Remarks on the Revised Baby-Friendly Hospital Initiative Framework
Roda –Parents in Action, Croatia
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Background

About Roda

Roda - Parents in Action is a Croatian civil society organisation that has been involved in the Baby-Friendly Hospital Initiative since 2001. Roda is a member of the International Baby Food Action Network (IBFAN) and as such is a member of the BFHI evaluation team in Croatia. Roda organises an annual breastfeeding conference for healthcare providers, has a peer-to-peer support network of breastfeeding consultants and is active in motoring and breastfeeding protection activities. Roda works closely with UNICEF Croatia and the Ministry of Health, and has members on the National Breastfeeding Committee.

Roda coordinated breastfeeding support with UNICEF Croatia during the Syrian Refugee and Migrant Crisis in Croatia during 2015-6, and continues to provide support to asylum seekers.

The BFHI in Croatia

After obtaining BFHI status in the 1980s and subsequently loosing it in the early 2000s, currently all public maternity hospitals (30 in total) are accredited BFHI sites. The process has been challenging at times but has been an important one, as the situation with regard to infant feeding in Croatian maternities has improved greatly. It is still very far from perfect, however, and it is important to have a strong framework for the BFHI in order to maintain and improve the quality of breastfeeding promotion, protection and education, especially among healthcare providers.

Authors and Collaborators on Remarks

These remarks were prepared by members of Roda's team who have been involved in the BFHI for the past 15 years: Ivana Zanze, Roda's Executive Director, BFHI Evaluator and member of the Croatian National Breastfeeding Committee; Ana Novina, the head of Roda's monitoring program and member of the International Lactation Consultant Association's International Code Committee; Daniela Drandic, Roda's representative on the Croatian Ministry of Health's Working Group for the Mother Friendly Hospital Initiative and member of the Board of Directors of the international NGO Human Rights in Childbirth. In preparing the remarks, we also consulted with Dr. Josip Grguric, MD, Ph.D., Coordinator for the BFHI in Croatia (UNICEF).

Finally, remarks were collected at the time when Roda was organising the First Central European Babywearing Conference in Zagreb, which brought together international experts on

attachment parenting, and we are grateful to Dr. Henrik Norholt, Ph.D. for providing his expertise.

Remarks

Section One – Introduction

1.1 We suggest that the final paragraph of the section be expanded to include natural disasters. Furthermore, the section should include a recommendation that government plans for emergency situations and disasters include breastfeeding support.

Rationale:
After recent experiences in providing breastfeeding support during two humanitarian disasters in a short period of time with no national framework on infant and young child feeding during disasters, Roda and Unicef worked together to prepare a publication that can be used during all future disasters called Breastfeeding during Humanitarian Disasters – Lessons (not) Learned.[1]

1.5 It is unfortunate that this new document does not include Mother-friendly hospitals, Baby-friendly communities, Baby-friendly paediatric units or Baby-friendly physicians' offices.

Rationale:
Although these are outside of the scope to some extent, it is also extremely valuable and important to link these initiatives to the BFHI, as something for hospitals to "strive for" once they have achieved the BFHI designation. By unlinking the initiatives, many will unfortunately die out, despite the fact that they are extremely necessary.

It has been our experience in Croatia that communities are instrumental in creating a "breastfeeding culture"[2,3] which is very different from the culture we currently have, whereby bottle feeding is the norm and breastfeeding, although touted as "best" and "natural" is not the norm. This has been (and continues to be) discussed widely in Croatian professional journals and in other professional and policymaking circles.

Thanks to the current BFHI, especially Step 10, the City of Zagreb, has, for example worked to create interesting public health campaigns and information promoting breastfeeding,[4,5] which

[1] Jelušić, Renata. Infant and Young Child Feeding During Humanitarian Disasters. Prepared by Roda – Parents in Action and Unicef Office in Croatia, February 2017. Available in English at http://www.roda.hr/en/reports/infant-and-young-child-feeding-during-humanitarian-disasters-%E2%80%93-lessons-not-learned.html
[2] Grgurić, Josip. Dojenje-javnozdravstveni diskurs. (Breastfeeding – Public Health Discourse). Liječničke novine (Medical Papers), no. 141:38-39.6, 2015.
[3] Cattaneo, Adriano. Promoting breast feeding in the community. BMJ 2009; 338 doi: https://doi.org/10.1136/bmj.a2657.
[4] Dojenje je Zakon! (a play on words – Breastfeeding is the law, which can also be used to mean Breastfeeding is cool), Facebook page with some of the materials created over the past two years: https://www.facebook.com/DojenjeJeZakon/. Activities are year-round but are especially concentrated around World Breastfeeding Week.
[5] More information about activities and support the City of Zagreb has organised are available on their website: http://www.zagreb.hr/dojenje/80651

would not have happened without the impetuous to include communities and local governments in promoting breastfeeding.

Thanks to pressure from requirement of the BFH initiative, smaller communities must regularly report on their activities on breastfeeding promotion and support, and they are slowly increasing their work in this field.

Support networks are integral to improving breastfeeding rates, especially in Europe where they are the lowest in the world.[6] Removing Mother-friendly hospitals, Baby-friendly communities, Baby-friendly paediatric units and Baby-friendly physicians' offices is therefore not based on best evidence, and will surely have a detrimental effect in Croatia and other countries.

1.5.1 The removal of step 9 will be very detrimental for breastfeeding at the population level, and the Cochrane Review on the topic specifically states that only mothers motivated for breastfeeding did not have any differences in breastfeeding duration with pacifier use.

Rationale:
Assuming that all mothers are equally motivated or have the same access to information and support is detrimental. The Cochrane Review on Restricted Pacifier Use and Duration of Breastfeeding only took into account mothers motivated to breastfeed, and although most mothers are motivated to breastfeed not all of them have access to the same support and information; assuming that they do and introducing pacifiers and artificial nipples early on will be very detrimental.[7]

In Roda's experience in Croatian maternities, it has been very difficult to change the pacifier and bottle culture, and many healthcare providers still encourage their use to all parents. Removing this step will only increase this, to the detriment of breastfeeding.

[6] Baño-Piñero, I. et. al., Impact of support networks for breastfeeding: A multicentre study. Women and Birth. Available online 10 October 2017. DOI: 10.1016/j.wombi.2017.10.002
[7] Jaafar S, Ho JJ, Jahanfar S, Angolkar M. Effect of restricted pacifier use in breastfeeding term infants for increasing duration of breastfeeding. Cochrane Database of Systematic Reviews 2016, Issue 8. Art. No.: CD007202. DOI: 10.1002/14651858.CD007202.pub4

Remarks on the Proposed New 10 Steps

We suggest the following changes to the wording of the "Ten steps to successful breastfeeding"

Step 1:

Where facilities provide antenatal care, pregnant women and their families should be counselled about the benefits and management of *extended skin-to-skin contact and* breastfeeding.

Rationale:

Whereas the BFHI has made great strides in increasing hospital staff understanding of the benefits of immediate postnatal skin-to-skin contact, the impact of skin-to-skin contact on breastfeeding outcomes beyond the immediate postpartum period is less well understood. The effects of kangaroo mother care (KMC) on breastfeeding outcomes in preterm and low-weight babies are very well established[8]and recently, two KMC studies have demonstrated improved breastfeeding outcomes on healthy full-term infants[9,10]. One study on extended parent-infant contact via a baby carrying device also demonstrated significantly improved breastfeeding outcomes[11]. Increasing parental awareness of the benefits of extended skin-to-skin contact beyond the immediate postpartum period as well as their competencies in safe skin to skin contact practices through prenatal counselling is hence very likely to improve breastfeeding outcomes and should be a key element.

Step Two:

Early and uninterrupted skin-to-skin contact between mothers and infants should be facilitated and encouraged as soon as possible after birth, and all mothers should be supported to initiate breastfeeding as soon as possible after birth, within the first hour ~~after delivery~~ *regardless of the mode of birth (caesarean section or vaginal birth)*.

Rationale:

Increasing caesarean rates worldwide (in many countries over 50%) and the documented problems with breastfeeding that mothers who have given birth surgically mean that it is very important to consider this mode of birth and the specificities it brings with it. Skin to skin after

[8] Boundy EO, Dastjerdi R, Spiegelman D, et al. Kangaroo Mother Care and Neonatal Outcomes: A Meta-analysis. *Pediatrics*. 2016;137(1). doi:10.1542/peds.2015-2238.

[9] Svensson KE, Velandia MI, Matthiesen A-ST, Welles-Nyström BL, Widström A-ME. Effects of mother-infant skin-to-skin contact on severe latch-on problems in older infants: a randomized trial. *Int Breastfeed J*. 2013;8(1):1. doi:10.1186/1746-4358-8-1.

[10] Bigelow AE, Power M, Gillis DE, Maclellan-Peters J, Alex M, McDonald C. Breastfeeding, skin-to-skin contact, and mother-infant interactions over infants' first three months. *Infant Ment Health J*. 2014;35(1):51-62. doi:10.1002/imhj.21424.

[11] Pisacane A, Continisio P, Filosa C, Tagliamonte V, Continisio GI. Use of baby carriers to increase breastfeeding duration among term infants: the effects of an educational intervention in Italy. *Acta Paediatr Oslo Nor 1992*. 2012;101(10):e434-438. doi:10.1111/j.1651-2227.2012.02758.x.

caesarean has been proven to increase breastfeeding rates.[12] Despite this, skin to skin with fathers is possible only in the operating theatre at one Croatian maternity hospital, while skin to skin with mothers is not possible until at least almost an hour after birth. The situation in countries with lower resources is even worse.

Step 3:

Mothers should receive practical support to enable them to initiate and maintain *skin-to-skin contact and* breastfeeding and manage common breastfeeding difficulties

Rationale:
Parents are likely to need assistance and guidance in conducting safe skin-to-skin contact practices[13,14].

Step 5:

Facilities providing maternity and newborn services should enable mothers and their infants to remain together and to practice rooming-in throughout the day and night, *incorporating safe skin-to-skin contact practices, which should also include fathers, when possible.*

Rationale:
Fathers' support for breastfeeding has been shown to influence breastfeeding outcomes[15,16,17]. Fathers' emotional investment in the newborn, their caregiving behaviour as well as their stress physiology and anxiety are positively influenced by skin-to-skin contact in the postnatal period[18,19,20]. Facilitating not only mothers', but also fathers' skin-to-skin contact is hence highly likely to improve breastfeeding outcomes.

Step Nine:

Health-facility staff who provide infant feeding services, including breastfeeding, should have sufficient knowledge, competence and skills to support women to breastfeed, *including practical knowledge*.

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[12] Gregson, S. et. al. Skin-to-skin contact after elective caesarean section: Investigating the effect on breastfeeding rates. British Journal of Midwifery 2016 24:1, 18-25.
[13] Blomqvist YT, Nyqvist KH. Swedish mothers' experience of continuous Kangaroo Mother Care. *J Clin Nurs*. 2011;20(9-10):1472-1480. doi:10.1111/j.1365-2702.2010.03369.x.
[14] Mitchell-Box KM, Braun KL. Impact of male-partner-focused interventions on breastfeeding initiation, exclusivity, and continuation. *J Hum Lact Off J Int Lact Consult Assoc*. 2013;29(4):473-479. doi:10.1177/0890334413491833.
[15] Hunter T, Cattelona G. Breastfeeding initiation and duration in first-time mothers: exploring the impact of father involvement in the early post-partum period. *Health Promot Perspect*. 2014;4(2):132-136. doi:10.5681/hpp.2014.017.
[16] Tsai S-Y. Influence of partner support on an employed mother's intention to breastfeed after returning to work. *Breastfeed Med Off J Acad Breastfeed Med*. 2014;9(4):222-230. doi:10.1089/bfm.2013.0127.
[17]Shorey S, He H-G, Morelius E. Skin-to-skin contact by fathers and the impact on infant and paternal outcomes: an integrative review. *Midwifery*. 2016;40:207-217. doi:10.1016/j.midw.2016.07.007.
[18] Chen E-M, Gau M-L, Liu C-Y, Lee T-Y. Effects of Father-Neonate Skin-to-Skin Contact on Attachment: A Randomized Controlled Trial. *Nurs Res Pract*. 2017;2017:e8612024. doi:10.1155/2017/8612024.
[19] Cong X, Ludington-Hoe SM, Hussain N, et al. Parental oxytocin responses during skin-to-skin contact in pre-term infants. *Early Hum Dev*. 2015;91(7):401-406. doi:10.1016/j.earlhumdev.2015.04.012.
[20] Hubbard JM, Gattman KR. Parent-Infant Skin-to-Skin Contact Following Birth: History, Benefits, and Challenges. *Neonatal Netw NN*. 2017;36(2):89-97. doi:10.1891/0730-0832.36.2.89.

Rationale: Medical knowledge is not enough when it comes to breastfeeding support, healthcare professionals must know how to help a woman integrate breastfeeding into her lifestyle, and how to help her handle practical issues that are not necessarily of a clinical nature.

Summary of updated directions for BFHI implementation

Step One: Appropriate care to protect, promote, and support breastfeeding is the responsibility of *every* facility providing maternity ~~and~~ newborn *and paedeatric* services.

Step Two: Countries need to establish national standards for the protection, promotion and support for breastfeeding in all facilities providing maternity ~~and~~ newborn *and paedeatric* services, based on the Ten Steps to Successful Breastfeeding.

Rationale:
Many parents whose children require hospitalisation in their first two years of life experience hospital procedures that do not facilitate the continuation of breastfeeding; parents are oftentimes not allowed to room-in overnight in hospitals with their infants, are not encouraged to continue breastfeed based on incorrect information that breastmilk is in collision with the child's treatment.

A hospital designated as Baby Friendly does not always (only) include a maternity unit but has a paediatric unit; these should also follow the 10 steps.

Section Two - The role of facilities providing maternity and newborn services

Providing print materials in languages ~~all~~ clients understand *and adapted for persons with disabilities (e.g. audio versions)*.

Rationale: This means that information must be made available for clients who do not speak the language of the majority, and that materials are adapted for persons with disabilities.

2.1.3. Support with Breastfeeding
Paragraph two:
Mothers delivering by caesarean section, ~~and~~ obese mothers *and mothers with motor or sensory disabilities*, may require additional help with positioning and latch.
Paragraph three: Mothers of ~~twins~~ *multiples* also need extra support, especially for positioning and attachment *and practical support on breastfeeding more than one child*.

2.1.4 No Supplements
Paragraph two: use of breastmilk substitutes
Mothers birthing by caesarean section who are not able to breastfeed directly in the hours after birth should be encouraged to express colostrum or should be allowed to choose the first food

their infant gets. This is extremely important, given that infants born by caesarean section are at increased risk for diseases linked to a lack of microflora diversity due to method of birth.[21] Ensuring that they get colostrum as soon as possible after birth can therefore have far-reaching effects on the development of their gut microflora and on their long-term health.

2.1.5 Rooming In

Paragraph two: Babies should only be separated from their mothers for justifiable reasons *and for as short a time as possible*.

Paragraph three: add: *In the case that any mother needs additional support to care for her infant while in hospital, she should have the possibility of having a family member or close friend stay with her to assist her for most of the day.*

2.2 Management Procedures to Support Breastfeeding

To ensure that the clinical practices are routinely carried out, facilities providing maternity and newborn services also need to adopt and maintain four critical management procedures, which should be part of national policies in support of breastfeeding. *This includes procedures for humanitarian disasters and national emergencies.*[22]

2.2.1 Facility Breastfeeding Policy

Add to the final sentence: The policy should be written and communicated to parents in an easy to understand manner, in a language they can understand, including parents with disabilities.

2.2.2 International Code of Marketing of Breastmilk Substitutes

Compliance with the *International Code of Marketing of Breast-milk Substitutes (13)* and subsequent relevant WHA resolutions *(14)* (the Code) is important for facilities providing maternity ~~and~~ newborn *and paediatric* services (*in the case of a BFHI hospital with a paediatric unit*), since the promotion of breast-milk substitutes is one of the largest undermining factors for breastfeeding *(52)*.

Paragraph three: In line with the WHO *Guidance on ending the inappropriate promotion of foods for infants and young children*, published in 2016 and endorsed by the World Health Assembly *(35)*, health workers and health systems should avoid conflicts of interest with companies that market foods for infants and young children. Health-professional meetings *trainings and congresses* should never be sponsored by industry and industry should not participate in parenting education.

Add an additional paragraph: *Staff need comprehensive and regular trainings on Code implementation in everyday practice, including examples.*

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[21] Chu, Derrick M. et. al. Maturation of the infant microbiome community structure and function across multiple body sites and in relation to mode of delivery. Nature Medicine 23, 314–326 (2017). doi:10.1038/nm.4272

[22] Jelušić, Renata. Infant and Young Child Feeding During Humanitarian Disasters. Prepared by Roda – Parents in Action and Unicef Office in Croatia, February 2017. Available in English at http://www.roda.hr/en/reports/infant-and-young-child-feeding-during-humanitarian-disasters-%E2%80%93-lessons-not-learned.html

Remarks on Section Three - Country level implementation and sustainability

3.2 Policies and professional standards of care
Paragraph two: add plans for humanitarian or natural disasters among the documents that need to include breastfeeding protection and promotion.

Paragraph three: add midwifery to the list of professional standards.

Rationale:
Breastfeeding during humanitarian and natural disasters is of extreme importance because it has an immense effect on survival rates and wellbeing of mothers and infants who are living in often unsanitary and unsafe conditions, where clean water is not always available. Given the increasing rate of natural disasters it is important to have countries have plans in place before disaster strikes.

Midwives are an integral and important profession who provide maternity care worldwide. The omission of midwifery from this list was likely a typographical error.

3.3 Capacity-strengthening
Add training on the importance of breastfeeding in humanitarian and natural disasters as part of pre-service and in-service curricula.

Rationale: see rational for 3.2, and the importance of being prepared to support breastfeeding.

3.4 External assessment
Add: External assessment should include independent stakeholders from the community in addition to clinical stakeholders.

Rationale: In Roda's experience in participating in the BFHI, community stakeholders who are in direct contact with mothers and families are a valuable addition to the external assessment team as they can disclose problems and concerns from the community. Furthermore, external stakeholders who are independent and active in monitoring activities offer an added quality to the program.

Final paragraph: breastfeeding should be the norm in all maternity ~~and~~ newborn *and infant* care.

Rationale: Exclusive breastfeeding is important for newborns in maternity units, but also for infants who must be in the maternity unit for a longer period of time due to prematurity or illness. This also means that breastfeeding support must be the norm in neonatal and paediatric units, with services including those that allow mothers to room-in with children and be with them the majority of the day, as well as provide them with expressed milk as appropriate.