A review and scoping out of the implications for extension of the Baby-friendly Initiative to community health care settings in Ireland

The aim of this project was to explore the interest, process and feasibility of establishing a Baby-friendly Initiative in community health care settings.

Extract from:

Report of Project to
HSE Population Health (Health Promotion) Directorate

December 2007

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Acknowledgements

We would like to acknowledge the assistance of the many people who participated in discussions, completed questionnaires, and provided information to enable the preparation of this report in a timely manner.

Glossary and Abbreviations

Mothers	used to refer to both pregnant woman and woman who have given birth
BFHI	Baby Friendly Hospital Initiative
BFCI	Baby Friendly Community (Health Services) Initiative
Health worker	All those who work in the health services in professional, clinical, ancillary, managerial or any other roles, as either employees, contractors, independent practitioners, or volunteers
PHN	Public Health Nurse
IBCLC	International Board Certified Lactation Consultant

Cite this report as:
Becker GE and Boyle C, (2007) A review and scoping out of implications for extension of the Baby-friendly Initiative to community health care settings in Ireland. Galway, BEST Services, for the Health Services Executive, Population Health (Health Promotion) Directorate.

Executive Summary

Not included in this extract

1. The background for a Baby-friendly Initiative

The importance of breastfeeding is widely recognised in the health and wellbeing of children and mothers, as well as economic and environmental importance, and thus contributing to a healthy nation. The Baby Friendly Hospital Initiative (BFHI) is a global project of the World Health Organisation and UNICEF which recognises that implementing best practice in the maternity service is crucial to the success of programmes to promote breastfeeding.

The Baby Friendly Hospital Initiative involves internal audit and external assessment of health promoting practices and can be viewed as a quality initiative implementing research based best practices. The successful implementation of the Ten Steps to Successful Breastfeeding ensures that the hospital/unit supports and promotes informed parental choice through the provision of appropriate, accurate and unbiased information and discussions.

The Initiative was launched in 1991 and by the end of 2006 more than 20,000 hospitals/maternity units worldwide, including over 300 in Europe, had been officially recognised as Baby Friendly. Ireland's BFHI commenced in April 1998 and by the end of 2007 seven maternity units in Ireland had achieved the Baby-friendly criteria with about 38% of births taking place in a Baby-friendly hospital. All twenty of the maternity units participate in the initiative at some level.

In conjunction with the Health Promoting Hospitals Network, the designating authority for the BFHI in Ireland, the global WHO/UNICEF maternity project has expanded to include a national Breastfeeding Supportive Health Service Workplace project and a Breastfeeding Supportive Paediatric Unit project.

Community health services have always been recognised as vital to sustaining breastfeeding. The National Breastfeeding Policy for Ireland (DOH 1994) made recommendations which stimulated activities in most community areas; the results of which were discussed in the *Interim Report of the National Breastfeeding Comm*ittee (DOHC 2004).

The success of the BFHI in maternity units in Ireland and the community BFI activities in other countries resulted in increasing interest to have a Baby-friendly initiative in the community health services in Ireland. *Breastfeeding in Ireland: A Five Year Strategic Action Plan* (DOHC 2005) supports the extension of this Initiative to community care settings in Action 19 with the following expected outcome: "The extension of the Baby Friendly Initiative beyond hospital settings is being pursued to include other relevant health settings, e.g. community health care setting.

Potential outcomes

Breastfeeding and support for mothers can have many positive outcomes as regards health and well-being. Attitudes and practices of health workers, mothers, and other people in the community can influence breastfeeding activity, satisfaction, and rates. Many aspects of these influences are best assessed qualitatively. Effects on health tend to be long-term studies. Therefore quantitative breastfeeding rates are generally used as a short-term indicator of the success of an initiative.

During the 1980s and early 1990s the breastfeeding rate (exclusive plus combined) on discharge from hospital had remained static at around 32% with some hospitals reporting less than 20% breastfeeding. Between 1998 and 2006 the national average discharge rate rose from approximately 36% to 46%, with an average initiation rate of 52% in 2006 and range of 40-63% (rates as reported by hospitals to BFHI Ireland). In maternity units, staff training on breastfeeding and its management is widespread. Practices that were uncommon ten years ago such as skin-to-skin contact in the delivery room, rooming-in, and supplements only for a medical indication are now considered standard practice in most maternity units.

There are limited national statistics on breastfeeding after hospital discharge. The Interim Report (2003) noted that local studies indicated breastfeeding rates of approximately 10% at 16 weeks, which were well below the target set in 1994 to reach of 30% by 2000. Data from the Parent Held Record database in the Mid-western area indicate the target of 30% was still not met in that area in 2005. This data listed areas where additional support may help mothers to continue breastfeeding. Breast problems, concerns regarding milk supply, crying baby or not enough support together account for 36% of mothers discontinuing breastfeeding earlier than they would have liked (internal report, Public Health Department, Limerick 2006). These difficulties can be reduced with effective community health services for breastfeeding.

Research evidence indicates that implementing supportive practices in maternity hospitals improves early breastfeeding rates and infant health; though the effect of maternity hospital only initiatives on breastfeeding duration rates is less clear (Aliperti, L C and MacAvoy, S 1996; Braun, M L G et al. 2003; Kramer, M et al. 2001; Merewood, A et al. 2005). The effectiveness of programmes that span pre- and postnatal periods appear to be greater than interventions that are compartmentalised – the concept of a seamless service which is a goal of the Transformation programme. Though the expansion of the BFHI beyond maternity units has not yet been evaluated in other countries, these programmes are based on activities that are evidence-based (EU 2004).

Other countries with Baby Friendly Community Initiatives have set goals that the initiative will:

- Increase the percentage of babies who are breastfeeding;
- Increase the duration of exclusive breastfeeding;
- Sustain breastfeeding after six months alongside the introduction of appropriate, adequate and safe complementary foods.

It is assumed that the short-term quantitative goals of a baby-friendly community initiative in Ireland would be similar.

A baby-friendly initiative would aim to encourage community health services to:

- provide consistent and accurate information to mothers,
- use evidence-based practice,
- facilitate a range of support services,
- work in a cross-discipline manner as well as linked with hospital services,

and thus to provide an environment that protects, supports and promotes breastfeeding as a normal way of nurturing a baby.

2. Baby-friendly Initiatives in community health care settings in other countries

The original 1991 WHO/UNICEF Baby Friendly Hospital Initiative focused solely on hospital settings. The *Baby Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care* (WHO/UNICEF 2006) recognised the need for greater coordination between hospitals and community health services and included a variety of alternative approaches. These expansion and integration options are intended to create the possibility for more creative and supportive mother and baby-friendly care in health services and the wider community. However due to the very different community health systems in place around the world no structured initiative was developed for the community services similar to the maternity services.

Countries with community health services initiatives

The BFHI lead persons in WHO and UNICEF headquarters were also contacted as was the UNICEF lead person who had left that post in December 2006. The national coordinators of the BFHI in other countries were contacted via the coordinators' list-serve. This network includes the European countries, including Central Asian Republics, as well as industrialised countries in non-European areas. The country reports to the 2006 BFHI coordinators meeting were also reviewed. Six industrialised countries were found that had Baby-friendly community health services initiatives and the coordinators in these countries were then contacted further.

The UNICEF UK Baby Friendly Initiative started a community aspect in 1999 and there are ten community facilities currently designated as Baby-friendly, of which three facilities are in Northern Ireland. It is to undergo restructuring in 2008. In Canada the community initiative started in 2002 and there are nine facilities designated Baby-Friendly, with two facilities in Ontario and all the rest in Quebec. The community initiative in The Netherlands started in 2001 and about 35% of children are seen in health clinics that are designated as Baby-friendly.

Three additional countries have community initiatives in pilot phases with no facilities assessed or designated as yet. New Zealand has 5 pilots running for the last 9-15 months with primary healthcare practitioners. Norway has 5 facilities as pilots since 2006. One region in Italy, Lombardia, commenced a pilot in October 2007. One respondent noted that it takes time for the pilot sites to reach the standards needed for assessment and that this buy-in, training, agreement and implementation of new practices may take longer than planned, and that the assessment materials also need to be developed and piloted which takes time.

In addition, a number of countries are in various stages of considering or actively planning programmes including Belgium, Australia and Israel. Other countries acknowledged that it is a useful expansion and there is interest however they are not actively pursuing it in the next few years primarily due to lack of funding / government support. The Gambia, Nicaragua and the Philippines have active programmes however these are targeted at a whole community being mother and baby friendly, including employers, schools, shops, people, etc rather than focused on individual health facilities.

Structures

In most of the countries with community initiatives the health services provides care to all the population either through a national or more local system and the population is enrolled with a specific health centre or similar. Shared maternity care between hospital and community health services is common. In most of the countries there are strong links between the hospital and community baby-friendly initiatives.

In New Zealand maternity care is provided by Lead Maternity Carers who may be employed by a maternity facility or working independently. Women can choose a midwife, obstetrician or general practitioner. The BFI has strong consumer participation at all levels including development and review of BFHI and BFCI documents, as members of the board and as BFHI assessors. Current maternity service contracts require all birth facilities to work towards becoming BFHI accredited. Facilities are also assessed on their compliance to the Treaty of Waitangi and its application to the care of Maori mothers and babies. The New Zealand Breastfeeding Authority is an agency formed from breastfeeding organisations and contracted by the Health Funding Authority to develop and run BFHI for New Zealand. It provides training, resources and assessments and has a staff of four full-time and one part-time plus contractors hired for specific tasks, with plans for funded regional teams.

In Norway the baby-friendly community initiative is linked with achieving the targets of the National Action Plan on Nutrition (2007-2011). An independent body, the Norwegian Resource Centre for Breastfeeding, is funded by government to implement the BFHI. Between 2007 and 2009 the resource centre together with the Directorate for Health and Social Affairs are holding seminars all over the country to inform community health workers about the project and how to implement the guidelines in the 1200 health centres.

BFI UK is self-funded through charges for assessments, training and resource materials with core employed staff (as employees of UNICEF) plus short-term contractors as needed for assessments. The BFI has an additional function to raise awareness of UNICEF activities and thus aid donations to UNICEF.

The Breastfeeding Committee Canada originally received central funding from Health Canada to conduct the BFHI though with the recent move from national to provincial the responsibility for health funding has become a concern. It now has a volunteer committee and hires short-term contractors as needed. It is placed as a nutrition activity in health planning.

The Netherlands BFHI is funded by the Ministry of Health on a five-yearly basis. It has two three-quarter time co-ordinators, two part-time administrators, and assessors who are contracted as needed. There is more demand for assessment than can be met with the funding/staffing levels. BFHI is run by Stichting Zorg voor Borstvoeding which is a charity with a board in which the Dutch Committee for UNICEF is represented

The BHFI in Italy is supported by the National Committee for UNICEF with training and assessments paid by hospitals or public health organizations and donations. The BFHI Network includes public health organizations, health professional associations and voluntary breastfeeding organisations. BFH is the first goal stated in the Child Health Program of the National Health Plan 2006-2008. There was no specific information available on the community project recently started in one area of Italy.

Criteria for assessment

The Canadian initiative is modelled on the UK "Seven Points" and New Zealand adapted the Canadian and UK materials. The Netherlands also has 7 steps though not the same as the UK points, while Norway has 6 Steps. Italy appears to have 7 steps though the wording could not be obtained during the time of preparing this report.

In all the countries the first three Steps/Points of policy, staff training, and information to pregnant women are the same, and are the same as the maternity Ten Steps. After those Steps there are differences between some of the countries. The countries and Steps are tabulated in Appendix D.

In addition to meeting the criteria based on the Steps, Canada requires that a community health service will be eligible for Baby-Friendly assessment when a minimum of 75% of mothers within the geographic boundary of that service are breastfeeding upon entry into the service (at hospital discharge). As far as could be ascertained, there is no minimum breastfeeding rate required in the other countries.

The unit of assessment (facility or service) varies in each country due to different systems of health provision. The UK is perhaps the most globally adaptable in their definition of community facilities as: "any facility providing community health care which can be clearly and unambiguously defined is able to apply for accreditation". This allows for GP surgeries, locality teams, health centres and other services to participate.

Process

All countries have a staged process where facilities indicate their interest by completing a self-appraisal process; attend training as needed; prepare and submit documentation such as a policy and implementation guidelines, educational materials; and then are externally assessed including interviews with staff to assess knowledge and skills, interviews with mothers, and observation of practices and the environment in the facility.

Monitoring of designated facilities is on-going with collection of breastfeeding rates and surveys of mother's satisfaction. Re-assessment occurs or is planned to occur at regular intervals.

Materials

The UK, Canada and New Zealand have extensive professionally designed materials on their web sites and in printed format for facilities interested or involved in the initiatives and additional materials are available for a fee. Norway has a manual for facilities including background of the Baby-friendly Initiative, the criteria to become a Baby-friendly community health service / well baby clinic, information/literature/how and where to get breastfeeding education, self-appraisal tool, data sheet for registration of breastfeeding data, and how to write a breastfeeding policy. The Netherlands BFHI web site indicates that materials are available, however they were not reviewed.

Evidence of effectiveness

Baseline audits were undertaken in most pilot areas. In general statistics such as an increase in breastfeeding rates at various time periods, an increase in exclusive breastfeeding, and in continuation of breastfeeding after the introduction of complementary foods at an appropriate age, are used to indicate effectiveness of the initiative, with maternal satisfaction data also collected.

3. Community health care settings in Ireland

The census 2006 figures reveal almost 65 000 babies were born in Ireland and these babies and their mothers are then provide with care by the community health services. Primary Care – a New Direction (2001) was a key component of the national Health Strategy. It promotes a team-based approach to service provision that aims to deal with health problems at the lowest level of complexity and within the local community. The move to management of the health services by the Health Service Executive (HSE) in 2005 continued this aim to provide a primary care focused service.

Health services/settings available to infants and their mothers

There are many health professionals and services with whom mothers come into contact through the various stages of their pre-natal and ante-natal care.

The General Practitioner (GP) and the practice nurse (PN) see the mother during pregnancy and then postnatally generally providing care for both the mother and baby. The Maternity and Infant Care Scheme provides an agreed programme of care to mothers who are enrolled in the scheme. In addition to hospital care, appointments and visits are planned with the GP during pregnancy and including examination of the infant at two weeks and again at six weeks. This programme provides regular opportunities for the GP and practice nurse to discuss breastfeeding, to ensure it is going well, and to assist in solving any difficulties it they occur.

Currently in Ireland, public health nurses employed by the Health Service Executive (HSE) provide home visits to new mothers as well as seeing mothers and young children at the health centre. The PHN rarely has contact with a mother prior to the birth which means no relationship is developed and an opportunity is missed to discuss and provide information on breastfeeding.

Mothers and children who need care from a more specialised health professional such as a speech and language therapist or a dietitian can be referred by the GP and in some situations by the PHN. At present there are very few specialists in breastfeeding such as International Board Certified Lactation Consultants (IBCLC) working in the HSE in a post where they can take referrals from a GP or PHN or with whom other health professionals can discuss a case. Some of the maternity hospitals provide a post-natal specialist breastfeeding service though the hours of availability are limited. A mother may need to consult a lactation consultant privately for specialist care, most of who will do home visits so that a distressed mother does not need to travel with her infant. There may be little contact between the primary care health professionals and the private practitioner to discuss a case.

Volunteer mothers also provide a breastfeeding support service in the community with group discussions and one-to-one contact in person or by phone. These volunteers are trained and supported by their organisations (mainly La Leche League and Cuidiu-ICT) to provide information and general support with breastfeeding and mothering. Their training relates to healthy mothers and babies though a small number have obtained an additional qualification as an IBCLC and can assist in more complex situations. There is generally little contact between a GP/PN/PHN and a volunteer mother to discuss a particular case.

Physical structured of services/settings with regard to access to mothers, and health workers for interview and observation of practice

The health centres currently in Ireland are there to serve the general public and most do not have any specific space available for mother and baby. Mothers may be reluctant to breastfeed in a public space and few centres have a private space available. The lack of a breastfeeding supportive environment may also deter a mother coming to seek medical attention for herself or another family member.

It takes time to observe a breastfeed, particularly if there are any concerns. Due to high case loads the time may not be available resulting in limited observation and the mother feeling rushed to get her baby to feed to suit the schedule of the health worker.

The availability of services varies according to the number of patients, needs of patients and location of the health centre or GP practice. The lack of an effective public transport system may restrict access to services and this may be particularly the case in rural areas and mothers from disadvantaged groups who may not have access to private transport. In areas of social deprivation there may be a higher demand for health services than in more economically advantaged areas where there may be a greater usage of private healthcare.

Training and skills of community health workers

As many health professionals in diverse health care settings may come into contact with pregnant women or mothers and infants it is crucial that training and a general awareness of the importance of breastfeeding are widely provided in pre-service education. This is of particular importance in Ireland as breastfeeding rates are generally lower than in other countries. Unlike the staff in maternity hospitals, most community health professionals provide services for a very wide range of clients, which makes it difficult for them to keep up-to-date in all the diverse areas and therefore continuing education and resources need to be tailored to their needs. The Interim report (2005), acknowledges the need for a detailed training scheme and evaluation process for breastfeeding among HSE health professionals in the community.

The aforementioned transformation of the health services in Ireland will provide a wide range of services in the community and may be an ideal setting for the promotion and support of breastfeeding by all of the health professionals when in operation. The planned Primary Care Teams will consist of GPs, Nurse/Midwife, health care assistant, Home-helps, Physiotherapist, Occupational Therapist and Social Worker. Primary Care Networks will also be formed and will consist of Chiropodists, Community Welfare Officers, Dentist, Dietician and Speech and Language Therapist.

Members of the Primary Care Network will work with more than one Primary Care Team which will be of particular significance in rural areas where large areas will be covered by one Primary Care Network. These Networks may service as a means of providing breastfeeding training and as a resource for continuing education of health workers in the network.

The Teams and Networks may provide an ideal setting for providing mothers and babies with breastfeeding education and support from a range of knowledgeable health professionals, with referral to more specialised practitioners as needed, ideally within the network. The Team and/or Network maybe a suitable entity to carry of baby-friendly assessments in a baby-friendly community initiative.

4. Consultations on Baby-friendly process for Ireland

Consultation documents

Steps/Criteria

Drawing on the Ten Steps used in the maternity services and the Steps/Points used in community initiatives in other countries a draft of ten steps for BFH community in Ireland was prepared. Ten Steps link better with the long established maternity initiative and facilitates understanding. For example, in the three initiatives Step 5 then refers to supporting breastfeeding if mother and baby are separated, and collaboration between hospital community health and community groups is Step 10 in all the maternity, paediatric and community steps (in Ireland), rather that Step 10 in one initiative and Point 7 in another initiative.

The WHO/UNICEF BFHI global revision in 2006 that is to be rolled out in Ireland in 2008-2009 includes attention to the non-breastfed baby and mothers are asked about information and assistance they have received however they are feeding their baby. New Zealand plan to include non-breastfeeding babies in their initiatives. As it might be a consideration that the community initiative include all mothers and babies the Steps were prepared for review in two forms - for breastfeeding only and for more inclusive infant feeding. The Steps are listed in Appendix E.

Questionnaire

A questionnaire (Appendix B) was prepared to gather views of stakeholders on:

- The value of a Baby-friendly Initiative in community health care settings
- Which community health workers/ settings would be part of the assessment
- Suitability of the Steps
- Feasibility including potential barriers to implementation

Reports

A desk review of existing relevant Irish reports was carried out. The 1994 National Breastfeeding Policy, the 2004 Interim Report, and the 2005 Strategic Plan were already mentioned. A review of the breastfeeding structures in the previous health board community care services reported that respondents were interested in a baby-friendly community initiative (Foley 2006).

How stakeholder views were sought

Stakeholder survey

A list of key stakeholders for consultation was developed in conjunction with the National Breastfeeding Coordinator. The aim was to represent views of public health nurses, practice nurses, doctors, other health professions, managers, user groups, and the BFHI National Advisory Committee and existing assessment team with as even a geographic coverage as possible. Appendix C lists the stakeholders contacted. Initially the survey was sent by post with a follow-up copy sent by fax or email.

Home birth midwives were not consulted for this report. They have a role in providing a baby-friendly health service but exactly where that role fits in an initiative would need further exploration. Private ante-natal teachers also have a role and again this would need further discussion as they provide different services in different settings. Other health workers such as receptionists, porters, home helps and care assistants were not consulted. However all health workers in any contact with pregnant women, infants and young children, and their mothers, have a role in supporting breastfeeding and implementing policies.

The two main volunteer mother-to-mother support groups, La Leche League of Ireland and Cuidiu-ICT, were consulted as representatives of mothers. These groups also have a role as providers of breastfeeding related services in the community and this dual role needs to be recognised.

Group discussions
The Directors of Public Health Nursing were contacted by letter to ascertain what areas were already working towards or actively considering baby-friendly community initiatives, particularly those using the BFI UK audit tools. Group discussions were arranged in four areas Bray, Limerick, Swords and Clare, though only the Bray and Limerick discussions actually took place. Bray was a multi-discipline group including medical officer, community dietitian, lactation consultants, voluntary mother to mother supporters, and public health nurses. The other groups were all public health nurses with the Limerick group including the community breastfeeding resource persons from the mid-west and from Killarney.

The National Council members of the Association of Lactation Consultants in Ireland were provided with copies of the questionnaire which they discussed among themselves and returned comments. The researcher then discussed these comments further by phone during one of their regular council meetings.

Originally it had been hoped that more group discussions could be arranged however due to the short period for preparing the report and the limitations on HSE staff time and travel additional groups could not be arranged. In some areas breastfeeding committees had disbanded awaiting the formation of regional committees and it was difficult to establish who suitable people to contact to arrange discussions were.

Individual discussions
There were informal conversations and emails with many people including those known to be interested in a baby-friendly initiative and those with little interest as during the period preparing the report the researcher raised the topic at any breastfeeding related events she attended. In addition a few people with a strong interest who had heard about the report initiated contact to share their views. Discussions were also had with health workers in community settings in Northern Ireland that were participating in the baby-friendly community initiative, as well as with BFHI national coordinators in other countries with an initiative or considering a community initiative.

Web site and newsletter notices
A notice asking for views was placed on the web site of the BFHI in Ireland and of the Association of Lactation Consultants in Ireland with a link to download the survey form. In addition a notice was put in the December newsletter of the Association of Lactation Consultants in Ireland as the only newsletter with time for a notice to be included for an issue to come out during the study period. No survey forms appeared to be returned solely as a result of seeing these notices.

Findings from the stakeholders

Not included in this extract

5. Strengths and challenges to the implementation of a Baby-friendly Initiative in community health care settings in Ireland

Not included in this extract

6. Recommendations

Not included in this extract

7. Conclusion

Not included in this extract

Appendices

Appendix A: References

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Appendix B: Questionnaire to stakeholders

«Title» «Name_1» «Name_2»
«Address_1»
«Address_2»
«Address_3»

Questionnaires were directed to a specific person and indicated that their views were sought as a specific occupation such as PHN, medical officer, manager etc.

As a** «Position_1» **would you give your views please?

Is a Baby Friendly Community Health Service Initiative of value, feasible, timely?

Would it help to promote, protect and support practices related to breastfeeding?

This survey is commissioned by the HSE Population Health and National Breastfeeding Strategy Implementation Committee to assist in Action Item 19 of the Breastfeeding Strategic Plan.

There is only a small sample so your views are important whether you work directly with breastfeeding mothers or not. If you are not able to give your views, please let me know at once so the views of another «Position_1» can be sought.

Please return your thoughts by **November 30th**
If you prefer, you can be contacted to give your thoughts by phone. Just let me know a convenient time to phone.

Thank you.

Genevieve Becker

If you need more information or have questions, contact:
Tel: 091-527511 bestservicesgalway@eircom.net

Further information:
Breastfeeding Strategic Action Plan www.breastfeeding.ie/information.asp
Baby Friendly Hospital Initiative in Ireland www.ihph.ie/babyfriendlyinitiative

Is it time for a Baby Friendly Community Health Service Initiative?

What is the Baby Friendly Initiative (BFI)?
The Baby Friendly Hospital Initiative (BFHI) is a global project of the World Health Organisation and UNICEF which recognises that implementing best practice in the maternity service is crucial to the success of programmes to promote breastfeeding.

The Initiative was launched in 1991 and by mid- 2007 more than 20,000 hospitals/maternity units worldwide, including over 350 in Europe, had been officially recognised as Baby Friendly. Ireland's BFHI commenced in April 1998 and by October 2007 six maternity units in Ireland had Baby-friendly status with all maternity units participating at some level. Breastfeeding rates have risen greatly. The National Strategic Action Plan for Breastfeeding (DOHC 2005) highlights participation in the BFHI as a key target.

The Baby Friendly Hospital Initiative can be viewed as a quality initiative implementing research based best practices. The successful implementation of the Ten Steps to Successful Breastfeeding ensures that the hospital supports and promotes informed parental choice through the provision of appropriate, accurate and unbiased information and discussions.

In some countries the Initiative has extended into the community heath services – health centres, public health nurses, GP practices and similar to facilitate a seamless service. The Ten Steps of the maternity services are adapted with some countries have more and some less steps or points, though still linked.

How does the BFI process work?
In the maternity hospital initiative, firstly, a hospital decides it wants to participate in the Initiative. They complete a self-appraisal of their practices and outline the areas they wish to work on. The self-appraisal form and the plan of action are returned to the BFHI office and a Certificate of Membership is awarded. The hospital may decide to work on their plan for a while or to apply for the next stage.

The second stage is an informal assessment by the BFHI team to assist the hospital in their progress and further development of targets. Completion of this stage results in awarding of a Certificate of Commitment recognising the hospital's commitment to supportive practices.

When the hospital is ready, they seek full external assessment of their practices according to the Global Criteria. This involves an assessment team visiting for two or more days looking at documentation, interviewing staff and mothers, and observing practices. If the criteria are fully met, the hospital is awarded Baby Friendly Status. Monitoring and scheduled re-assessment are required to retain the award.

In the community, there might be a similar process with Membership, Commitment, and Status with on-going monitoring and re-assessment.

What about staff training?
All staff (and volunteers connected with the facility) in contact with pregnant and breastfeeding women and their children should be aware of how they can support breastfeeding and the facility's policies. This includes nurses, midwives, doctors, dietitians, physiotherapists, pharmacists, administrative and ancillary staff. Staff with direct responsibility for assisting breastfeeding should have training in breastfeeding management. Staff without this training should refer mothers to trained staff. It is recommended that some staff have further specialised knowledge of breastfeeding in order to act as a resource to other staff.

Each facility that is a member of the Initiative receives regular mailings of information. BFHI Link, the newsletter of the BFHI in Ireland and there is a BFHI Ireland web site. Hospitals/units are encouraged to network with other facilities in the Initiative. Hospitals/units are also encouraged to implement supportive practices to assist their own staff to continue breastfeeding after return to work.

What about mothers who do not want to breastfeed?
Parents have the right to decide how to feed and care for their babies. Facilities and staff have the responsibility to encourage best practice and to ensure parents are given accurate, unbiased and appropriate information to allow them to make an informed choice. Facilities will not be penalised at assessment if individual mothers indicate they have made informed choices which are not in accordance with the Ten Steps.

Your views are sought on implementing a Community Initiative.

Baby Friendly Initiative – Community Health Services Survey

1. Would extending the Baby Friendly Hospital Initiative, which is currently running in maternity units, into community health services assist in promoting, protecting and supporting best practices related to breastfeeding?

Would greatly assist	Would assist	Would not assist	Not needed

Comments:_____

_____

2. What Community Health workers would be considered to have 'clinical responsibility' for assisting Breastfeeding? Which additional staff could be considered as 'having contact with pregnant women, infants and mothers'?

	Responsibility	*Contact*
GP	____	____
Public Health Nurse	____	____
Area Medical Officer	____	____
Nutritionist/Dietician	____	____
Social Worker	____	____
Community Welfare Officer	____	____
Health Promotion Officer	____	____
Other: _____	____	____
_____	____	____
_____	____	____

3. What do you consider should be the setting or entity participating in the initiative and assessed?

Health Centre ☐
Primary Care Teams ☐
Community Care Areas ☐
Other: _____

_____

4. (a) Do you think Mothers would agree to be interviewed by an external Baby Friendly assessment team about the services they received?
Yes ____ **No**____

(b) How could a varied sample of mothers be found in your area?

_____

5. (a) On the next page are draft 'Steps to a Baby-friendly Community Health Service'. Would you modify these Steps in any way? **Yes ____** **No____**

   If yes, how do they need to be modified?

   _____

   _____

   (b) Which Steps or aspects of Steps would be most difficult to implement? What might make it easier to implement them?

   _____

   _____

6. Should the Baby-friendly Community Health Service Initiative include both breastfeeding and non-breastfeeding mothers and babies? (See two versions of Steps on the next page).
   Yes ____ **No____**

7. What do you consider to be the potential barriers to implementing the Baby-friendly Community Health Service Initiative?

   _____

   _____

   _____

   _____

   Any Additional comments:

   _____

   _____

   _____

   _____

Thank you for sharing your thoughts.
Name: _____ (not for publication)

Position: (e.g) PHN, GP, parent etc _____
Phone if you are willing to discuss in more detail: _____

Please return by: Friday 30 November 2007

To: *BEST Services*
2 Kylemore Park
Taylor's Hill, Galway

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Appendix C: List of stakeholders consulted

Not included in this extract

Appendix D: Steps/Points for the Baby-friendly Community Initiative in other countries

Health facilities providing care for pregnant women, mothers, infants and young children should:

	UK	Canada	New Zealand	Netherlands	Norway:
1	Have a written breastfeeding policy that is routinely communicated to all healthcare staff	Have a written breastfeeding policy that is routinely communicated to all staff and volunteers.	Have a written breastfeeding policy that is routinely communicated to all staff and volunteers	similar	Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2	Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy	Train all health care providers in the knowledge and skills necessary to implement the breastfeeding policy.	Train all health care providers in the knowledge and skills necessary to implement the breastfeeding policy.	similar	Train all healthcare staff in the knowledge and skills necessary to practice in accordance with the breastfeeding policy
3	Inform all pregnant women about the benefits and management of breastfeeding	Inform pregnant women and their families about the benefits and management of breastfeeding.	Inform pregnant women and their families about the benefits and management of breastfeeding.	similar	Inform pregnant women about the benefits and management of breastfeeding.
4	Support mothers to initiate and maintain breastfeeding	Support mothers to establish and maintain exclusive breastfeeding to six months.	Support mothers to establish and maintain *exclusive breastfeeding* to six months.	Breastfeeding women are stimulated and supported to do so while attention is given to the prevention and solving of problems	Establish a reliable system of communication to ensure continuity of care between prenatal care, hospitals and community heath services. The community health services should give mothers contact details of breastfeeding support groups.

	UK	Canada	New Zealand	Netherlands	Norway:
5	Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods	Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods	Encourage sustained breastfeeding beyond six months, to two years or more, alongside the introduction of appropriate, adequate and safe complementary foods.	Women receive information about the fact that the baby doesn't need other food than breastmilk until about 6 months of age and that breastfeeding, together with complementary foods, may thereafter continue for as long as mother and child wish	Show mothers how to breastfeed and how to maintain lactation.
6	Provide a welcoming atmosphere for breastfeeding families	Provide a welcoming atmosphere for breastfeeding families.	Provide a welcoming atmosphere for breastfeeding families	Women receive information about the possibilities to combine breastfeeding with work or study outside the home.	Give mothers appropriate information and support to maintain exclusive breastfeeding for the first six months. After introduction of solid foods breastfeeding should be sustained up to the end of the first year and beyond as desired.
7	Promote co-operation between healthcare staff, breastfeeding support groups and the local community	Promote collaboration between health care providers, breastfeeding support groups and the local community.	Promote collaboration among health services, and between health services and the local community	The service stays in touch with other facilities and disciplines about breastfeeding support and refers parents to the breastfeeding support groups.	only six Steps
	Births 2005: 659,000 www.babyfriendly.org.uk	Births 2005: 327,000 www.breastfeedingcanada.ca/ html/bfi.html	Births 2005: 54,000 www.babyfriendly.org.nz	Births 2005: 187,000 www.zvb.borstvoeding.nl	Births 2005: 54,000

Information was not available on the pilot project in Lomardia, Italy that commenced in October 2007

Note from The Netherlands: Step 6 is there because the maternity leave is 12 weeks after delivery and work & breastfeeding is really a problem. Step 7 asks more than the original step 10 (maternity) does; the facility or service has to work together with partners in health care in order to come to continuity in advice and care. This requirement is added also to step 10 (maternity), because the Dutch system is very fragmented with the independent midwifery practices, maternity care at home etc.

Appendix E: Draft Steps for BFCI Ireland *(Amended after consultation process)*

	Community (Bf version)	Rationale	Maternity (existing)	Paediatric (existing)
1	Have a written breastfeeding policy that is routinely communicated to all health workers and parents.	Consistency with other initiatives.	Have a written breastfeeding policy that is routinely communicated to all health care staff.	Have a written breastfeeding policy, which is formulated in conjunction with the maternity services (where relevant).
2	Train all health workers in the knowledge and skills necessary to implement the breastfeeding policy.	Consistency with other initiatives.	Train all health care staff in skills necessary to implement this policy.	Train health care staff caring for breastfeeding children in the skills necessary to implement the policy.
3	Discuss with pregnant women and their families about the importance and management of breastfeeding, and supportive birth practices	Consistency with other initiatives. Birth practices added because there is increased focus on them in revised BFHI	Inform all pregnant women about the benefits and management of breastfeeding.	Provide parents with evidence-based written and verbal information about the benefits and management of breastfeeding and breastmilk feeding.
4	Assist mothers to establish and maintain practices that assist breastfeeding: • effective positioning, attachment and suckling • baby-led feeding • keeping baby near • avoiding artificial teats or pacifiers • ways of dealing with minor problems	Combined into one step with the overall focus of supportive practices.	Help mothers to initiate breastfeeding within a half-hour of birth.	Plan all nursing and medical care to minimise disturbance to the breastfeeding and parent-child relationship.
5	Support the continuance of breastfeeding if mother and baby are separated	Consistency with other initiatives.	Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.	Support mothers in their feeding method, assisting in the establishment and maintenance of breastfeeding and/or the safe expression and storage of breastmilk.
6	Encourage exclusive breastfeeding for six months and continued thereafter with appropriate complementary foods.	Consistency with other initiatives.	Give newborn infants no food or drink other than breast milk, unless medically indicated.	If a baby is unable to feed at the breast alternative techniques conducive to breastfeeding should be used.
7	Document method(s) of infant feeding and progress at each routine point of contact and review rates periodically.	Audit could be in Step 1 as an aspect of policy if there was another item to go here.	Practise rooming-in - allow mothers and infants to remain together 24 hours a day.	Provide facilities that allow parents and children to be together 24 hours a day in order to promote breastfeeding on demand.

	Community (Bf version)	Rationale	Maternity (existing)	Paediatric (existing)
8	Provide a welcoming atmosphere for breastfeeding families	Consistency with paediatric. Supportive environment facilitates baby-led feeding.	Encourage breastfeeding on demand (baby-led).	Provide mothers with an environment and facilities that meet their needs for privacy, information and appropriate nutrition.
9	Abide by the International Code of Marketing of Breast-milk Substitutes and subsequent resolutions	Increased focus in revised BFHI on Code compliance.	Give no artificial teats or pacifiers to breastfeeding infants.	Give no bottles or dummies/soothers to breastfeeding children unless medically indicated and with parents' permission.
10	Promote collaboration between health care providers, breastfeeding support groups and the local community.	Consistency with other initiatives.	Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.	Provide parents with information about breastfeeding support services and groups during admission and on discharge from hospital

Infant feeding version (order amended after consultation process)

1. Have a written infant feeding policy that is routinely communicated to all health workers and parents.
2. Train all health workers in the knowledge and skills necessary to implement the infant feeding policy.
3. Inform pregnant women and their families about the importance and management of breastfeeding, consequences of not breastfeeding, and supportive birth practices.
4. Assist mothers to establish and maintain practices that assist effective feeding:
   - breastfeeding positioning, attachment, and suckling
   - baby-led feeding
   - keeping baby near
   - avoiding artificial teats or pacifiers if breastfeeding
   - safe use of infant formula if used
5. Support the continuance of breastfeeding if mother and baby are separated
6. Encourage exclusive breastfeeding/formula for six months and continued thereafter with appropriate complementary foods.
7. Document method of infant feeding and progress at each routine point of contact and review rates periodically.
8. Provide a welcoming atmosphere for families
9. Abide by the International Code of Marketing of Breast-milk Substitutes and subsequent resolutions
10. Promote collaboration between health care providers, support groups and the local community.

Appendix F: Example of Action Plan

Introduction of a Baby-friendly Community Health Service Initiative in Ireland (BFCI)
This plan assumes that the overarching recommendations are agreed and functioning.

Year One
Develop BFCI information packs for managers and for front-line staff
Develop self-appraisal materials
Select at least one pilot site in each region and appoint a link person in each site
Carry out baseline studies in those sites and report
Begin development of the external assessment criteria for BFCI
Develop and present workshops on implementing BFCI supportive practices for the pilot sites
Keep in touch with similar projects in other countries

Year Two
Maintain contact with pilot sites and support as needed in their working to reach standards
Evaluate available resource materials and education workshops and source/provide additional as needed
Develop process and infrastructure for assessment
Establish assessor training programme
Develop draft external assessment tools
Evaluate pilot sites using draft assessment tools

Year Three:
Maintain contact with pilot sites and support as needed in their working to reach standards
Finalise BFCI information and process documentation, and assessment documentation
Evaluate pilot phase and prepare report
Carry out formal external assessment if pilot sites are ready
Prepare for roll-out to more sites
Launch BFCI

Pilot phase evaluation criteria:
Changes from baseline study
Mother's views of practices and supports received
Staff views of participating in the initiative and assessment
Costs

Staffing level for pilot stage: (could be job-shares)
National: One WTE with expertise related to baby-friendly practices and assessment process, training, administration and project management.
One WTE administrative support (Grade IV)
Three sessional external assessors for approximately three days per pilot site per year
Pilot site: 0.20 link person with knowledge of baby-friendly practices, training experience, awareness of audit processes, and IT skills.

Other costs:
Printing and distribution of documentation and resource material for pilot sites
Travel expenses for visits to pilot sites and workshops
General office space, equipment, consumables and communication expenses
Costs at pilot site level for staff training time and resources

Note to extracted version – this was a suggestion, and no decision has yet been taken on action arising from this report