supply
- how to manage breastfeeding challenges, including how to care for their breasts

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6 Provide a supportive atmosphere for breastfeeding families, and for all users of the service

All staff of the CHS recognise and support breastfeeding as the biologically normal way to feed an infant. The CHS supports and welcomes breastfeeding in all areas. A clean, pleasant, comfortable area is provided for breastfeeding and, where space allows, a private area is provided on request.

The **Head of Service** confirms:

- breastfeeding is supported and welcomed in all areas of the CHS and affiliated sites and that a private area is available on request, where space allows
- signs indicating that breastfeeding is welcome are posted in public areas of the CHS and affiliated sites
- the facility does not accept gifts, materials, sponsorship or support for infant feeding related education or events from companies which distribute or market products within the scope of the WHO Code

Out of the randomly selected staff from **Groups 1, 2 and 3,** and the **Antenatal/ Postnatal Educator, Breastfeeding Clinic/ Day Service/ Residential Service Coordinator** at least 80% can:

- explain the service policy regarding supporting and welcoming breastfeeding and describe how they make mothers feel welcome and supported to breastfeed

Out of the **all mothers interviewed,** 80% confirm they:

- felt supported and welcome to breastfeed their babies while attending the CHS and, if requested, privacy was facilitated (where space allows),
- have not seen used, displayed, or been given any materials in the CHS which picture or promote artificial feeding or a proprietary product that is within the scope of the Code including toddler milk,
- have not received any free sample(s) of infant formula or other breastmilk substitutes, inappropriate for age foods, products or promotional items including coupons and/or redeemable vouchers for same.

Observations in the CHS confirm:

- a clean, pleasant, comfortable area for breastfeeding, including a private area if space allows
- signage indicates that breastfeeding is supported and welcomed in all areas of the CHS
- no materials or literature produced by a company which markets or distributes products covered by the scope of the WHO Code are used, displayed or distributed
- all educational materials (including DVD's, posters, booklets and handouts) or sample bags available and/or distributed to women are free of promotion for artificial feeding bottles, teats or dummies and do not contain samples of infant formula, infants foods or drinks, teats, bottles or dummies, or redeemable vouchers for these products.

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7 Promote collaboration between staff and volunteers, breastfeeding support groups and the local community in order to promote, protect and support breastfeeding

The **Head of Service** can describe a process for the transition from hospital, birthing centre or midwife to the CHS that ensures a continuum of care including the following:

- evidence of intake processes from external services to the CHS
- a system of follow-up for all mothers after they are discharged from external services (e.g. early postnatal or lactation clinic check-up, home visit, clinic visit, telephone call, referral to a mother support group)
- collaboration between the CHS and the local community to promote/support breastfeeding e.g. (general practitioners, obstetricians, paediatricians, midwives, public and private practice lactation consultants, dieticians, pharmacists, breastfeeding support groups, schools, businesses, local government and the media) in promoting breastfeeding and making them aware of community breastfeeding resources.

Out of the randomly selected staff interviewed from **Group 2, 3**, and the **Antenatal/Postnatal Educator,** at least 80% can identify the appropriate professional within the CHS to contact for assistance with breastfeeding information.

Out of the randomly selected **mothers who are breastfeeding** at least 80% can confirm that:

- they are aware of and know how to access breastfeeding support services available in the community as follows:
  - Australian Breastfeeding Association (ABA) for information and peer support
  - breastfeeding clinics
  - lactation consultants
  - 24 hr breastfeeding support help line
  - any other appropriate breastfeeding support service
- they were offered and/or were given written information and contact details of these breastfeeding support services.

Out of the randomly selected staff from **Group 1** and the **Breastfeeding Clinic/Day Service/Residential Service Coordinator,** at least 80%:

- were able to identify an appropriate referral pathway to support mothers who require assistance with breastfeeding,
- can explain the community based breastfeeding supports in their local area, i.e. breastfeeding clinic, Australian Breastfeeding Association , lactation consultants, mothers' groups.

Out of the randomly selected staff from **Group 2** at least 80%:

- can explain sources of breastfeeding support in the community such as Australian Breastfeeding Association, lactation consultants and mothers' groups.

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Appendix 1
Definitions and Glossary of Terms

Breastfeeding Definitions[7]

Breastmilk
Human milk and colostrum (including expressed breastmilk and breastmilk from a donor or donor milk bank).

Breastmilk substitute
Any milk (other than breastmilk), or food-based fluid used in infant feeding feeding as a replacement for breastmilk, whether or not it is suitable for that purpose (commonly includes infant formula, cow's milk, and other milks fed to infants).

Complementary feeding (partial breastfeeding)
The infant receives both breastmilk and any other fluid or food, including infant formula.

Complementary foods
Any nutrient-containing foods or liquids (other than breastmilk) given to infants receiving breastmilk. Also commonly known as weaning or family foods.

Exclusive breastfeeding
The infant has received only breastmilk from his/her mother or a wet nurse, or expressed breastmilk, and no other liquids or solids, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Predominant breastfeeding
The infant's predominant source of nourishment has been breastmilk. However, the infant may also have received water and water-based drinks (sweetened and flavoured water, teas, infusions etc.); fruit juice; oral rehydration salts solution; drop and syrup forms of vitamins, minerals and medicines; and ritual fluids (in limited quantities). With the exception of fruit juice and sugar-water, no food-based fluid (such as infant formula or non-human milk) is allowed under this definition.

Full breastfeeding
This definition includes both exclusive breastfeeding and predominant breastfeeding.

Partial breastfeeding
See complementary feeding.

Breastfeeding
The infant is receiving breastmilk, either directly from the breast or expressed. This definition may include exclusive, predominant and complementary breastfeeding.

Artificial feeding
Infant being fed fully or predominantly with infant formula, and receiving no breastmilk.

Supplementary feeding
See complementary feeding.

[7] Definitions from Australian Institute of Health and Welfare (2011) 2010 Australian National Infant Feeding Survey: indicator results.

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Glossary

Antenatal Services
Antenatal care, antenatal education, antenatal clinics.

Community Health Service (CHS)
A CHS is any service that offers health care to pregnant women, mothers, babies and families. This may include (but is not limited to) child and family health centres, community health centres, general practice, pharmacies, private lactation clinics, early childhood and parenting centres.

Co-location service
Where a CHS is providing services, but does not own the building and therefore is co-locating with another service or business. Or where the CHS owns the building or venue and other services or businesses co-locate within it. For BFHI accreditation purposes, the CHS being assessed will only be held responsible for materials produced, displayed and distributed by them, however where compliance with the WHO Code is in question, evidence of negotiation with the co-locating service or business is required.

Donor Milk
Expressed breastmilk, not from the biological mother. This milk may be from human donor milk banks.

EBM
Expressed breastmilk. Generally from the infant's mother, but may be from a donor or donor milk bank.

Hands-off Techniques
Supporting a mother to breastfeed without the staff member touching the mother or baby. Close observation and support with verbal and visual cues are used by the staff member to empower the mother to correctly position and attach her baby for breastfeeding. It is recognised that individual care takes priority and these techniques are not applicable to every situation.

Head of Service
The most senior clinician in the CHS who can confirm breastfeeding practises and clinical protocols.

Human Milk Banks
Privately-run or hospital-based service that collects and processes donor human milk.

IBCLC
International Board Certified Lactation Consultant.

Informed decision making
The act of making a decision based on sound, unbiased evidence and information and the weighing up of all relevant options. CHS have the responsibility to ensure that parents are given the opportunity to make informed decisions by adopting a partnership approach to their care, and providing up-to-date, relevant, accurate information in a non-coercive manner.

Lactation Aids
These assist a mother to continue to breastfeed in challenging circumstances. Lactation aids include supplementary feeding systems ('supply lines'), cup feeding, finger feeding, syringe feeding, nipple shields and breast pumps. In some cases, lactation aids may be used as an alternative to providing complementary feeds of infant formula, where needed and appropriate.

LAM
Lactational Amenorrhea Method is a drug-free contraception method that relies on the woman's observations of her body throughout her menstrual cycle and is compatible with breastfeeding.

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Mothers who are breastfeeding (Breastfeeding Mothers)
Mothers who are breastfeeding their babies, or expressing their milk for their baby.

Outreach Service
A service offered at an external venue.

Peer support
In Australia, for BFHI purposes, this is defined as breastfeeding support provided by other mothers who are currently breastfeeding or who have done so in the past. These mothers have completed specific training to become a breastfeeding counsellor and may provide support individually face to face or over phone or email, or in a group setting at mother-to-mother support groups. Support includes psycho-emotional support, encouragement, education about breast-feeding, and help with solving problems.

Referral Pathway
A recognised process with clear referral criteria that the health professional uses to access another level of support for the client and the health professional. Referral includes an appropriate referral follow up for the mother to support the agreed partnership plan with the health professional.

Room sharing
When infants sleep in the parent's room for the first 6-12 months. For information and recommendations regarding safe sleeping and room sharing for infants, see http://www.sidsandkids.org/wp-content/uploads/LongB2012LR.pdf

Separation from baby
For BFHI Community purposes, separation is where a baby's access to breastfeeding is interrupted. Reasons for this interruption or separation can include illness in the mother or infant, returning to work, or spending time away from baby. It may also include the short-term use of medication that is contraindicated whilst breastfeeding**.**

Skin-to-skin contact
The baby is naked (or wears only a nappy) and is prone on the mother's naked chest. Mother and baby may then be covered for warmth and privacy in a way that does not restrict their interaction or inhibit the baby's innate feeding behaviours.

Residential or Day Stay Parenting Services
A service that provides early parenting support, including breastfeeding.

Supervised Clinical Experience
This assists the practitioner to reflect on and learn from their experience and to build competency. For BFHI purposes, the practitioner should be supervised by someone with a high level of skills and experience in evidenced based, contemporary breastfeeding practices consistent with BFHI standards. The supervised clinical experience may be acquired in a single session or cumulatively during normal working day activities. It may include observation and/or assisting with a particular practice e.g. assisting with a breastfeed, teaching hand expression, assisting with breastfeeding challenges, discussing breastfeeding with pregnant woman, and support provided to a mother who is not breastfeeding. Currently certified IBCLC's and current Australian Breastfeeding Association Counsellors are exempt from the requirement of 'clinical supervision'.

Tandem Breastfeeding
Breastfeeding two infants or children of different ages.

WHO Code
World Health Organization (WHO) *International Code of the Marketing of Breast Milk Substitutes*. For BFHI purposes, the WHO Code includes the subsequent revisions (resolutions) introduced by the World Health Assembly (WHA).

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Appendix 2
Acceptable Medical Reasons for Use of Breastmilk Substitutes

© World Health Organization 2009

Appendix 2 is the March 2009 updated version of the WHO/UNICEF document of the same name, reproduced by BFHI Australia with permission.

The following link provides access to the publication:
http://whqlibdoc.who.int/hq/2009/WHO_FCH_CAH_09.01_eng.pdf

Acceptable medical reasons for use of breast-milk substitutes

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Preface

A list of acceptable medical reasons for supplementation was originally developed by WHO and UNICEF as an annex to the Baby-friendly Hospital Initiative (BFHI) package of tools in 1992. WHO and UNICEF agreed to update the list of medical reasons given that new scientific evidence had emerged since 1992, and that the BFHI package of tools was also being updated. The process was led by the departments of Child and Adolescent Health and Development (CAH) and Nutrition for Health and Development (NHD). In 2005, an updated draft list was shared with reviewers of the BFHI materials, and in September 2007 WHO invited a group of experts from a variety of fields and all WHO Regions to participate in a virtual network to review the draft list.

The draft list was shared with all the experts who agreed to participate. Subsequent drafts were prepared based on three inter-related processes: a) several rounds of comments made by experts; b) a compilation of current and relevant WHO technical reviews and guidelines (see list of references); and c) comments from other WHO departments (Making Pregnancy Safer, Mental Health and Substance Abuse, and Essential Medicines) in general and for specific issues or queries raised by experts.

Technical reviews or guidelines were not available from WHO for a limited number of topics. In those cases, evidence was identified in consultation with the corresponding WHO department or the external experts in the specific area. In particular, the following additional evidence sources were used:

- *The Drugs and Lactation Database* (LactMed) hosted by the United States National Library of Medicine, which is a peer-reviewed and fully referenced database of drugs to which breastfeeding mothers may be exposed.
- *The National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*, review done by the New South Wales Department of Health, Australia, 2006.

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

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

Acknowledgments
This list was developed by the WHO Departments of Child and Adolescent Health and Development and Nutrition for Health and Development, in close collaboration with UNICEF and the WHO Departments of Making Pregnancy Safer, Essential Medicines and Mental Health and Substance Abuse.

The following experts provided key contributions for the updated list: Philip Anderson, Colin Binns, Riccardo Davanzo, Ros Escott, Carol Kolar, Ruth Lawrence, Lida Lhotska, Audrey Naylor, Jairo Osorno, Marina Rea, Felicity Savage, María Asunción Silvestre, Tereza Toma, Fernando Vallone, Nancy Wight, Antony Williams and Elizabeta Zisovska. They completed a declaration of interest and none identified a conflicting interest.

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

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

Positive effects of breastfeeding on the health of infants and mothers are observed in all settings. Breastfeeding reduces the risk of acute infections such as diarrhoea, pneumonia, ear infection, *Haemophilus influenza*, meningitis and urinary tract infection[1]. It also protects against chronic conditions in the future such as type-1 diabetes, ulcerative colitis, and Crohn's disease.

Breastfeeding during infancy is associated with lower mean blood pressure, total serum cholesterol and with lower prevalence of type-2 diabetes, overweight and obesity during adolescence and adult life.[2] Breastfeeding delays the return of a woman's fertility and reduces the risks of post-partum haemorrhage, pre-menopausal breast cancer and ovarian cancer.[3]

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

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

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

- 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 (some breastfeeding is possible, under careful monitoring).

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

- 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 (such as those who are preterm, small for gestational age or who have

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experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic[5]) if their blood sugar fails to respond to optimal breastfeeding or breast milk feeding.

Maternal Conditions

Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines. Mothers who may need to avoid breastfeeding:

- HIV infection: if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS)[6].

[The most appropriate infant feeding option for an HIV-infected mother depends on her and her infant's individual circumstances, including her health status, but should take consideration of the health services available and the counselling and support she is likely to receive. 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 who 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:
  - sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available[7];
  - radioactive iodine-131 is better avoided given that safer alternatives are available - a mother can resume breastfeeding about two months after receiving this substance;
  - excessive use of topical iodine or iodophors (e.g. povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided;
  - cytotoxic chemotherapy requires that a mother stops breastfeeding during therapy.

Mothers who 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[8];
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter[9]; *NB In Australia immunisation providers follow the current Australian Immunisation Handbook re administration of Hepatitis B in infants[10]*
- Hepatitis C;
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition[8];
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines[11];
- Substance use[12]:
  - maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
  - alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

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

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Appendix 3
Summary of Code Compliance Standards

This appendix outlines how the World Health Organization *International Code of Marketing of Breast-milk Substitutes* ("WHO Code") and subsequent World Health Assembly (WHA) resolutions, and how these are incorporated into BFHI standards for both hospital and community, the *Ten Steps to Successful Breastfeeding* and the *7 Point Plan*.

Aim of the WHO Code
The aim of the *WHO 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 of the WHO Code
The *WHO 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.

Point 1 / Step 1
The facility protects breastfeeding by adhering to the relevant provisions of the *WHO Code* and subsequent WHA resolutions. The breastfeeding and infant feeding policy:

- prohibits all promotion of artificial feeding and materials which promote the use of infant formula, feeding bottles and teats
- does not permit the facility to receive free and subsidised (low cost) products within the scope of the Code
- does not permit the distribution of samples and supplies of infant formula to parents
- addresses restrictions on access to the facility and staff by representatives from companies which distribute or market products within the scope of the *WHO Code*
- prohibits direct or indirect contact of these representatives with pregnant women or mothers and their families
- does not allow the facility to accept free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events from these companies
- ensures that instruction on preparation and feeding of infant formula is given individually and only to parents who need to use it; there is no group instruction
- supports 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.

Point 2 / Step 2
For Groups 1 and 2, education must include health worker responsibilities under the *WHO Code*.

Point 3 / Step 3
The antenatal or postnatal services comply with BFHI standards and the *WHO Code* and do not promote or distribute infant formula or bottles and teats. All educational materials, handouts or sample bags available and/or distributed to antenatal women are free of promotion of artificial feeding.

At least 70% of pregnant women who are in their third trimester and have attended at least two antenatal visits:

- confirm they have not seen displayed in the facility or been given any materials which picture or promote artificial feeding or a proprietary product that is within the scope of the *WHO Code*

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

Point 4 & 6 / Step 6
Artificial feeding education and written materials are provided to individual mothers as needed - there is no group education on artificial feeding. No materials or literature produced by a company which markets or distributes products covered by the scope of the *WHO Code* are used, displayed or distributed to parents. No materials or literature which picture or refer to a proprietary product that is within the scope of the Code are used, displayed or distributed.

Of all mothers:

- at least 80% confirm they have not seen used or displayed in the facility or been given any materials which picture or promote artificial feeding or a proprietary product within the scope of the *WHO Code*.
- 100% confirm that they have not been given any free samples or supplies of infant formula, bottles or teats to take home (excluding babies with documented medical needs).

Observations and review of materials confirm that:

- breastmilk substitutes and equipment for artificial feeding in clinical areas are stored discretely and are not openly on display
- the facility has an adequate space and necessary equipment for giving individual demonstrations of how to prepare formula away from breastfeeding mothers
- all handouts or sample bags distributed to new parents are free of promotion of artificial feeding or inappropriate breastfeeding practices and do not contain samples of infant formula, foods or drinks or redeemable vouchers for these products.

The facility and its staff do not accept or distribute to mothers free or subsidised (low cost) samples or supplies of breastmilk substitutes[8]. A review of records and receipts indicate that any breastmilk substitutes, including special formula and other supplies, are purchased by the facility for at least the wholesale price, or by government tender, or brought in by parents for feeding their own infants.

Point 4 & 6 / Step 9
The facility and its staff do not accept or distribute to mothers free or low cost teats, bottles or dummies. A review of records and receipts indicate that these products are purchased by the facility for at least the wholesale price, or by government tender, or brought in by parents for use by their own infants.

All educational materials, handouts or sample bags available and/or distributed to new parents are made available for the assessors to review and are free of promotion of bottles, teats or dummies and do not contain samples of, or redeemable vouchers for these products.
Dummies, bottles and teats are not displayed in a promotional way in the hospital shop or kiosk and are not included in baby gift packs for sale in the facility.

[8] Services using ready-to-use liquid infant formula should be particularly vigilant regarding the purchase price as these products are commonly sold to maternity facilities at a subsidised price.

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