Exploring the Impact of the Baby-Friendly Hospital Initiative on Mothers, Infants, and Hospitals

An Honors Thesis (HONR 499)

by

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EXPLORING THE IMPACT OF THE BABY-FRIENDLY HOSPITAL INITIATIVE

Abstract

The Baby-Friendly Hospital Initiative (BFHI), developed in 1991 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), is an international program that recognizes certain hospitals and birthing centers that provide the best care for infant feeding and bonding of the mother and baby. In order to be designated Baby-Friendly, a hospital or birthing facility must practice The Ten Steps to Successful Breastfeeding, which include training staff members on the set breastfeeding policy, offering mothers the information and skills needed to begin and continue breastfeeding their babies, as well as allowing the mothers and infants to be together 24 hours a day and giving no pacifiers or artificial nipples. The hospital must also implement the International Code of Marketing of Breast-Milk Substitutes, which includes no advertisement of breast milk substitutes, no free samples or supplies, no pictures that promote artificial feeding, and the information on artificial feeding must explain the benefits of breastfeeding versus the costs and risks of artificial feeding. Using evidence-based practice, we created a research paper that looked into the creation of the Baby-Friendly Hospital Initiative, how a facility can reach this accreditation, and the effects on mothers, infants, and the hospital as a whole.
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The Baby-Friendly Hospital Initiative (BFHI) was developed in 1991 by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF). It recognizes hospitals that become Baby-Friendly, which means the hospital offers the highest level of care for mothers and babies to bond and for infants to feed. The BFHI assists the hospitals in helping mothers get the education, skills, and confidence needed to successfully breastfeed or safely formula feed their infants. Becoming a Baby-Friendly hospital is a journey; the facilities must challenge existing policies in order to provide the best, quality evidence-based care. This journey includes successfully meeting the criteria for The Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-Milk Substitutes. As a whole, the BFHI increases patient satisfaction scores and improves health results, which shows how the Initiative provides guidelines to shape and lead the hospitals, mothers, and infants towards a brighter future.

In the 1990s, a push for mothers to breastfeed their children began because it was found that breastfeeding had overwhelming benefits for both the mother and baby. Breast milk is uniquely constructed for infants and is considered the biologically natural way to feed the newborns. “Infant formulas are able to mimic a few of the nutritional components of breast milk, but formula cannot hope to duplicate the immense and constantly changing array of essential nutrients in human milk” (Benefits of Breastfeeding, 2014). Compared to cow’s milk, human milk is low in protein and casein, making it easier to digest and not as stressful on the infant’s kidneys. Human milk contains lipids and enzymes that promote competent digestion and the consumption of nutrients. This leads breastfed infants to be leaner at the one year mark than formula fed infants while continuing normal activity level and development. This early growth pattern may later influence growth patterns and reduce the risk of obesity (Benefits of Breastfeeding, 2014).
Evidence has shown that breastfeeding protects against a wide range of immediate and long term adverse health outcomes. Infants are fragile and extremely susceptible to disease, partially due to their bodies not being fully developed. Breastfeeding also helps enhance the infant's immune system. Infants who are breastfed show improved immune response to polio, diphtheria, tetanus, and *Haemophilus influenzae* in comparison to those who are formula fed. Evidence has also shown that breastfeeding can produce an earlier development of the immune system (Benefits of Breastfeeding, 2003).

In regards to infectious disease, breast milk can help protect against upper and lower respiratory tract infections, gastrointestinal illnesses, and otitis media, both during the infancy period and beyond. One meta-analysis found that, in developed countries, formula fed infants were three times more at risk for severe respiratory tract illnesses that required hospitalization compared to those who were exclusively receiving breast milk for at least four months. The protection against infectious diseases is derived from the immunological and antibacterial properties of human milk along with the elimination of exposure to pathogens that may have been introduced during the preparation and delivery of formula feedings. There are even some studies that show that the benefits of breastfeeding continue after cessation. Research has shown that breastfeeding may help the children avoid disease such as type 1 and type 2 diabetes, high cholesterol, and inflammatory bowel disease later in life (Benefits of Breastfeeding, 2003).

Beyond the benefits to the infant, mothers who breastfeed also gain much from the experience. There are many different hormonal, physical, and psychosocial effects on mothers. According to the U.S. Department of Health and Human Services, breastfeeding raises the levels of oxytocin in mothers. This hormone stimulates uterine contractions to help eject the placenta, minimize postpartum maternal blood loss, and induce a quicker uterine involution. Exclusively
breastfeeding can act as an effective form of contraception for women. Breastfeeding impedes the recommencement of normal ovarian cycles and the return of fertility. Women who lactate for a total of two or more years can decrease their risk of breast cancer by up to 24 percent. The psychological benefits of breastfeeding include increased self-confidence and facilitated bonding with their child. Research has shown that the relationship between nursing mothers and their children is stronger than any other human contact, even stronger than the psychological experience of carrying the fetus in the womb for nine months (Benefits of Breastfeeding, 2003).

Furthermore, there are apparent socioeconomic benefits not only to the family of the breastfed child, but also the health care system and employers. Families save hundreds of dollars by breastfeeding their children, even if breast pump equipment is used. “Breastfed infants typically require fewer sick care visits, prescriptions, and hospitalizations, especially if breastfed exclusively or almost exclusively” ((Benefits of Breastfeeding. 2003). This, in turn, reduces total medical care expenditures of fully breastfed babies by about 20%. Breastfeeding is an excellent option for those stricken by poverty. In addition, employers of breastfeeding mothers also receive benefits. Breastfed children often require less sick care, so maternal absenteeism from work is decreased. Employer medical costs are lower and employee production is increased (Benefits of Breastfeeding, 2003).

Even with the knowledge of all of these benefits, breastfeeding rates were not as high as they should have been, according to WHO and UNICEF. Health services in multiple parts of the world have shown that breastfeeding was not being promoted effectively. In a study conducted by WHO, researchers found a negative correlation between attending prenatal clinics and the prevalence and duration of breastfeeding noted globally. Furthermore, in countries where both home and hospital deliveries could be compared, there was a negative association between
breastfeeding and giving birth in an institution. This shows that health services were not adequately promoting breastfeeding. More recent studies found knowledge, attitudes, and skills of health workers in most parts of the world are insufficient in regards to breastfeeding promotion. These findings, in conjunction with breastfeeding rates not increasing at appropriate levels to reach national health goals, pointed toward a need for new approaches, especially in the health services (Baby-Friendly Hospital Initiative, 2009).

After finding these studies, WHO and UNICEF implemented the Baby-Friendly Hospital Initiative. This Initiative was created in response to the 1990 Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding. The Innocenti Declaration, created also by WHO and UNICEF, recognizes that breastfeeding is a distinctive practice that provides ideal nutrition and contributes to their healthy growth and development and reduces the incidence and severity of infectious diseases, which in turn, reduces the risk of infant morbidity and mortality. The Innocenti declares “a global goal for optimal maternal and child health and nutrition, all women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breast milk from birth to 4-6 months of age” (UNICEF in Action). The child should then be breastfed, along with appropriate supplemental foods, for up to two years of age or beyond. To achieve this goal, countries need to be committed to creating an appropriate environment of awareness and support to reinforce the “breast-feeding culture”. The declaration also believes that all governments should craft national breastfeeding policies and establish appropriate national targets. With this in mind, the Baby Friendly Hospital Initiative was born (UNICEF in action).

The Baby-Friendly Hospital Initiative (BFHI) is a global program launched by the World Health Organization (WHO) along with the United Nations Children’s Fund (UNICEF) in 1991.
The program was adopted during a meeting of pediatricians, obstetricians, community health workers, and members of non-governmental organizations in Ankara, Turkey, on the 28th of June in 1991. The goal of the Initiative was to “encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding” (Baby-Friendly USA). Hospitals that officially become Baby-Friendly must implement the Ten Steps to Successful Breastfeeding as well as the International Code of Marketing of Breast-Milk Substitutes. In 2009 the Baby Friendly Hospital Initiative underwent revisions to “take into account the current global context, with consideration given to HIV/AIDS, to address obstacles to the processes that have been encountered over the years, and include recent evidence-based findings related to infant and young child feeding” (Baby-Friendly Hospital Initiative, 2009).

Since its induction in 1991, most countries have taken steps to start national Baby-Friendly campaigns. In the last 15 years more than 20,000 maternity facilities in 150 countries around the world have earned the Baby-Friendly designation. Furthermore, 156 countries have, at one time or another assessed hospitals and designated at least one facility Baby-Friendly. As of 2005, out of 37 industrialized counties, 28 had at least one accredited hospital. Although these numbers may sound appealing, there are actually very few Baby-Friendly status hospitals. In the industrialized countries, only 6.4% of hospitals are Baby-Friendly. In the United States in 2005, there were only 55 hospitals that had reached this level, less than 2% of all hospitals. This is an increase from 33 Baby-Friendly hospitals in 2000. In correlation with this, the number of breastfeeding mothers in the United States is still relatively low. In 2009, 77% of U.S. mothers initiated breastfeeding but only 36% continued to exclusively breast feed at three months postpartum. As of 2012, about 6.2% of live births in the U.S. occur in BFHI facilities. The state
of Maine currently has the highest rate of births in Baby-Friendly hospitals at 27.7%. There are also 16 states that presently do not have any Baby-Friendly facilities (Hawkins et al., 2014).

The 2011 U.S. Surgeon General’s Call to Action to Support Breastfeeding selected the Baby Friendly Hospital Initiative (BFHI) as a critical strategy for increasing high quality maternity care. This same year the Center for Disease Control and Prevention (CDC) made efforts to increase the number of Baby-Friendly hospitals. The CDC awarded the National Initiative for Children’s Healthcare Quality to help hospitals throughout the nation improve maternal care. In order to achieve the highest quality care, the National Initiative aims to boost the number of U.S. Baby-Friendly hospitals. The objective of the project is to improve hospital practices to better support breastfeeding and move towards the Baby-Friendly accreditation (CDC, 2011).

Most countries have made progress in introducing Baby-Friendly campaigns, including “vigorous steps towards improved support to breastfeeding in hospitals, actions to protect breastfeeding by national policy implementation, and public promotion campaigns” (Baby-Friendly Hospital Initiative, 2009). The process of becoming Baby-Friendly is long and tedious. In short, it begins with a self-appraisal by the facility, followed by an external assessment, and when the Global Criteria is met, they are awarded the Global Baby-Friendly Hospital designation (Baby-Friendly Hospital Initiative, 2009).

There are five steps that are necessary in implementing the BFHI at the country level. The first step is to create, re-energize, or plan a meeting of the National Breastfeeding, Infant and Young Child Feeding, or Nutrition Authority, to institute or evaluate its function related to BFHI. If a country already has an established National Authority, it needs to make sure that it is up to current standards outlined in the Global Strategy for Infant and Young Child Feeding. If
there is not a National Authority in place, one should be created by looking at those who are members of a National Authority and their role in relation to the BFHI. The country can then set up a meeting to move on to the next steps in becoming Baby-Friendly (Baby-Friendly Hospital Initiative, 2009).

The next step is to identify, or re-establish, national BFHI goals and approaches. If BFHI committees and goals are already in place, as they are in multiple countries, they need to make certain that these are presently part of a national or regional programming. If actions towards reaching these goals have not recently been implemented, the country may need to perform a literature review or baseline survey of “country-level breastfeeding and complementary feeding practices, support activities, number and location of facilities previously designated, and status of those facilities to assess current standards or practice” (Baby-Friendly Hospital Initiative, 2009). Since Baby-Friendly now goes beyond the Ten Steps to Successful Breastfeeding, the National Authority may choose to include newer components into local context (Baby-Friendly Hospital Initiative, 2009).

The third step in country level implementation is to recognize, designate, or create a BFHI coordination group (BCG). It is recommended that a country develop a separate group for Baby-Friendly matters rather than making this an additional role for the National Breastfeeding, Infant and Young Child Feeding or Nutrition Authority. The National Authority is in charge of designing a BFHI coordination group. This group is in charge of coordinating the process and procedures for facility designation. The coordination group must be sure that the high Baby-Friendly standards are met for accreditation and that no conflicts of interest arise (Baby-Friendly Hospital Initiative, 2009).
There are four major aspects of step four, all involving the National Authority. The National Authority must guarantee that the BFHI coordinating group fulfills its duty in providing the initial or ongoing assessment of facilities. These assessments should be carried out by specially trained local or external assessors. They also need to help plan training and curriculum revisions, if necessary. Using the needs found during the assessment, preparation should be taken to carry out the 20-hour course in every facility in addition to performing curricula updates. The National Authority also needs to ensure that the national health information system includes a record of feeding status on all contacts with children less than two years of age. They should periodically review the records to see if progress is being made and if the program should be adjusted. The last part of step four involves monitoring and evaluating the plan. The National Authority must keep records and support planning to make sure that hospitals are following the Baby-Friendly criteria (Baby-Friendly Hospital Initiative, 2009).

The final step for a country to implement the Baby Friendly Hospital Initiative is for the coordination group to manage facility-level assessments, reassessments, and designation of Baby-Friendly status. Assessments may be started as soon as the coordination group is established and the facility’s self-evaluation is completed. Once designation is reached, the designation must be for a pre-set number of months or years. If a hospital is not in compliance when later reassessed, it will be given an extra opportunity to reach the necessary standards. After adjusting the components in which they had previously failed, the hospital needs to be reassessed before they can be considered for designation once again. If a facility has an expired designation or is non-compliant with the rules of the Baby-Friendly designation, the National Authority removes the designation plaques and removes the facility’s name from the list of designated hospitals (Baby-Friendly Hospital Initiative, 2009).
The BFHI is initiated at the national level through the National Authority and coordination group. At the facility level, the assessment and designation process includes a number of diverse steps with each facility following a different path, depending on their outcomes at a variety of stages. The facility must first use the Self-Appraisal Tool to perform a self-assessment of whether it is meeting the Baby-Friendly standards. It also must look at the Global Criteria to decide if an external assessment would give similar results. If the hospital meets the high standards set forth and has 75% of mothers exclusively breastfeeding from birth to discharge, they must request an external assessment to be performed by the BFHI coordination group. If they do not meet the standards and recognize their need for improvement, the facility must restudy the Global Criteria and create a plan of action. Next they would implement the plan of action in order to meet the Baby-Friendly standards, usually with staff training until Baby-Friendly practices become the status quo (Baby-Friendly Hospital Initiative, 2009).

After the facility’s request is sent, the BCG sends external assessors to conduct an assessment using the Hospital External Assessment Tool. If the facility is found to have met the Global Criteria for a Baby-Friendly hospital, the coordination group will award them with the WHO/UNICEF Global BFH Award and Plaque. If they do not meet the criteria, the facility receives a Certificate of Commitment to becoming Baby-Friendly. The hospital then analyzes their problem areas and works towards fixing them. The facility will then implement the new plan of action and re-invite the external assessors to re-evaluate them. After receiving the accreditation, the facility will continue to monitor its practices and work to maintain the Baby-Friendly standards. Three years after the recognition, the facility must be reassessed using the Assessment Tool or another reassessment form. If the facility passes reassessment, they receive an extension of the BFH award. If not, they must look at their problem areas, fix them until
Baby-Friendly practices are in place, and then be reassessed. (Baby-Friendly Hospital Initiative, 2009)

The backbone of the Baby-Friendly Hospital Initiative is the Ten Steps for Successful Breastfeeding and the International Code of Marketing of Breast-Milk Substitutes. These are the minimum requirements that a facility must follow in order to apply for the BFHI accreditation. Additional criteria are provided for mother-friendly care and HIV and infant feeding, but these are optional for facilities to implement. It is recommended that mother-friendly care is gradually implemented into the hospital following the staff’s training on this subject. The Global Criteria that is used in assessing potential Baby-Friendly facilities is the standard to which adherence to the Ten Steps and the Code is measured (Baby-Friendly Hospital Initiative, 2009).

The Ten Steps for Successful Breastfeeding were created by a team of global experts and consist of evidence-based practices that have been shown to increase breastfeeding initiation and duration. The first step is to have a written breastfeeding policy that is routinely communicated to all health care staff. The facility should have a written breastfeeding or infant feeding statement that addresses all Ten Steps and protects breastfeeding by following the International Code of Marketing of Breast-Milk Substitutes. Another requirement is that mothers who are HIV-positive are given counseling on infant feeding and direction on how to select an option that is suitable for their particular situation. The policy needs to be available for reference by all staff members who are in direct care of mothers and babies. Summaries of the policy should also be visibly posted in any area in which a pregnant woman, mother, infant, and/or child would be cared for. Areas included in this are the labor and delivery area, postpartum wards, and infant care areas. These summaries need to be in languages and wording that are most commonly understood by mothers and staff (Baby-Friendly Hospital Initiative, 2009).
The second step is to train all health care staff in skills necessary to implement the breastfeeding policy. The head of maternity services needs to make sure that all health care staff members who have any type of contact with pregnant women, mothers, and/or babies have received orientation on the new breastfeeding/infant feeding policy. Documentation of training indicates that “80% or more of the clinical staff who have contact with mothers and/or infants and have been on the staff 6 months or more have received the training at the hospital, prior to arrival, or through well-supervised self-study or on-line courses that covers all 10 Steps, the Code and subsequent WHA [World Health Assembly] resolutions, mother-friendly care” (Baby-Friendly Hospital Initiative, 2009). Usually 20 hours of targeted training are necessary to build up the knowledge and skills needed to effectively support mothers. In addition, non-clinical staff should receive training that is adequate for their role to provide them with the essential skills and knowledge to support mothers in successfully feeding their infants. This training needs to be documented as well. Training should cover topics such as risks and benefits of feeding options, helping the mother choose what is acceptable, feasible, affordable, sustainable, and safe (AFASS) in her situation, and how to reduce the likelihood that breastfeeding mothers will switch to formula (Baby-Friendly Hospital Initiative, 2009).

Step three is to inform all pregnant women about the benefits and management of breastfeeding. If a hospital is affiliated with an antenatal clinic or in-patient antenatal ward, a written description of breastfeeding information and available printed materials for pregnant women need to be available. Antenatal discussion should include the importance of breastfeeding, the significance of immediate and sustained skin-to-skin contact, early initiation of breastfeeding, rooming-in, feeding on cue or baby-led feeding, frequent feeding to assure enough milk, good positioning and attachment, exclusive breastfeeding for the first six months,
risks of formula or other breast milk substitutes, and the fact that breastfeeding is still important after six months when other foods are introduced (Baby-Friendly Hospital Initiative, 2009).

The fourth step is for the facility to assist mothers in initiating breastfeeding within a half hour of birth. After revisions in 2009, the step is now interpreted as placing infants in skin-to-skin contact with their mother immediately following birth for at least a half hour. Workers need to persuade mothers to identify when their newborn is ready to breastfeed and offer help when needed. It is preferred that infants are left longer than a half hour if possible, as they may take longer than an hour to breastfeed. Furthermore, the infant should not be forced to breastfeed but, rather, supported to do so when ready. The staff can help place the child so that he/she is able to move toward her breast and latch on when ready (Baby-Friendly Hospital Initiative, 2009).

Step five is to show mothers how to breastfeed as well as how to maintain lactation, even if they are going to be separated from their newborn. The head of maternity services needs to report that mothers who have not breastfed previously or who have had trouble with breastfeeding before receive special attention and support in both the antenatal and postpartum periods. Staff should be able to appropriately demonstrate how to prepare and feed breast milk substitutes. Mothers should then be asked to provide a return demonstration. Staff should also offer further assistance to mothers within six hours (Baby-Friendly Hospital Initiative, 2009).

Giving newborn infants no food or drink other than breast milk, unless medically indicated, is the sixth step. “Hospital data indicate that at least 75% of babies delivered in the last year have been exclusively breastfed or exclusively fed expressed breast milk from birth to discharge of, if not, that there were documented medical reasons” (Baby-Friendly Hospital Initiative, 2009). Mothers should not be given materials that recommend breast milk substitutes, scheduled feeds, or other inappropriate practices. It is necessary that the facility have a space and
equipment that is adequate for demonstrating how to prepare formula and other feeding options. This area must be away from breastfeeding mothers (Baby-Friendly Hospital Initiative, 2009).

The seventh step is to practice rooming-in. This allows mothers and infants to remain together 24 hours a day. If the mother and infant are separated, there needs to be a justifiable reason for the separation. Step number eight is to encourage breastfeeding on demand. It is essential that staff teach mothers how to be aware of when their child is hungry and different feeding cues. Mothers also need to be advised to feed their infant as often and for as long as the child desires. Step nine is to not give any artificial teats or pacifiers (commonly referred to as dummies or soothers) to their breastfeeding infants. Mothers need to be informed of the risks of using bottles or teats (Baby-Friendly Hospital Initiative, 2009).

The final step in the Ten Steps for Successful Breastfeeding is to foster the establishment of breastfeeding support groups and refer mothers to them when discharged from the facility. The head of maternity services must report that mothers are given proper information on where they are able to receive support with feeding their child after returning home. The facility should cultivate the creation or coordination of support groups and other community services that offer breastfeeding or infant feeding support for mothers. Staff needs to persuade mothers and their newborns to make an appointment to be seen soon after discharge. The preferred time-frame is to set up an appointment two to four days following birth and again the second week. The purpose of these groups is to assess feeding and give any support to breastfeeding mothers (Baby-Friendly Hospital Initiative, 2009).

Along with the Ten Steps to Successful Breastfeeding, a Baby-Friendly facility must also follow the International Code of Marketing of Breast-Milk Substitutes. The Code was established in 1981 by the World Health Assembly in order to “promote safe and adequate
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nutrition for infants, by the protection and promotion of breastfeeding and by ensuring the proper use of breast-milk substitutes, when these are necessary” (Baby-Friendly Hospital Initiative, 2009). A main principle of this code is to make certain that health care facilities are not used for the purpose of endorsing breast milk substitutes, feeding bottles, or teats. When the BFHI was launched, it was hoped that all maternity units would become breastfeeding support centers. For this to be true, hospitals must avoid being used to promote breast milk substitutes, bottles or teats, or distributing free formula. The Code establishes the basic principles necessary to reach this goal (Baby-Friendly Hospital Initiative, 2009).

The Code covers several main points. Facilities following this code must not advertise breast milk substitutes or other products to the public. “No facility of a health care system should be used for the purpose of promoting infant formula or other products” (International Code of Marketing of Breast-Milk Substitutes, 1981). They are not allowed to hand out free samples to mothers. They are unable to donate or receive free or subsidized supplies for breast milk substitutes or other products in any part of the health care system. No gifts or personal samples are to be given to health workers. Furthermore, facilities cannot accept free or low cost breast milk substitutes or supplies. There should not be pictures of infants or other pictures or texts that idealize artificial feeding. Information on artificial feeding should be scientific and factual and explain the benefits of breastfeeding along with the costs and risks of artificial feedings. Demonstrations on how to prepare infant formula should not be given to anyone who does not need them (International Code of Marketing of Breast-Milk Substitutes, 1981).

Health care workers in a facility that follows the Code have numerous responsibilities to which they must adhere. The first is to encourage and protect breastfeeding. It is necessary for workers to be knowledgeable about the benefits of breastfeeding, maternal nutrition, the negative
effects of introducing partial bottle feeding while breastfeeding, and the difficulty of reversing
the decision to abstain from breastfeeding. Staff needs to ensure that packages of breast milk
substitutes purchased by the facility are not on display or visible to mothers. Refusal of gifts
offered by manufacturers or distributors is mandatory of all workers. Samples of infant formula
or related products should be refused, as well as not passed on to pregnant women or mothers.
Lastly, staff must be aware that support and other incentives for programs and health
professionals working in infant and young-child health should not create a conflict of interests

Unlike the required Ten Steps to Successful Breastfeeding and the International Code of
Marketing of Breast-Milk Substitutes, mother-friendly care is solely an encouraged option for
health facilities to implement when working towards becoming certified Baby-Friendly. This
care is focused on making the mother comfortable and able to have the best birthing process as
possible. Under this policy, women should be encouraged to have companions of their choice to
provide support, both physical and emotional, during the labor and birthing process, if they
desire. Women are also allowed to drink and eat light foods during labor. Mothers should be
encouraged to use analgesic or anesthetic drugs only when necessary because of complications
and should thus be persuaded to try non-drug methods of pain relief. Walking and moving during
labor, as well as assuming positions of the mother’s choice, are encouraged unless they have
specific restrictions. Care that does not entail procedures such as rupture of the membranes,
induction of labor, or Caesarean sections need to be avoided unless required for a complication
(Baby-Friendly Hospital Initiative, 2009).

Following the induction of BFHI, there was an HIV pandemic, calling for a revision of
Baby-Friendly guidelines. These revisions brought about the policy on HIV and infant feeding,
which is optional for facilities to implement. In order to meet the Global Criteria, the head of maternity services must report that the hospital has policies and procedures in place that adequately concern providing or referring pregnant women for testing and counseling for HIV. They also need to have private, individual counseling for pregnant women and mothers who are HIV positive that provide information on feeding options. If a woman is concerned that she may be HIV positive or at risk to become so, the facility should refer her to a community support service for HIV testing and counseling. Training is necessary for staff covering the risks of HIV transmission during pregnancy and delivery, the importance of being tested for HIV, the local availability of feeding options, and how the workers can assist HIV positive mothers. Printed information needs to be available and distributed to HIV positive mothers regarding various feeding options (Baby-Friendly Hospital Initiative. 2009).

As mentioned, the BFHI has changed over the years, but the number of Baby-Friendly hospitals is still rather low. As of 2012, there were 156 Baby-Friendly designated facilities and 595 working towards the designation (MacEnroe, 2012). In order to explore why these numbers are not higher, it is important to look at how this Initiative has affected those to whom it matters most: mothers, infants, and hospitals. It is also important to see how these effects may impact hospitals considering Baby-Friendly designation, because this affects the future of the Initiative and the future of nursing as a whole.

The Baby-Friendly Hospital Initiative has a major impact on mothers who come into the hospital, whether with breastfeeding, skin-to-skin contact, or rooming-in. The level of education the mother has on the Baby-Friendly Hospital Initiative impacts how much she may or may not support the movement. If a mother does not realize she is giving birth at a Baby-Friendly hospital, she may be surprised by the rules set forth by the staff. She may have given birth to
another baby at the same hospital before it was Baby-Friendly or at a non-Baby-Friendly hospital, which could impact how she feels about the current birth. She may not understand why hospital policies were changing, so if the mother is aware of the Initiative, she may be more receptive to its practices and to breastfeeding for a longer period of time. Educating the mother about the health benefits of breastfeeding and the rationale behind the policies can lead to more positive results in implementing the Initiative and its success in the long run.

Even if the mother has decided not to breastfeed, the policies at the Baby-Friendly hospital would affect her care. It is “ultimately the mother’s choice as long as she has been given all the correct information” (Walsh, Pincombe, & Henderson, 2011); then the Baby-Friendly Hospital Initiative is designed to assist those mothers in that decision. If a mother chooses to breastfeed, she has to make a committed and conscious choice to do so. The hospital employs lactation consultants to help and educate the mothers in breastfeeding. These lactation consultants can take the time that a nurse might not have to assist the mothers in feeding. The mothers are able to accept the care and direction from the lactation consultants that the Baby-Friendly Hospital can provide.

One barrier for the Baby-Friendly Hospital Initiative is that in the past, hospitals would allow mothers to supplement breast milk with formula if requested. If the mother was having trouble breastfeeding, she was also allowed to give formula until breastfeeding was established. Although the lactation consultants can coach the mothers toward more successful breastfeeding, sometimes the mother’s body may not cooperate or it may be too painful. The mother may become discouraged without the supplementation of formula to rely on and may get worried her baby is not receiving enough nutrition. For these mothers, however, breast pumps can be used to stimulate milk production. Nurses can also cup feed newborns when supplementation is
medically necessary instead of using bottles. Hospitals would also give out diaper bags with samples of formula when the mother was discharged from the hospital, which may be an endearing tradition the mothers and staff would enjoy (Bohling Smith, Moore, & Peters, 2012). The BFHI is attempting to stray from the “bottle-feeding culture”, which may be difficult for some mothers to grasp onto and implement for their future.

If the mother chooses not to breastfeed, it is important to look at whether or not Baby-Friendly hospitals coerce the mothers into breastfeeding or make them feel guilty about their decision to forgo the breast. According to Schulte (2014), one mother stated she had decided not to breastfeed, but after her daughter was born, the staff “were ripping open [her] gown and trying to set the baby up to breast-feed” and that she was “forced into that position”. The mothers’ feelings should be taken into account because each patient should be supported, encouraged, and treated with the highest quality of care.

Other aspects of the Baby-Friendly Hospital Initiative, skin-to-skin contact and rooming-in, also have an effect on mothers. In the past, and still in certain hospitals today, newborn infants were taken to the nursery while the mother was kept in her separate hospital room. The mothers waited long hours to see their babies and were only allowed to see them during feeding times. It was believed that the mothers would get more sleep and the babies would be safer. Now, however, it is shown that it is better for the mother and baby to stay together after birth. As the baby is held skin-to-skin, the brain releases oxytocin and endorphins, which help the mother to feel calm and responsive as well as cause her temperature to increase, which keeps the baby warm. The babies also breathe better and have more stable blood sugar (Crenshaw, 2007). The mother is usually able to produce more milk and is able to breastfeed longer.
Rooming-in allows the mother to learn her baby’s needs and how to satisfy those needs more quickly. In order to assist mothers in getting sleep during rooming-in, the nurses are supposed to assist the families to sleep while the baby is sleeping and to learn the baby’s feeding cues. The mother may even sleep more tranquilly knowing the baby is with her in the room. Studies show that mothers with rooming-in infants get the same amount and quality of sleep as mothers whose babies went to the nursery (Sinusas & Gagliardi, 2001). The mothers also spend more time holding, touching, and talking to their babies than those who do not room-in (Bohling Smith et al., 2012). On the other hand, however, if the mother is exhausted after an extensive labor or a C-section, rooming-in may not be in the best interest of the mother or baby (Stephens, 2012). It may be important to follow the policy but to take the mother’s well-being into account as well.

The Baby-Friendly Hospital Initiative affects the mother not only during her time in the hospital, but after she leaves the hospital as well. Breastfeeding, skin-to-skin contact, and rooming-in have been shown to improve the connection and bonding between mother and baby. Mothers who breastfeed also typically show lower levels of symptoms of depression than mothers who do not breastfeed (Hahn-Holbrook, Haselton, Dunkel Schetter, & Glynn, 2013). The education learned at the Baby-Friendly hospital can be utilized in order to maintain the practices started in the hospital setting for a longer period of time.

The Baby-Friendly Hospital Initiative not only has an impact on the mothers in the hospital, but also their newborn infants. Although it may be easy to discount the neonates since they have just come into the world, it is important to look at what the Initiative can do for them as well. As mentioned earlier, the benefits of breastfeeding for the infant cannot be overstated.
Along with breastfeeding, skin-to-skin contact affects the baby because they "stay warm more easily, cry less, have lower levels of stress hormones, and breastfeed sooner than newborns who are separated from their mothers" (Crenshaw, 2007, p. 40). They also "spend more time quietly sleeping...take in more breast milk...gain more weight per day...and are less likely to develop jaundice" (Crenshaw, 2007, p. 41). Long-term benefits can include lower rates of child abuse, neglect, and abandonment for mothers who spent more time with their infants after birth.

The infant should be placed on the mother's chest or upper abdomen immediately after delivery. Humans are the only mammals that separate mothers and babies in the first few days of life (Stephens, 2012), which would point towards flaws in that system. Infants who are placed skin-to-skin nurse more successfully at the first feeding. The infant should be allowed to crawl spontaneously to the breast, and those that go to the breast spontaneously have a better tongue position with their latch-on (Sinusas & Gagliardi, 2001) and are able to feed better. Infants need skin-to-skin contact to be able to gain their bearings in the world and do what comes natural to them, including moving toward and latching on to the breast. Getting a successful start can help infants be more successful in their feedings in the future.

Rooming-in also affects infants because studies have shown that newborns who do not room-in are more irritable, even in response to milder stimuli. They also do not put as much effort into quieting themselves and are more successful in their efforts after enduring upsetting stimuli (Ahn, Ko, Kyung, Lee, & Shin, 2008). Although babies spend most of their time sleeping, being in the mere presence of their mothers can have effects on their health and happiness.

In Baby-Friendly Hospitals, pacifiers are only used during painful procedures and the parent must be given education that pacifiers are not to be used until breastfeeding is established,
which is usually when the infant is around three to four weeks of age (Bohling Smith et. al, 2012). If the infant is crying excessively and is not soothed by feeding, a diaper change, or being held, the infant may feel as if his or her needs are not being met. The mother also may be too exhausted from rooming-in or from breastfeeding attempts to be able to tend to the infant immediately. The pacifier may serve as a soothing device that other methods cannot provide. This correlates with the psychologist Erik Erikson’s stage of Trust vs. Mistrust. Infants develop a sense of trust if the caregiver is reactive and dependable with their basic needs being met. Infants develop mistrust if their needs for food and care are not given to them regularly. Infants who are not securely attached may become less willing and more aggressive in their relations with their mothers. Later in life, they can become less sympathetic with peers and are not as explorative or determined within their environment (Cramer, Flynn, & LaFave, 1997). The use of the pacifier may hurt or help the newborn, depending on whether the sense of trust can be established without it.

The Baby-Friendly Hospital Initiative also has an effect on the hospital as a whole, especially the staff working at the hospital and those considering working at the hospital. This globally prestigious award may draw prospective employees toward that hospital over their competitors. It can instill a sense of pride in those already working at the hospital. It can enhance the environment of competence, leadership, and teamwork among the staff members. The BFHI has been shown to deliver evidence-based care centered around the patient. It has improved patient satisfaction scores, such as at Rockford Memorial Hospital in Rockford, Illinois, which scored “above the 90th percentile for six of eight domains (communication with nurses, responsiveness, clean/quiet, pain management, communication with provider and discharge information)” (Velarde, 2014). Higher patient satisfaction scores can turn into financial profits
for the hospitals, which also benefits the staff. Baby-Friendly hospitals show commitment to quality improvement. They meet corporate compliance requirements and meet Joint Commission perinatal core measures for exclusive breast milk feeding (MacEnroe, 2012).

At Baby-Friendly hospitals, the nursing staff on maternity floors must complete a total of 20 hours of training, with 15 sessions identified by UNICEF/WHO and 5 hours of supervised clinical experience. All staff who have contact with mothers, including housekeeping, should have some training on the Initiative. This includes having a basic understanding of exclusive breastfeeding, knowing their role in assisting the mother and baby, feeling comfortable with witnessing the practices that support breastfeeding, and knowing who to contact if the mother has a question or issue with breastfeeding. Each facility must develop a policy for how much training is required for staff in other units and roles. The hospital and staff members must keep track of their training hours and keep up with the continuing education involved with the Baby-Friendly designation.

For some of the policies of the Baby Friendly Initiative, the staff would have had to learn how to adjust, especially if it changed the way they had always done things. For rooming-in, some nurses and physicians were hesitant to stop using the nursery and discontinue having set feeding times. It was also difficult to adjust to having medical procedures performed at the bedside. In the past, the weight, bath, and footprints were performed after the baby was born. Following implementation of the practice of skin-to-skin contact immediately after the birth, these practices had to be delayed. The staff would have to change their routines, which may be tough for those who have been doing it a certain way for years. The staff may feel as if they do not have enough time to spend teaching and assisting each woman with breastfeeding and the Baby-Friendly policies. The staff may also have an increased amount of documentation,
including documenting the amount of breastfeeding being done, the time the infant spends in the nursery and the reason for going to the nursery, and the amount of skin-to-skin time. This all may be seen as extra work in an already busy schedule.

The staff at a Baby-Friendly hospital must look at their own opinions and decide if working at this type of hospital is right for them. They must comply with the standards of the hospital, and if they do not agree with the practices, they may need to work elsewhere. They also need to be able to guide the women in their breastfeeding practices without appearing to push them too hard, which may make the mother want to quit. According to Walsh et al. (2011), those not participating in Baby-Friendly have used the terms “mother unfriendly, breastfeeding Nazi’s, or bullies” to describe the Baby-Friendly staff, so it may be frustrating to the staff to have to defend themselves. There are many factors overall that play into the role of the staff at a Baby-Friendly Hospital.

As for the effect of the cost of the Initiative on hospitals, a study done by DelliFraine et al. in 2007 showed that Baby-Friendly hospitals were only about 1.6% to 5% more expensive per delivery than non-Baby-Friendly hospitals. This shows that the BFHI does not have much of an impact on cost for the hospital. Improving maternity care practices does not translate to increasing costs (Allen, Longenecker, Perrine, & Scanlon, 2013). Although the movement may be more expensive at first to implement due to designation fees and training, the cost per year is not significant enough to have an effect on the hospital.

In regards to the community as a whole, the Baby-Friendly Hospital Initiative is designed to make long-term changes. Breastfeeding has an impact because it creates reduced healthcare costs, better school performance, and a lower burden of chronic disease. In looking at the bigger picture, in using formula or not promoting breastfeeding, “we’re actually causing more work for
ourselves because the babies have to come back as inpatients because they’re unwell, because they’re not protected against disease, or they come back and they’re obese. It just spirals out of control” (Schmied, Gribble, Sheehan, Taylor, & Dykes, 2011). The community, however, may not be receptive of breastfeeding if there are beliefs it is immodest and there is a lack of locations for the mothers to breastfeed. The mothers may have more difficulty returning to work because of the baby’s need. Individuals may criticize the mother, saying that bottle feeding is easier. This may make it more difficult for the mother, and community-wide education needs to be done in order for the BFHI to be entirely successful.

Since it has been implemented, the Baby-Friendly Hospital Initiative has improved the rates of breastfeeding initiation, but the implementation of the Ten Steps still remains well below the target goal. In order for the number of Baby-Friendly hospitals to increase, the barriers to becoming Baby-Friendly need to be addressed. There are sociopolitical, organizational-level, and individual-level barriers. The sociopolitical barriers include the assertive marketing of the formula companies, the government taking a laid-back approach to the Code, and sociocultural feeding norms that do not favor breastfeeding. Organizational barriers include deficient money and short staffing. Individual factors include inadequate staff knowledge, negative views toward breastfeeding, and opinions of implementing the BFHI as too “dogmatic or time consuming” (Semenic, Childerhose, Lauziere, & Groleau, 2012). It has also been shown that hospitals find it easier to comply with certain steps, such as Step 3, 5, and 8, while Steps 1, 6, and 7 were more difficult to implement. Although every barrier may not be able to be prevented, the BFHI is working to overcome them.

Some recommendations for starting the practice of Baby-Friendly policies include the “endorsement of both local administrators and governmental policy makers to leverage resources
for BF[H]I implementation, effective leadership of the practice change process, and the training of health care workers to improve breastfeeding practices and shift attitudes toward breastfeeding. Also in need of change are the influence of formula companies and the integration of hospital and community-based perinatal health services” (Semenic, et al., 2012). There are some changes that need to be made, but with commitment, compliance, and quality control, more hospitals can become Baby-Friendly in years to come.

In the 1990's, there was a tremendous push towards having a mother breastfeed her child. Numerous benefits for the infant can occur during breastfeeding, including decreased risk of disease and a closer bond with the mother. UNICEF and WHO, seeing these benefits, created the Baby-Friendly Hospital Initiative to encourage more mothers to breastfeed their newborns. Hospitals work for years to reach this prestigious accreditation. Following the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-Milk Substitutes, hospitals must create a new environment that promotes breastfeeding as the optimal method of feeding newborns. Some of the changes that hospitals must make include new policies on breastfeeding and educating staff on the policies, performing skin-to-skin contact immediately following birth, and no longer being able to hand out free formula samples to mothers. The road to becoming Baby-Friendly may be long and tedious, but it provides numerous effects for the mothers, infants, and staff. Using the Baby-Friendly method, mothers are able to identify their baby's needs and satisfy them more quickly, which improves the level of trust in the infant. Staff in Baby-Friendly hospitals have improved leadership and teamwork as well as enhanced patient satisfaction scores. Since its initiation, the number of Baby-Friendly hospitals has continued to slowly rise. With continuing education and marketing, the Baby-Friendly Hospital Initiative will hopefully become the standard of care for hospitals nationwide.
References


