

National Infant Feeding Policy for Maternity and Neonatal Services
Updated July 2015

Cite as: Health Service Executive, (2015) *Infant Feeding Policy for Maternity and Neonatal Services* HSE.
Available at www.breastfeeding.ie ; www.babyfriendly.ie

Document Reference Number	National PPPG QPS 103	Document developed by	National Co-ordinator of the Baby Friendly Health Initiative in Ireland (BFHI) and National Breastfeeding Co-ordinator
Revision Number	02	Document approved by	National Director ISD, National Director of Clinical Care Programmes and National Director Quality & Patient Safety in 2012
Approval Date	Approved 24/01/2012	Responsibility For implementation	Service Managers
Revision Date	20/07/15	Responsibility for audit and review	Service Managers

Revision History

The 2012 policy was revised and updated in 2015 by the BFHI National Co-ordinator, National Breastfeeding Co-ordinator and CMS Lactation, Portlincula Hospital, in consultation with Maternity and Neonatal services.

The main changes are in relation to roles and responsibilities reflecting the Hospital Group structure. Implementation and Evaluation, Audit and Reporting of Compliance have been included in more detail in Section 8.

A new section for neonatal units has been added to the policy – Section 7.11, and issues related to the neonatal unit have been considered throughout the policy document.

Contents

- 1. Policy**
- 2. Purpose of the Policy**
- 3. Scope**
- 4. Related policies**
- 5. Glossary of Terms and Definitions**
- 6. Roles and Responsibilities**
- 7. Procedure**
 - 7.1 Communicating the Policy**
 - 7.2 Training for Healthcare staff**
 - 7.3 Providing Information to Pregnant Women**
 - 7.4 Supporting early contact & initiation of breastfeeding**
 - 7.5 Showing Mothers how to breastfeed and maintain lactation**
 - 7.6 Giving newborn infants no food or drink other than breast milk, unless medically indicated**
 - 7.7 Rooming-in**
 - 7.8 Baby-led feeding**
 - 7.9 Avoiding artificial teats or pacifiers (also called dummies or soothers)**
 - 7.10 Support on discharge**
 - 7.11 Supportive Neonatal Unit**
 - 7.12 Protecting Breastfeeding**
 - 7.13 Supporting staff who are breastfeeding**
- 8. Revision and Audit**
- 9. References**
- 10. Appendices**
- 11. Revision History**

1. Policy

- 1.1 **Policy statement:** It is the policy of the HSE that all staff must protect, support and promote best practice in relation to breastfeeding in accordance with this policy and the procedural elements as outlined.

2. Purpose of the Policy

- 2.1 The purpose of this policy is to direct consistent evidence based best practice in order to:

- provide high quality service for patients;
- ensure that consistent infant feeding information is 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.

- 2.2 The Infant Feeding Policy for Maternity and Neonatal services was approved by the HSE in 2012 and adopted as the policy of all 19 maternity units. The policy was revised and updated in 2015.

3. Scope

- 3.1 This policy, and its appendices, apply to all employees providing maternity and neonatal hospital services to pregnant women, infants and their mothers, to those providing these services on behalf of the hospital, and, as relevant, to all other staff of the HSE where their actions, or lack of actions, would impinge on the functioning of this policy.

The information contained within this policy is the most accurate and up-to-date, at date of writing.

- 3.2 In accordance with HSE, DOH 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.
- 3.3 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.
- 3.4 Staff should support women in carrying out their chosen method of infant feeding.

4. Other related policies

- 4.1 This Policy includes the principles of care that are embedded in the WHO/UNICEF Baby Friendly Hospital Initiative (BFHI) as this represents current best evidence based practice.
The BFHI Global criteria and standards provide indicators to benchmark practice.
- 4.2 This policy supports the *Breastfeeding in Ireland: A Five Year Strategic Action Plan* (DoHC 2005). It is in line with the *Global Strategy for Infant and Young Child Feeding* (WHO/UNICEF, 2002); the *UN Convention on the Rights of the Child* (UN1989); and *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025* (DoH, 2013), which commits to addressing risk factors and promoting protective factors at every stage of life, including pre-natal and through early childhood.
- 4.3 The implementation of this policy can assist in meeting the standards of the National Standards for Safer, Better Healthcare (HIQA, 2013) and can form part of Quality Improvement Plans for maternity hospitals.
- 4.4 This policy supports the National Healthcare Charter
- 4.5 This policy supports the European Communities (Infant and Follow on Formulae) Regulations 2007 to 2014 S.I. No. 852 of 2007 – Principal Regulations (& amendments S.I. 209 of 2009, S.I. 384 of 2013, S.I. No. 92 of 2014) as well as the International Code of Marketing of Breast-milk Substitutes and its subsequent resolutions.

5. Glossary of Terms

Areas that provide maternity and neonatal care to pregnant women, infants and their mothers include the Maternity Unit, Delivery Suite, Theatre, neonatal units, 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 Health 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.

Competence: The ability of the staff member to practice safely and effectively fulfilling his/her responsibility within their scope of practice.

Donor human milk: Milk that is provided by donors. 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.

Father and Family: Father includes partner or significant other person. Family includes significant others and is defined by the parents.

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.

Kangaroo Mother: Care (KMC) The definition of the KMC method is: Early, prolonged and continuous skin-to-skin care between a mother and her low birth weight infant in hospital and after early discharge, with (ideally) exclusive breastfeeding, early discharge and adequate follow-up. In this document, KMC is used for all models of skin-to-skin care (intermittent and continuous) between parents and preterm/low birth weight/ill infants requiring neonatal care.

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. This may be in a maternity, paediatric or general hospital.

Stable infant: means absence of severe apnoea, desaturation and bradycardia.

6. Roles and Responsibilities

- 6.1 It is the responsibility of all Hospital Group CEOs and Directors to ensure that management in maternity and neonatal services are aware of the policy and ensure its implementation.
- 6.2 All managers of services in contact with pregnant women, infants and young children and their mothers 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.
- 6.3 Managers include nursing and midwifery managers; clinical medicine leads including consultant obstetricians, paediatricians, neonatologists and anaesthetists; managers of all hospital departments, i.e. pharmacy, radiology, laboratory, physiotherapy, dietetics, catering, hygiene services, porters, security and administration;
- 6.4 It is the responsibility of Clinical Specialists in Lactation to ensure that appropriate breastfeeding and lactation management training is available for staff to obtain the skills necessary to implement this policy. In those units that do not have a Clinical Specialist in Lactation post, management must assign the responsibility of co-ordinating training to an appropriate staff member.
- 6.5 It is the responsibility of management to ensure staff participate in training appropriate to their role.
- 6.6 **All staff** must adhere to this policy in its entirety.
- 6.6.1 It is the responsibility of all staff to facilitate a positive and supportive environment for breastfeeding at all times.
- 6.6.2 Each health care worker is accountable for their practice. This means being answerable for decisions made and providing a rationale for those decisions.
- 6.6.3 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
- 6.6.4 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 within their role.
- 6.6.5 It is the responsibility of all staff to facilitate a positive and supportive environment for breastfeeding at all times.

7. Procedure

These procedures are based on the WHO/UNICEF best evidence-based *10 Steps to Successful Breastfeeding*, which underpin the Baby Friendly Initiative
(See Appendix 1)

7.1 Communicating the Policy

- 7.1.1 The policy and their role in relation to the policy should be communicated to all health care employees who have contact with pregnant women, infants and young children and their mothers.
- 7.1.2 All new staff must be orientated to the policy as soon as their employment begins.
- 7.1.3 All staff must have ready access to a copy of this policy.
- 7.1.4 The Policy should be available on Q-pulse (or similar system) with links to related procedures and guidance
- 7.1.5 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.
- 7.1.6 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.

7.2 Training of health care staff

- 7.2.1 All health care and support staff who have contact with pregnant women and mothers of infants and young children must receive training and continuing professional development at a level appropriate to their role to ensure they implement this policy (Appendix 3- Staff Training) Core training courses should be accredited by relevant professional bodies.
- 7.2.2 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 Appendix 3 – Staff Training).
- 7.2.3 New staff requiring training must receive this training within six months of taking up their posts, if this training was not received in a previous employment/pre-service training. Training must include both theoretical knowledge and supervised clinical practice.
- 7.2.4 All clerical and ancillary staff should be orientated to the policy and receive training relevant to their role and responsibility.

- 7.2.5 A record of staff who have received training and those awaiting training should be kept and available on request.

7.3 Providing information to pregnant women

- 7.3.1 All pregnant women must 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.
- 7.3.2 Antenatal education and discussion should extend throughout the antenatal period and cover the following key points:
- 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 importance of breastfeeding for health and the potential risks of a decision not to breastfeed.
- 7.3.3 Documentation of the discussion, and oral and written information provided should be made in the Antenatal Checklist in the woman's Maternity Healthcare Record and signed by the staff member providing the information.
- 7.3.4 It should be assumed that all women will breastfeed. Women should not be asked to state their infant feeding intention antenatally, unless there is a specific medical reason why a decision needs to be made during pregnancy.
- 7.3.5 Pregnant women who request information on using infant formula should be provided with accurate, research based information and discussion to support them to make an informed decision (Appendix 4 – Antenatal information)
- 7.3.6 No routine group instruction on the preparation of artificial feeds should be given in the antenatal period.
- 7.3.7 Pregnant women who are in-patients should also be provided with antenatal information and opportunities for discussion as outlined above.
- 7.3.8 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.
- 7.3.9 When admission to the neonatal unit is expected, antenatal information and discussion should take place specific to the importance of mothers milk and the practices and neonatal unit supports to help establish breastfeeding
- 7.3.10 Pregnant women should be encouraged to attend mother 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

7.4 Supporting early contact and initiation of breastfeeding

- 7.4.1 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, and the reason recorded in her notes.
- 7.4.2 Women in labour should be encouraged to have a companion of their choice with them during labour and birth.
- 7.4.3 Women should be permitted to drink and eat light foods during labour, if desired.
- 7.4.4 Women should be encouraged to walk and move about during labour, if desired, and to assume the positions of their choice while giving birth.
- 7.4.5 Women should be encouraged to consider the use of non-drug methods of pain relief, while respecting the personal preferences of the woman.
- 7.4.6 Invasive procedures such as rupture of membranes, episiotomies, induction or acceleration of labour, caesarean sections or instrumental deliveries should be avoided, unless medically indicated.
- 7.4.7 Immediate skin to skin contact is important for the physiological and psychological well-being of both baby and mother. It commences with delivery of the infant onto the mother's abdomen while waiting for the cord to be ready for clamping. Infants may manoeuvre themselves towards the breast (breast crawl) over the first hour. Initial checks can be carried out while the baby is in safe skin to skin contact (Appendix 5 Skin-to-skin contact)
- 7.4.8 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.
- 7.4.9 If skin-to-skin contact is delayed or interrupted for medical reasons or maternal choice it should be re-instigated as soon as possible.
- 7.4.10 Staff should not interrupt this early contact for routine procedures.
- 7.4.11 Skin-to-skin contact may continue during transfer to the ward and may continue thereafter.
- 7.4.12 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 should be given the opportunity to do so until the mother is able.
- 7.4.13 If a mother has received a general anaesthetic, skin-to-skin contact should commence as soon as 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 alert.
- 7.4.14 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.

- 7.4.15 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 breastfeed, and encouraged to offer this first feed.
- 7.4.16 Mothers should be offered help with feeding, if it is needed, without interfering with the baby's natural ability to self-attach.
- 7.4.17 Mothers should not be asked about their proposed method of feeding until after the first skin-to-skin contact with their newborn babies.

7.5 Showing mothers how to breastfeed and how to maintain lactation

- 7.5.1 All 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.
- 7.5.2 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, and to express their milk by hand.
- 7.5.3 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, or
 - when the baby has experienced birth trauma or instrumental delivery
- 7.5.4 Mothers of babies in neonatal units who cannot immediately initiate breastfeeding should be:
 - Offered help to initiate lactation within 4-6 hours (ideally within the first 1 hour) of their babies' births, ;
 - Shown how to express their breast milk by hand, and once their milk "comes in", or sooner if desired by the mother, also shown how to use a breast pump.
 - Informed of the need to breastfeed or express at least 8 times in 24 hours (to include at least once during the night) to establish 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.

- 7.5.5 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 (See additional points in Section 7.11).
- 7.5.6 A mother who is not breastfeeding should be provided with individualised information and time for discussion and:
- Encouraged to have close contact with her baby.
 - Informed about the possible risks and about the 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.

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

- 7.6.1 Exclusive breastfeeding should be the normal practice.
- 7.6.2 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.
- 7.6.2 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.
- 7.6.3 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. Artificial formula should only be given when medically indicated and when own mother's milk or donor milk is not available.
- 7.6.4 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 decision. A full record of this discussion should be made in the mother's and baby's nursing and medical records, as relevant.
- 7.6.5 Reasons for supplement, type, amount given and feeding method should be documented in the mother/baby's notes.

7.7 Rooming-in

- 7.7.1 The mother has primary responsibility for the care of her baby, and they should remain together 24 hours a day. This applies to all mothers and babies.
- 7.7.2 Staff should educate and support the mother in the care of her baby.
- 7.7.3 Mothers recovering from caesarean section should be given appropriate care while keeping mother and baby together.
- 7.7.4 If separation occurs, the reason for the separation and the length of the separation should be documented in the mother/infant notes. Documentation must include, information on care and support provided for the mother, who removed the infant and the reason, who was responsible for the infant, where the infant was cared for and the care provided, who returned the infant to its mother and signed to say that identification bands were checked.
- 7.7.5 All mothers/parents should be given appropriate information about safe sleeping

7.8 Baby-led feeding

- 7.8.1 Mothers should be assisted to learn how to recognise normal infant behaviours, the early signs indicating that their baby needs feeding, how to wake a sleepy baby, and when their baby has fed sufficiently. Learning of these skills applies to mothers who are artificially feeding as well as those who are breastfeeding.
- 7.8.2 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.
- 7.8.3 Hospital routines or non-urgent procedures should not interfere with baby-led feeding.
- 7.8.4 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.

7.9 Avoiding artificial teats or pacifiers (also called dummies or soothers)

- 7.9.1 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.
- 7.9.2 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. Mothers using a nipple shield

prior to her milk coming in should be assisted to stimulate her milk supply by expressing. The infant's intake must be closely monitored.

- 7.9.3 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.
- 7.9.4 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.

7.10 Discharge

- 7.10.1 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 observed as 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.
- 7.10.2 Hospitals should liaise with the public health nursing service to ensure that all mothers are visited within 48 hours of discharge.
- 7.10.3 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.
- 7.10.4 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.
- 7.10.5 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.
- 7.10.6 Hospitals should provide out-patient breastfeeding support services, particularly for infants discharged from neonatal units or where clinical issues exist that could impact adversely on breastfeeding.
- 7.10.7 The hospital should support co-operation between health care staff and voluntary support groups and should involve representatives of community and voluntary providers of breastfeeding services in staff training and the planning and organisation of services.

7.11 Supportive neonatal unit

- 7.11.1 Care in the neonatal unit should provide an individualised developmentally supportive environment that is appropriate for the infant and the parents and facilitates breastfeeding.
- 7.11.2 The unit should provide family-centred care that facilitates breastfeeding, supports the 24/7 presence of parents and involvement in care of the infant, assists to develop

a parental identity, and orients parents to facilities, breastfeeding supports parent care role when the baby is admitted.

- 7.11.3 Parents should be informed about and encouraged to commence provision of skin-to-skin contact (SSC) as early as possible, ideally from birth, without unjustified delay. Parents should be encouraged and facilitated to provide Kangaroo Mother Care (KMC) for as long periods each day as they want, without unjustified restrictions.
- 7.11.5 The importance of mother's milk for the baby should be promoted and information, support, facilities and equipment provided that assist in the initiation and maintenance of milk production. (Appendix 6)
- 7.11.6 Skilled lactation assistance should be available from time of infant admission to support the mother in breastfeeding/providing her milk, and to develop and implement a care pathway towards baby feeding at the breast, with pre-feeding skills at the breast recognised as an important part of this pathway.
- 7.11.7 Infant stability should be the only criterion for early initiation of breastfeeding (nutritive sucking at the breast) and for transition from tube to feeding at the breast.
- 7.11.8 Donor bank human milk should be available in the unit at all times and offered to parents of all suitable infants. Parents should not need to incur financial cost or to arrange for supplies of donor human milk themselves.
- 7.11.9 For infants of mothers who intend to breastfeed, the first nutritive sucking experience should be at the breast. Bottles should not be introduced to breastfed infants and to infants whose mothers intend to exclusively feed at breast unless the mother explicitly requests it and has been informed of the possible risks.
- 7.11.10 Appropriate feeding strategies for increasing infants' breast milk intake should be applied before introduction of fortifiers or artificial formula. Routine administration of milk after each breastfeeding episode given by another feeding method should be avoided, unless medically indicated.
- 7.11.11 Parents are informed about justifiable reasons for use of pacifiers in the neonatal ward, when the mother is unavailable for comforting the infant and giving pain relief at her breast, and informed about alternative ways of soothing the infant, and how to minimize pacifier use after discharge from the neonatal ward.
- 7.11.12 Administration of medications and performance of procedures should be scheduled to cause the least possible disturbance of breastfeeding and mother/baby contact. Withholding of breastfeeding (fasting or fluid restrictions) related to tests and procedures should be monitored and restricted no longer than is strictly needed
- 7.11.13 Facilities should provide a place to rest, and access to food and fluids for mothers who are not resident in the hospital. Mothers of infants in a neonatal unit should be considered as needing additional supports.
- 7.11.14 Continuity of care should include antenatal information and discussion when admission to the neonatal unit is expected, coordination of care between neonatal and postnatal units, through to planned discharge ensuring parental skills and access to support and follow-up after discharge.
- 7.11.15 When the infant is transferred to another hospital the transfer notes should include information on stocks of mother's milk being transferred with the baby, mother's skills and needs related to providing her milk, and

development of the infant's ability to feed at the breast, as well as parental involvement in care.

- 7.11.16 If the baby is being discharged home directly from the neonatal unit, mother/parents should be provided with facilities to care for their baby for at least a full 24 hours before discharge, with the support of the neonatal staff available during this time.
- 7.11.17 When the infant of a mother who intends to breastfeed is discharged before breastfeeding is established there should be a plan for how to attain her breastfeeding goal (exclusivity and duration).
- 7.11.17 Parents of an infant who will be using artificial feeds after discharge should be provided with education appropriate to their needs including how to safely prepare and give feeds with an opportunity to prepare a feed before discharge.
- 7.11.18 Practices listed in other sections of this policy (support for breastfeeding as the norm, assistance for the mother to provide her milk and learn to feed her baby, skin to skin contact, feeding in response to baby's needs and cues, exclusive breastfeeding, avoidance of artificial teats, education if not breastfeeding, discharge process) will apply in the neonatal unit as standard care unless there is a medical reason, which will be recorded in the baby's chart.

7.12 Protecting breastfeeding

- 7.12.1 The hospital should abide by the International Code of Marketing of Breast-milk Substitutes and the subsequent relevant WHA resolutions and related Irish legislation thereby protecting infants, their families, hospital staff, and assisting safe feeding. (Appendix 2)
- 7.12.2 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.
- 7.12.3 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.
- 7.12.4 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.
- 7.12.5 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.
- 7.12.6 The hospital environment must not facilitate marketing events of manufacturers of breastmilk substitutes, including advertising of sponsored

events and study days. The hospital or institution name must not be associated with marketing events or sponsored study days.

7.12.7 Contact between a manufacturer or distributor of a Code related product and hospital staff should be restricted to providing information that is accurate, scientific and factual and related to the specific product. Care should be taken that this contact is not used as a marketing event.

7.12.8 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.

7.13 Supporting breastfeeding

7.13.1 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.

7.13.2 Breastfeeding mothers who are in-patients of the hospital, other than in the Maternity Department, should also be supported to continue to breastfeed their baby

7.13.3 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.

7.13.4 When the medical condition of the mother or baby cannot accommodate breastfeeding, information and facilities to express and store breast milk should be provided.

7.13.5 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.

7.14 Staff who are breastfeeding

7.14.1 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).

7.14.2 Participation in the Health Promoting Health Service Breastfeeding Supportive Workplace activities should be encouraged.

8. Revision and Audit

8.1 The Infant Feeding Policy for Maternity and Neonatal services was approved by the HSE in 2012 and adopted as the policy of all 19 maternity units. The policy was reviewed and updated in 2015 by Genevieve Becker, BFHI National Co-ordinator, Mary Mahon CMS Lactation Portiuncula Hospital, Siobhan Hourigan, National Breastfeeding Co-ordinator.

8.2 This policy will be reviewed every 2 years, or before if required and revised as needed. The review and revision will be the responsibility of the National Breastfeeding Co-ordinator.

8.3 Implementation Plan

8.3.1 Each Hospital Group CEO will cascade the policy to all individual hospital managers for implementation.

8.3.2 At hospital level, an implementation plan should be developed that takes into account the particular audiences the policy and plan is to address and disseminated in such a way that users become aware of them and are able to easily access and make use of them.

8.3.3 The implementation plan should include:

- Identification of those responsible for rolling out (implementation) the policy and related implementation procedures
- Staff education and training is required in order to implement the policy.
- Service user information is required
- All services should be aware of resource and cost allocation

8.3.4 A record should be kept of all staff who have read and understood this policy.

8.4 Evaluation, Audit and Reporting of Compliance

8.4.1 A senior staff member in each hospital is to be assigned responsibility for evaluation, audit and reporting of compliance of the policy.

8.4.2 Compliance to this policy will be monitored, evaluated and reported annually for example through the following:

- Review of documentation (charts and records)
- Analysis of Maternity Information Systems and related data
- Observation of practice
- Questionnaires, interviews, or focus groups of staff and of service users
- Review of educational materials for staff and for service users
- Review of training provided for staff, competency assessment (performance) and knowledge and skills gaps
- Reports, monitoring, audits and assessments as part of the Baby Friendly Health Initiative

8.4.3 Evaluation and audits will take into account the effect on staff practices, service-users experiences and the impact on resources

8.4.4 Where the care provided/ treatment plan does not comply with this policy the staff member involved will record the deviation from the policy in the medical records. Where appropriate a clinical incident report should be completed.

8.4.5 All incidents of deviation should link with the hospital's risk management system and an action plan developed to address issues as required.

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

Bibliography

World Health Organisation, Nutrition for Health and Development (NHD)

<http://www.who.int/nutrition/publications/infantfeeding/en/index.html>

Infant and young child feeding: Model Chapter for textbooks for medical students and allied health professionals (2009)

Global strategy for infant and young child feeding (2003)

Baby-Friendly Hospital Initiative (2009) Revised, updated and expanded for integrated care

Acceptable medical reasons for use of breast-milk substitutes (2009)

Protecting, promoting and supporting breast-feeding (1989) The special role of maternity services

The International Code of Marketing of Breast-Milk Substitutes (2008). Frequently asked questions (updated version 2008)

Guidelines on HIV and infant feeding 2010. Principles and recommendations for infant feeding in the context of HIV and a summary of evidence

HIV and infant feeding 2010, an updated framework for priority action (2012), WHO guidelines
Training courses

Baby-friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care BFHI

Section 3: Breastfeeding Promotion and Support in a Baby-friendly Hospital, a 20-hour course for maternity staff (2009)

Infant young child feeding counselling: An integrated course (2006)

World Health Organisation, Department of Child and Adolescent Health (CAH)

www.who.int/child_adolescent_health/documents/infant_feeding/en/index.html

Long-term effects of breastfeeding: a systematic review (2013)

Evidence for the Ten Steps to Successful Breastfeeding WHO/CHD/98.9

Breastfeeding counselling: A training course (revised 2010)

Guidelines on optimal feeding of low-birth-weight infants (2011): Technical review

Academy for Breastfeeding Medicine, worldwide organization of physicians dedicated to the promotion, protection and support of breastfeeding and human lactation.

Clinical Protocols available <http://www.bfmed.org>

Guidance on the development of policies and guidelines for the prevention and management of Hypoglycaemia of the Newborn (2013) UNICEF/UK Baby Friendly Hospital Initiative

<http://www.unicef.org.uk/BabyFriendly/Resources/Guidance-for-Health-Professionals/Writing-policies-and-guidelines/Hypoglycaemia-policy-guidelines/>

NICE Clinical Guideline 190 (2014) Intrapartum Care: care of healthy women and their babies during childbirth. www.nice.org

American Academy of Pediatrics (2012) Policy Statement: Breastfeeding and the Use of Human Milk. *Pediatrics*, 129 (3). 827-841. <http://pediatrics.aappublications.org/content/129/3/e827.full>

Breastfeeding the Healthy Term Baby (2013) Policy, Guideline and Procedure Manual. The Royal Women's Hospital, Melbourne, Australia. <https://www.thewomens.org.au/health-professionals/clinical-resources/clinical-guidelines-gps/>

Neo-BFHI Core document, Three Guiding Principles and Ten Steps to protect, promote and support breastfeeding in neonatal wards (revised, version) April 2015

<http://www.ilca.org/i4a/pages/index.cfm?pageid=4214>

Department of Health, Dublin

Healthy Ireland : A Framework for Improved Health and Well-being 2013 – 2025.

<http://health.gov.ie/blog/publications/healthy-ireland-a-framework-for-improved-health-and-wellbeing-2013-2025/>

Breastfeeding in Ireland: A Five Year Strategic Action Plan (2005)

<http://health.gov.ie/blog/publications/breastfeeding-in-ireland-a-five-year-strategic-action-plan-national-committee-on-breastfeeding-2005/>

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:

- Have a written breastfeeding policy that is routinely communicated to all health care staff.
- Train all health care staff in skills necessary to implement this policy.
- Inform all pregnant women about the benefits and management of breastfeeding.
- Help mothers to initiate breastfeeding within a half-hour of birth.
- Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
- Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
- Practise rooming-in - allow mothers and infants to remain together 24 hours a day.
- Encourage breastfeeding on demand.
- Give no artificial teats or pacifiers to breastfeeding infants.
- 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 Health Initiative in Ireland: <http://www.babyfriendly.ie>

Details of the criteria for each Step and the expected standard can be read at

<http://www.babyfriendly.ie/images/BFHI%20Ireland%20Global%20Criteria%20Oct%202014.pdf>

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?

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:

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

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. Thereafter staff should attend regular training and skills updates to ensure they have the knowledge and skills required.
- 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,
- the risks of giving formula or other breast milk substitutes
- Availability of postnatal assistance to establish feeding, and where mothers can find help on feeding their infants after return home.

A pregnant woman who request information on formula feeding should be given information and the opportunity to have an individual discussion, including:

- Types of formula suitable for newborn infants
- The importance of safe preparation and use of formula
- Equipment required
- The cost of using formula
- The safety of local water supply / bottled water
- Social aspects of feeding decisions and health risks
- Availability of postnatal assistance to safely preparing formula, 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, and BFHI Link, newsletter of the Baby Friendly Initiative in Ireland www.babyfriendly.ie Discussing infant formula use: *Issue 43*

The Infant Feeding Antenatal Checklist in the National Maternity Chart covers the areas for discussion in the antenatal period NMHCR-QPSD–D-008-1
http://hsenet.hse.ie/Intranet/qualitypatientsafety/?importUrl=http://localhost:82/eng/about/Who/qualityandpatientsafety/safepatientcare/healthrecordsmgmt/Healthcare_Records_Management.html

Discussions and information provided should be recorded on the Infant Feeding Antenatal Checklist. Discussions should be modified to meet the individual woman's needs. Open questions should be included and opportunities for the woman to ask questions. Information can be provided by the the antenatal team /midwife / obstetrician/ GP / Practice nurse and documented in the checklist.

Appendix 5: Positioning during Skin-to-Skin contact in the time immediately after birth

The position of the infant is a key factor in minimizing the risk of Sudden Unexpected Postnatal Collapse (SUPC) while in skin to skin contact.

Positioning in skin to skin contact Mother, or other person providing skin-to-skin contact, is in a slightly upright position, not lying flat Infant is dried, including hair, and positioned when at rest and not actively moving with legs flexed, shoulders flat against mother's chest, chest to chest with mother, not under or between breasts, head turned to one side with neck straight, not bent far forward or far back, face uncovered with nose and mouth visible and covered with dry blankets, with infant wearing a hat/cap if the room is cold or baby is low birth weight.

Baby may be lying lengthways on mother's chest or across her chest above the level of her breasts.

The midwife or recovery room nurse must educate mother and support person on the above points and assess the risk factors to determine the level of supervision required. Continuous surveillance by the health professional responsible is recommended during the first hour post-birth, and appropriate supervision and parent education is provided during separate periods of skin to skin contact.

The Neonatal Resuscitation Program (NRP) (in Ludington –Hoe and Morgan,2014) recommends that a health professional observes the following while infants are in skin to skin contact immediately after birth infant breathing (easy, grunting/flaring, retractions, tachypneic) activity (sleep, quiet alert, active alert/crying/breastfeeding/moving, non-responsive) colour (pink, pale, dusky) tone (head turned to one side, neck straight, nose and mouth visible, well

Bibliography

Ministry of Health New Zealand, Observation of mother and baby in the immediate postnatal period: Consensus statements guiding practice – July 2012.

<http://www.health.govt.nz/publication/observation-mother-and-baby-immediate-postnatal-period-consensus-statements-guiding-practice>

Neonatal Resuscitation Program (NRP) in Ludington-Hoe, S.M. and Morgan,K. (2014) Infant Assessment and Reducing Sudden Unexpected Postnatal Collapse During Skin to Skin Contact. *Newborn and Infant Nursing News*.14 (1):28-33. <http://www.medscape.com/viewarticle/822017>

Appendix 6: Breastfeeding Equipment in neonatal units

All neonatal units should have:

- Simple model for demonstrating hand expression (knitted or cloth breast, balloon or inflated plastic glove)
- Hospital grade electric breast pump(s) (closed system) that can be used as single or double pumping with sufficient number of pumps for the number of infants

- Single use pumping sets or a procedure for adequate sterilisation of individual use sets
- Supplies of sterile milk containers
- Freezer for expressed milk with means of separating each mother's milk containers (shelf dividers, plastic box or bag etc)
- Refrigerator or other designated place for defrosting of frozen milk
- Comfortable chairs for mothers with cushions and foot stools available if needed
- Private place to express milk if mother would like privacy
- Hand washing facilities in or near where mothers are expressing milk

Appendix 7: 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^(b) 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:

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

Mothers who 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)

Technical updates of the guidelines on Integrated Management of Childhood Illness (IMCI). Evidence and recommendations for further adaptations. Geneva, World Health Organization, 2005.

Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses. Geneva, World Health Organization, 2007.

León-Cava N et al. Quantifying the benefits of breastfeeding: a summary of the evidence. Washington, DC, Pan American Health Organization, 2002 (<http://www.paho.org/English/AD/FCH/BOB-Main.htm>, accessed 26 June 2008).

Resolution WHA39.28. Infant and Young Child Feeding. In: Thirty-ninth World Health Assembly, Geneva, 5–16 May 1986. Volume 1. Resolutions and records. Final. Geneva, World Health Organization, 1986 (WHA39/1986/REC/1), Annex 6:122–135.

Hypoglycaemia of the newborn: review of the literature. Geneva, World Health Organization, 1997 (WHO/CHD/97.1; http://whqlibdoc.who.int/hq/1997/WHO_CHD_97.1.pdf, accessed 24 June 2008).

HIV and infant feeding: update based on the technical consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Infants, Geneva, 25–27 October 2006. Geneva, World Health Organization, 2007 (http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf, accessed 23 June 2008).

Breastfeeding and maternal medication: recommendations for drugs in the Eleventh WHO Model List of Essential Drugs. Geneva, World Health Organization, 2003.

Mastitis: causes and management. Geneva, World Health Organization, 2000 (WHO/FCH/CAH/00.13; http://whqlibdoc.who.int/hq/2000/WHO_FCH_CAH_00.13.pdf, accessed 24 June 2008).

Hepatitis B and breastfeeding. Geneva, World Health Organization, 1996. (Update No. 22).

Breastfeeding and Maternal tuberculosis Update No. 23. Geneva, World Health Organization, 1998.

Background papers to the national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn. Commissioned by the Ministerial Council on Drug Strategy under the Cost Shared Funding Model. NSW Department of Health, North Sydney, Australia, 2006.

http://www.health.nsw.gov.au/pubs/2006/bkg_pregnancy.html

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>

Full version of this document is available from Child and Adolescent Health, WHO, Geneva http://www.who.int/child_adolescent_health/documents/WHO_FCH_CAH_09.01/en/index.html

Revision History

The 2012 policy was revised and updated in 2015 by the BFHI National Co-ordinator, National Breastfeeding Co-ordinator and CMS Lactation, Portiuncula Hospital, in consultation with Maternity and Neonatal services.

The main changes were in relation to roles and responsibilities reflecting the Hospital Group structure. Implementation and Evaluation, Audit and Reporting of Compliance have been included in more detail in Section 8.

A new section for neonatal units has been added to the policy – Section 7.11, and issues related to the neonatal unit have been considered throughout the policy document.

END OF POLICY AND APPENDICES