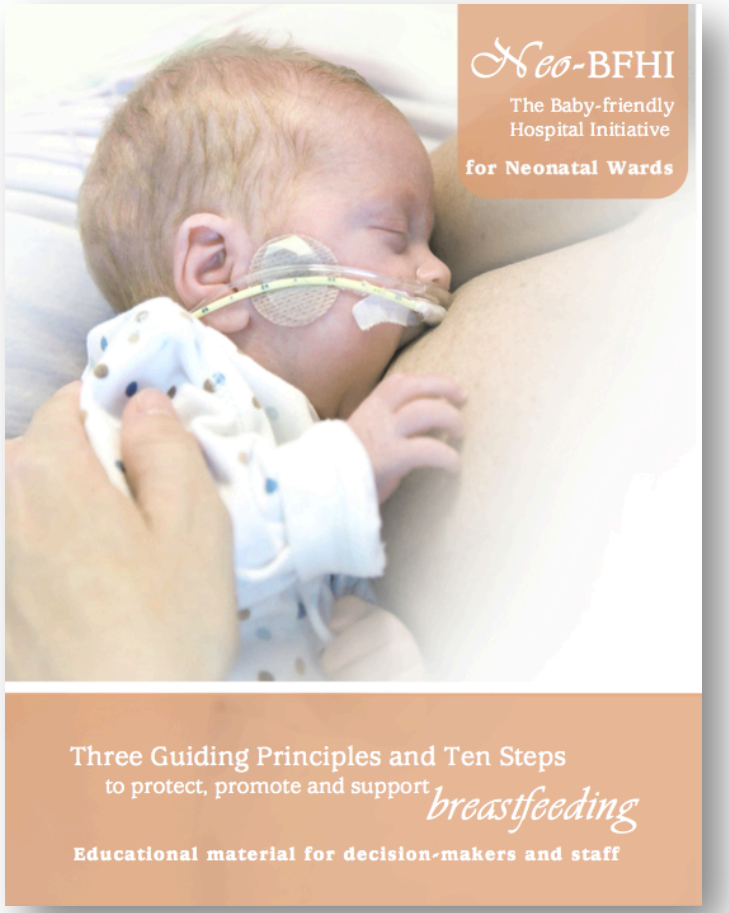

Neo-BFHI
The Baby-friendly Hospital Initiative for Neonatal Wards
Educational materials for decision-makers and staff

First edition: June 2015

Title of the document:

Neo-BFHI: The Baby-friendly Hospital Initiative for Neonatal Wards. Three Guiding Principles and Ten Steps to protect, promote and support breastfeeding. *Educational materials for decision-makers and staff.*

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)

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 educational materials 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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This document can be found at the International Lactation Consultant Association (ILCA) website: http://www.ilca.org/i4a/pages/index.cfm?pageid=4214

How to use the materials

- This presentation is based on the Neo-BFHI Core document with recommended standards and criteria available at the ILCA website: www.ilca.org/i4a/pages/index.cfm?pageid=4214
- All reference numbers (in parentheses) refer to the same reference in the Core document.

Background for expanding the BFHI to neonatal care

In the 2009 update, the WHO/UNICEF stated the need to expand the Baby-friendly Hospital Initiative (BFHI) into all health care systems and other relevant sectors, including neonatal care.

Expansion is important for the following aims:

- To support the recommendation of exclusive breastfeeding for 6 months and continued breastfeeding for up to 2 years of age or beyond.
- To provide women with the support required to achieve their breastfeeding goals, within the family, community and workplace.

Background for expanding the BFHI to neonatal care

- The Nordic and Quebec Working Group was formed in Copenhagen, March 2009 by health professionals from Sweden, Norway, Denmark, Finland and Quebec, Canada to address the expansion of the BFHI to neonatal care.
- The working group developed a unified expansion of the BFHI for neonatal wards ("Neo-BFHI") based on evidence, expert opinion and clinical experience implementing Baby-friendly practices in neonatal wards.

Objectives of the Working Group

Main objective:

- To expand and adapt the Ten Steps to protect, promote and support breastfeeding in neonatal wards* based on the WHO/UNICEF BFHI program.

**The term "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.*

Objectives of the Working Group

Specific objectives:

- To examine the evidence in relation to breastfeeding promotion, protection and support in neonatal wards and make appropriate revisions and additions.
- To develop and adapt standards and criteria focused on neonatal wards.
- To develop an assessment tool to evaluate whether neonatal wards comply with the criteria.
- To conduct pilot tests of the new assessment tool.

Objectives of the Working Group

Specific objectives (continued):

- To promote implementation of the expanded standards.
- To encourage research to assess the effectiveness of the expansion.

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Aims of the educational materials

These materials were developed:

- To disseminate knowledge of the Neo-BFHI.
- To describe the Neo-BFHI's Three Guiding Principles and expanded Ten Steps.
- To provide evidence-based tools for achieving change in clinical practice in wards with different levels of neonatal intensive care.

PART 1

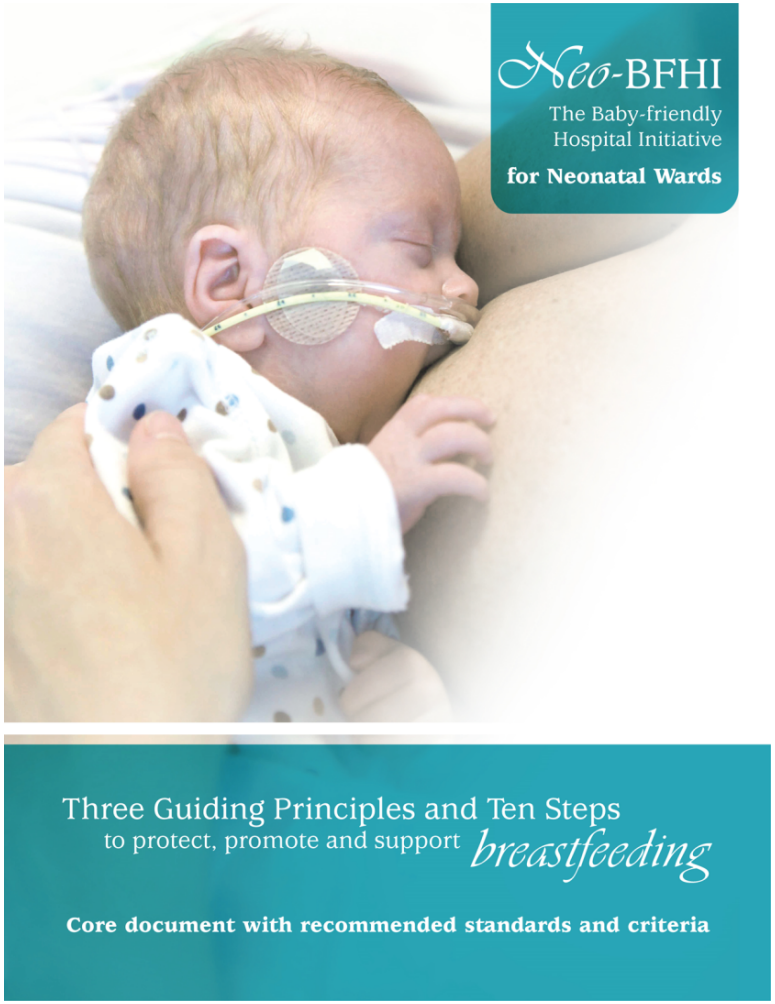
The rationale behind the Neo-BFHI

The rationale for expanding the BFHI

- 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 – with appropriate support – can begin breastfeeding when they mature.

The rationale for expanding the BFHI

The initiation and maintenance of breast milk production is of great importance for enabling mothers to breastfeed preterm or sick infants.



The rationale for expanding the BFHI

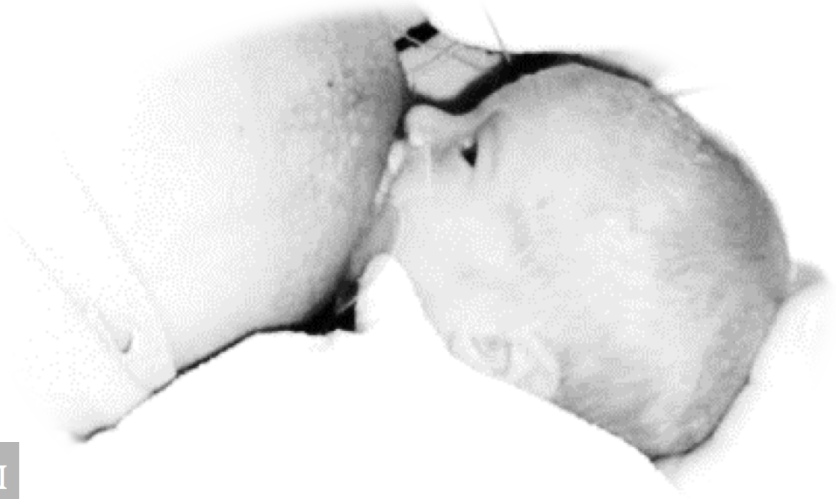
Early, systematic and continuing support for mothers to initiate breast milk expression and breastfeeding as soon as their infants are stable is essential to help them succeed in overcoming physiological and emotional challenges related to lactation and breastfeeding (5, 6).

The rationale for expanding the BFHI
Compliance

- Compliance with the BFHI "Ten Steps to Successful Breastfeeding" has proven effective in increasing breastfeeding duration and exclusivity (10).
- Evidence for this arises from randomized control trials examining policies and practices outlined in the individual steps as well as a large randomized control trial – the PROBIT trial – that measured effectiveness of the initiative as a whole (10).

The rationale for expanding the BFHI
WHO Essential Newborn Care

- Breastfeeding is specifically addressed in the WHO Essential Newborn Care program, which was developed to reduce neonatal mortality and morbidity, and includes clean cord care, thermal care and the initiation of breastfeeding immediately or within the first hour after birth (19).



The rationale for expanding the BFHI

Improved health outcomes

- Exclusive and prolonged breastfeeding improves maternal-infant health in both developing and industrialized countries (10, 20-23).
- Breast milk is species-specific, and all substitute feeding preparations differ markedly from it, making breast milk uniquely superior for infant feeding.

The rationale for expanding the BFHI

Risks because of suboptimal breastfeeding

- A survey in low-income and middle-income countries concluded that suboptimal breastfeeding is associated with increased risk of mortality in the first 2 years of life (24).

The rationale for expanding the BFHI

Benefits of breast milk feeding

- Breast milk-fed preterm infants receive significant benefits with respect to host protection and improved developmental outcomes compared with those who are formula-fed (4, 25).
- More specifically, the immunological components of breast milk protect preterm infants from infections and life threatening illnesses such as neonatal sepsis and necrotizing enterocolitis, even in the developed world (3, 25-27).

The rationale for expanding the BFHI

Components in breast milk

- Components in breast milk also support the development and maturation of infants' immune systems, which may explain some of the long-term health benefits observed in breastfed children (4, 21, 23).

The rationale for expanding the BFHI

Influence on mothers

- Premature birth and admission to a neonatal ward may have a negative influence on the mothers' views of themselves.
- Mothers of preterm infants may feel that they failed when they give birth prematurely and that the only task left to do right is to breastfeed (28).

The rationale for expanding the BFHI

Influence on mothers

- Mothers of preterm infants describe breastfeeding as an action that makes them feel important (29) and that rewards them with feelings of closeness and bonding with their infants (30).
- For these mothers, breastfeeding becomes even more important.

The rationale for expanding the BFHI

Infants with special needs

- It has been found that the establishment of breastfeeding during the hospital stay is also possible in infants with malformations requiring surgery and those with hormonal conditions such as hyperinsulinism (31-33).
- Their mothers have a particular need for pre- and postnatal lactation and breastfeeding counselling.

The rationale for expanding the BFHI

Costs of preterm birth

- According to the WHO Global Action Report on Preterm Birth "Born too soon" (20) the rate of preterm birth is rising; 15 million infants – more than 1 in 10 – are born prematurely every year around the world.
- Prematurity is the leading cause of newborn death. Nevertheless, death from prematurity complications can be reduced by over 75%, even without neonatal intensive care.

The rationale for expanding the BFHI

Costs of preterm birth

- In low-income settings half of the infants born before 32 weeks of gestation continue to die due to a lack of feasible, cost-effective evidence-based interventions, such as Kangaroo Mother Care (KMC) and breastfeeding.
- Implementation of these proven interventions could save an estimated 450,000 infants each year (20). Education and health promotion are essential to attain this goal.

The rationale for expanding the BFHI

International experiences

- Several countries have expanded the BFHI to other settings that care for breastfeeding mothers and babies, such as community health centers and neonatal wards (18).

The rationale for expanding the BFHI
International experiences

Experiences in the Nordic countries:

- Norway developed a certification process similar to the one used for maternities and most neonatal wards have been designated Baby-friendly (34).
- In Denmark, an unpublished pilot study was conducted in 2 hospitals and Ten Steps for preterm infants were developed.
- In Sweden, a study about the adaptation of the Ten Steps to the neonatal setting showed that mothers need more and different kinds of breastfeeding support (47).

The rationale for expanding the BFHI
International experiences

Experiences in Estonia and the US:

- In Estonia the concept of "Humane neonatal care“ was introduced in the early 1980s. The concept included mother-infant non-separation and breastfeeding support in intermediate neonatal care wards (46).
- In the United States, Spatz developed a modified model for sick infants: "Ten steps for promoting and protecting breastfeeding for vulnerable infants" (35).

The rationale for expanding the BFHI
Evidence based practices

- There is an increasing number of publications documenting the effectiveness of lactation and breastfeeding-related best practices in neonatal wards.
- Recent systematic reviews have established the importance of professional and peer support for the implementation of hospital practices, such as skin-to-skin contact/KMC and rooming-in, and the adoption of effective methods to support mothers in initiating and maintaining milk production (5, 6, 36).

The rationale for expanding the BFHI

Evidence based practices

- Early initiation of breastfeeding, with infant stability as the only criterion, is an important issue to be considered (37-39).
- Positive effects of implementing the original BFHI standards on breastfeeding rates and exclusivity in neonatal wards have been reported in Brazil (40, 41), Italy (42) and the United States (43), where improvement in breastfeeding rates continued 10 years after the BFHI designation (44).

The rationale for expanding the BFHI

Evidence based practices

- Up until now there has been a lack of comprehensive international guidelines for optimal lactation and breastfeeding support in neonatal intensive units, in spite of the considerable disparities between the needs of infants in neonatal and maternity wards.

The rationale for expanding the BFHI

Evidence based practices

The main differences are that:

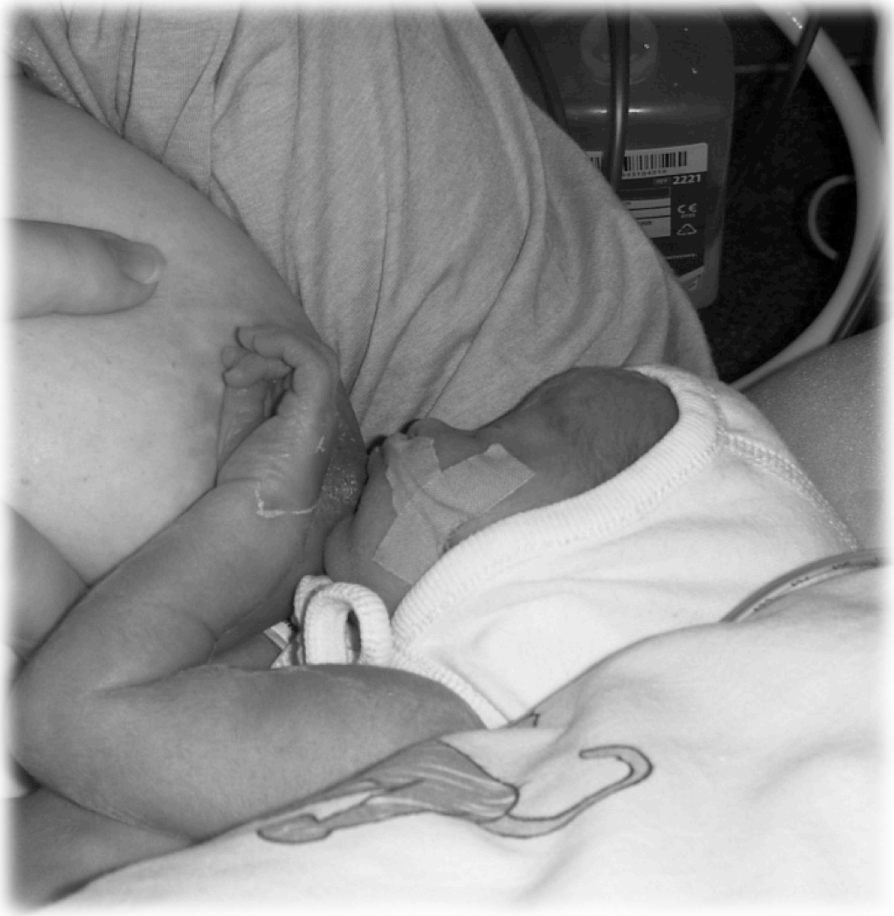
- Most neonatal wards separate the mothers from their infants; there is little or no space for the mothers, a chair or a bed at the infants bedside is not always provided.
- Mothers of premature or sick infants need more support from fathers and other family members since they desire to spend time in the hospital with their infants, and suffer the trauma of having given birth to preterm or sick infants (45).

The rationale for expanding the BFHI
Conclusions

- Health professionals should be aware of mothers' feelings about breastfeeding, and improve respect, guidance and support for breastfeeding mothers, as well as for non-breastfeeding mothers and those who give supplementation.
- These mothers' and infants' special needs must be taken into consideration when developing standards for the BFHI in neonatal wards.

PART 2

Three Guiding Principles and Ten Steps to protect and promote breastfeeding



Links between the BFHI and Neo-BFHI

- The BFHI 2009 Global Criteria (18) are followed as closely as possible in the Neo-BFHI.
- The original formulation of the Ten Steps is presented in each section followed by the expanded version of the recommendation.
- The formulation of some of the expanded steps are the same as in the original version (Step 1 and Step 6).

Three Guiding principles (GP)

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

GP 2: The facility must provide family centered care, supported by the environment.

GP 3: The health care system must ensure continuity of care from pregnancy to after the infant's discharge.

Guiding Principle 1

Staff attitudes toward the mother must focus on the individual mother and her situation.

The rationale for GP 1

- Preterm birth is a traumatic event for parents (51).
- Mothers of preterm infants give birth before they have completed the full prenatal process of preparing for motherhood (52).
- For mothers in a neonatal ward, the transition to motherhood can entail a crisis, which takes time to resolve (45).

The rationale for GP 1

- Mothers' motivation for establishment of lactation and breastfeeding is enhanced by support offered with empathy, and in a psychologically and culturally appropriate way (62, 63).
- Mothers should be supported in a sensitive way to make and implement informed decisions about milk production, breastfeeding and infant feeding, according to their wishes.

GP 1 - Practice guidelines in brief

- Every mother is treated with sensitivity (meaning staff are responsive to what she communicates), empathy and respect for her maternal role.
- 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.

GP 1 - Practice guidelines in brief

- Decisions made by mothers and staff, and the acceptable medical or other justifiable reasons for them, are documented appropriately.
- Mothers receive focused individualized support with respect to milk production, breastfeeding and infant feeding.

Guiding Principle 2

The facility must provide family-centered care, supported by the environment.

The rationale for GP 2

- Infants have the right to be cared for by their parents (UN Convention on the Rights of the Child).
- Parents are the most important persons in their infant's life and should be encouraged to act as the infant's primary caregivers, ideally from birth, considering the infant's medical condition and treatment (69, 70).
- This is achieved by offering parents unrestricted presence in the neonatal ward 24/7 and encouraging the father's presence at all times, as the mother's supporter and the infant's caregiver.

GP 2 - Practice guidelines in brief

- Family-centered care is integrated into the organization and functions of the neonatal ward.
- Core concepts of family-centred care are dignity and respect, information sharing, participation and collaboration (71).
- The care is transferred gradually to the parents, beginning as soon as possible after birth, with freedom of choice regarding performance of caregiving tasks, and adequate instruction and support.

GP 2 - Practice guidelines in brief

- Parents can designate other members of their social network as their substitutes.
- The neonatal ward provides an individualized, developmentally supportive environment, that is appropriate for infants and parents, offers them adequate privacy and facilitates breastfeeding.

GP 2 - Practice guidelines in brief

The neonatal ward provides practical support to enable parents to stay with their infants including:

- A place to sleep at their infants' bedsides:
  - bed/mattress (level ***)
  - chair with armrest or recliner (level **)
  - chair without armrest or recliner (level *)
- A place to eat close to the neonatal ward:
  - in the ward (level ***)
  - very close to the ward (≤ 5 min. walk) (level**)
  - close to the ward (6 to 10 min. walk) (level *)

Guiding Principle 3

The health care system must ensure continuity of care from pregnancy to after the infant's discharge.

The rationale for GP 3

- Care to the family (89) is given in all phases: prenatal care, birth and postnatal until weaning.
- Continuity is achieved when providers deliver consistent care that is responsive to the infant's and his/her family's changing needs (89, 91, 92).
- This requires shared policies and guidelines for infant care and for parents' role, and parent education programs (group activities, individual counselling, printed/digital information) to achieve management continuity (89).

The rationale for GP 3

- The family-centered care approach facilitates continuity of care (93) by promoting parents' presence and participation as primary caregivers (94).
- Continuity of care is enhanced when parents are well informed about their infants' condition and care, and participate in decisions about their infant's care.
- Continuity of care boosts parents' confidence in their infants' safety.

GP 3 - Practice guidelines in brief

- Care related to lactation and breastfeeding support during each stage of health care delivery is consistent.
- Information regarding the infants' medical management and families' preferences is shared among all health care providers and organizations involved in lactation and breastfeeding support.

Step 1

Original step

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

Neo-BFHI Expansion (Same as original step)

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

The rationale for Step 1

- Hospitals with comprehensive breastfeeding policies are likely to have better breastfeeding support services and breastfeeding outcomes (10, 17).
- BFHI accreditation in hospitals with both maternity and neonatal care has resulted in improvements in breastfeeding-related outcomes for infants admitted to the neonatal ward as well (5).

The rationale for Step 1

- Implementation of the BFHI in neonatal wards has been associated with increased breastfeeding initiation and duration rates (42, 43).
- Facilities that include KMC guidelines in their policies have higher breastfeeding rates (67, 99-102).
- Clear guidelines are an essential component in the implementation of BFHI in neonatal wards (103, 104).

Step 1: Practice guidelines in brief

- The health facility has a written breastfeeding or infant feeding policy that addresses the Three Guiding Principles, Neo-BFHI Ten Steps, and the International Code of Marketing of Breast-milk Substitutes (Code) in the neonatal wards.
- The policy includes guidance for how the above should be implemented, and requires that mothers – regardless of their feeding methods – receive the individualized support they need.

Step 1: Practice guidelines in brief

- The policy protects breastfeeding in the neonatal wards by adhering to the Code.
- The policy is available so that all clinical staff can refer to it.
- Summaries of the policy 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.

Step 2

Original step

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

Neo-BFHI Expansion

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

The rationale for Step 2

- In "Non-Baby-friendly/Baby-friendly Intent" settings, nurses often lacked knowledge about best practices in breastfeeding initiation, and the hospital policies were not evidence-based (107).
- Training of the neonatal ward staff in breastfeeding resulted in higher maternal milk production, more mother-infant time skin-to-skin, more cup-feeding, and higher frequency of feeding at the breast (109).

The rationale for Step 2

- If training is voluntary and senior staff uncommitted, attendance is likely to be poor, and only those with favorable attitudes will participate (114, 115).
- Training of staff and BFHI accreditation improve the breastfeeding counselling practices.
- Skilled support from trained staff is potentially cost-effective (5).

Step 2: Practice guidelines in brief

- All clinical staff members are aware of the breastfeeding/infant feeding policy and have basic knowledge in breastfeeding and preterm and sick infants' special needs.
- The neonatal ward has a plan for staff education and training.
- Clinical staff working in the ward for at least 6 months have knowledge of breastfeeding and lactation corresponding to the Guiding Principles, the Neo-BFHI Ten Steps and the Code, including supervised clinical experience.

Step 2: Practice guidelines in brief

- Key topics of the training are:
  - 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 minimize the likelihood that breastfeeding mothers will be influenced to use formula

Step 3

Original step

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

Neo-BFHI 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.

The rationale for Step 3

- Mothers of infants in a neonatal ward may feel discouraged from providing their milk due to their own health problems, lack of information, worries about their infants' condition and concern about their milk supply (121).
- Antenatal lactation information should be directed particularly to hospitalized primiparas and women who did not attend antenatal classes (119).
- Mothers who gave birth prematurely by C-section may experience delayed initiation of milk expression and low pumping frequency (120).

Step 3: Practice guidelines in brief

- Hospitalized pregnant women at risk of having infants admitted to the neonatal ward are visited by staff from that ward to discuss breastfeeding, and how lactation and breastfeeding/breast milk feeding may be established.
- Information is given, taking into consideration the individual woman's knowledge, previous breastfeeding experience, and indication (if given) of intention to give her baby something other than breast milk.

Step 3: Practice guidelines in brief

The discussion with the pregnant women includes:

- The neonatal ward open access policy and the importance of the parents' presence for their infant's well-being.
- The fact that milk production begins after a preterm birth in the same way as for a full term infant.
- Why and how early stimulation of milk production is important to provide preterm or ill infants with colostrum and breast milk as early as possible.
- The particular benefits of breastfeeding and breast milk feeding for these infants and their mothers.

Step 3: Practice guidelines in brief

The discussion with the pregnant women includes (continued):

- The importance of skin-to-skin contact as early as possible and of letting the infant begin breastfeeding early.
- Preterm infants' capacity for nutritive sucking at the breast; for some this may be affected by their medical conditions.
- The importance of frequent expression (at least 7 times per day) and practical information about how to do it.

Step 4

Original step

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

Neo-BFHI Expansion

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

*New interpretation in 2009

The rationale for Step 4

- The core concepts in KMC are warmth, breast milk and love (124).
- Depending on the circumstances, KMC can be practiced continuously (24 hours/day) or intermittently. Prolonged intermittent or continuous KMC supports infant development (125), accelerates breastfeeding establishment (126), and prevents hypothermia (127, 128).
- Mothers expressing close to their infants, particularly during and immediately after KMC, obtain higher milk volumes (131).

Step 4: Practice guidelines in brief

- The neonatal ward has a written KMC protocol.
- 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.
- They are encouraged to provide skin-to-skin contact/KMC continuously, or for as long and as often as they are able and willing to, without unjustified restrictions, while in the ward, the remainder of the hospital stay, and as well as after early discharge.

Step 5

Original step

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

Neo-BFHI Expansion

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

The rationale for Step 5

- Early, systematic and continuing support for mothers ensures their success in the establishment of lactation and breastfeeding, and helps them overcome physiological and emotional challenges (142-145).
- Mothers have faith in the healing properties of their milk and feel they are “giving life” to their infants when providing it (147).

The rationale for Step 5

- There are consistent positive effects of mother-infant skin-to-skin contact on milk production and successful breastfeeding (99, 101, 126, 130, 132, 134, 136).
- Frequency of milk expression is closely correlated with milk volume (152, 154, 161, 162).
- Pumping 7 or more times a day results in increasing milk volumes at 2 weeks, compared to pumping less than 7 times per day (163).

Step 5: Practice guidelines in brief

- Mothers who are able to breastfeed are:
  - encouraged and supported to do so.
  - supported to correctly position and attach their babies for the 1st feed and thereafter
- Mothers who want to breast milk feed are:
  - offered support and practical help with milk expression within 6 hours of birth
  - expression can start at the delivery room or postoperative area
  - explained the importance of frequent expression to initiate lactation (at least 7 times per day)

Step 5: Practice guidelines in brief

- Infant stability is the only criterion for initiation of breastfeeding (rather than gestational, postnatal or postmenstrual age, or current weight).
- Mothers of late preterm infants are offered the same breastfeeding support as mothers of other preterm infants.
- Mothers who do not breastfeed or use breast milk substitutes receive support on how to safely prepare and give feeds to their babies.

Step 6

Original step

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

Neo-BFHI Expansion (Same as original step)

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

The rationale for Step 6

- Breastfeeding is the normal way of providing infants with the nutrients they need for healthy growth and development (1, 2), including preterm and ill newborns (3, 27, 170).
- Compared with formula-fed preterm infants, breast milk fed preterm infants have:
  - better host protection
  - improved developmental outcomes (3, 171)

The rationale for Step 6

- When mother's own milk is not available, screened human donor milk is the next best option, particularly for ill and premature infants (3, 171, 172).
- When human donor milk is not available, commercial formula is the next best option (3).
- With extremely preterm infants, high volume intake of mother's milk fortified with individualized supplementation of protein and minerals is associated with adequate infant growth (177).

Step 6: Practice guidelines in brief

The breastfeeding policy states that:

- Newborns admitted to a neonatal ward are to be breastfed.
- If this is not possible or sufficient, they are given the mother's own expressed milk.
- Infants are not given anything else unless:
  - there are acceptable medical reasons or
  - the mother has made an informed decision not to express milk or breastfeed
- AFASS guidelines are used when appropriate.

Step 6: Practice guidelines in brief

- When there are acceptable medical reasons, mothers who do not provide enough breast milk are informed about the option of using:
  - banked human milk (when available) or
  - infant formula for feeding their infants,

  in this order of priority
- Mothers' informed decisions are supported.
- Considering infants' feeding tolerance, appropriate feeding strategies for increasing milk intake are applied before introducing breast milk fortifiers.

Step 6: Practice guidelines in brief

- Staff members discuss risks and benefits of available feeding options with mothers who have decided not to breastfeed or whose infants are given formula, to help them decide what is suitable in their situation.
- In accordance with the Code, no materials that recommend breast milk substitutes or inappropriate feeding practices are distributed to mothers.

Step 7

Original step

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

Neo-BFHI Expansion

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

The rationale for Step 7

- The UN Convention on the Rights of the Child states that infants shall not be separated from their parents against their will. This covers all children (68).
- Rooming-in promotes breastfeeding in preterm infants (126, 181-183), as well as bonding/ attachment and parent empowerment (83).

The rationale for Step 7

- Mothers separated from their newborns experience emotional strain and anxiety; they feel like outsiders and experience lack of control when their infants are admitted to the neonatal ward (187).
- Opportunities for rooming-in can help parents in a neonatal ward feel like a family, not like they are just visiting their own babies (83, 87).

Step 7: Practice guidelines in brief

- The breastfeeding policy states that:
  - the neonatal ward is open to mothers 24h/7d
  - the mothers' presence beside their infants is unrestricted day and night, even during emergency situations and medical rounds
- Mothers and infants are allowed to be together in the neonatal ward without restrictions, unless there are justifiable reasons for being separated.
- The neonatal ward provides practical opportunities for mothers' unrestricted presence.

Step 7: Practice guidelines in brief

Mothers have the possibility to sleep close to their infants in a:

- bed in the same room as the infant (level***)
- bed in another room in the ward (level**)
- bed in another area in the hospital or close to the hospital (level*)

during:

- the infant's whole hospital stay (level***)
- at least 50% of the infant's hospital stay (level**)
- at least 1 night just before the infant's discharge to home (level*)

Step 8

Original step

Encourage breastfeeding on-demand.

Neo-BFHI Expansion

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

The rationale for Step 8

- On demand (baby-led or ad-libitum) feeding means the infant is breastfed based on the mother's observation of behavioral cues indicating interest in sucking (rooting) (191).
- This feeding strategy is appropriate around term age, when the infant has reached neurological maturity - evidenced by co-ordination between hunger and satiety, and sleep-awake state regulation - and is associated with a higher likelihood of breastfeeding and longer breastfeeding duration (192, 193).

Step 8: Practice guidelines in brief

- The breastfeeding process is guided by the preterm and ill infant's competence and stability rather than a certain gestational, postnatal or 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.
- Mothers are offered alternative strategies for attaining exclusive breastfeeding.

Step 8: Practice guidelines in brief

- Mothers are supported in selecting strategies for establishment of exclusive breastfeeding and reduction of daily volume of milk given by other feeding methods.
- Mothers are guided in observing and responding to their infants' feeding cues and transition between sleep and alertness.
- Medications are administered and procedures scheduled to cause the least possible disturbance of breastfeeding.

Step 9

Original step

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

Neo-BFHI Expansion

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

The rationale for Step 9

- Use of bottles negatively influence breastfeeding success in both full term (116, 203) and preterm infants (204–207), whereas cup feeding is associated with higher breastfeeding rates at discharge in preterm infants (202).
- Compared to cup feeding and breastfeeding, bottle feeding is associated with lower temperature, lower oxygen saturation, lower transcutaneous pO2, and higher frequency of desaturations in preterm infants and infants with congenital heart disease (207, 209-212).

The rationale for Step 9

- Non-nutritive sucking gives pain relief during procedures, reduces stress and anxiety, and makes the infant less fussy and more relaxed during tube feeding. A pacifier can therefore be offered when breastfeeding is not possible or when the mother is not available (217-223).
- When establishing breastfeeding in preterm infants, minimizing the use of a pacifier resulted in earlier attainment of exclusive breastfeeding (126) and greater likelihood of being breastfed exclusively at discharge (126, 156).

Step 9: Practice guidelines in brief

- The first nutritive sucking experience for preterm and ill infants whose mothers intend to breastfeed is at the breast.
- Bottles are not introduced in the neonatal ward to breastfed infants and to infants whose mothers intend to exclusively breastfeed, unless the mother explicitly asks for them and has been informed of the risks.
- Clinical staff use, recommend and teach parents to use oral feeding methods other than bottles, until breastfeeding has been well established.

Step 9: Practice guidelines in brief

- Pacifiers are used in the neonatal ward for justifiable reasons such as:
  - to comfort infants when their mothers are unavailable or during stressful events
  - for pain relief if they cannot suck at the breast
- Parents are informed about:
  - justifiable reasons for pacifier use in the ward
  - alternative ways of soothing the infant
  - why pacifier use should be minimized during breastfeeding establishment

Step 9: Practice guidelines in brief

- 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 without the shield.
- If a nipple shield is introduced, the mother is counselled on how to try to discontinue its use.

Step 10

Original step

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

Neo-BFHI Expansion

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

The rationale for Step 10

- All mothers of infants receiving neonatal care, who are breastfeeding or expressing their milk, need skilled follow-up after discharge.
- The most vulnerable period for breastfeeding preterm or sick infants is the first month after discharge (67).
- Breastfeeding peer counsellors can facilitate lactation for mothers of infants in neonatal wards. They are considered peers by virtue of the shared experience of providing milk for their infants while admitted in these wards (228).

The rationale for Step 10

- Lack of a plan for follow-up and continued support may constitute a serious hazard for infants discharged from a neonatal ward (232).
- Preparation of parents for continued breastfeeding after their infants' discharge from the ward by professionals in collaboration with peer counsellors enhances mothers' motivation to breastfeed (5, 142, 234, 235).
- Collaboration with counsellors/volunteers can be helpful to support mothers in achieving their lactation goals, in the hospital and after discharge (142, 235).

Step 10: Practice guidelines in brief

- Mothers are given information on how and where they can get support if they need help with feeding their babies after returning home.
- The facility fosters the establishment of, or coordinates with, mother support groups and other community services that provide infant feeding support to mothers.
- Hospital discharge for infants cared for in the neonatal ward is planned in collaboration with the family and the community health services.

Step 10: Practice guidelines in brief

- When the infants of mothers who intend to breastfeed are discharged from the hospital before breastfeeding is established, the parents and staff together should develop an individualized plan as to how the mothers can attain their breastfeeding goals.
- The staff members encourage mothers and their babies to be seen soon after discharge, at the facility or in the community, by skilled breastfeeding support persons who can provide the support needed.

International Code of Marketing of Breast-milk Substitutes

- The Neo-BFHI has been formulated in accordance with the WHO International Code of Marketing of Breast-milk Substitutes (Code) and the subsequent World Health Assembly resolutions.
- The Neo-BFHI recommends compliance with the Code as outlined in the WHO/UNICEF 2009 Global Criteria (18).

International Code of Marketing of Breast-milk Substitutes

- Neonatal wards require extra vigilance regarding Code violations due to:
  - a high level of commercial presence because preterm and ill infants often require various types of nutrition and use different enteral and oral feeding methods
  - parents' presence in the ward which may constitute a risk for direct information, marketing and gifts of breast milk substitutes, bottles and other feeding utensils from commercial representatives to family members

Publications

Nyqvist KH, Maastrup R, Hansen MN, Haggkvist AP, Hannula L, Ezeonodo A, Kylberg E, Frandsen AL, Haiek LN. **Neo-BFHI: The Baby-friendly Hospital Initiative for Neonatal Wards. Core document with recommended standards and criteria.** Nordic and Quebec Working Group;2015. *http://www.ilca.org/i4a/pages/index.cfm?pageid=4214*

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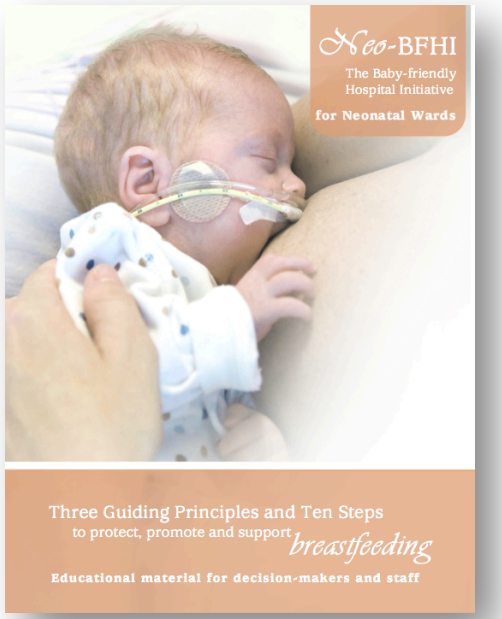

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