Implementing the Baby-Friendly Initiative (BFHI): *Challenges and future directions*

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Canadian Perinatal Program Coalition
Montreal, Quebec, June 23, 2014

Impact of the WHO/UNICEF Baby-Friendly Initiative (BFI)

The BFI is associated with increased rates of breastfeeding initiation, exclusivity, and duration (and consequently, improved maternal and infant health outcomes) at both the local and population levels in diverse cultural contexts.

Journal of Human Lactation, August 2012, 28 (3)
Special issue : The Baby-Friendly Initiative

Canadian Pediatric Society Position (2012):

POSITION STATEMENT

The Baby-Friendly Initiative: Protecting, promoting and supporting breastfeeding

Canadian Paediatric Society

Nutrition and Gastroenterology Committee and Hospital Paediatrics Section
Canadian Paediatric Society

Paediatr Child Health 2012;17(6):317-321

Abstract

Breastfeeding confers extens
benefits and is recognized as a
ventative health measure for
Except in very few specific me
ing should be universally enco
infants. To improve worldwide
duration rates, the WHO and
by-Friendly Initiative (BFI) in
tect, promote and support bre
the WHO's "Ten Steps to Successful Breastfeeding". Since then, more than 20,000 hospitals in 156 countries have achieved Baby-Friendly status, with a resultant increase in both breastfeeding initiation and duration. Still, only 500 hospitals are currently designated Baby-Friendly in industrialized countries, including 37 health centres or health authorities in Canada. Health care practitioners have a

additional month of exclusive breastfeeding may reduce hospital admissions secondary to infection by as much as 30% in the first year of life. A meta-analysis of 33 studies examining healthy infants in developed nations showed similar results, with formula-fed infants experiencing three times more severe respiratory illnesses compared with infants who had been exclusively breastfed for four months (10). Breastfeeding has also been linked to a decrease in Sudden Infant Death Syn-

CPS Recommendation 2012 (Evidence 1A):
"All health care facilities and providers caring for mothers, infants and children should aim to adhere to BFI practices, which are known to increase the initiation, duration and exclusivity of breastfeeding."

BFI in Canada:

Integrated Ten Steps for Hospitals and Community Health Services

Breastfeeding Committee for Canada, http://breastfeedingcanada.ca

1. Have a written breastfeeding policy that is routinely communicated to all HCPs
2. Ensure all HCPs have the knowledge and skills necessary to implement the policy
3. Inform all pregnant women about the importance and process of breastfeeding
4. Place babies skin-to-skin with their mothers immediately post-birth for at least 1 hr
5. Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants
6. Support mothers to exclusively breastfeeding for the first six months, unless supplements are *medically* indicated
7. Facilitate 24-hour rooming-in for all mother-infant dyads
8. Encourage baby-led feeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods
9. Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers
10. Provide a seamless transition between the services provided by the hospital, community and peer support programs

And: Adherence with the International Code of Marketing of Breastmilk Substitutes

Number of Baby-Friendly Facilities in Canada

All provinces except Quebec (as of Dec. 2013)**:**

- *Ontario*
  - 3 hospitals; 12 district health units or community health centres
- *British Columbia*
  - 2 hospitals
- *Saskatchewan*
  - 1 public health centre

In Quebec (as of March 2014):

- 8 hospitals, 6 birthing centres, 47 community health centres

Key components of Quebec's breastfeeding strategy

- Release of Quebec's breastfeeding policy (2001)
  - *By 2007, at least 20 hospital and 40 community health centers will be BFHI-certified*
- Dedicated ministry funding ($900,000/yr)
- Integration of the BFHI into public health policy
  (*Programme national de santé publique 2003-2012, Politique de Périnatalité 2008-2018)*
- Creation of ministry- and regional-level breastfeeding committees
- Ministry assumes responsibility for the BFHI accreditation process
  (development of BFHI assessment tools; training of external assessors)
- Provincial surveys of breastfeeding rates (2006) and level of BFHI implementation (2011)

However…

- # BFI-designated organizations in Quebec remain below policy objectives, and are geographically clustered within a few regions
- BF initiation rates vary from 61% - 90% across regions, and rates of BF duration and exclusivity remain low

  (2006: only 3% exclusively breastfeed for 6 months)
- BF rates remain lower among more vulnerable groups (women living in poverty, LBW infants)
- Many barriers/challenges to BFI implementation at the organizational levels

Barriers and facilitators to implementing the BFI in Quebec

(funded by the FQRSC)

1) Integrative literature review of barriers/facilitators to BFI implementation

2) Multiple case study of BFI implementation in Quebec:

- What are the social processes (e.g., cultural, organizational, political, contextual) that facilitate or impede implementation of the BFI?

- What are mothers' perceptions (positive and negative) and experiences related to breastfeeding promotion and support?

Methods – Multiple case study

- **Design:**
  - Qualitative, multiple case study with embedded units of analysis (Yin, 1994)

- **Sources of data:**
  - 6 cases (CSSSs or university hospitals) that varied in size, geographical location and level of BFI implementation (high vs. low)
  - In-depth interviews with health care managers and BFI leaders (N=42)
  - Focus group discussions with hospital and community-based health care providers (N=95 participants)
  - Focus group discussions with breastfeeding mothers (N=52 participants)

- **Analysis:**
  - Thematic content analysis; findings interpreted using Roger's Diffusion of innovation theory, critical theory, institutional theory

International literature review:

Review

International Lactation Consultant Association

Journal of Human Lactation
28(3) 317–334

DOI: 10.1177/0890334412445195
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Barriers, Facilitators, and Recommendations Related to Implementing the Baby-Friendly Initiative (BFI): An Integrative Review

Sonia Semenic, RN, PhD[1], Janet E. Childerhose, PhD[2], Julie Lauzière, RD, MSc[3], and Danielle Groleau, PhD[4]

Abstract

Despite growing evidence for the positive impact of the Baby-Friendly Initiative (BFI) on breastfeeding outcomes, few studies have investigated the barriers and facilitators to the implementation of Baby-Friendly practices that can be used to improve uptake of the BFI at the local or country levels. This integrative review aimed to identify and synthesize information on the barriers, facilitators, and recommendations related to the BFI from the international, peer-reviewed literature. Thirteen databases were searched using the keywords *Baby Friendly, Baby-Friendly Hospital Initiative, BFI, BFHI, Ten Steps, implementation, adoption, barriers, facilitators,* and their combinations. A total of 45 English-language articles from 16 different countries met the inclusion criteria for the review. Data analysis was guided by Cooper's five stages of integrative research review. Using a multiple intervention program framework, findings were categorized into sociopolitical, organizational-level, and individual-level barriers and facilitators to implementing the BFI, as well as intra-, inter-, and extraorganizational recommendations for strengthening BFI implementation. A wide variety of obstacles and potential solutions to BFI implementation were identified. Findings suggest some priority issues to address when pursuing Baby-Friendly designation, including the endorsements of both local administrators and governmental policy makers, effective leadership of the practice change process, health care worker training, the marketing influence of formula companies, and integrating hospital and community health services. Framing the BFI as a complex, multilevel, evidence-based change process and using context-focused research implementation models to guide BFI implementation efforts may help identify effective strategies for promoting wider adoption of the BFI in health services.

Journal of Human Lactation (2013), 28 (3), 317-334

Barriers and facilitators to implementing the BFI in Quebec:

Fonds de recherche sur la société et la culture
Québec

Rapport de recherche

PROGRAMME ACTIONS CONCERTÉES

L'évaluation de la mise en œuvre des lignes directrices en allaitement maternel au Québec

Rapport de recherche

Chercheuses principales
Sonia Semenic, Université McGill et CUSM
Danielle Groleau, Université McGill et Hôpital Général Juif – IRMLD

Cochercheuses
Charo Rodríguez, Université McGill
Katherine Gray-Donald, Université McGill
Linda Bell, Université de Sherbrooke

Collaboratrices
Laura Haiek, Université McGill et MSSS
Lindiwe Sibeko, Université McGill

http://www.frqsc.gouv.qc.ca/upload/capsules_recherche/fichiers/capsule_76.pdf

Challenges to BFI implementation

1) Inadequate resources – need sufficient staffing, time and money for :

- **Staff training** (min. 18 hours per staff)
- **Time at bedside to support breastfeeding mothe**
- **Facility renovations** (e.g., to support 24-hr rooming-in)
- **Project management**
- **Monitoring and feedback activities**

Challenges to BFI implementation

2) Attitudes /opinions re. breastfeeding or the BFI

- **Cultural attitudes/norms** (e.g., unsupportive milieu, unrealistic breastfeeding expectations, “societé de facilité”)

- **Fear of instilling maternal guilt** (breastfeeding “backlash”)

- **Staff resistance to change**
  (specialist MDs, senior RNs; resistance to “dogma”, under-resourcing)

Challenges to BFI implementation

3) Lack of continuity of care:

- **In-hospital (pre - intra - postnatal)**
- **Hospital - community health – breastfeeding support groups** (uneven access to breastfeeding support)
- **Interprofessional (RNs, MDs, midwives)**

Key strategies for overcoming barriers to BFI implementation

- establish breastfeeding as a clinical priority and leverage sufficient resources
- designate skilled, credible, dedicated project "champion(s)" with protected time and establish mentoring networks with other Baby-Friendly centers
- adopt a non-dogmatic, participatory, multi-disciplinary and appropriately-paced approach to BFI implementation
- embed BFI in larger organizational missions of family-centered care; quality improvement
- audit and feedback

Key strategies for overcoming barriers to BFI implementation

- adopt innovative, flexible means for providing breastfeeding education (HCPs and families)
- promote maternal empowerment; prepare families for realities of breastfeeding; engage all support persons in education/support
- integrate hospital and community-based services (including private MD offices, peer support program)
- social marketing campaigns focused on promoting the *social acceptance* (not benefits) of breastfeeding

PROTECTING, PROMOTING AND SUPPORTING BREASTFEEDING

A PRACTICAL WORKBOOK FOR COMMUNITY-BASED PROGRAMS

2nd EDITION

http://breastfeedingcanada.ca/documents/Breastfeeding Workbook 2014.pdf

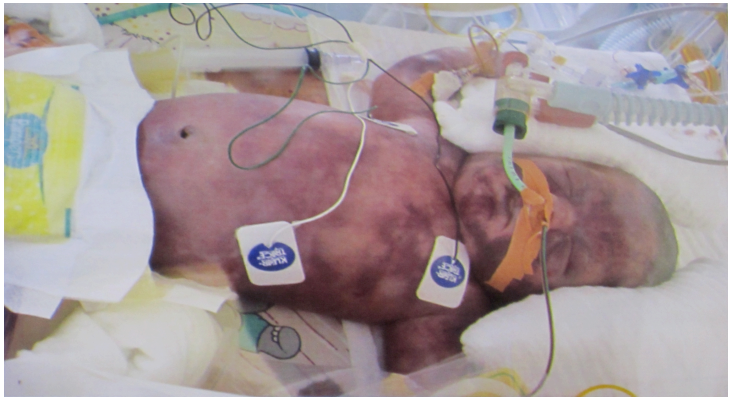
Summary of challenges to BFI implementation:

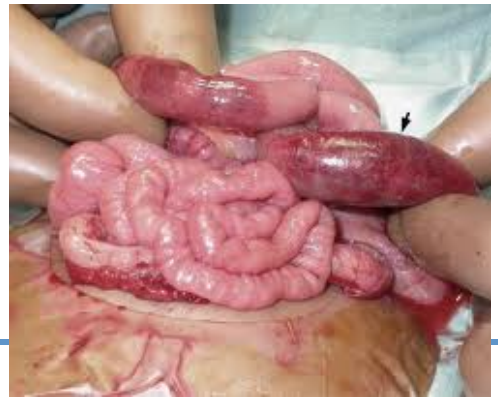
- the BFI is a complex practice change process that requires dedicated financial and human resources, skilled leadership, and effective change-management strategies
- recognition of breastfeeding as a clinical and/or public health priority and support from all levels of the health care system are needed to promote widespread implementation of the BFI at the population level
- breastfeeding promotion activities must be accompanied by access to adequate postnatal breastfeeding support, to avoid negative psychological outcomes among mothers who choose not to breastfeed or who wean due to lack of breastfeeding support

New frontiers for the BFI:
The Baby-Friendly Hospital Initiative for Neonatal units

Benefits of supporting breastfeeding in the NICU

- Enzymatic, immunomodulatory, anti-infective, and anti-inflammatory properties of human milk protection against:
  - **nosocomial infections**
  - **neonatal sepsis**
  - **NEC**





Additional benefits of breastfeeding for ill or preterm infants:

- improved neuro-developmental outcomes
- lower rates of severe retinopathy of prematurity
- improved feeding tolerance and faster attainment of full enteral feedings
- promotion of maternal-infant attachment
- earlier NICU discharge
- decreased rates of re-hospitalization for illness in the first year following NICU discharge

Development of the NEO-BFHI

8 face-to-face meetings

The Nordic and Quebec Working Group

International consultation (27 countries)

Aim of the Neo-BFHI working group:

To expand and adapt the Ten Steps to protect, promote and support breastfeeding in neonatal units, based on the WHO/UNICEF's BFHI:

1. Examine the evidence in relation to breastfeeding promotion, protection and support in neonatal units
2. Develop and adapt the BFHI's standards and criteria
3. Develop and pilot test an assessment tool to evaluate neonatal units compliance with the criteria
4. Promote implementation of the adapted standards
5. Encourage research to assess the effectiveness of the adaptation

Components of the Neo-BFHI

- Three Guiding Principles
- Ten Steps for Successful Breastfeeding adapted for the NICU population and context
- Adherence to the International Code of Marketing of Breastmilk Substitutes

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Frequently Asked Questions
The NEO-BFHI: The Baby-Friendly Hospital Initiative Expanded For Neonatal Intensive Care
Description of the initiative
The Nordic and Quebec working group was formed in Copenhagen, March 2009, by health professionals from Sweden, Norway, Denmark, Finland and Quebec, Canada to address the expansion of the BFHI to neonatal care. The working group has developed a unified expansion of the Baby-Friendly Hospital Initiative to Neonatal Wards or Neo-BFHI, based on review of the evidence, expert opinion, and experiences in the Nordic countries and other countries around the world.
To remain consistent with the WHO/UNICEF 2009 update of the BFHI standards (i.e., the "Global Criteria"), it was decided that the expansion to neonatal wards should closely follow the BFHI's Ten Steps to Successful Breastfeeding (Ten Steps). To ensure that the recommended practices focus on respect to mothers, a family-centred approach and continuity of care, the working group formulated three Guiding Principles meant to be basic tenets in the Ten Steps. In agreement with the BFHI, the adaptation also includes respect of the International Code of Marketing of Breast milk Substitutes. It must be noted that in the spirit of this adaptation, neonatal wards typically cover all levels of neonatal care, including healthier infants who may require episodic or short-term monitoring or medical interventions.
A preliminary version has been prepared of the core document: Three guiding principles and ten expanded steps to protect, promote and support breastfeeding. A final version is under preparation, in
The final version will be completed towards the end of 2014 in connection with an international conference (see below).
Progress of preparation – time table
Assessment tools
Pilot tests of the External Assessment tool (based on Baby Friendly Hospital Initiative. Revised, Updated and Expanded for Integrated Care: Section 5) have been made in hospitals in Quebec and

Three Guiding Principles:

International Lactation Consultant Association
A Worldwide Network of Lactation Professionals

Special Report

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Expansion of the Ten Steps to Successful Breastfeeding into Neonatal Intensive Care: Expert Group Recommendations for Three Guiding Principles

Kerstin Hedberg Nyqvist, RN, PhD[1], Anna-Pia Häggkvist, RN, MSc, IBCLC[2], Mette Ness Hansen, RN, IBCLC[2], Elisabeth Kylberg, PhD, IBCLC[3], Annemi Lyng Frandsen, RN, IBCLC[4], Ragnhild Maastrup, RN, IBCLC[5], Aino Ezeonodo, RN, CEN, CPN, CNICN, MHC[6,7], Leena Hannula, RN, MNSc PhD[7], Katja Koskinen, RN, IBCLC[8], and Laura N. Haiek, MD, MSc[9]

Abstract

The World Health Organization/United Nations Children's Fund *Baby-Friendly Hospital Initiative: Revised, Updated, and Expanded for Integrated Care* (2009) identifies the need for expanding the guidelines originally developed for maternity units to include neonatal intensive care. For this purpose, an expert group from the Nordic countries and Quebec, Canada, prepared a draft proposal, which was discussed at an international workshop in Uppsala, Sweden, in September 2011. The expert group suggests

J. Human Lactation, 2012, 28(3), 289-96

Guiding Principle # 1:
The staff approach toward the mother must focus on the individual mother and her situation

Holbaek Hospital, Holbaek, Denmark

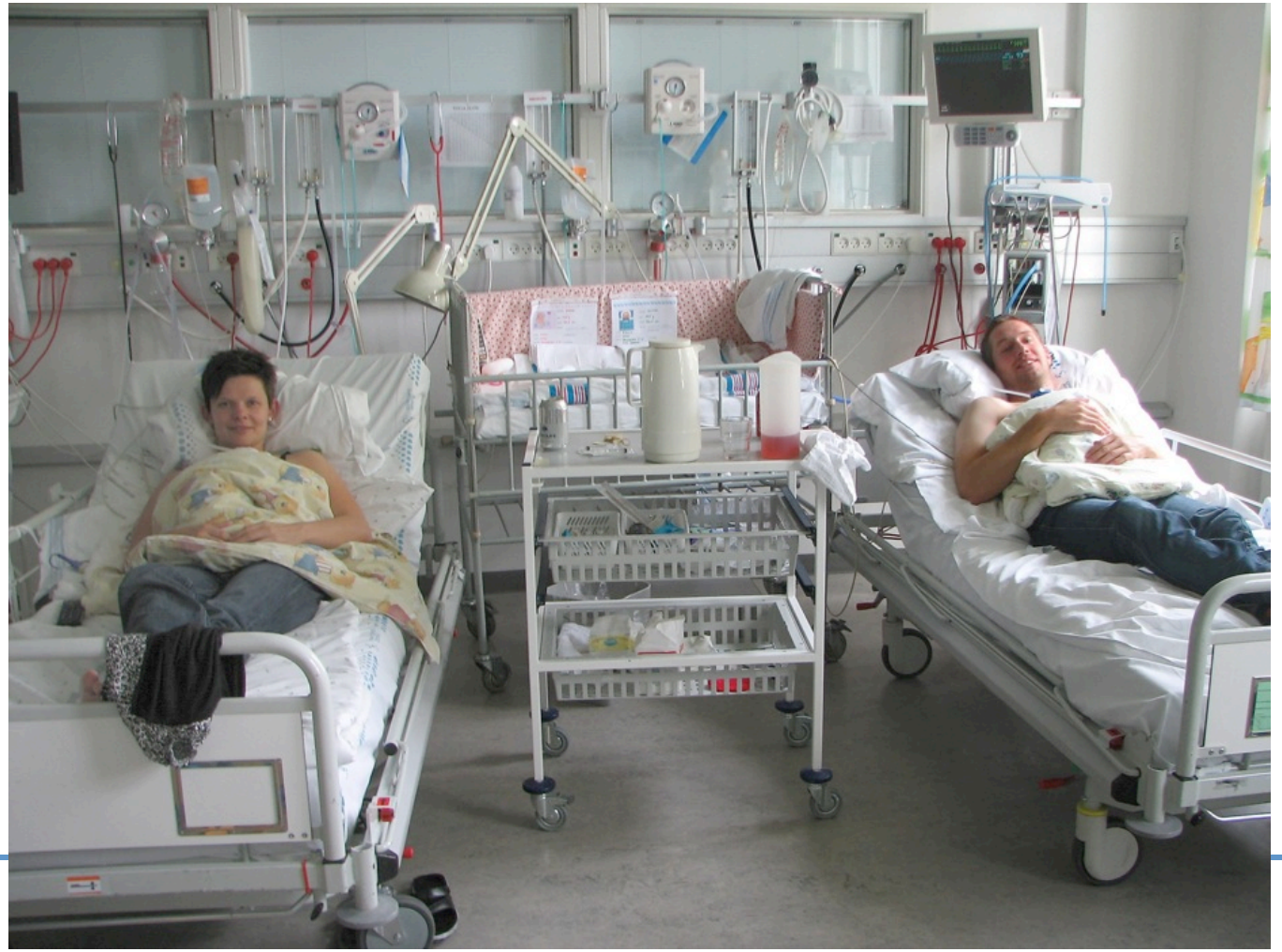
GP1 considers the particular challenges in lactation and breastfeeding faced by mothers of preterm and ill infants:

- Risk of delayed or impaired development of maternal identity as transition to motherhood is shortened and involves a crisis
- Mother-infant separation because of a prolonged hospital stay
- Risk of compromised milk production (maternal illness, delayed lactogenesis, challenges in pumping/milk expression, etc.)
- Pressure on mother to provide milk ("milk as medicine")
- Need for psychologically- and culturally-appropriate lactation counseling offered with empathy and sensitivity

Guiding Principle # 2:
The facility must provide family-centered care, supported by the social and physical environment in the unit

- **Family-centered care**
- **Respect for the rights of infants to be cared for by their parents, and for parents to assume their natural role**
- **An environment in the unit that promotes family-centered care and that optimizes development care**

An NICU environmental design that supports family-centered care and development care



Neo-BFHI requires that NICU staff shift their roles from that of primary caregiver…

…to educator and supporter of parents as their infant's primary caregivers in the NICU.

Principle # 3:
Ensure continuity of care: pre-, peri- and post-natal, and post-discharge care

GP3 addresses the particular challenges faced by families that transit through several units during the hospital stay:

- Continuity of care in the case of premature and ill infants include several distinct phases, all of which can be anxiety-provoking to parents
- "Continuity in approach" to care, which necessitates shared policies and guidelines
- Contradictory advice from different health professionals (especially related to breastfeeding)

The expanded Ten Steps and the Code:

Special Report

International Lactation Consultant Association

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Expansion of the Baby-Friendly Hospital Initiative Ten Steps to Successful Breastfeeding into Neonatal Intensive Care: Expert Group Recommendations

Kerstin H. Nyqvist, RN, PhD[1], Anna-Pia Häggkvist, RN, MSc, IBCLC[2], Mette N. Hansen, RN, RM, IBCLC[2], Elisabeth Kylberg, PhD, IBCLC[3], Annemi L. Frandsen, RN, IBCLC[4], Ragnhild Maastrup, RN, IBCLC[5], Aino Ezeonodo, RN, CEN, CPN, CNICN, MHC[6,7], Leena Hannula, RN, RM, MNSc, PhD[7], and Laura N. Haiek, MD, MSc[8]

Abstract

In the World Health Organization/United Nations Children's Fund document *Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care*, neonatal care is mentioned as 1 area that would benefit from expansion of the original Ten Steps to Successful Breastfeeding. The different situations faced by preterm and sick infants and their mothers, compared to healthy infants

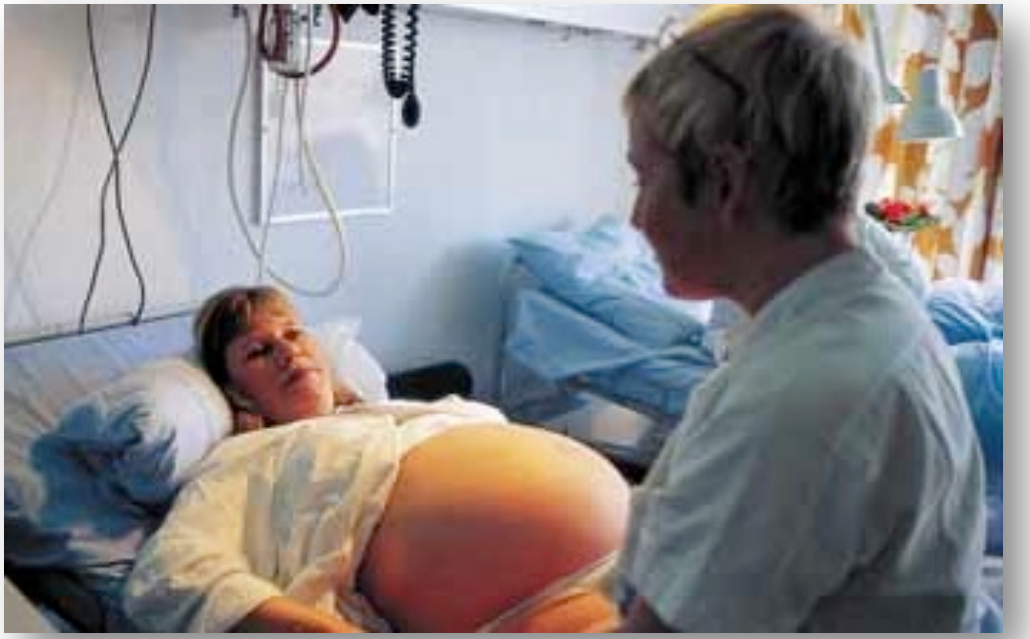
J Hum Lact, 2013, 29(3):300-9.

Step 1: Have a written breastfeeding policy that is routinely communicated to all health care staff.

Step 2: Educate and train all staff in the specific knowledge and skills necessary to implement this policy.

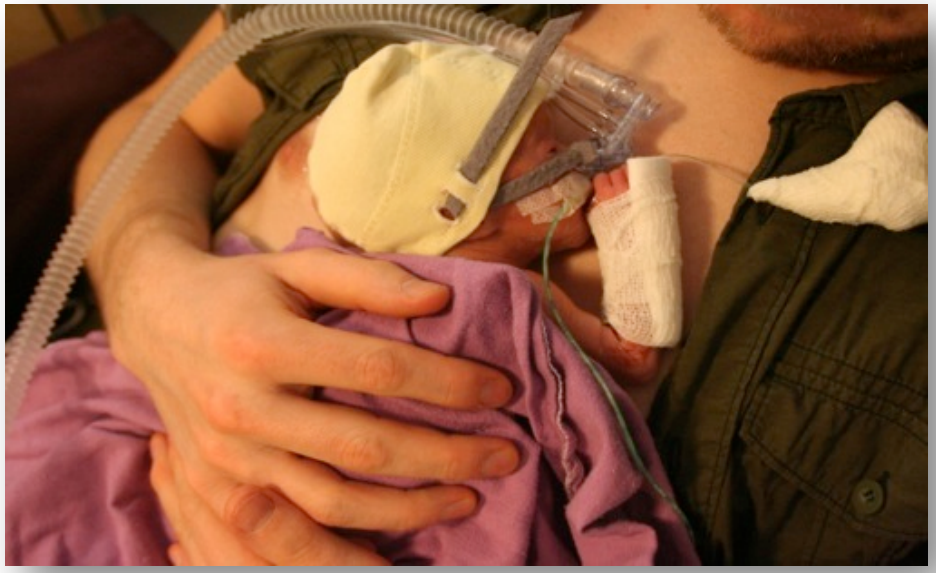
Step 3:

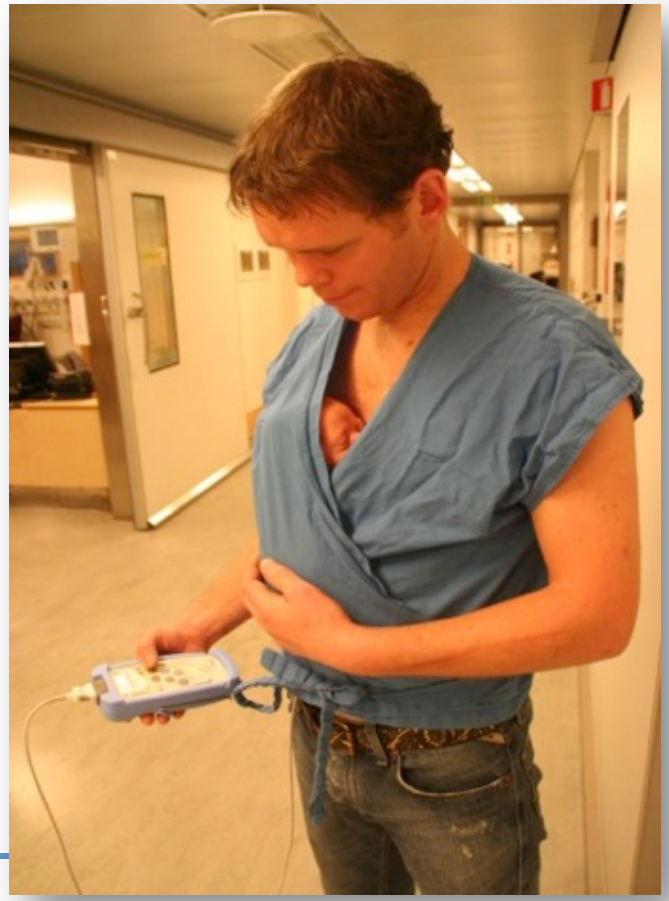
Inform hospitalized pregnant women at risk for preterm delivery or birth of an ill infant about the management of lactation and breastfeeding and the benefits of breastfeeding.



STEP 4:

Encourage early, continuous and prolonged mother-infant skin-to-skin contact (kangaroo mother care) without unwarranted restrictions.





Olavs University Hospital, Trondheim, Norway

Step 5:

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

Step 6:
Give newborn infants no food or drink other than breast milk unless medically indicated.

Order of priority

- Mother's own milk directly at the breast
- Mother's expressed milk
- Donor milk
- Non-human milk

Milk Bank, Ribeirao Preto

Step 7:
Enable mothers and infants to remain together 24 hrs/day

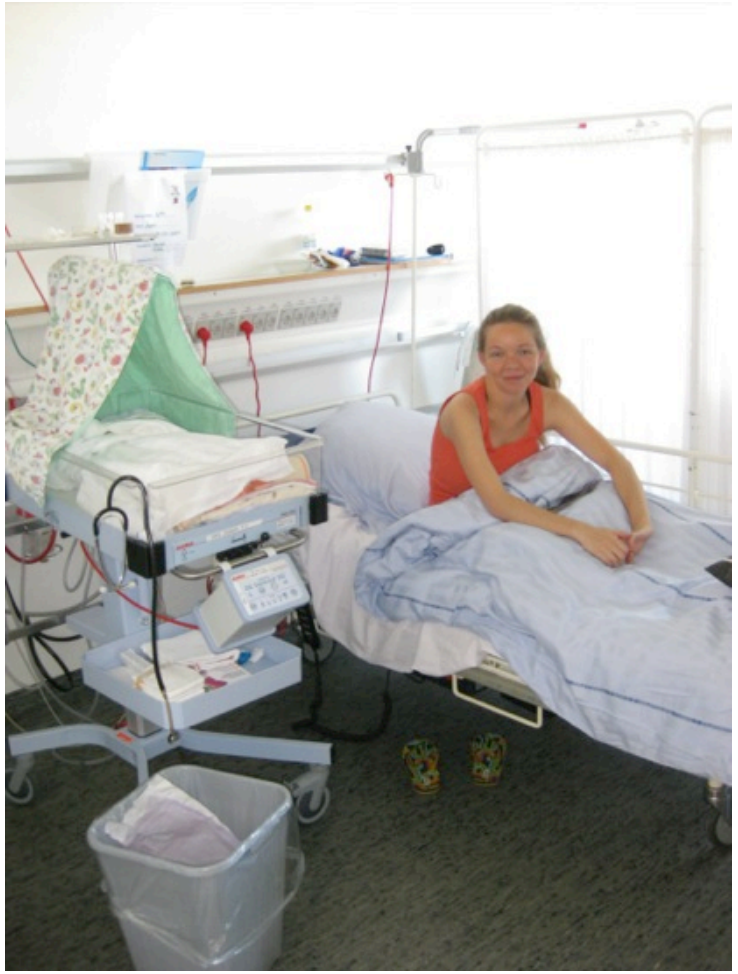
Mothers should have the opportunity to sleep close to the infant:

Levels ("gold, silver, bronze"):

*** Bed in the same room as the infant

** Bed in another room in the neonatal ward

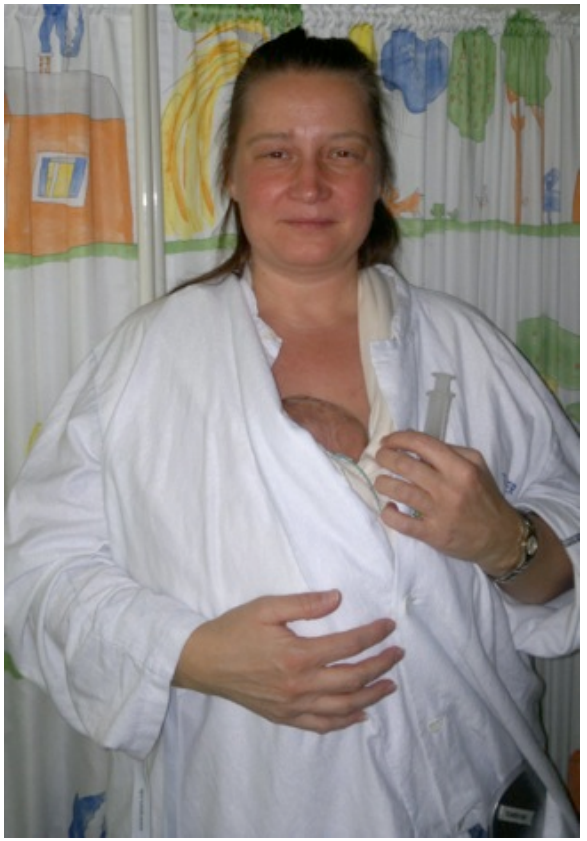
* Bed in another area in the hospital



Rigshospitalet, Copenhagen, Denmark

Step 8:

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



Step 9:

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

Uppsala University Children's Hospital, Sweden

Step 10:

Prepare parents for continued breastfeeding and ensure access to support

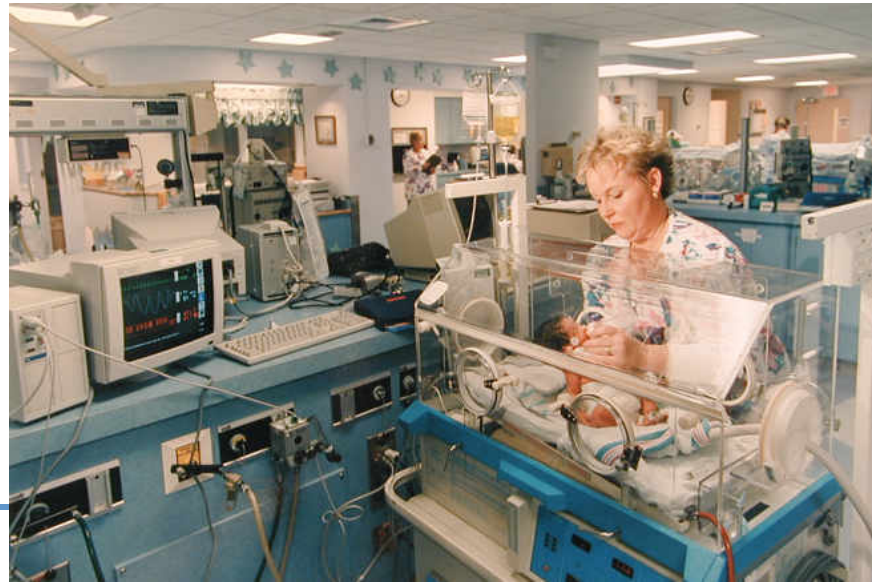
Barriers and Facilitators to Implementing the NEO-BFHI

- Qualitative, descriptive study (2013)
- 2 university-affiliated, level 3 NICUs in Montreal, Quebec
  - *NICU A – in a maternity center, primarily premature infants*
  - *NICU B – in a pediatric hospital, primarily medical/surgical cases*
- In-depth, face-to-face, semi-structured interviews with health care managers, educators, lactation consultants (N = 11)
- Focus groups with direct care providers including nurses, nursing assistants, physicians, respiratory technicians (4 focus groups per hospital with a total of 65 participants)

Challenges to implementing the BFHI in the NICU

Structural/environmental:

- Lack of privacy and/or space to pump or breastfeed
- Noisy/stressful environment interferes with pumping and breastfeeding
- Physical separation of mothers and infants (especially if mother gave birth in another hospital)

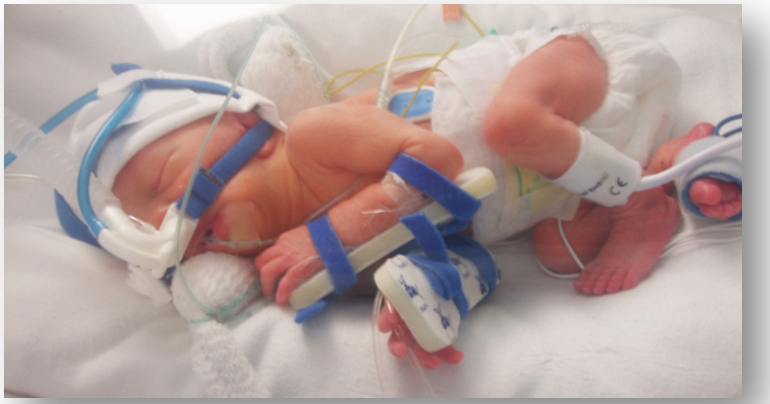


Challenges to implementing the BFHI in the NICU

NICUs not ready for continuous parental presence:

- Family members “get in the way” in the crowded NICU
- Lack of facilities for families to meet their basic needs (eg, comfortable chairs, meal preparation)
- Staff feel “watched” by parents
- Parents not allowed in unit during medical rounds (for confidentiality reasons)
- NICUs limit visitors during infection outbreaks

Challenges to implementing the BFHI in the NICU



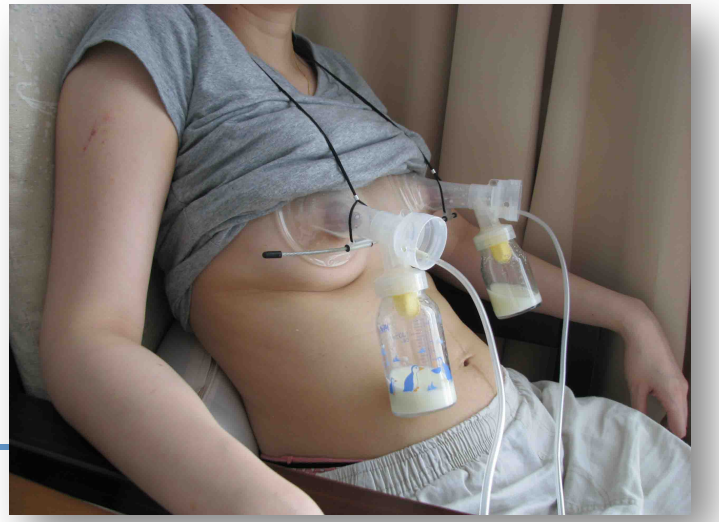
Population of fragile/ill infants:

- Prioritization of medical needs over breastfeeding support
- Infant instability limits skin-to-skin care (eg, fear of dislodging lines, intubators)
- Breastfeeding challenges associated with infant illness/prematurity (eg, NPO status, oral aversion, delayed sucking reflex, poor sucking coordination)
- NICU focus on infant growth with strict documentation of calories/ volumes (staff are reluctant to allow demand/semi-demand feeding)

Challenges to implementing the BFHI in the NICU

Maternal reliance on milk expression:

- Delayed initiation of pumping (role confusion between postpartum and NICU staff)
- Logistical difficulties re. transport of breast milk to the NICU
- Challenges related to long-term pumping (eg, difficulties maintaining maternal milk supply, discouragement)
- Conflicting information about how to use the pump and maintain milk supply
- Limited access to pumping equipment due to costs



Challenges to implementing the BFHI in the NICU

Insufficient human resources

- Staff shortages / heavy workloads
- Lack of staff with expertise in breastfeeding support
- Time pressures →
  - faster to gavage or bottle feed than help baby to breast
  - lack of time to set parents up for Kangaroo care
  - lack of time for parent teaching

Challenges to implementing the BFHI in the NICU

Inadequate education (staff + parents)

- Staff knowledge gaps related to Baby-Friendly practices:
  - how to support transition to direct breastfeeding
  - safety of alternative feeding methods (eg, cup)
  - positioning of infants with central lines, intubators in skin-to-skin contact
- Lack of time for staff to attend breastfeeding education
- Lack of maternal prenatal preparation for breastfeeding

Challenges to implementing the BFHI in the NICU

Staff attitudes:

- Negative staff attitudes towards breastfeeding or the BFHI/ resistance to changing practices
- Perception of NICU as separate “worlds” from postpartum wards, with separate responsibilities
- Focus on the infant as the unit of care (not the family)

Challenges to implementing the BFHI in the NICU

Lack of continuity of breastfeeding support :

- Inconsistent messages about breastfeeding across different care providers and units (eg, between postpartum units and NICU)
- Rapid transfers of infants out to other units / hospitals
- Lack of knowledge of, or access to, post-discharge breastfeeding support service

Recommendations for implementing Baby-Friendly practices in the NICU

- Provide accessible, inter-disciplinary breastfeeding education for healthcare providers to enhance knowledge/skills and promote continuity of breastfeeding support

- Establish prenatal or early postpartum contact with families to better prepare them for the realities of long-term pumping and/or breastfeeding the preterm or ill infant

- Develop a core group of BFHI “Champions” (including physicians) in the NICU dedicated to the implementation and monitoring of Baby Friendly practices

Recommendations for implementing Baby-Friendly practices in the NICU

- Increase access to lactation consultants in the NICU to provide expert lactation support, role modeling of Baby Friendly care, and increased visibility of successful breastfeeding experiences in the NICU

- Ensure sufficient staffing to support skin-to-skin care, direct breastfeeding attempts, and semi-demand/demand feeding

- Modify the physical environment to enhance parental involvement in care and minimize parent-infant separation (eg, single rooms)

THANK YOU

Questions ????