



Neo-BFHI

The Baby-friendly
Hospital Initiative

for Neonatal Wards

Three Guiding Principles and Ten Steps
to protect, promote and support

breastfeeding

Self-Appraisal Tool to assess standards and criteria

Neo-BFHI: The Baby-friendly Hospital Initiative for Neonatal Wards.
Three Guiding Principles and Ten Steps to protect, promote and support breastfeeding.
Self-Appraisal Tool to assess standards and criteria.

Based on the:

Baby-friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care.
World Health Organization and UNICEF, 2009 (Original BFHI Guidelines developed 1992)

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The content of this publication does not reflect the opinion of the organisations to which the Working Group members are affiliated. Although the Neo-BFHI is based on the original WHO/UNICEF BFHI, the tool presented in this document has been produced independently from the WHO and the UNICEF and does not represent a formal program of these organisations.

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Introduction

The expansion of the BFHI to neonatal wards

Breastfeeding is the normal way of providing infants and young children with the nutrients they need for healthy growth and development (1, 2), including those who are born preterm or ill (3, 4). These infants may not be able to breastfeed right from birth but can – with appropriate support – begin breastfeeding when they mature.

The initiation and maintenance of breast milk production is of great importance for enabling mothers to breastfeed preterm or sick infants. Early, systematic and continuing support for mothers to initiate breast milk expression and breastfeeding as soon as their infants are stable is essential for helping them to succeed in overcoming physiological and emotional challenges related to lactation and breastfeeding (5, 6). This is the rationale for expanding the World Health Organization/UNICEF Baby-friendly Hospital Initiative (BFHI) to neonatal wards.

Since 1991 the BFHI has provided an evidence-based set of standards for the protection, promotion and support of breastfeeding in maternity wards worldwide (7-9). In 2009, the WHO/UNICEF updated the BFHI package to ensure that all concerned sectors of the health care system and other relevant settings support the recommendation of exclusive breastfeeding for 6 months and continued breastfeeding for up to 2 years of age or beyond, while providing women with the support that they require to achieve their individual breastfeeding goals (10). That same year, the Nordic and Quebec Working Group was formed in Copenhagen by health professionals from Sweden, Norway, Denmark, Finland and Quebec, Canada, to address the special situation of preterm and sick infants and their families. The working group has developed the present unified expansion of the BFHI to neonatal wards ("Neo-BFHI") based on evidence, expert opinion and experiences implementing Baby-friendly practices in neonatal wards in the Nordic and other countries. The components of the Neo-BFHI are presented at the end of this section.

In order to disseminate the expansion, the working group has published a *Core document with recommended standards and criteria* (11) and two peer-reviewed articles (12, 13). These publications can be consulted to obtain detailed information on the background and rationale for the expansion, as well as recommended standards and criteria. The key points are listed here:

- To remain consistent with the original BFHI, its expansion to neonatal wards follows as closely as possible the Ten Steps to Successful Breastfeeding (Ten Steps) and related Global Criteria. To emphasize this close relationship between both programs, each section presents the original formulation of the Ten Steps followed by the expanded version of the recommendation. Some of the expanded steps are the same as in the original version.
- To ensure that the recommended practices focus on respect for mothers, a family-centred approach and continuity of care, the working group added Three Guiding Principles meant to be basic tenets underpinning the Ten Steps.
- The adaptation also includes compliance with the International Code of Marketing of Breast-milk Substitutes (14) and subsequent relevant World Health Assembly resolutions (Code).
- The Global Criteria proposed by the WHO/UNICEF for babies in Special Care have also been adapted and are integrated into the Neo-BFHI Ten Steps.
- Like the original BFHI, the expansion aims to help ensure that all mothers of infants admitted to neonatal wards, regardless of feeding method, get the support they need. For the Neo-BFHI, the recommendations for non-breastfeeding mothers have also been expanded to include mothers whose infants are being supplemented with formula.

- The adaptation focuses on neonatal wards that provide various levels of neonatal care, ranging from care for extremely preterm infants and infants with serious medical/surgical conditions, to care for late preterm infants, term low birth weight infants, and term infants, who may require episodic or short-term monitoring or medical interventions.
- To account for different levels of compliance, a grading system is used when assessing certain criteria. This system identifies the levels as follows: Gold is represented by 3 stars (***), Silver by 2 stars (**), and Bronze by 1 star (*). The minimum required for Neo-BFHI designation for these criteria is one star.
- The breastfeeding statistics required for Neo-BFHI designation are the same as specified by the BFHI: “the maternity facility’s annual statistics should indicate that at least 75% of the mothers who delivered in the past year are either exclusively breastfeeding or exclusively feeding their babies human milk from birth to discharge or, if not, this is because of acceptable medical reasons. (In settings where HIV status is known, if mothers have made fully informed decisions to replacement feed, these can be considered acceptable medical reasons, and thus counted towards the 75% exclusive breastfeeding goal)”. This means that annual statistics relative only to infants admitted to the neonatal ward are not required; however, it is desirable for monitoring purposes that separate statistics be compiled for the neonatal ward, when possible.

The Self-Appraisal Tool

The revised WHO/UNICEF BFHI package, “Section 4: Hospital Self-Appraisal and Monitoring” (15) provides tools that can be used by managers and staff to help determine whether their facilities are ready to apply for external assessment, and – once their facilities are designated Baby-friendly – to monitor continued adherence to the Ten Steps. The Neo-BFHI *Self-Appraisal Tool to assess standards and criteria* is modelled after the tool included in the WHO/UNICEF document.

Any neonatal ward interested in obtaining Neo-BFHI designation could – as a first step – appraise its current policies and practices with regard to the Three Guiding Principles, the Neo-BFHI Ten Steps and the Code by completing the checklist provided in this document. The person(s) answering the questions should ideally have become acquainted with the Neo-BFHI recommendations before the self-appraisal.

When a facility can answer most of the questions with “yes,” it may then wish to take further steps towards obtaining Neo-BFHI designation. A facility with numerous “no” answers on the Self-Appraisal Tool may want to develop an action plan to guide the implementation of the recommended Neo-BFHI standards.

It should be noted that this document only intends to provide guidance on how to appraise Baby-friendly policies and practices in a neonatal ward. WHO/UNICEF Section 4 can be consulted for more complete information on the self-appraisal exercise (11). It is understood that countries, regions or facilities that want to use it will need to adapt the Neo-BFHI Self-Appraisal Tool to their particular settings. Finally, guidance on the assessment process is not addressed here because the revised BFHI package provides detailed information about it in “Section 1: Background and Implementation” and “Section 5. External Assessment and Reassessment” (available only to BFHI national authorities). Interested facilities can consult health authorities or the UNICEF and WHO country offices to obtain more information on the Neo-BFHI designation process.

The components of the Neo-BFHI

The Baby-friendly Hospital Initiative for Neonatal Wards or Neo-BFHI	
Three Guiding Principles	
Guiding Principle 1	Staff attitudes toward the mother must focus on the individual mother and her situation.
Guiding Principle 2	The facility must provide family-centered care, supported by the environment.
Guiding Principle 3	The health care system must ensure continuity of care from pregnancy to after the infant's discharge.
Expanded Ten Steps to Successful Breastfeeding	
Step 1	Have a written breastfeeding policy that is routinely communicated to all health care staff.
Step 2	Educate and train all staff in the specific knowledge and skills necessary to implement this policy.
Step 3	Inform hospitalized pregnant women at risk for preterm delivery or birth of a sick infant about the benefits of breastfeeding and the management of lactation and breastfeeding.
Step 4	Encourage early, continuous and prolonged mother-infant skin-to-skin contact/ Kangaroo Mother Care.
Step 5	Show mothers how to initiate and maintain lactation, and establish early breastfeeding with infant stability as the only criterion.
Step 6	Give newborn infants no food or drink other than breast milk, unless medically indicated.
Step 7	Enable mothers and infants to remain together 24 hours a day.
Step 8	Encourage demand breastfeeding or, when needed, semi-demand feeding as a transitional strategy for preterm and sick infants.
Step 9	Use alternatives to bottle feeding at least until breastfeeding is well established, and use pacifiers and nipple shields only for justifiable reasons.
Step 10	Prepare parents for continued breastfeeding and ensure access to support services/groups after hospital discharge.
Compliance with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.	

Definitions and Abbreviations

Abbreviations

AFASS	Acceptable, feasible, affordable, sustainable and safe; criteria for infant feeding/nutrition when the mother does not breastfeed.
Code	International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions
KMC	Kangaroo Mother Care
NICU	Neonatal Intensive Care Unit
24h/7d	24 hours a day, 7 days a week

Definitions in this document

Breastfeeding	<p>Breastfeeding means feeding directly at the breast.</p> <p>For statistical purposes, as proposed by the WHO to define infant feeding practices, exclusive breastfeeding means that the infant receives breast milk (including expressed breast milk, donor milk, or breast milk from a wet nurse) and allows infants to receive oral rehydration solutions, drops, syrups (vitamins, minerals, medicines), but nothing else.¹</p> <p>¹ World Health Organization. <i>Indicators for assessing infant and young child feeding practices - Part 1, Definitions. Conclusions of a consensus meeting held 6–8 November 2007 in Washington, DC, USA.</i> 2008. Geneva, Switzerland: World Health Organization.</p>
Breastfeeding or infant feeding policy	Overall policy for feeding, breastfeeding and nutrition including the Three Guiding Principles, the Neo-BFHI Ten Steps and the Code. The policy could address the implementation of the Neo-BFHI alone or in combination with the BFHI or other programs related to infant nutrition.
Breast milk feeding	Providing infants with breast milk by other feeding methods than directly at the breast.
Breastfeeding protocol	Guidelines for the implementation of specific breastfeeding-related practices in the neonatal ward.
Clinical staff	<p>Includes staff members providing clinical care for mothers and their preterm or sick babies who are being cared for in the neonatal ward or related areas, and for pregnant women at risk of giving birth to preterm or sick babies. Clinical staff may include nurses, midwives, doctors and any other staff member providing health care for these women and babies.</p> <p>In the text of the standards and criteria, clinical staff refers to those working in the neonatal ward or related areas.</p>

Father	Includes partner or significant others.
Family	Includes significant others and is defined by the parents.
Gestational age	Time elapsed between the first day of the last menstrual period and the day of delivery.
Head/director of nursing	The professional who has the main responsibility for nursing care in the neonatal ward and related areas.
Infant or baby	Refers to preterm and/or ill infants/babies. Otherwise infants or babies are described as healthy and/or full term infants/babies.
Kangaroo Mother Care (KMC)	<p>The definition of the KMC method is: “early, prolonged and continuous (as allowed by circumstances) skin-to-skin contact between a mother and her newborn low birthweight infant, both in hospital and after early (depending on circumstances) discharge, until at least the 40th week of post-natal gestational age, with ideally exclusive breastfeeding and proper follow-up”¹</p> <p>In this document, the term KMC is used for all types of skin-to-skin care (intermittent and continuous) between parents/family members and preterm/low birth weight/ill infants requiring neonatal care.</p> <p>¹ Cattaneo A, Davanzo R, Uxa F, Tamburlini G. <i>Recommendations for the implementation of Kangaroo Mother Care for low birthweight infants. International Network on Kangaroo Mother Care. Acta paediatrica</i>, 1998. 87(4): p. 440-05</p>
KMC protocol	Guidelines for the implementation of skin-to-skin/KMC practices in the neonatal ward.
Levels ***, **, *	Levels in meeting criteria for certain standards: *** Gold, ** Silver and * Bronze. Neo-BFHI designation can be given if at least level * is achieved in all the criteria with levels. The long term goal should be to progress to level ***.
Maternal role	See definition below: Parent as primary caregiver
Mothers/Parents	Mothers/parents refer to those with infants admitted to the neonatal ward.
Neo-BFHI	The expansion of the Baby-friendly Hospital Initiative for neonatal wards.
Neonatal ward	<p>“Neonatal ward” covers all levels of neonatal care (levels I-IV) and paediatric wards where infants are admitted, as well as infants in maternity/postpartum wards who require some kind of monitoring and medical/nursing interventions.</p> <p>In the text of the standards and criteria, the term refers to all neonatal wards and related areas in the facility.</p>

Non-clinical staff	<p>These include staff members providing non-clinical care for mothers and their preterm or sick babies who are being cared for in the neonatal ward and related areas, and for pregnant women at risk of giving birth to preterm or sick babies, or who have contact with them in some aspect of their work.</p> <p>In the text of the standards and criteria, non-clinical staff refers to those working in the neonatal ward or related areas.</p>
Nursing supplementer	A method for supplementation by using a feeding tube device with a bag/bottle to hold milk, connected to fine tubing taped to the mother's nipple, delivering supplementation to the baby at the same as he/she suckles the breast.
Pacifier	Also called dummy or soother.
Parent as primary caregiver	Role of the mother, father or significant other who provides an infant with all caregiving except for certain medical-technical procedures which, if performed by individuals without adequate training and knowledge, would be considered a hazard for the infant.
Postmenstrual age	Corresponds to gestational age plus chronological age.
Postnatal age	Corresponds to the chronological age or time elapsed from birth.
Preterm infant	<p>Born alive before 37 weeks of pregnancy are completed. There are sub-categories of preterm birth, based on gestational age:</p> <ul style="list-style-type: none"> • Extremely preterm (<28 weeks) • Very preterm (28 to <32 weeks) • Moderate preterm (32 to <34 weeks) • Late preterm (34 to <37 weeks).
Printed or digital information/material	Includes written, pictorial or other type of formats more easily understood by the families served by the facility.
Skin-to-skin contact	The infant is placed between the mother's breasts in an upright position, chest to chest. The baby is naked, except for a diaper, a warm hat and socks to allow face, chest, abdomen, arms and legs to remain in skin-to-skin contact with the mother's chest and abdomen. Skin-to-skin contact can also be provided by the father or significant others.
Stable infant: Related to breastfeeding	Infants who respond to routine care and handling without experiencing severe apnoea, desaturation and bradycardia.
Stable infant: Related to KMC	Infants for whom there is ample research evidence of safety and positive effects of Kangaroo Mother Care: Infants born at a gestational age of at least 28 weeks without severe physiological instability associated to routine care and handling.
Supplementation	Supplementation means feeding by other means than at the breast and can consist of breast-milk or formula.
Tactile contact	Therapeutic intervention provided to the infant using touch by containment/"hand swaddling", stroking, massage, holding, etc.

The Self-Appraisal Tool

Neonatal ward data sheet

Date:

General information on senior management, services, staff and statistics

Identification of the facility	
Name of the facility:	
Person to contact:	
Address:	
Telephone:	E-mail:
Director general of the facility:	
Nom:	
Telephone:	E-mail:
Head/Director of nursing services:	
Nom:	
Telephone:	E-mail:
Head/Director of the neonatal ward:	
Name:	
Telephone:	E-mail:
Breastfeeding, BFHI or Neo-BFHI coordinator, if available:	
Name:	
Telephone:	E-mail:

Services available	Yes	No	N	Comments
Prenatal services for pregnant women at risk of delivering a preterm or sick infants				
Outpatient services for pregnant women at risk	<input type="checkbox"/>	<input type="checkbox"/>		
Hospitalizations for pregnant women at risk	<input type="checkbox"/>	<input type="checkbox"/>		
Other services for pregnant women at risk	<input type="checkbox"/>	<input type="checkbox"/>		
Neonatal services				
Intensive neonatal care unit/ward (levels III-IV)	<input type="checkbox"/>	<input type="checkbox"/>		Head of the unit:
• Maximal capacity				
• Mean occupancy				
Intermediate neonatal care unit/ward (levels I-II)	<input type="checkbox"/>	<input type="checkbox"/>		Head of the unit:
• Maximal capacity				
• Mean occupancy				
Ward/unit for late preterm/low birthweight infants	<input type="checkbox"/>	<input type="checkbox"/>		
Wards with infants requiring monitoring/interventions	<input type="checkbox"/>	<input type="checkbox"/>		
Other services: _____	<input type="checkbox"/>	<input type="checkbox"/>		

Staff responsible for lactation/breastfeeding/infant feeding in the neonatal ward.

The following staff has direct responsibility for assisting mothers with lactation and breastfeeding, feeding using alternative feeding methods, feeding using breast milk substitutes, or providing counselling on HIV and infant feeding.

Number		Number	
Nurses	<input type="checkbox"/>	Neonatologists	<input type="checkbox"/>
Neonatal ward nurses	<input type="checkbox"/>	Paediatricians	<input type="checkbox"/>
Midwives	<input type="checkbox"/>	Obstetricians	<input type="checkbox"/>
Lactation consultants	<input type="checkbox"/>	Other physicians	<input type="checkbox"/>
Dieticians	<input type="checkbox"/>	Occupational therapists	<input type="checkbox"/>
Others staff (specify):	<input type="checkbox"/>	Speech therapists	<input type="checkbox"/>
		Lay peer counsellors	<input type="checkbox"/>

Are there any breastfeeding, BFHI, Neo-BFHI or HIV infant feeding committees in the facility?

Yes No If yes, please describe:

Statistics on admissions to the neonatal ward	N	Comments
Total number of infants admitted to this neonatal ward last year:		
Number of infants transferred from the delivery unit at this hospital:		
Number of infants transferred from the maternity unit or other wards at this hospital:		
Number of infants transferred from other hospitals:		
Other services:		

Statistics on infant feeding during admission to the neonatal ward	%	Comments
<i>Total number of infants admitted to the neonatal ward last year:</i>		
% exclusively breastfed or fed human milk:		
% received at least one feed other than breast milk (formula, water or other fluids) because of an acceptable medical reason:		
% received at least one feed other than breast milk <u>without</u> an acceptable medical reason:		
TOTAL: (Note: the total percentages listed above should equal 100%.)		

Statistics on infant feeding at discharge from the neonatal ward	%	Comments
<i>Total number of infants discharged from the neonatal ward last year:</i>		
% exclusively breastfeeding (at the breast) :		
% exclusively breastfed or fed human milk:		
% exclusively breastfed or fed human milk and receiving feeds other than breast milk (formula, water or other fluids):		

Please describe sources for the above data:

Guiding principle 1: Staff attitudes toward the mother must focus on the individual mother and her situation.

This step applies to all infants admitted to the neonatal ward, whether they are breastfed or not.

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

GP1 a	Every mother is treated with sensitivity (meaning staff are responsive to what she communicates), empathy and respect for her maternal role.
GP1 b	Mothers are supported in making informed decisions about milk production, breastfeeding and infant feeding. This includes respect for mothers who decide or are advised not to breastfeed, or are supplementing their baby with infant formula. Decisions made by mothers and staff, and the acceptable medical or other justifiable reasons for them, are documented appropriately.
GP1 c	Mothers receive focused individualized support with respect to milk production, breastfeeding and infant feeding.

Self-Appraisal questions

	YES	NO
1. Are mothers treated with sensitivity, empathy and respect for their maternal roles by the clinical staff?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are mothers supported by the clinical staff in making informed decisions about milk production, breastfeeding and infant feeding?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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Guiding principle 2: The facility must provide family-centered care, supported by the environment.

This step applies to all infants admitted to the neonatal ward, whether they are breastfed or not.

In the Standards and Self-Appraisal questions below, the term “mother/parent” refers to mothers/parents of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

GP2 a	Family-centred care is integrated into the organization and functioning of the neonatal ward.
GP2 b	The presence of the father in the neonatal ward is encouraged at all times, as he is the mother’s supporter and the infant’s caregiver.
GP2 c	The care of infants admitted to the neonatal ward is transferred gradually by the staff to the parents, beginning as soon as possible after birth.
GP2 d	The neonatal ward provides practical support, such as a place to rest, sleep and eat, that will enable mothers/parents to stay with their babies as long as they want.
GP2 e	The neonatal ward provides an individualized developmentally supportive environment that is appropriate for the infants and the parents and facilitates breastfeeding.

Self-appraisal questions

	YES	NO
1. Does the clinical staff know how family-centered care is integrated in their neonatal ward?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are all fathers welcomed in the ward 24/7, without restrictions?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do parents begin to participate in their infants’ care within the first 24 hours after the birth?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are all mothers able to rest by their infants’ bedsides according to at least one the following levels? <input type="checkbox"/> Bed/mattress (level ***) <input type="checkbox"/> Chair with armrest or recliner (level **) <input type="checkbox"/> Chair without armrest or recliner (level *).	<input type="checkbox"/>	<input type="checkbox"/>
5. Are all mothers able to eat close to the neonatal ward according to at least one of the following levels? <input type="checkbox"/> Eat in the ward (level ***) <input type="checkbox"/> Eat very close to the ward (5 minutes walking distance or less) (level **) <input type="checkbox"/> Eat close to the ward (6 to 10 minutes walking distance) (level *).	<input type="checkbox"/>	<input type="checkbox"/>

6. Is the illumination in the ward individualized, so that preterm infants' eyes are not exposed to direct light and the sound level is low?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the environment in the neonatal ward (light, sound, activity and privacy) appropriate for the mothers' presence and for breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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Guiding principle 3: The health care system must ensure continuity of care from pregnancy to after the infant’s discharge.

This step applies to all infants admitted to the neonatal ward, whether they are breastfed or not.

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

GP3 a	Care in regards to lactation and breastfeeding support during each stage of health care delivery (prenatal care, the arrival of a “potentially” critical infant, the acute/critical care phase, the stable-improving phase, the transfer-discharge phase, and the follow-up or continuing care phrase) is consistent.
GP3 b	Information regarding the infants’ medical management and families’ preferences is shared among the relevant health care providers, institutions, and organizations involved in lactation and breastfeeding support.

Self-Appraisal questions

	YES	NO
1. Are all clinical protocols or standards in the hospital related to lactation, breastfeeding and feeding support in preterm and sick infants in line with the Neo-BFHI standards and current evidence-based guidelines?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the facility provide continuity of care related to lactation, breastfeeding and feeding support during each stage of health care delivery? Does the facility have a specific protocol regarding continuity of care?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the information that mothers receive regarding lactation, breastfeeding and feeding support for their infants consistent throughout the continuum of care?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the clinical staff know the infants’ medical conditions and current care plans (including current lactation, breastfeeding and feeding support strategy)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is information regarding the current situation and plan for lactation, breastfeeding and feeding support included in reports provided by the neonatal ward when infants are transferred to the next phase of care?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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Step 1: Same for the original BFHI and the Neo-BFHI.

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

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

1 a	The health facility has a written breastfeeding or infant feeding policy that addresses the Three Guiding Principles, all Neo-BFHI Ten Steps and the Code in the neonatal wards.
1 b	The policy includes guidance for how each of the Three Guiding Principles, Neo-BFHI Ten Steps, and the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions should be implemented in the neonatal ward and other areas serving pregnant women at risk of having preterm or sick babies, and requires that mothers – regardless of their infant feeding methods – receive the individualized feeding support they need. It also requires that HIV-positive mothers with babies in these wards receive counselling on infant feeding and guidance on selecting options likely to be suitable for their situations. The policy protects breastfeeding in the neonatal ward by adhering to the Code.
1 c	The policy is available so that all clinical staff members can refer to it. Summaries of the policy covering the Three Guiding Principles, the Neo-BFHI Ten Steps, the Code, and support for HIV-positive mothers, are visibly posted or available as written and visual information in the neonatal ward and other areas serving pregnant women at risk of having preterm or sick babies. These areas may include in-patient wards for antenatal care, the labour and delivery area and clinic/consultation rooms. The summaries are displayed in the language(s) and written with wording most commonly understood by mothers and clinical staff.

Self-Appraisal questions

	YES	NO
1. Does the health facility have a written breastfeeding/infant feeding policy that addresses the Three Guiding Principles, the Neo-BFHI Ten Steps and the Code for neonatal wards?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the breastfeeding policy include guidance for how the Three Guiding Principles, the Neo-BFHI Ten Steps and the Code should be implemented in neonatal wards and other areas serving pregnant women at risk of having preterm or sick babies?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the breastfeeding/infant feeding policy available so all staff who take care of mothers and babies can refer to it?	<input type="checkbox"/>	<input type="checkbox"/>

4. Is a summary of the breastfeeding/infant feeding policy or visual images posted or displayed in the neonatal wards and in all other areas serving pregnant women at risk of having preterm or sick babies?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the summary of the policy posted in language(s) and written with wording most commonly understood by mothers and staff?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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

Expansion: Educate and train all staff in the specific knowledge and skills necessary to implement this policy.

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

2 a	All clinical staff are aware of the existence of the breastfeeding/infant feeding policy. They have basic knowledge in breastfeeding as well as of the special needs of preterm and sick infants, and of how to support their mothers to enable early initiation of breast milk production and breastfeeding.
2 b	The neonatal ward has a plan in place for education and training of various types of staff members. Continuing education in the field should be provided on a regular basis.
2 c	All clinical staff who have been on working in the neonatal ward 6 months or more have acquired knowledge corresponding to the breastfeeding and lactation content in the Three Guiding Principles, the Neo-BFHI Ten Steps and the Code, including supervised clinical experience in the neonatal ward. In addition to this, they receive continuing breastfeeding education on these topics on a regular basis.
2 d	<p>Training on how to provide support for non-breastfeeding mothers is provided to staff. A copy of the course session outlines for training on how to support non-breastfeeding mothers is also available for review. The training covers key topics such as:</p> <ul style="list-style-type: none"> • the risks and benefits of various feeding options; • helping the mother choose feeding that is acceptable, feasible, affordable, sustainable and safe (AFASS) in her circumstances; • the safe and hygienic preparation, feeding and storage of breast-milk substitutes; • how to teach the preparation of various feeding options; • and how to minimize the likelihood that breastfeeding mothers will be influenced to use formula.
2 e	Non-clinical staff members have received training that is adequate, given their roles, to provide them with the skills and knowledge needed to support mothers in successfully feeding their infants in the neonatal ward.

Self-Appraisal questions

	YES	NO
1. Do all health care staff members who have any contact with pregnant women at risk of having preterm or sick babies, and/or mothers and their babies cared for in the neonatal wards, receive orientation on the breastfeeding/infant feeding policy when they begin working in the neonatal ward?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do clinical staff members know the importance of breastfeeding/breast milk feeding for preterm/ill infants, including psychological benefits to the mothers?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the neonatal ward have a curricula or course session outlines for training for various types of staff in breastfeeding promotion and support in the neonatal ward?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do clinical staff members working in the neonatal ward for 6 months or more receive sufficient amount of training to adequately support breastfeeding and lactation? The required hours may vary according to the type of clinical work but it is likely that at least 20 hours of targeted training will be required.	<input type="checkbox"/>	<input type="checkbox"/>
5. Does part of this training include at least 3 hours of supervised clinical experience in the neonatal ward?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the training cover the Three Guiding Principles, the Neo-BFHI Ten Steps and the Code?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do clinical staff members working in the neonatal ward for less than 6 months receive orientation on the breastfeeding/infant feeding policy and their roles in implementing it in the neonatal ward?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do clinical staff members working in the neonatal ward receive training on how to provide support for non-breastfeeding mothers?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do non-clinical staff members receive sufficient training, given their roles, to support mothers in successfully feeding their infants?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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

Expansion: Inform hospitalized pregnant women at risk for preterm delivery or birth of a sick infant about the benefits of breastfeeding and the management of lactation and breastfeeding.

In the Standards and Self-Appraisal questions below, the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

3 a	<p>Hospitalized pregnant women who are at risk of having infants admitted to the neonatal ward are visited by the clinical staff from that ward to discuss breastfeeding, and how lactation and breastfeeding/breast milk feeding may be established, depending on the infants’ conditions. The discussion reflects the needs of the family and include the following:</p> <ul style="list-style-type: none"> • The neonatal ward open access policy and the importance of the parents’ presence for the infant’s well-being. • The fact that milk production begins after the birth of a preterm infant (irrespective of gestational age) in the same way as after the birth of a full term infant. • The significance of early stimulation of milk production to provide the infant with colostrum as early as possible, and practical information about how to do it. • The particular benefits of breastfeeding/breast milk feeding for preterm/ill infants and their mothers. • The importance of skin-to-skin contact with the infant after birth, as early as possible. • The importance of letting the infant begin breastfeeding early. • The fact that very and extremely preterm infants also have the capacity for nutritive sucking at the breast; however, this may be affected by their medical conditions. • The importance of expressing frequently (at least 7 times a day). <p>Information is given, taking into consideration the individual woman’s knowledge and whatever previous experience she may have with breastfeeding, and the woman’s indication (if this is the case) that she intends to give her baby something other than breast milk.</p>
3 b	<p>A written description of the information about breastfeeding, breast milk feeding, milk expression, and skin-to-skin contact, and any printed/digital material provided to hospitalized pregnant women who are at risk of having an infant admitted to the neonatal ward is available.</p>

Self-Appraisal questions

	YES	NO
1. Are hospitalized pregnant women who are at risk of having infants admitted to the neonatal ward visited by the clinical staff from that ward to offer them information about breastfeeding and lactation specific to their situations?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the neonatal ward have a written description of the information about breastfeeding, breast milk feeding, milk expression and skin-to-skin contact provided to hospitalized pregnant women who are at risk of having infants admitted to the neonatal ward?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Step 4: Place babies in skin-to-skin contact with their mothers immediately following birth for at least one hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.

Expansion: Encourage early, continuous and prolonged mother-infant skin-to-skin contact/Kangaroo Mother Care.

This step applies to all infants admitted to the neonatal ward, whether they are breastfed or not.

In the Standards and Self-Appraisal questions below, the term “mother/parent” refers to mothers/parents of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

4 a	The neonatal ward has a written KMC protocol.
4 b	Parents of preterm or sick infants are informed about and encouraged to initiate skin-to-skin contact as early as possible, ideally from birth, unless there are medically justifiable reasons.
4 c	Parents of preterm or sick infants are encouraged to provide skin-to-skin contact/KMC in the neonatal ward continuously or for as long and as many periods per day as they are able and willing to, without unjustified restrictions.
4 d	Parents of preterm or sick infants are encouraged to continue providing skin-to-skin contact/KMC for the remainder of the hospital stay and also after early discharge.

Self-Appraisal questions

	YES	NO
1. Does the neonatal ward have a KMC protocol confirming that:	<input type="checkbox"/>	<input type="checkbox"/>
- A stable preterm or sick infant born vaginally or by cesarean section without general anesthesia should be placed in skin-to-skin contact/kangaroo position on the mother in the delivery or operating room as early as possible, ideally from birth, unless there are medically justifiable reasons not to do so.		
- A stable preterm or sick infant born by cesarean section under general anesthesia should be placed in skin-to-skin contact/kangaroo position on the mother as soon as the mother is responsive and alert (when appropriate considering the mother’s condition).		
- An initially unstable preterm or sick infant should be placed in skin-to-skin contact/kangaroo position as soon as the infant tolerates transfer back and forth from the mother.		

<ul style="list-style-type: none"> - The father and significant others of a preterm or sick infant are encouraged to provide skin-to-skin contact/KMC as a substitute for the mother. - Transport of a stable preterm or sick infant from the labour and delivery wards to the neonatal ward in skin-to-skin/kangaroo position on a parent's chest is promoted. - Skin-to-skin contact/KMC is promoted for all preterm and sick infants, whether they are breastfed or not. 		
<p>2. Are mothers informed about the benefits of early initiation of skin-to-skin contact/KMC?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. Are babies placed in skin-to-skin contact/kangaroo position with their mothers as early as possible, ideally from birth according to at least one of the following levels:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin-to-skin contact/KMC initiated immediately or within 5 minutes after birth (level ***) <input type="checkbox"/> Skin-to-skin contact/KMC initiated during the first hour after birth (after the first 5 minutes but during the first hour) (level **) <input type="checkbox"/> Skin-to-skin contact/KMC initiated during the 2nd to 24th hour of life (later than 1 hour after the birth, but during the first day of life) (level *). 	<input type="checkbox"/>	<input type="checkbox"/>
<p>4. Are stable preterm and sick infants born by cesarean section under general anesthesia placed in skin-to-skin contact/kangaroo position with their mother as early as possible, according to at least one of the following levels:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin-to-skin contact/KMC initiated immediately or within 5 minutes after the mothers are responsive and alert (level ***) <input type="checkbox"/> Skin-to-skin contact/KMC initiated during the first hour after the mothers are responsive and alert (after the first 5 minutes but during the first hour) (level **) <input type="checkbox"/> Skin-to-skin contact/KMC initiated during the 2nd – 24th hour after the mothers are responsive and alert (later than 1 hour, but during the first day) (level *). 	<input type="checkbox"/>	<input type="checkbox"/>
<p>5. Is skin-to-skin contact/kangaroo position initiated in the neonatal ward as soon as the infant tolerates transfer back and forth from the mother?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>6. Are infants allowed to remain in skin-to-skin contact/kangaroo position in the neonatal ward continuously, or for as long and as often every day as the parents are able and willing to?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>7. Are mothers informed and encouraged to continue providing skin-to-skin contact/KMC for the remainder of the hospital stay and after early discharge?</p>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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

Expansion: Show mothers how to initiate and maintain lactation, and establish early breastfeeding with infant stability as the only criterion.

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

5 a	Mothers are supported by staff - using hands-off techniques (unless the mother explicitly asks for hands-on assistance) - to correctly position and attach their babies for the first breastfeed and continue to have access to breastfeeding support by staff during the whole hospital stay.
5 b	Mothers of infants who are able to breastfeed are encouraged and supported to do so.
5 c	Mothers who are not exclusively breastfeeding and want to breastfeed/breastmilk feed receive information, support and practical help with initiation and maintenance of milk production within 6 hours of the infants’ births. They are shown how to express their milk by hand and pump (when available) and told the importance of frequent expression to initiate lactation (at least 7 times every 24 hours, including during the night). The information is given orally or in printed/digital form.
5 d	Mothers who have difficulties in establishing and maintaining milk production get focused, individualized support.
5 e	Infant stability is the only criterion for early initiation of breastfeeding (i.e., sucking at the breast) in preterm and sick infants, rather than gestational/postnatal/postmenstrual age or current weight.
5 f	Mothers of late preterm infants are offered the same breastfeeding support as mothers of other preterm infants.
5 g	Mothers who do not breastfeed or who use breast-milk substitutes receive support on how to safely prepare and give feeds to their babies.

Self-Appraisal questions

	YES	NO
1. Does the neonatal ward breastfeeding protocol state that staff members use a hands-off technique when supporting mothers with positioning and attaching their infants for breastfeeding, unless mothers explicitly ask for hands-on assistance?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do breastfeeding mothers have access to breastfeeding support in the neonatal ward whenever needed?	<input type="checkbox"/>	<input type="checkbox"/>

3. Does the clinical staff teach mothers how to position and attach their babies for breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do the mothers know the signs that indicate that their infants are well positioned, and that they are latched and sucking well?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the clinical staff routinely encourage and support mothers to feed at the breast whenever their infants are able to do so?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are mothers who plan to breastfeed/breast milk feed offered information, support and practical help with initiation and maintenance of milk production within 6 hours of their infants' births?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are mothers who need to initiate lactation by expression informed that the optimal strategy is to express their milk at least 7 times every 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are mothers who are breastfeeding/breastmilk feeding or intending to do so shown how to express their milk by hand or given printed/digital information.	<input type="checkbox"/>	<input type="checkbox"/>
9. Are mothers who are not exclusively breastfeeding and want to breastfeed/breastmilk feed shown how to use a breast pump if readily available in their settings? Is the information given orally or in printed/digital form?	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the clinical staff able to describe or demonstrate how they teach mothers an appropriate technique for hand expression, or to whom the mother can be referred for this instruction?	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the clinical staff –in settings where breast pumps are available– able to describe or demonstrate how they teach mothers an appropriate technique for pumping, or to whom the mother can be referred for this instruction?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the clinical staff discuss with mothers how to initiate and maintain a sufficient milk supply?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the ward have written routines for monitoring mothers' milk production and for counselling mothers with decreasing or insufficient milk supply?	<input type="checkbox"/>	<input type="checkbox"/>
14. Is infant stability the only criterion for early initiation of breastfeeding (i.e., sucking at the breast)?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does the neonatal ward breastfeeding protocol recognize late preterm infants as preterm, and state that their mothers should be offered the same support in the establishment of lactation and breastfeeding as those of more immature infants?	<input type="checkbox"/>	<input type="checkbox"/>
16. Are mothers who have decided not to breastfeed shown individually how to prepare and give their babies feeds and asked to prepare feeds themselves, after being shown how?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Step 6: Same for the original BFHI and the Neo-BFHI.

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

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

6 a	The breastfeeding policy states that the normal breastfeeding pattern is not to be interrupted: all newborns, including those admitted to the neonatal ward, are to be breastfed. If this is not possible or sufficient, they are given their mother’s own expressed milk using appropriate alternative feeding methods. They are not given anything else unless there are acceptable medical reasons or unless the mother has made an informed decision not to express milk/breastfeed. AFASS guidelines are used when appropriate.
6 b	When there are acceptable medical reasons as stated in Standard 6 a, mothers who do not provide all the breast milk required by their infants are informed about and have the option of using banked human milk (when available) or infant formula for feeding their infants - in this order of priority. Their informed decisions about feeding method are supported.
6 c	When feasible, considering infants’ feeding tolerances, appropriate feeding strategies for increasing the milk intake of infants cared for in the neonatal ward are applied before the introduction of fortifiers.
6 d	In accordance with the Code, no materials that recommend feeding breast milk substitutes or other inappropriate feeding practices are distributed to mothers.
6 e	Clinical staff discuss the various feeding options available and their risks and benefits with mothers who have decided not to breastfeed or whose infants are given formula, to help them decide what is suitable in their situations.

Self-Appraisal questions

	YES	NO
1. Are infants in the neonatal ward fed only breast milk (at breast or expressed) or banked human milk, unless there are acceptable medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the neonatal ward breastfeeding protocol state that - when feasible and considering infants’ feeding tolerances - appropriate feeding strategies for increasing infants’ milk intake are applied before the introduction of fortifiers?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the clinical staff discuss the various feeding options available and their risks and benefits with mothers who have decided not to breastfeed or whose infants are given formula, and help them decide what is suitable in their situations?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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

Expansion: Enable mothers and infants to remain together 24 hours a day.

This step applies to all infants admitted to the neonatal ward, whether they are breastfed or not.

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

7 a	The breastfeeding policy states that there are no restrictions on the mothers’ presence in the neonatal ward.
7 b	Mothers and infants are allowed to be together in the neonatal ward without restrictions, unless there are justifiable reasons for being separated.
7 c	The neonatal ward provides practical opportunities for mothers’ unrestricted presence day and night.

Self-Appraisal questions

	YES	NO
1. Is the neonatal ward open to mothers 24h/7d?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the mothers’ presence beside their infants unrestricted, even during emergency situations and medical rounds?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the neonatal ward make sure there are no signs or posters restricting mothers’ presence beside their infants?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do mothers have the possibility of being in the same room as – and without separation from – their infants admitted to the neonatal ward?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do mothers of infants in the neonatal ward have the possibility to sleep close to their infants admitted to the neonatal ward, according to at least one of the following levels:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bed in the same room as the infant (level ***)		
<input type="checkbox"/> Bed in another room in the neonatal ward (level **)		
<input type="checkbox"/> Bed in another area of the hospital or close to the hospital (10 minutes walking distance from infant or less) (level *)		

6. Do mothers of infants in the neonatal ward have the possibility to sleep close to their infants for a part of their infants' hospital stays, according to at least one of the following levels: <input type="checkbox"/> Infant's whole hospital stay (level ***) <input type="checkbox"/> At least 50% of the infant's hospital stay (level **) <input type="checkbox"/> At least 1 night just before the infant's discharge to home (level *)	<input type="checkbox"/>	<input type="checkbox"/>
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Comments

Step 8: Encourage breastfeeding on demand.

Expansion: Encourage demand breastfeeding or, when needed, semi-demand feeding as a transitional strategy for preterm and sick infants.

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

8 a	The breastfeeding process is guided by the preterm and ill infant’s competence and stability rather than a certain gestational/postnatal/postmenstrual age or weight. Transition from scheduled feeding with set volumes and frequencies to semi-demand feeding is introduced when there are no medical indications for scheduled feeding and the infant is able to obtain some milk at the breast.
8 b	Mothers are offered alternative strategies for establishment of exclusive breastfeeding and reduction of daily volume of milk given by other feeding methods, and are supported in participating in decisions about selection of strategies.
8 c	Mothers are guided in observing and responding to their infants’ signs of feeding cues and behavioral state shifts (transition between sleep and alertness).
8 d	Medications are administered and procedures are scheduled so as to cause the least possible disturbance of breastfeeding in infants admitted to the neonatal ward.

Self-Appraisal questions

	YES	NO
1. Does the neonatal ward breastfeeding protocol state that the individual infant’s ability and stability – not a certain gestational/postnatal/postmenstrual age or weight – indicates when it is possible to discontinue scheduled feedings and tube feedings?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the neonatal ward breastfeeding protocol include strategies for transition from scheduled feedings to semi-demand feeding?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the neonatal ward breastfeeding protocol state that routine administration of milk after each nutritive sucking session at the breast (to attain a certain milk volume) is only performed for acceptable medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>

4. Do mothers receive guidance from staff in observing their infants' signs of feeding cues and behavioral state shifts to help determine when it is appropriate to breastfeed?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the neonatal ward breastfeeding protocol confirm that medications are administered and procedures are scheduled so as to cause the least possible disturbance to breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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

Expansion: Use alternatives to bottle feeding at least until breastfeeding is well established, and use pacifiers and nipple shields only for justifiable reasons.

In the Standards and Self-Appraisal questions below, the term “mother/parent” refers to mothers/parents of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

9 a	Bottles are not introduced in the neonatal ward to breastfeeding infants and to infants whose mothers intend to exclusively breastfeed unless the mother explicitly asks for them and has been informed of the risks.
9 b	The first nutritive sucking experience for preterm and ill infants whose mothers intend to breastfeed is at the breast.
9 c	Clinical staff use, recommend and teach parents to use oral feeding methods other than bottles, until breastfeeding can be established.
9 d	Pacifiers are used in infants admitted to the neonatal ward for justifiable reasons, such as for comforting infants when their mothers are unavailable, or during stressful events, and giving pain relief when the infant cannot suck at the breast.
9 e	Parents are informed about justifiable reasons for pacifier use in the neonatal ward, about alternative ways of soothing the infant, and why the use of pacifiers during breastfeeding establishment should be minimized.
9 f	Nipple shields are not used routinely in the neonatal ward. They should only be used after the mother has received skilled support in solving the underlying breastfeeding problem, and after the mother’s repeated attempts to breastfeed her infant without the shield. If a nipple shield is introduced, the mother is counselled on how to try to discontinue its use.

Self-Appraisal questions

	YES	NO
1. Are mothers who are breastfeeding, or intending to do so, feeding their infants without using bottles or, if they are using them, have they been informed of the risks?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the clinical staff avoid introducing bottles to breastfeeding infants unless there are justifiable reasons?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are mothers who want to introduce a bottle informed of the risks?	<input type="checkbox"/>	<input type="checkbox"/>

4. Does the neonatal ward breastfeeding protocol include alternative methods to bottle feeding and describes appropriate and safe ways of using these methods?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are mothers who are breastfeeding, or intending to do so, taught how to feed their infants with tube feeding, cup feeding or other oral feeding methods than bottles, if supplementation is required?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the neonatal ward breastfeeding protocol describe justifiable reasons for using pacifiers?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are clinical staff members aware of the justifiable reasons for using pacifiers in the neonatal ward?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are breastfeeding mothers informed about justifiable reasons for use of pacifiers in the neonatal ward and why their use should be minimized during establishment of breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are breastfeeding mothers informed about alternative ways of soothing their infants other than pacifiers?	<input type="checkbox"/>	<input type="checkbox"/>
<p>10. Does the neonatal ward breastfeeding protocol describe what conditions should be met before recommending use of a nipple shield?</p> <ul style="list-style-type: none"> - Mothers have received skilled breastfeeding support in solving the underlying breastfeeding problems. - The breastfeeding problems persist after the mothers' repeated attempts at helping their infants at the breast without a nipple shield. - Mothers have been informed about the risks of using a nipple shield. - Mothers have been informed about how to clean the nipple shield. - If the nipple shield is introduced, mothers are counselled on how to try to discontinue its use. 	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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

Expansion: Prepare parents for continued breastfeeding and ensure access to support services/groups after hospital discharge.

In the Standards and Self-Appraisal questions below, the term “mother” refers to mothers of infants who are cared for in the neonatal ward, and the term “staff” refers to staff working in the neonatal ward or related areas.

Standards

10 a	Mothers are given information on how and where they can get support if they need help with feeding their babies after returning home.
10 b	The facility fosters the establishment of, and/or coordinates with, mother support groups and other community services that provide breastfeeding/infant feeding support to mothers.
10 c	Hospital discharge for infants who have been cared for in the neonatal ward is planned in collaboration with the family and the community health services.
10 d	When infants of mothers who intend to breastfeed are discharged from the hospital before breastfeeding is established, parents and staff should develop an individualized plan as to how mothers can attain their breastfeeding goals.
10 e	Staff members encourage mothers and their babies to be seen soon after discharge (individualized according to the infants’ conditions) at the facility or in the community by skilled breastfeeding support persons who can assess feeding and give any support needed.

Self-Appraisal questions

	YES	NO
1. Are mothers given information on how to get help from the facility or how to contact support groups, peer counsellors or other community health services if they have questions about feeding their babies after return home?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is printed/digital information given to mothers before discharge, if appropriate, on how and where they can find help on feeding their infants after returning home?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the neonatal ward foster the establishment of, and/or coordinate with, mother support groups and other community services that provide breastfeeding/infant feeding support to mothers?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is hospital discharge for infants who have been cared for in the neonatal ward planned in collaboration with the family and the community health services?	<input type="checkbox"/>	<input type="checkbox"/>

5. Are there plans in place for mothers' establishment of breastfeeding when their infants are discharged from the hospital before they have attained their breastfeeding goals?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are mothers encouraged to have their babies seen soon after discharge at the facility or in the community by skilled breastfeeding support persons who can assess feeding and give any support needed?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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Compliance with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.

The Baby-friendly Hospital Initiative for Neonatal Wards or Neo-BFHI has been formulated in accordance with the WHO International Code of Marketing of Breast-milk Substitutes (14) and the subsequent World Health Assembly resolutions (Code). Hence, in addition to the assessment of the Three General Principles and the Neo-BFHI Ten Steps, compliance with the Code should be assessed as outlined in the 2009 Global Criteria (10).

In neonatal wards extra vigilance regarding violations of the Code may be needed due to a higher level of commercial presence in the ward environment compared to maternity/postpartum units. This can be attributed to preterm and ill infants' special requirement of various types of nutrition and the use of different methods for provision of enteral and oral feeding.

The presence of parents and other family members in the neonatal ward may also constitute a risk for direct information, marketing and gifts by commercial representatives to family members of breast milk substitutes, bottles and other feeding utensils, etc.

The Self-Appraisal questions below refer to the Code as it applies to the neonatal ward and related areas.

	YES	NO
1. Does the healthcare facility refuse free or low-cost supplies of breast-milk substitutes, purchasing them for the wholesale price or more?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is all promotion for breast-milk substitutes, bottles, teats, or pacifiers absent from the neonatal ward, with no materials displayed or distributed to pregnant women or mothers?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are employees of manufacturers or distributors of breast-milk substitutes, bottles, teats, or pacifiers prohibited from any contact with pregnant women or mothers?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the hospital refuse free gifts, non-scientific literature, materials or equipment, money or support for in-service education or events from manufacturers or distributors of products within the scope of the Code?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the hospital keep infant formula cans and pre-prepared bottles of formula out of view unless in use?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the hospital refrain from giving pregnant women, mothers and their families any marketing materials, samples or gift packs that include breast-milk substitutes, bottles/teats, pacifiers or other equipment or coupons?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do staff members working in the neonatal ward understand why it is important not to give any free samples or promotional materials from formula companies to mothers?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Breastfeeding/Infant Feeding Policy Checklist

[This checklist is for the portion of the policy that addresses the Neo-BFHI. Note that a hospital policy does not have to have the exact wording or points as in this checklist, but should cover most or all of these key issues.]

The policy should clearly cover the following points:		YES	NO
Guiding Principle 1:	Decisions made by mothers and staff, and the acceptable medical or other justifiable reasons for them, are documented appropriately.	<input type="checkbox"/>	<input type="checkbox"/>
	The need for focused individualized support with respect to milk production, breastfeeding and infant feeding.	<input type="checkbox"/>	<input type="checkbox"/>
Guiding Principle 2:	The father is welcomed in the neonatal ward 24/7, without restrictions.	<input type="checkbox"/>	<input type="checkbox"/>
	The care of infants admitted to the neonatal ward is transferred to the parents as soon possible after the birth.	<input type="checkbox"/>	<input type="checkbox"/>
Guiding Principle 3:	Continuity of care in regards to the lactation and breastfeeding support during each stage of health care delivery is addressed.	<input type="checkbox"/>	<input type="checkbox"/>
Neo-BFHI 1:	All mothers, regardless of the way they feed their infants, get the support they need in the neonatal ward.	<input type="checkbox"/>	<input type="checkbox"/>
Neo-BFHI 2:	Training for clinical staff includes breastfeeding and lactation management and feeding of infants who are not breastfed. It should also include the special needs of infants admitted to the neonatal ward and supporting mothers to enable early initiation of breast milk production and breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>
Neo-BFHI 4:	The neonatal ward has a protocol guiding the practice of skin to skin/KMC.	<input type="checkbox"/>	<input type="checkbox"/>
Neo-BFHI 5:	Staff members encourage and support mothers to feed at the breast whenever their infants are able to do so.	<input type="checkbox"/>	<input type="checkbox"/>
	Infant stability is the only criterion for early initiation of breastfeeding (i.e., sucking at the breast), rather than gestational/postnatal/ postmenstrual age, current weight, any test of sucking strength, or requirement of suck training.	<input type="checkbox"/>	<input type="checkbox"/>
Neo-BFHI 6:	Newborns are given no food or drink other than their mothers' breast milk unless there are acceptable medical reasons.	<input type="checkbox"/>	<input type="checkbox"/>
	AFASS guidelines are used when appropriate.	<input type="checkbox"/>	<input type="checkbox"/>
	When there are acceptable medical reasons, mothers are informed about and have the option of using banked human milk (when available) or infant formula, for feeding their preterm infants, in this order of priority.	<input type="checkbox"/>	<input type="checkbox"/>

Neo-BFHI 7:	The neonatal ward is open to mothers 24h/7d.	<input type="checkbox"/>	<input type="checkbox"/>
	The mothers' presence beside their infants is unrestricted, even during emergency situations and medical rounds.	<input type="checkbox"/>	<input type="checkbox"/>
Neo-BFHI 8:	Infants who are able to obtain some milk intake at the breast are breastfed on demand or with a semi-demand strategy (depending on the infants' ability).	<input type="checkbox"/>	<input type="checkbox"/>
Neo-BFHI 9:	The first nutritive sucking experience for infants of mothers who intend to breastfeed is at the breast.	<input type="checkbox"/>	<input type="checkbox"/>
	Nipple shields are not used routinely in the neonatal ward.	<input type="checkbox"/>	<input type="checkbox"/>
Code compliance in the neonatal ward:	The policy prohibits the display of posters or other materials provided by manufacturers or distributors of breastmilk substitutes, bottles, teats and dummies or any other materials that promote the use of these products.	<input type="checkbox"/>	<input type="checkbox"/>
	The policy prohibits any direct or indirect contact between employees of these manufacturers or distributors and pregnant women or mothers in the facility.	<input type="checkbox"/>	<input type="checkbox"/>
	The policy prohibits the distribution of samples or gift packs with breast-milk substitutes, bottles or teats or of marketing materials for these products to pregnant women or mothers or members of their families.	<input type="checkbox"/>	<input type="checkbox"/>
	The policy prohibits acceptance of free gifts, non-scientific literature, materials or equipment, money, or support for in-service education or events, from manufacturers or distributors of breast milk substitutes, bottles, teats or pacifiers.		
	The policy prohibits the demonstrations of preparation of infant formula for anyone that does not need them.	<input type="checkbox"/>	<input type="checkbox"/>
	The policy prohibits the acceptance of free or low cost breast-milk substitutes or supplies.	<input type="checkbox"/>	<input type="checkbox"/>
HIV:	All HIV-positive mothers receive counselling, including information about the risks and benefits of various infant feeding options and specific guidance in selecting what is best in their circumstances.	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Summary

	YES	NO
<p>Does your hospital fully implement all Three Guiding Principles for protecting, promoting, and supporting breastfeeding in the neonatal ward?</p> <p><i>(if “No”)</i> List questions for each of the Three Guiding Principles where answers were “No”:</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Does your hospital fully implement all Ten Steps for protecting, promoting, and supporting breastfeeding in the neonatal ward?</p> <p><i>(if “No”)</i> List questions for each of the Ten Steps where answers were “No”:</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Does your hospital fully comply with the International Code of Marketing of Breast-milk Substitutes in the neonatal ward?</p> <p><i>(if “No”)</i> List questions concerning the Code where answers were “No”:</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>If the answers to any of these questions in the Self Appraisal Tool are “No”, what improvements are needed?</p>		
<p>If improvements are needed, would you like some help? If yes, please describe:</p>		

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