National Infant Feeding Policy for Maternity and Neonatal Services

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</tr>
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**Glossary of Terms**

**Areas that provide maternity and neonatal care to pregnant women, infants and their mothers** include the Maternity Unit, Delivery Suite, Theatre, SCBU, Out Patient Departments, Gynaecological Department and A & E, as well as general public areas of the hospital including reception areas, hospital shop, and cafe. Aspects of the policy may apply to other areas as well which are providing care for women and infants.

**BFHI:** Baby Friendly Hospital Initiative, a global WHO/UNICEF initiative that is active in Ireland since 1998.

**Code:** The International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly resolutions.

**Donor human milk:** Milk is collected from donors all over Ireland. The milk is then processed in accordance with UKAMB Guidelines and distributed to units throughout Ireland by Irvinestown Human Milk Bank; it is run as part of the Western Health and Social Care NHS Trust.

**Exclusive breastfeeding:** Infant receives only breast milk (at the breast, own mother’s expressed milk or donor human milk) and no other food or fluids except medicines.

**Healthcare worker/staff:** Medical, midwifery, nursing, other professional and non-professional staff including voluntary or unpaid workers, who provide care for pregnant women, infants and their mothers, attending the hospital or associated services such as off-site clinics.

**Hospital:** this term will be used to include associated services such as off-site clinics.

**Infant Formula Feeding:** Infant receives artificial infant formula that conforms to the nutritional requirements for babies from birth to one year of age as set down by the relevant EU Directives.

**Lactation consultant:** An International Board Certified Lactation Consultant (IBCLC) is a health care professional with specialist knowledge and clinical expertise in breastfeeding and human lactation. IBCLCs are certified by the International Board of Lactation Consultant Examiners, Inc. (www.iblce.org).

**Managers:** health service managers, both clinical and administrative.

**Neonatal units:** These include special care baby units (SCBU), neonatal intensive care units, high dependency neonatal units, low dependency neonatal units, neonatal surgical units etc.
1. Purpose of the Policy

The purpose of this policy is to provide consistent evidence based direction for best practice in order to:

- provide consistent high quality service for patients
- avoid conflicting information being given to users and providers of services;
- ensure legislative and regulatory requirements are met;
- enable employers and employees to carry out their roles and responsibilities in implementing the policy;
- act as a basis for audit and evaluation.


In accordance with HSE, DOH&C and WHO/UNICEF recommendations, all hospital staff should encourage and enable mothers to breastfeed exclusively for the first 6 months and continue thereafter as part of a wider diet until two years of age or beyond.

All parents have the right to receive clear evidence-based information to enable them to make fully informed decisions about how their babies are fed and cared for.

Staff should support women in their chosen method of infant feeding, regardless of method chosen.

1. Scope

This policy, and its appendices, applies to all employees providing maternity and neonatal hospital services to pregnant women, infants and their mothers, and to those providing these services on behalf of the hospital.

Note: Unless otherwise stated, it should be assumed that the policy refers to healthy term infants and healthy mothers.

2. Responsibilities and accountability

All staff must adhere to this policy in its entirety.

- Each health care worker is accountable for their practice. This means being answerable for decisions made and providing a rationale for those decisions.
- It is the responsibility of all staff to ensure that they abide by the policy and obtain and maintain the knowledge and skill base to enable them to implement the policy.
- Policies represent a statement reflecting an expected standard of care. Any deviation from the policy must be documented in the mother and infant’s medical and nursing records, as relevant, together with the rationale for the policy deviation.

All managers including nursing and midwifery managers; clinical medicine leads including consultant obstetricians, paediatricians, and anesthetists; managers of all hospital departments, i.e. pharmacy, radiology, laboratory, physiotherapy, dietetics, catering, hygiene
services, porters, security and administration; in their own areas and as part of the hospital management team, have the responsibility to:

- ensure that employees (full-time, temporary and contract staff) are made aware of the policy and their responsibility to adhere to it;
- facilitate policy orientation when new staff commence work;
- provide policy-linked training for staff relevant to their role;
- ensure that staff comply with the Policy;
- audit policy implementation and effectiveness.

3. Communicating the Policy

The policy and their role in upholding it should be communicated to all health care employees who have contact with pregnant women, infants and young children and their mothers.

- All new staff should be orientated to the policy as soon as their employment begins.
- All staff must have ready access to a copy of this policy.

The policy or a summary should be displayed in all areas of the hospital providing services to pregnant women, infants and young children and their mothers.

Where a mother’s/parent’s summary of the policy is displayed in patient areas, a complete version should be available on request in each service area. A statement to this effect should be included on the mother’s/parent’s summary version. The summary policy should also be available in audio format and in other languages, as needed.

4. Policy and Procedures for Implementation

1. Training of health care staff
- All health care and support staff who have contact with pregnant women and mothers of infants and young children should receive training in support of this policy at a level appropriate to their role. (Appendix 3)
- New staff requiring training should receive this training within six months of taking up their posts. Training should include both theoretical knowledge and supervised clinical practice.
- All clerical and ancillary staff should be orientated to the policy and receive training relevant to their role and responsibility.
- Written curricula covering all Ten Steps to Successful Breastfeeding, mother-friendly birth practices, International Code of Marketing and feeding of the infant who is not breastfed should be available for all staff training (see Appendices).
- A record of staff who have received training and those awaiting training should be kept and available on request.

2. Providing information to pregnant women
- All pregnant women should be given information and opportunities for one-to-one discussion before 32 weeks gestation. This information should also be available to their partners and other support persons. Discussion and information should include the following:
  - The importance of exclusive breastfeeding to baby and to mother in the first six months and breastfeeding’s continued importance after 6 months when other foods are added to the infant’s diet.
Practices that support the initiation and continuation of breastfeeding, including labour and birth practices.

Basic breastfeeding management.

The benefits of breastfeeding and the potential risks of a decision not to breastfeed.

- It should be assumed that all women will breastfeed. Women should not be asked their infant feeding intention antenatally, unless there is a specific medical reason why a decision needs to be made during pregnancy.

- No routine group instruction on the preparation of artificial feeds should be given in the antenatal period.

- Pregnant women who are in-patients should also be provided with antenatal information and opportunities for discussion as outlined above.

- Pregnant women should be encouraged to attend breastfeeding support groups in their local area to help them gain confidence from meeting experienced breastfeeding mothers and counsellors. Information on the venues, dates and times of these support groups should be provided by hospital staff.

- Pregnant women who have experienced difficulties with previous breastfeeding, or where difficulties are anticipated, should be given extra time to discuss their individual situation and relevant information.

3. Supporting early contact and initiation of breastfeeding

- Research shows that mother-friendly birthing practices have a positive effect on mothers and infants, regardless of infant feeding intention. The following practices should, therefore, be provided unless medically contraindicated, in which case the reason should be explained to the woman:
  - Women in labour should be encouraged to have their partner, or other companion of their choice, with them during labour and birth.
  - Women should be permitted to drink and eat light foods during labour, if desired.
  - Women should be encouraged to walk and move about during labour, if desired, and to assume the positions of their choice while giving birth.
  - Women should be encouraged to consider the use of non-drug methods of pain relief, while respecting the personal preferences of the woman.
  - Invasive procedures such as rupture of membranes, episiotomies, induction or acceleration of labour, caesarean sections or instrumental deliveries should be avoided, unless medically indicated.

- Immediate skin to skin contact is important for the physiological and psychological well-being of both baby and mother.
  - All mothers and their babies should have skin-to-skin contact immediately following the birth and it should be continued uninterrupted for at least 60 minutes.
  - If skin-to-skin contact is delayed or interrupted for medical reasons or maternal choice it should be re-instigated as soon as possible.
  - Staff should not interrupt this early contact for routine procedures. Skin-to-skin contact may continue during transfer to the ward and may continue thereafter.
  - If for medical reasons the mother is unable to hold her baby in skin-to-skin contact immediately after delivery her partner/other family member may be given the opportunity to do so until the mother is able.
If a mother has received a general anaesthetic, skin-to-skin contact should commence when the mother is alert and responsive, unless the partner or other person can supervise the baby’s safety while in skin-to-skin contact with the mother, until she is fully alert.

Newborns requiring transfer to the neonatal unit for non-emergency reasons should be given the opportunity to have skin-to-skin contact with their mothers and initiate breastfeeding prior to transfer. Newborns needing emergency transfer to the neonatal unit should be held in skin-to-skin contact as soon as their condition allows.

Most healthy newborns in skin to skin contact will initiate breastfeeding within the first hour of life.

All mothers should be shown how to recognise the signs of their babies’ readiness to breastfeeding, and encouraged to offer this first feed.

Mothers should be offered help with feeding, if it is needed.

Mothers should not be asked about their proposed method of feeding until after the first skin-to-skin contact with their newborn babies.

4. Showing mothers how to breastfeed and how to maintain lactation

All breastfeeding mothers should be offered assistance with the first feed on the postnatal ward. A midwife or other trained person should be available to assist a mother at all feeds during her postnatal stay, if needed.

All breastfeeding mothers should be offered assistance and support to:

- acquire the skills of positioning and attachment for effective feeding,
- identify feeding cues,
- recognise if feeding is effective,
- express their milk by hand.

Additional support with breastfeeding should be offered to women who have had:

- a narcotic analgesic or a general anaesthetic, as the baby may not initially be responsive to feeding,
- a caesarean section, and have limited movement,
- delayed initial contact with their baby,
- previous problems with breastfeeding, to reduce the risk of problems occurring again.

Mothers of babies in neonatal units who cannot initiate breastfeeding should be:

- Offered help to initiate lactation within 4-6 hours of their babies’ births;
- Shown how to express their breast milk by hand, and once their milk “comes in”, shown how to use a breast pump.
- Informed of the need to breastfeed or express at least 6-8 times in 24 hours (to include at least once during the night) to keep up their supply.
- Given information on how to safely handle and store breast milk.
- Provided with assistance to put the baby to the breast as soon as the baby’s condition is sufficiently stable, to provide comfort and to develop the skills of breastfeeding.

If the mother has been discharged and the baby remains in the neonatal unit, the staff in the hospital should continue to provide assistance and support to the mother in establishing and maintaining breastfeeding.

Mothers who are not breastfeeding should be:

- Encouraged to have close contact with her baby.
Informed about the risks and management of various feeding options and helped to decide what is suitable in her circumstances.

Assisted to learn how to choose, prepare, handle and give artificial feeds and how to effectively clean and sterilize feeding equipment.

Provided with an opportunity to prepare a feed to ensure they can do so safely and accurately, either individually or in small groups, in the postnatal period.

Given information on how to care for their breasts if they become engorged.

5. Giving newborn infants no food or drink other than breast milk, unless medically indicated.
   - Exclusive breastfeeding should be the normal practice.
   - Clear evidence-based protocols or guidelines should be in place for the management of conditions such as hypoglycaemia, jaundice, dehydration or excessive weight loss where supplementation may be considered. These guidelines should firstly require an assessment of breastfeeding effectiveness and address this as a priority.
   - No materials should be given to any mothers that suggest the necessity for feeding artificial formula supplements to healthy breastfeeding infants, scheduling feedings, or other practices unsupportive of establishing and sustaining breastfeeding.
   - Supplements/replacement feeds may be medically/clinically indicated, if so, the reasons should first be discussed with the mother. If a supplement is indicated, the first and optimal choice of supplement should be the mother’s own expressed breast milk given to the baby via sterilised spoon or cup. Artificial formula should only be given when medically indicated and when own mother’s milk or donor milk is not available.
   - Parents who request supplementation should be informed of the possible health implications of this and the adverse impact such action may have on the success and duration of breastfeeding to enable them to make a fully informed choice. A full record of this discussion should be made in the mother’s and baby's nursing and medical records, as relevant.
   - Reasons for supplement, type, amount given and feeding method should be documented in the mother/baby’s notes.

6. Rooming-in
   - Mothers should assume primary responsibility for the care of their babies, and they should remain together 24 hours a day. This applies to babies who are formula feeding as well as those who are breastfeeding.
   - Separation of mother and baby should not occur unless the health of either mother or baby requires this.
   - Mothers recovering from caesarean section should be given appropriate care, while keeping mother and baby together.
   - If separation is required for a medical reason, the reason and the length of the separation should be documented in the mother/infant notes.
   - All mothers should be given appropriate information about safe bed sharing with their infants, the benefits of this and the contraindications.
7. Baby-led feeding
   - Mothers should be taught how to recognize the early signs indicating that their baby needs feeding and when their baby has had sufficient milk.
   - No restrictions should be placed on the frequency or duration of breastfeeds for healthy babies. Where there is a medical indication, due to the baby's condition, for scheduled feeding or limited feeding, this should first be discussed with the mother.
   - Hospital routines or procedures should not interfere with baby-led feeding.
   - If a baby is sleepy, weak or otherwise compromised, or if a mother's breasts are overfull and uncomfortable it may be necessary to wake a baby for feeds. This should be instigated as a temporary measure until the clinical rationale for doing this no longer applies.

8. Avoiding artificial teats or pacifiers (also called dummies or soothers)
   - Health care staff should not recommend the use of artificial teats and dummies during the establishment of breastfeeding. Parents wishing to use these should be advised of the possible detrimental effects such use may have on breastfeeding, to enable them to make a fully informed choice. A record of the discussion and parents' decision should be made in the baby's notes.
   - Nipple shields should not be recommended, unless there is a clinical reason for their use and this reason should be discussed with the mother and documented. Any mother considering the use of a nipple shield must have the potential risks explained to her prior to commencing use. She should remain under the care of a skilled practitioner whilst using the shield and should be helped to discontinue its use as soon as possible.
   - If any teats, dummies or nipple shields are used, mothers should be informed about the need to keep these clean and facilitated to do so while in hospital.
   - Where a supplement is indicated for the breastfed baby, cup feeding (or teaspoon, syringe, if small amounts) should be the method of choice. This is a temporary method of feeding while baby learns how to breastfeed and should not be used indiscriminately or indefinitely.

9. Discharge
   - The midwife/neonatal nurse or other discharging health professional must ensure that the mother is able to feed her baby, and that the baby is feeding effectively prior to discharge. Any difficulties must be highlighted and communicated to the Public Health Nurse/community midwife so she/he can continue care.
   - Hospitals should liaise with the public health nursing service to ensure that all mothers are visited within 48 hours of discharge.
   - Mothers should be encouraged to have a review of their infant feeding soon after discharge, preferably 2-4 days after discharge, and again the following week.
   - Prior to discharge from the postnatal ward all mothers should be given information about the support services available to them. This information should include how and where to access hospital, community health services, other professional support, such as lactation consultants, and voluntary mother-to-mother support services such as provided by La Leche League and Cuidiú.
   - Contact details for hospital and community support groups should be available throughout the maternity unit. These details should be regularly checked and updated to ensure correct information is distributed.
10. Protecting breastfeeding

- The hospital should heed the International Code of Marketing of Breast-milk Substitutes and the subsequent relevant WHA resolutions and related Irish legislation to protect infants, their families, hospital staff, and assisting safe feeding. (Appendix 2)
- Healthcare staff should not promote one brand of formula or feeding equipment over another brand. Where there is a clinical indication for a specific brand of product, information on this product should be provided without marketing.
- Where specific instruction materials produced by a commercial company on the use of a specialised feeding product is deemed essential in an individual circumstance, approval for its use should be sought from hospital management.
- Stocks of artificial infant feeds should not be on display in ward areas. In-patient infants who are formula feeding should be given feeds as needed and stocks of formula feeds should be stored securely and accessed only by staff. Mothers, whether breastfeeding or artificially feeding, should not be given bottles of ready-to-feed or any formula products on discharge.
- Any contribution made by a manufacturer or distributor to an employee, or accepted on their behalf, for fellowships, research grants, study, or the like should be disclosed by the recipient and by the sponsoring company to hospital management.
- No direct or indirect contact is permitted or facilitated between employees of manufacturers or distributors of breast milk substitutes, feeding bottles, teats, dummies or other feeding equipment and pregnant women, mothers or members of their families.

11. Supporting breastfeeding

- Mothers, babies and visitors attending the services should be facilitated and supported to feed their babies in all public areas of the facility. A place should be made available for mothers who request privacy while breastfeeding.
- Breastfeeding mothers who are in-patients of the hospital, other than the Maternity Department, should also be supported to continue to breastfeed their baby.
- Infants and young children who are in-patients of the hospital, other than the Maternity or Neonatal Department, should also be supported to continue to breastfeed.
- When the medical condition of the mother or baby cannot accommodate breastfeeding, information and facilities to express and store breast milk should be provided.
- Every effort should be made to use treatments and medications that are compatible with breastfeeding. If breastfeeding is contraindicated for a medical reason, this should be discussed with the mother and recorded. If cessation of breastfeeding is essential, mothers and babies should be assisted to stop breastfeeding in a manner conducive to good health. If breastfeeding cessation is
only temporary, mothers and babies should be assisted to maintain/re-establish lactation and breastfeeding as soon as it is appropriate and safe to do so.

12. **Staff who are breastfeeding**
   - Staff members who are breastfeeding should be supported to continue breastfeeding on return to work by the provision of lactation breaks, facilities and support from managers and co-workers. The minimum level of provision should be in accordance with the relevant legislation (Maternity Protection (Amendment) Act 2004).
   - Participation in the Health Promoting Hospitals/ BFHI Breastfeeding Supportive Workplace activities is encouraged.

5. **Stakeholder Involvement**
   The policy, which is based on WHO/UNICEF best evidence based recommendations, was developed by Dr Genevieve Becker, National Coordinator, Baby Friendly Hospital Initiative and Maureen Fallon, National Breastfeeding Coordinator and has been endorsed by the National Breastfeeding Strategy Implementation Monitoring Committee whose membership includes:

   Ms. Catherine Murphy, Assistant National Director, HSE, Population Health, Health Promotion (chair)

   Dr. Tom Fahey, Professor of General Practice, Royal College of Surgeons of Ireland

   Ms. Biddy O’Neill, Function Manager for Programmes, HSE Population Health, Health Promotion

   Mr. Richie Dooley, HSE, National Hospitals Office, Network Manager, South East

   Dr. Pearl Treacy, Professor of Nursing, University College Dublin

   Ms. Patricia Hughes, Director of Nursing and Midwifery, Coombe Women and Infants University Hospital

   Dr. Deirdre Murphy, Professor of Obstetrics and Gynaecology, Consultant Obstetrician, Coombe Women and Infant’s University Hospital

   Ms. Mary McDermott, Assistant Director of Public Health Nursing, HSE Dublin North East

   Dr. Tessa Greally, Acting Director of Public Health, HSE West (mid West area)

   Ms Geraldine Regan, Director of Nursing, Our Lady’s Hospital for Sick Children, Crumlin

   Ms. Louise McMahon, HSE, National Hospitals Office, Hospital Network Manager, Dublin South City.

   Ms. Sarah Mumford, Acting Community Dietician Manager, HSE Dublin mid Leinster.

   Ms. Mary Bird, Leader, La Leche League of Ireland.

   Ms. Dorrie Mangan, General Manager, HSE, Primary Continuing and Community Care, Dublin mid Leinster.

   Ms. Geraldine Cahill, Cuidiú-Irish Childbirth Trust.

   Dr. Colm O’Donnell, Consultant Neonatologist, National Maternity Hospital, Dublin

   Ms. Bridget Catterson, Director of Public Health Nursing, HSE Primary Continuing and Community Care.
In addition to the above Committee, the review process circulated the draft policy to all maternity hospitals/units seeking feedback from all staff sectors.

6. Implementation Plan

Each Hospital Network Manager will be made aware of this National Infant Feeding Policy for Maternity and Neonatal Services and instructed to cascade the policy to all individual hospital managers for implementation.

7. Evaluation and Audit

A senior staff member in each hospital is to be assigned responsibility for auditing and evaluating the implementation of the policy.

Results of yearly audits of the policy should be included in the hospital's annual report and made available on request. Participation in the Baby Friendly Hospital Initiative and other quality programmes will also require reporting of audits.
8. Appendices

Appendix 1: Ten Steps to Successful Breastfeeding

Ten Steps to Successful Breastfeeding
First published in a joint WHO/UNICEF statement in 1989 -
Protecting, promoting and supporting breastfeeding: the special role of the maternity services.

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers to initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in - allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

The global BFHI and thus Irish BFHI underwent a revision process in 2006-2009. The main revisions relate to inclusion of criteria for mother-friendly labour and birth practices; clarity on inclusion of mothers of infants who are not breastfeeding ensuring information and support for these mothers; and strengthened implementation of the International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly resolutions International Code of Marketing of Breast-milk Substitutes.

Step 4: “Help mothers initiate breastfeeding within a half-hour of birth”, is now interpreted as: Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed.

Global Baby Friendly Hospital Initiative:
http://www.who.int/nutrition/topics/bfhi/en/index.html
http://www.unicef.org/nutrition/index_breastfeeding.html

Baby Friendly Hospital Initiative in Ireland: http://www.ihph.ie/babyfriendlyinitiative
Appendix 2: International Code of Marketing of Breast-milk Substitutes

What is the Code?
The Code was adopted in 1981 by the World Health Assembly (WHA) to promote safe and adequate nutrition for infants, by the protection and promotion of breastfeeding and by ensuring the proper use of breast-milk substitutes, when these are necessary. One of the main principles of the Code is that health care facilities should not be used for the purpose of promoting breast milk substitutes, feeding bottles or teats. Subsequent WHA resolutions have clarified the Code and closed some of the loopholes.

Which products fall under the scope of the Code?
The Code applies to breast milk substitutes when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk. Special formulas for infants with special medical or nutritional needs also fall under the scope of the Code.

Since exclusive breastfeeding is to be encouraged for 6 months, any food or drink during this period is a breast milk substitute and thus covered by the Code. This would include baby teas, juices and waters, as well as cereals, processed baby meals, including bottle-fed complementary foods, and other products marketed or otherwise represented for use before six months.

Since continued breastfeeding is to be encouraged for two years or beyond, any milk product shown to be substituting for the breast milk part of the child’s diet between six months and two years, such as follow-on formula, is a breast-milk substitute and is thus covered by the Code.

The Code also applies to feeding bottles, teats and soothers.

What does the Code say?
The main points in the Code include:

- no advertising of breast-milk substitutes and other related products to the public;
- no free samples to mothers or their families;
- no promotion of products, i.e. no product displays, posters, calendars, or distribution of promotional materials;
- no donations of free or subsidised supplies of breast-milk substitutes or related products in any part of the health care system;
- no company-paid personnel to contact or to advise mothers;
- no gifts or personal samples to health workers;
- no pictures of infants, or other pictures or text idealizing artificial feeding, on the labels of the products;
- information to health workers should only be scientific and factual;
- information on artificial feeding should explain the importance of breastfeeding, the health hazards associated with artificial feeding and the costs of using artificial feeding;
- all products should be of a high quality, and unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

Who is a “health worker” for the purposes of the Code?
According to the Code, any person working in the health care system, whether professional or non-professional, including voluntary and unpaid workers, in public or private practice, is a health worker. Under this definition, ward assistants, health care assistants, housekeeping, nurses, midwives, social workers, dieticians, physiotherapists in-hospital pharmacists, doctors, administrators, clerks, etc. are all health workers.
What are a hospital and health worker’s responsibilities under the Code?

1. **Encourage and protect breastfeeding.** Health workers involved in maternal and infant nutrition should make themselves familiar with their responsibilities under the Code, and be able to explain the following:
   - the importance and superiority of breastfeeding;
   - the role of maternal nutrition in breastfeeding;
   - the preparation for and maintenance of breastfeeding;
   - the negative effect on breastfeeding of introducing partial bottle-feeding;
   - the difficulty of reversing the decision not to breastfeed; and
   - where needed, the proper use of infant formula, whether manufactured industrially or home-prepared.

   When providing information on the use of infant formula, health workers should be able to explain:
   - the social and financial implications of its use;
   - the health hazards of inappropriate foods or feeding methods; and
   - the health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes.

2. **Ensure that the health facility is not used for the display of products within the scope of the Code,** for placards or posters concerning such products, including logos of manufacturers. Ensure that packages of breast milk substitutes and other supplies purchased by the health facility are not on display or visible to mothers.

3. **Refuse any gifts offered by manufacturers or distributors,** including mugs, pens, Post-its, entertainment or financial support.

4. **Refuse samples** (meaning single or small quantities) of infant formula or other products within the scope of the Code, or of equipment or utensils for their preparation or use, unless necessary for the purpose of professional evaluation or research at the institutional level.

5. **Never pass any samples to pregnant women, mothers** of infants and young children, or members of their families. Samples of infant formula should not be given to mothers on discharge.

6. **Disclose any contribution made by a manufacturer or distributor** for fellowships, study tours, research grants, attendance at professional conferences, or the like to management of the health facility.

7. **Be aware that support and other incentives for programmes and health professionals working in infant and young-child health should not create conflicts of interests.**

Adapted from:
Appendix 3: Staff training

All clinical staff members who have contact with mothers and/or infants should receive training, either at the hospital or prior to joining the staff that covers:

- Ten Steps to Successful Breastfeeding,
- mother-friendly birth practices,
- the International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly resolutions.

For staff with direct care responsibilities for assisting breastfeeding, it is likely that at least 20 hours of targeted training will be needed to develop the knowledge and skills necessary to adequately support mothers and should include supervised clinical practice.

Training on how to provide infant feeding support for non-breastfeeding mothers is also provided to staff as relevant to their work. The training covers key topics such as:

- the risks and benefits of various feeding options,
- helping the mother choose what is acceptable, feasible, affordable, sustainable and safe (AFASS) in her circumstances,
- the safe and hygienic preparation, feeding and storage of breast-milk substitutes,
- how to teach the preparation of various feeding options, and
- how to minimize the likelihood that breastfeeding mothers will be influenced to use formula.

Non-clinical staff members receive training that is adequate, given their roles, to provide them with the skills and knowledge needed to implement this policy and support mothers in successfully feeding their infants.

From: UNICEF/WHO, Baby-friendly Hospital Initiative: revised, updated and expanded for integrated care, Section 1, Background and Implementation, 2008

Appendix 4: Antenatal information

The antenatal information and discussion with all pregnant women should cover:

- breastfeeding as the normal way to feed and care for a baby, and the importance of breastfeeding,
- supportive labour and birth practices
- the importance of early skin-to-skin contact and early initiation of breastfeeding,
- rooming-in on a 24 hour basis,
- good positioning and attachment for effective feeding,
- feeding on demand or baby-led feeding, and frequent feeding to help ensure a good milk supply,
- exclusive breastfeeding for the first 6 months, and that breastfeeding continues to be important after 6 months when other foods are given,
- avoidance of artificial teats and supplements,
- availability of postnatal assistance to establish feeding, and where mothers can find help on feeding their infants after return home.

From: UNICEF/WHO, Baby-friendly Hospital Initiative: revised, updated and expanded for integrated care, Section 1, Background and Implementation, 2008
Appendix 5: Acceptable medical reasons for use of breast-milk substitutes
(WHO 2009)

Introduction

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

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

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

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

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

INFANT CONDITIONS

Infants who should not receive breast milk or any other milk except specialized formulae

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

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

- Very low birth weight infants (those born weighing less than 1500g);
- Very preterm infants, i.e. those born less than 32 weeks gestational age;
- Newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic if their blood sugar fails to respond to optimal breastfeeding or breast-milk feeding(5)).

MATERNAL CONDITIONS

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

Mothers who may need to avoid breastfeeding

- HIV infection(6) if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS)(6).
Mothers who may need to avoid breastfeeding temporarily

- Severe illness that prevents a mother from caring for her infant, for example sepsis;
- Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved;
- Maternal medication:
  - sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available (7);
  - radioactive iodine-131 is better avoided given that safer alternatives are available - a mother can resume breastfeeding about two months after receiving this substance;
  - excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided;
- cytotoxic chemotherapy requires that a mother stop breastfeeding during therapy.

Mothers who can continue breastfeeding, although health problems may be of concern

- Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started (8).
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter (9).
- Hepatitis C.
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition (8).
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines (10).
- Substance use (11):
  - maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
  - alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.
  - Mothers should be encouraged not to use these substances and given opportunities and support to abstain (b).

Footnotes:

a) The most appropriate infant feeding option for an HIV-infected mother depends on her and her infant’s individual circumstances, including her health status, but should take consideration of the health services available and the counselling and support she is likely to receive. When replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), avoidance of all breastfeeding by HIV-infected women is recommended. Mixed feeding in the first 6 months of life (that is, breastfeeding while also giving other fluids, formula or foods) should always be avoided by HIV-infected mothers.

b) Mothers who choose not to cease their use of these substances or who are unable to do so should seek individual advice on the risks and benefits of breastfeeding depending on their individual circumstances. For mothers who use these substances in short episodes, consideration may be given to avoiding breastfeeding temporarily during this time.
References for Acceptable medical reasons for use of breast-milk substitutes (WHO 2009)


Further information on maternal medication and breastfeeding is available at the United States National Library of Medicine (NLM) website: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

Appendix 6: Bibliography

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