

An Overview of The Baby-Friendly Hospital Initiative

One (1.0) Contact Hour

Course Expires: 2/28/2020

Course Published: 2/26/2014

Reproduction and distribution of these materials is prohibited without an RN.com content licensing agreement.

Copyright © 2013 by RN.com.
All Rights Reserved.

Acknowledgements

RN.com acknowledges the valuable contributions of...

....*Jennifer Turney MSN, RN, CNS, CPN*

Conflict of Interest

RN.com strives to present content in a fair and unbiased manner at all times, and has a full and fair disclosure policy that requires course faculty to declare any real or apparent commercial affiliation related to the content of this presentation. Note: Conflict of Interest is defined by ANCC as a situation in which an individual has an opportunity to affect educational content about products or services of a commercial interest with which he/she has a financial relationship.

The author of this course does not have any conflict of interest to declare.

The planners of the educational activity have no conflicts of interest to disclose.

There is no commercial support being used for this course.

Purpose and Objectives

The purpose of this two contact hour course is to provide nurses with an understanding of the Baby-Friendly Hospital Initiative and how this initiative can positively affect breastfeeding outcomes.

Material Protected by Copyright

After successful completion of this course, you will be able to:

1. Review the Baby-Friendly Hospital Initiative (BFHI).
2. Discuss breast milk benefits for babies and mothers.
3. Compare current breastfeeding initiation and duration rates in the US today.
4. List and discuss the 10 steps to successful breastfeeding.
5. Discuss the guidelines for Baby-Friendly facilities.
6. Identify barriers to implementation of the BFHI.
7. Describe the components of a hospital Policy Statement that is supportive of breastfeeding.

Introduction

The Baby-Friendly Hospital Initiative (BFHI), is a worldwide program of the World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF), that began in 1991 (Baby-Friendly USA, 2012a & UNICEF, 2017). This initiative is part of a global effort to improve breastfeeding initiation and duration rates, to support mothers in breastfeeding their infants, for the best start in life (Baby-Friendly USA, 2012a & UNICEF, 2017). In the United States BFHI is implemented through the work of Baby-Friendly USA, Inc (BFUSA) (Baby-Friendly USA, 2012a)

The initiative aims at improving the care of pregnant women, mothers and newborns at health facilities that provide maternity services for protecting, promoting and supporting breastfeeding; in accordance with the International Code of Marketing of Breast milk Substitutes (Baby-Friendly USA, 2012a & UNICEF, 2017).

The BFHI aims to increase the numbers of babies who are exclusively breastfed worldwide, a goal which the WHO & American Academy of Pediatrics [AAP] estimates could contribute to avoiding over a million child deaths each year, and potentially many premature maternal deaths as well (AAP, 2012 & WHO, 2015). Achieving Baby-Friendly designation is supported by the Healthy People's 2020 (HP2020) objective to increase exclusive breastfeeding of mothers during the early postpartum period, the AAP recommendation that mothers exclusively breastfeed their infants for the first 6 months after birth; and the Joint Commission's perinatal core measure for exclusive breastfeeding while in the hospital (Peters, 2013).

Did You Know?

Health facilities that meet the criteria for Baby-Friendly can apply for accreditation as Baby-Friendly (Baby-Friendly USA, 2012a).

Please note!

AAP, UNICEF, the WHO and many national government health agencies recommend that babies are breastfed exclusively for their first six months of life with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant (AAP, 2012 & WHO 2015).

The Importance of Breast Milk

Breast milk is a unique nutritional source that cannot adequately be replaced by any other food, including infant formula (Martin, Ling & Blackburn, 2016). It is widely acknowledged as the most complete form of nutrition for infants, with a range of benefits for infants' health, growth, immunity and development, as well as numerous maternal health benefits (AAP, 2012 & Martin, Ling & Blackburn,

2016).

Breast milk has many health benefits for both the infant and the mother (AAP, 2012 & Martin, Ling & Blackburn, 2016).

Did You Know?

Breastfeeding is one of the most effective ways to ensure child health and survival (WHO, 2015). If every child was breastfed within an hour of birth, given only breast milk for their first six months of life, and continued breastfeeding up to the age of two years, about 800,000 child lives would be saved every year (WHO, 2015).

Please note!

Breastfeeding is often devalued, both in the United States and abroad, due to societal and commercial pressure to stop breastfeeding and competes with relentless advertising by infant-formula companies (UNICEF, 2015).

Protective Components of Breast Milk

It is thought that the protective components in human milk are directly responsible for reducing the incidence of many illnesses in infancy and childhood (AAP, 2012 & Martin, Ling & Blackburn, 2016).

Human milk provides many protective factors that can enhance the immune system of the newborn against infection, offering the immediate protection of antibodies and cells involved in fighting infection, as well as growth factors that continue to develop the baby's own immunity (AAP, 2012 & Martin, Ling & Blackburn, 2016).

The antibodies in breast milk are important in the protection against infection because they are directed against bacteria, fungi, viruses and other antigenic substances to which the mother has been recently exposed (Martin, Ling & Blackburn, 2016). In addition, mother's milk contains lactoferrin that has an anti-inflammatory action; lysozyme that attacks the walls of certain bacteria; oligosaccharides that prevent binding of toxic substances to the cells lining the airway and fats that have an antibacterial action (Martin, Ling & Blackburn, 2016). As well, breast milk contains a number of specific factors that promote growth and maturation of the baby's immune system (Martin, Ling & Blackburn, 2016).

The newborn's gut and skin are "colonized" by whatever microbes he or she first comes into contact with (Martin, Ling & Blackburn, 2016). Breast milk provides specific antibodies to afford protection against pathogens in the infant's unique environment (Martin, Ling & Blackburn, 2016). The non-inflammatory and probiotic properties of human milk also help ensure that the infant's intestinal tract will not be permeable to enteric pathogens (Martin, Ling & Blackburn, 2016).

Numerous studies strongly indicate significantly decreased risks of infection, allergy, asthma, diabetes, obesity, cardiovascular disease, and various cancers in breastfed individuals (AAP, 2012 & Martin, Ling & Blackburn, 2016).

The Importance of Breast Milk for Babies

Studies have shown that breastfed babies are less likely to suffer from serious illnesses, including respiratory illnesses, gastrointestinal tract infections, ear infections, Sudden Infant Death Syndrome (SIDS), asthma, atopic dermatitis and eczema (AAP 2012 & Martin, Ling & Blackburn, 2016).

- Respiratory illness is far more common among formula-fed children. The risk for hospitalization for lower respiratory tract infections in first year is reduced by 72% in infants who were breastfed exclusively for 4 months (AAP, 2012).
- Any breastfeeding has shown to decrease incidence of non-specific gastrointestinal tract infections by 64% and continue to protect the gut from disease for 2 months after cessation of breastfeeding (AAP, 2012).
- Breastfeeding has been shown to reduce the likelihood of ear infections, and to prevent recurrent ear infections. Exclusive breastfeeding for more than 3 months reduces incidence of otitis media by 50% (AAP, 2012).
- Researchers have observed a decrease in the probability of SIDS in breast-fed infants. For babies who received any breastfeeding the rate of SIDS reduced by 45% and with exclusive breastfeeding SIDS reduced by 73% (AAP, 2012).
- Another apparent benefit from breastfeeding may be protection from allergies. The AAP (2012) reports 42% reduction in asthma, atopic dermatitis and eczema in babies with a positive familial history.

The Importance of Breast Milk for Children

Some benefits of breastfeeding become apparent as the child grows older. Among the benefits demonstrated by research:

- In infants who are breast-fed dental cavities were reduced by 68% throughout their lives (Cesar et al, 2016).
- Infants who are breast-fed show a long-term positive effect on weight control and feeding regulation (AAP, 2012). Children who were breast-fed are 30% less likely to become obese later in childhood and the 40% less likely to develop type 2 diabetes (AAP, 2012).
- Breastfeeding may also decrease the risk of childhood cancer in children. For infants breastfed for 6 months or longer there is a 20% reduction in acute lymphocytic leukemia and 15% reduction in acute myeloid leukemia (AAP, 2012).
- Celiac disease is reduced 52% in infants who were breastfed at the time of gluten exposure (AAP, 2012). Also, breastfeeding is associated with a 31% reduction in the risk of childhood inflammatory bowel disease (AAP, 2012).
- Breastfeeding was consistently associated with higher performance in intelligence tests in children and adolescents, with a pooled increase of 3-4 intelligence quotient (IQ) points (Cesar et al, 2016)

Test Yourself

Children who were breastfeeding in infancy are more likely to:

- Perform better on intelligence tests.- Correct!**
- Develop a tolerance to fatty acids in the diet.
- Experience allergic reactions to cow's milk products.

The Importance of Breastfeeding for Women

There are both short and long term health benefits for mothers who breastfeed.

- Women who breastfeed have decreased postpartum blood loss and more rapid involution of the uterus (AAP, 2012).
- Continued breastfeeding is associated with increased child spacing secondary to lactational amenorrhea (AAP, 2012).
- Reduced maternal depression is associated with breastfeeding (AAP, 2012 & Cesar et al., 2016)
- A more rapid return to pre pregnancy weight is associated with breastfeeding (AAP, 2012)

Women who don't breastfeed have increased risk of developing heart disease, hypertension, diabetes, high cholesterol, breast cancer, ovarian cancer and rheumatoid arthritis (AAP, 2012 & Cesar et al, 2016).

Breastfeeding Initiation and Duration Rates

Healthy People 2020 (HP2020) set national breastfeeding targets of 81.9% of newborns be breastfed at least once, 60.6% of infants be breastfed for 6 months and 34.1% be breastfed for one year (CDC,2016a). The goals for breastfeeding exclusively are 46.2% at 3 months and 25.5% at 6 months (CDC, 2016a).

Breastfeeding rates continue to rise in the U.S. Among infants born in 2013, 4 out of 5 (81.1%) started to breastfeed, over half (51.8%) were breastfeeding at 6 months, and almost one third (30.7%) were breastfeeding at 12 months (CDC, 2016a).

More than half of states (29 states, including D.C. and Puerto Rico) have already met the HP2020 objective of 81.9% ever breastfeeding (CDC, 2016a). Despite high breastfeeding initiation rates and continued improvement in breastfeeding duration, most states are not yet meeting HP2020 breastfeeding duration and exclusivity targets (CDC, 2016a). For infants born in 2013, 12 states met the HP2020 breastfeeding objective for 6 months duration (60.6%) (CDC,2016a).

National estimates from the United States National Immunization Surveys indicate substantial racial/ethnic differences in breastfeeding (CDC, 2013). National surveys of breastfeeding initiation and duration rates (at 6 and 12 months respectively) show a highest incidence of breastfeeding in non-Hispanic Caucasians, followed by Hispanics. African Americans have the lowest initiation and duration rates (CDC, 2013). Education and higher socio-economic status are also linked to higher breastfeeding initiation and duration rates (CDC, 2013).

Did You Know?

Breast milk without supplements during the first six months reduces the possibility of food contamination due to tainted water or malnutrition as a result of over-diluted formula (AAP, 2012).

Test Yourself

Breastfeeding initiation and duration rates are highest among:

- A. Affluent Caucasians- Correct!**
- B. Affluent Hispanics
- C. Affluent African Americans

Rational: National surveys of breastfeeding initiation and duration rates (at 6 and 12 months

respectively) show a highest incidence of breastfeeding in non-Hispanic Caucasians, followed by Hispanics. African Americans have the lowest initiation and duration rates (CDC, 2013). Education and higher socio-economic status are also linked to higher breastfeeding initiation and duration rates.

Situations in Which Breastfeeding Is NOT Advisable

According to the CDC (2016b), breastfeeding is not advisable if one or more of the following conditions is true:

- Maternal Human Immunodeficiency Virus (HIV), human T-lymphotropic virus (HTLV)-1 and HTLV-2 infection.
- Is taking antiretroviral medications
- Maternal herpes simplex virus infection (when a lesion is present on the breast).
- Has active or untreated maternal tuberculosis (milk can be pumped and given to baby by a care provider).
- Is using or dependent upon illicit drug
- Mothers on medications that contraindicate breastfeeding (eg, antimetabolites, therapeutic doses of radiopharmaceuticals, penicillamine).
- Is undergoing radiation therapies; however, such nuclear medicine therapies require only a temporary interruption in breastfeeding.
- A newborn with galactosemia.

In the situation where the presence or level of risk is unclear, the benefits should be weighed against the theoretic risk for the hazard involved and a decision made on an individual basis (CDC, 2016b).

Did You Know?

When the risk is temporary, the mother should be taught methods to maintain her milk production (AAP, n.d).

The Role of the Health Care System

The health care system has an important role to play in the promotion and support of breastfeeding (AWHONN, 2015). Health facilities that support breastfeeding encourage higher rates of the practice (WHO, 2015).

Breastfeeding support is particularly critical in the first few weeks postpartum, as lactation is being established (AWHONN, 2015). Health care systems can support breastfeeding by providing new mothers with easy access to lactation management support provided by trained physicians, nurses, lactation specialists, peer counselors, and other trained health care providers, especially during the first days and weeks postpartum (AWHONN, 2015).

All health care providers who interact with women or infants should be knowledgeable about the basics of lactation and the role their specialty plays in breast-feeding (AWHONN, 2015). Providers of maternal and child health care have a special role in the promotion of breastfeeding during the prenatal and postnatal periods (AWHONN, 2015).

Health facilities that support breastfeeding encourage higher rates of the practice (WHO, 2015). Breastfeeding has to be learned and many women encounter difficulties at the beginning (AWHONN, 2015). Nipple pain and fear that there is not enough milk to sustain the baby are common. Health facilities that support and encourage higher rates of breastfeeding can be awarded the "Baby-Material Protected by Copyright

Friendly” status as recognition of the facility’s commitment to excellence in the support of breastfeeding mothers and babies.

Currently, there are "baby-friendly" facilities in about 170 countries worldwide, thanks to the WHO-UNICEF Baby-Friendly Hospital Initiative (Baby-Friendly, 2016). Within the United States, 416 U.S. hospitals and birthing centers in 49 states and the District of Columbia hold the Baby-Friendly designation (Baby-Friendly USA, 2017).

More Info

[Click here](#) to find facilities in the U.S. that have Baby-Friendly status

Did You Know?

A woman’s ability to optimally breastfeed her infant depends on the support she receives from those around her.

10 Steps for Baby-Friendly Hospital Accreditation

Baby Friendly USA (2016) has Ten Steps to Successful Breastfeeding that was developed by a team of global experts and consists of evidence-based practices that have been shown to increase breastfeeding initiation and duration. Baby-Friendly hospital and birthing facilities must adhere to the Ten Steps to receive, and retain, a Baby Friendly designation (Baby Friendly USA, 2016).

The Tens Steps to Successful Breastfeeding are: criteria that need to be met are:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, not even sips of water, unless medically indicated.
7. Practice rooming in - that is, allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Note that the program also restricts use by the hospital of free formula or other infant care aids provided by formula companies (Baby Friendly USA, 2016).

Step One

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

All full-term infants should be considered to be breastfeeding infants unless, after giving birth and being offered help to breastfeed, the mother has specifically stated that she has no plans to breastfeed (Baby-Friendly USA, 2016).

The facility should have a written policy that communicates a baby-friendly philosophy and addresses

Material Protected by Copyright

the implementation of the 10 steps to successful breastfeeding, as well as the International Code of Marketing of Breast Milk Substitutes (Baby-Friendly USA, 2016).

What is the International Code of Marketing of Breast Milk Substitute?

This Code aims to protect and promote breastfeeding by ensuring appropriate marketing and distribution of breast milk substitutes (formula), feeding bottles and teats (WHO, 2016). The code prohibits the direct marketing of these products to the public and forbids the practice of distributing educational materials or giving free samples to mothers, their families or health workers (WHO, 2016). According to this code, health care facilities cannot receive free or low-cost supplies of breast milk substitutes to any part of the health care system (WHO, 2016).

All areas of the facility that potentially interact with childbearing women and babies will have language in their policies about the promotion, protection and support of breastfeeding (Baby-Friendly USA, 2016).

Test Yourself

The BFHI restricts designated hospitals from using free formula provided by formula companies.

- A. True- Correct!
- B. False

Rational: The International Code of Marketing of Breast Milk Substitutes prohibits the direct marketing of these products to the public and forbids the practice of distributing educational materials or giving free samples to mothers, their families or health workers (WHO, 2016).

Step Two

Train all health care staff in skills necessary to implement this policy (of breast milk as the standard for infant feeding).

All health care professionals who interact with childbearing women and babies will be trained to promote, protect and support breastfeeding (Baby-Friendly USA, 2016).

Training for nursing staff on maternity should comprise of a total of 20 hours, inclusive of the 15 sessions identified by UNICEF/WHO and 5 hours of supervised clinical experience (Baby Friendly USA, 2016).

Clinical competence that is assessed includes:

- Counseling the feeding decision
- Providing skin-to-skin contact in the immediate postpartum period and beyond
- Assisting and assessing the mother and infant in achieving comfortable and effective positioning and attachment at the breast.
- Counseling mothers regarding maintaining exclusive breastfeeding
- Learning feeding cues
- Assuring rooming in
- Teaching and assisting mothers with hand expression of milk
- Teaching formula preparation and feeding to parents when necessary
- Assisting mothers in finding support upon discharge

All health care providers (physicians, midwives, physician assistants, and advanced practice

registered nurses) with privileges of labor, delivery, maternity, and nursery/newborn care should have minimum of 3 hours of breastfeeding management education pertinent to their role (Baby-Friendly USA, 2016). It is expected healthcare providers have a full understanding of the benefit of exclusive breastfeeding, physiology of lactation, how their specific field of practice impacts lactation and how to find out about safe medications for use during lactation (Baby-Friendly, 2016).

Test Yourself

Distribution of educational pamphlets from Nestle® to breastfeeding mothers is an acceptable practice in a Baby-Friendly facility.

A. True

B. False- Correct!

Rational: The International Code of Marketing of Breast Milk Substitutes prohibits the direct marketing of breastfeeding products to the public and forbids the practice of distributing educational materials or giving free samples to mothers, their families or health workers (WHO, 2016).

Step Three

Inform all pregnant women about the benefits and management of breastfeeding.

Education about breastfeeding, including individual counseling, should be made available to pregnant in the first trimester whenever possible (Baby-Friendly USA, 2016). For facilities without an affiliated prenatal clinic or services the nursing leadership should foster and develop relationships with community based programs (Baby-Friendly USA, 2016).

Education should cover:

- Importance of exclusive breastfeeding
- Non-pharmacological pain relief
- Rooming-in on a 24 hour basis
- Feeding on demand or baby-led feeding
- Frequent feeding to assure optimal milk production
- Effective positioning and attachment
- Exclusive breastfeeding for 6 months and importance after 6 months when other foods are given.
- Individualized education when special medical or contraindications are identified

Step Four

Help mothers initiate breastfeeding within one hour of birth.

There have been many interpretations of Step Four. The most recent interpretation is: *Place infants in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their infants are ready to breastfeed, offering help if needed* (Baby-Friendly USA, 2016).

For vaginal deliveries, all babies should be placed in skin-to-skin contact with their mothers immediately, within 5 minutes after birth, until completion of first feeding, or for at least an hour if not breastfeeding (Baby-Friendly USA, 2016). Infants born by cesarean section should be placed in continuous, uninterrupted skin-to-skin contact with their mothers as soon as the mother is responsive and alert, unless separation was medically indicated, until completion of first feeding or at least an hour if not breastfeeding (Baby-Friendly, 2016).

Routine procedures such as assessments, APGAR scores and vitamin K shots should be done with the baby skin to skin (kangaroo care) with the mother, whenever possible (Baby-Friendly USA, 2016).

Procedures that require separation of the mother and baby (bathing, for example) should be delayed until after this initial period of skin-to-skin contact, and should be conducted, whenever feasible, at the mother's bedside (Baby-Friendly USA, 2016). Additionally, skin-to-skin contact should be encouraged throughout the hospital stay, in the form of kangaroo care (Baby-Friendly USA, 2016).

What is Kangaroo Care?

Kangaroo care is the practice of placing a naked, diapered baby on the mother's bare chest, between her breasts, with a blanket draped over the baby's back. This direct skin-to-skin contact benefits both the mother and her baby (March of Dimes, 2014).

[Click here to learn more...](#)

Step Five

Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.

Health care professionals should assess the mother's breastfeeding techniques and, if needed, should educate her about correct breastfeeding positioning and attachment, optimally within three hours and no later than six hours after birth (Baby-Friendly USA, 2016).

Prior to discharge, breastfeeding mothers should be educated on basic breastfeeding practices, including:

- The importance of exclusive breastfeeding.
- How to maintain lactation for exclusive breastfeeding for about 6 months.
- How to assess if the baby is getting enough breast milk.
- How to express, handle, and store breast milk, including manual expression.
- How to sustain lactation if the mother is separated from her infant or will not be exclusively breastfeeding after discharge.

Additional assistance should be provided to high risk and special needs mothers of infants who have breastfeeding problems or must be separated from infants (Baby-Friendly USA, 2016). Standards of care should include procedures that assure that milk expression is begun as soon as possible, but no later than 6 hours after birth (Baby-Friendly USA, 2016). Expressed milk should be given to infant as soon as the infant is medically ready and used prior to any supplementation or breast milk substitute when medically appropriate (Baby-Friendly USA, 2016).

Step Six

Give infants no food or drink other than breast milk unless medically indicated.

Exclusive breast milk feeding is the expected norm of feeding from birth until discharge (Baby-Friendly USA, 2016).

When a mother chooses to not to breastfeed or requests breastmilk substitute the health care staff are expected to explore the request and address the concerns raised while at the same time educate the mother about possible consequences to the health of the infant (Baby-Friendly USA, 2016). In the case the mother still chooses not to breastfeed or use breastmilk substitute documentation of an informed decision is made (Baby-Friendly USA, 2016).

Most facilities track exclusive breast milk feeding according to The Joint Commission definition of exclusive breast milk feeding (The Joint Commission, 2015).

The eligibility criteria for exclusive breast milk feeding include all live-born newborns discharged from the hospital, with the exception of infants who were:

- Diagnosed with galactosemia
- Enrolled in a clinical trial
- Fed parentally
- Length of Stay >120 days
- Patients transferred to another hospital
- Patients who are not term or with <37 weeks gestation completed
- Experienced death (The Joint Commission, 2015)

The facility should compare its annual rate of supplementation of breastfed babies to that rate reported by the CDC's National Immunization Survey data for the geographic-specific region in which the facility is located (Baby Friendly USA, 2014c).

The Joint Commission's defines exclusive breast milk feeding as newborn receiving only milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines (The Joint Commission, 2015).

Test Yourself

The standard practice of early supplementation of sterile water or dextrose water does not contravene the tenets of the BFHI.

A. True

B. False- Correct!

Rational: According to the BFHI, no supplementation, other than breast milk, should be given to newborn infants, unless medically indicated (Baby-Friendly USA, 2016).

Step Seven

Practice rooming in - allow mothers and infants to remain together twenty-four hours a day.

The facility should provide rooming-in twenty-four hours a day as the standard for mother-baby care for healthy, full-term infants, regardless of feeding choice (Baby-Friendly USA, 2016). When a mother

Material Protected by Copyright

requests that her baby be cared for in the nursery, the health care staff should explore the reasons for the request and should encourage and educate the mother about the advantages of having her infant stay with her in the same room twenty-four hours a day (Baby-Friendly USA, 2016). An informed decision should be documented if the mother continues to persist that the baby be cared for in the nursery (Baby-Friendly USA, 2016). In addition, the medical and nursing staff should conduct newborn procedures at the mother's bedside whenever possible, and should avoid frequent separations and/or absences of the newborn from the mother for more than an hour (Baby Friendly USA, 2016).

If the baby is kept in the nursery for medical reasons, the mother should be provided access to feed her baby at any time (Baby Friendly USA, 2016).

Step Eight

Encourage breastfeeding on demand.

Health care professionals should help all mothers (regardless of feeding choice) to feed according to feeding cues, including:

- Understand that no restrictions should be placed on the frequency or length of feeding.
- Understand that newborns usually feed a minimum of eight times in 24 hours.
- Recognize cues that infants use to signal readiness to begin and end feeds.
- Understand that physical contact and nourishment are both important.

Please note!

This step applies to all babies, regardless of feeding method, and is now interpreted as “Encourage feeding on cue” (Baby-Friendly USA, 2016).

Step Nine

Give no pacifiers or artificial nipples to breastfeeding infants.

Health care professionals should educate all breastfeeding mothers about how the use of bottles and artificial nipples may interfere with the development of optimal breastfeeding (Baby-Friendly USA, 2016).

When a mother requests that her breastfeeding baby be given a bottle, the health care staff should explore the reasons for this request, address the concerns raised, educate her on the possible consequences to the success of breastfeeding, and discuss alternative methods for soothing and feeding her baby (Baby-Friendly USA, 2016).

If the mother still requests a bottle, the process of counseling and education, and the informed decision of the mother should be documented (Baby-Friendly USA, 2016).

Any fluid supplementation (whether medically indicated or following informed decision of the mother) should be given by tube, syringe, spoon or cup in preference to an artificial nipple or bottle (Baby-Friendly USA, 2016).

Step Ten

Foster the establishment of breastfeeding support groups and refer mothers to them on

discharge from the hospital or birth center.

Health care professionals should ensure that, prior to discharge, a responsible staff member explores with each mother and a family member or support person, the plans for infant feeding after discharge (Baby-Friendly USA, 2016). Discharge planning for the breastfeeding mothers and infants should include information on the importance of exclusive breastfeeding for about 6 months as well as available and culturally specific breastfeeding support services without ties to commercial interests (Baby-Friendly USA, 2016).

Examples of the information and/or support to be provided include giving the name and phone numbers of La Leche League or other community-based support groups: WIC Program breastfeeding support services, telephone help lines, lactation clinics, home health services, and individualized specialized resource persons (Baby-Friendly USA, 2016).

An early post-discharge follow-up appointment with their pediatrician, family practitioner or other pediatric care provider should also be scheduled (Baby-Friendly USA, 2016). The facility should establish in-house breastfeeding support services if no adequate source of support is available for referral (Baby-Friendly USA, 2016).

Breastfeeding Policies and Procedures

As a health care professional, our clinical practice should always be guided by policies and procedures. In order to truly support the initiation and maintenance of breastfeeding in the early postpartum period, we need to establish and follow breastfeeding policies (AAP, 2012).

The AAP (2012), American College of Obstetricians and Gynecologists [ACOG] (2016) and American Academy of Family Physicians [AAFP] (2015) recommend that all facilities develop a Breastfeeding Policy for Newborns. This policy will establish and promote a philosophy and standards of care for the initiation and support of breastfeeding that is congruent with the promotion and protection of breastfeeding in the early postpartum period.

Exclusive breastfeeding is defined as providing breast milk as the sole source of nutrition. Exclusively breastfed babies receive no other liquids or solids (AAP, 2012).

Breastfeeding Policy Statements

Many hospitals have practices that are detrimental to breastfeeding including the routine use of formula supplementation and free samples, pacifier use, and the separation of mother and infant. The AAP (n.d) Section on Breastfeeding and the Section on Perinatal Pediatrics has written a sample breastfeeding hospital policy that outlines the policies and procedures that hospitals should take to support breastfeeding.

Most breastfeeding policy statements should include the following points:

- **Responsibility:** Assign a director to chair a multispecialty taskforce that will be responsible for implementation of the written policy.
- **Staff Training for Policy Implementation:** All health professionals attend educational sessions on lactation management and breastfeeding promotion to ensure that correct, current, and consistent information is provided to all mothers wishing to breastfeed

Process for Pregnant Mothers and Mothers with Healthy Newborns

- **Maternal Education:** The decision to breastfeed or provide breastmilk for her newborn should

be an informed choice made by the mother. Mothers should be encouraged to breastfeed unless medically contraindicated. When risk is temporary, the mother should be taught methods to maintain her production. All pregnant women should be provided with information on the benefits of breastfeeding free of any formula marketing materials. A woman's desire to breastfeed should be documented in her medical record.

- **Initiation of Breastfeeding:** At birth or soon thereafter, all stable newborns should be placed skin-to-skin with the mother. Assessments, Apgar scores, identification banding can all be performed while newborn is with mother. Babies whom an immediate pediatric assessment takes precedence over skin-to-skin include: preterm (born before 37 weeks' gestation), exhibit respiratory distress or cyanosis, have major congenital anomalies that might lead to cardiorespiratory compromise, are born through meconium-stained amniotic fluid and exhibit hypotonia or weak cry, are born in the context of markedly elevated infection risk (maternal temperature $\geq 101^{\circ}\text{F}$), or have evidence of perinatal depression (eg, decreased muscle tone, apnea, bradycardia).
Except under special circumstance, the newborn should remain with the mother throughout the recovery period
- **Management of Lactation:** Nursing staff will offer each mother further assistance with breastfeeding within 6 hours of delivery. The mother should be guided so that she can help the newborn latch onto the breast properly. Trained caregivers will undertake daily formal evaluation of the breastfeeding process in each mother-baby dyad, including observation of position, latch, and suckling. Each nursing shift will document these evaluations in the medical record. Breastfeeding babies will be weighed each day. Weight loss in the first 72 hours of 7% or more from birth weight indicates a possible breastfeeding problem and requires more intensive evaluation of breastfeeding and possible intervention to correct problems and improve milk production and transfer.
- **Supplementation:** It is uncommon for breastfeeding newborns to need any supplementation during the first week; thus, routine supplements (water, glucose water, formula, and other fluids) should not be given to breastfeeding newborns unless ordered by a physician. For mothers who choose partial breastfeeding, the request for formula for their babies should be respected by the staff and their preference should be documented in the chart. For mothers who intend to breastfeed, distribution of formula on discharge will be discouraged, unless medically indicated. For breastfeeding mothers who intend to feed their newborns with formula, the distribution of formula on discharge will be consistent with the physician's written order. Newborns with hyperbilirubinemia may continue breastfeeding unless there are specific orders from the physician to the contrary.
- **Rooming In:** Rooming-in is a policy that is encouraged in Baby-Friendly facilities, and serves to promote early bonding. This facilitates lactation. Skin-to-skin contact can be encouraged as much as possible.
- **Frequency of Feeds:** Breastfeeding infants, including cesarean-birth babies, are put to breast at least 8 to 12 times each 24 hours. Infant feeding cues (such as increased alertness or activity, mouthing, or rooting,) will be used as indicators of the baby's readiness for feeding. Time limits for breastfeeding will be avoided. After 24 hours of life, if the baby has not latched onto the breast or latches on but feeds poorly, the mother will be instructed to initiate hand expression and electric pumping every 3 hours. Any collected colostrum will be fed to the newborn by an alternative method. Skin-to-skin contact will be encouraged. Until the mother's milk is available, a collaborative decision should be made among the mother, nurse, and clinician about the need to supplement the baby, the type of formula, the volume, and the mode of delivery. (If available, advice from a lactation consultant will be requested).
- **Selective Use of Pacifiers and Assurance of Adequate Breastfeeding Assessment and**

Education: Avoid use of pacifiers to normal full-term breastfeeding infants. Pacifier use has been independently associated with significant declines in the duration of breastfeeding. Studies have shown that women who introduced pacifiers tended to breastfeed their infants less frequently and experienced more breastfeeding problems consistent with infrequent feeding. Yet, preterm infants in the NICU or infants with specific medical conditions may be given pacifiers for non-nutritive sucking.

- **Preparation for Discharge:** All babies should be seen for follow-up within the first few days postpartum. This visit should be with a pediatrician or other qualified healthcare practitioner for a formal evaluation of breastfeeding performance, a weight checks, assessment of jaundice and age appropriate elimination. For infants discharged at less than 48 hours of age, follow up should be scheduled at 2 to 4 days of age. For infants discharged at more than 2 days of age, follow-up should be scheduled at 4 to 5 days of age. All newborns should be seen by 1 month of age

Process for Mothers Who Deliver Prematurely or Are Separated From their Newborns for Medical Reasons

- **Maternal Education:** Mothers who deliver prematurely may not be aware of the benefits of human milk for their preterm newborns and commonly base their decisions on health-related issues. Staff (physicians and nurses) will therefore stress the protective properties of breast milk and recommend mothers provide breast milk without necessarily making the commitment to breastfeed.
- **Initiation of Pumping:** When direct breastfeeding is not possible, expressed humanmilk, fortified when necessary for the premature baby, is the preferred diet. Banked human milk may be a suitable feeding alternative for newborns whose mothers are unable or unwilling to provide their own milk. Human milk banks in North America adhere to national guidelines for quality control of screening and testing of donors and pasteurize all milk before distribution. Fresh human milk from unscreened donors is not recommended because of the risk of transmitting infectious agents.
The first post-delivery encounter with the physician, or as soon as it is appropriate, should include discussion of human milk, its role in the preterm newborn's care, and the urgency to begin expressing or pumping. The responsibility for initiating and maintaining an expressing or pumping routine (at least 6 times/day with a hospital-grade pump) will belong to the nursing staff and should begin within the first 6 hours postpartum, or as soon after delivery as the mother is stable (not "recovered"). The aim is to mimic the optimal breastfeeding stimulation provided by a healthy full-term newborn.
- **Management of Lactation:** Mothers who are separated from their newborns for more than 8 hours will be:
 - Assisted with and instructed on how to hand-express colostrum.
 - Assisted with and instructed on how to use the double electric pump every 3 hours (or 6–8 times per day, with no period >5 hours between 2 sessions).
 - Encouraged and taught how to provide small volumes of fresh colostrum for their newborn.
 - Provided a pumping diary/log to record their pumping history.
 - Encouraged to practice skin-to-skin care as soon as the baby is stable.
 - Encouraged to initiate nonnutritive suckling as soon as mother's and baby's condition permits. Initiating oral feedings at the breast is preferred over bottle feeding.
 - Encouraged to initiate breastfeeding on demand as soon as mother's and baby's condition permits.
 - Taught proper collection, storage, and labeling of human milk.
 - Instructed on how to hand express and, if needed, use effective techniques with pumps once milk "comes in."

- Provided anticipatory guidance, when appropriate, on management of engorgement.
- Assisted with obtaining electric pump (hospital grade) for home usage prior to discharge.

The 4-D Pathway to Designation

Your facility can make a commitment to improve infant feeding policies, training and practices by embarking on the 4-D pathway to designation (Baby-Friendly USA, 2012b). This journey creates an environment that is supportive of best practices in maternity care and of optimal infant feeding (Baby-Friendly USA, 2012b).

The 4-D pathway is applicable to all institutions; large and small hospitals, for profit and not-for-profit hospitals, teaching hospitals, and hospitals at various stages of development in their breastfeeding education and support services, as well as birthing centers (Baby-Friendly USA, 2012b).

Hospitals providing maternity care throughout the U.S. may earn designation by successfully completing all 4 phases of the 4-D pathway, implementing the Guidelines and Evaluation Criteria and passing an on-site assessment (Baby-Friendly USA, 2012b).

The Baby-Friendly Designation process requires verification of policies, curriculum, action plans, quality improvement projects, staff training, and competency verification, as well as a readiness interview and an on-site survey (Baby-Friendly USA, 2012b).

Upon successful completion of this process, as determined by the onsite assessment, the facility will be granted a license to use the Baby-Friendly certification mark (Baby-Friendly USA, 2012b).

Following the 4-D pathway will ensure that hospitals and birthing centers implement Baby-Friendly principles in a logical and efficient manner (Baby-Friendly USA, 2012b).

What Are the Steps in the 4-D Pathway?

D1:Discovery Phase

Facilities submit a two-part registration form with Baby-Friendly USA and learn about the process for Baby-Friendly designation (Baby-Friendly USA, 2012b).

D2:Development Phase

Facilities make a commitment to the process and receive a comprehensive set of tools to assist in implementing the Ten Steps to Successful Breastfeeding. Baby-Friendly USA provides technical assistance to the facility to create a plan for achieving Baby-Friendly guidelines (Baby-Friendly USA, 2012b).

D3:Dissemination Phase

Facilities implement the plans they established during the Development phase. They collect data and measure their results against the Baby-Friendly USA Guidelines and Evaluation Criteria (Baby-Friendly USA, 2012b). Quality improvement activities continue until audit results indicate that all required standards are being met (Baby-Friendly, 2012b).

D4: Designation Phase

Facilities continue their quality improvement program, evaluating their findings against Baby-Friendly

USA Guidelines and Evaluation Criteria (Baby-Friendly, 2012b). The assessment process begins when the facility completes implementation of the Guidelines and Evaluation Criteria and discusses their status with Baby-Friendly USA during a readiness assessment telephone interview (Baby-Friendly, 2012b). The facility then invites Baby-Friendly USA to send a survey team to their facility to conduct the on-site assessment (Baby-Friendly, 2012b). The team visits the facility and conducts a series of interviews, observations and document reviews. Baby-Friendly designation is conferred when the External Review Board reviews the survey tool and confirms that the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast Milk Substitutes have been properly implemented (Baby-Friendly, 2012b).

Barriers to Implementation-Organizational

There are several barriers that prevent facilities from trying to achieve the BFHI.

On an organizational level the major barriers to implementation include:

- Lack of strong administrative support, designated leader/coordinator and autocratic top-down management of BFHI implementation process (Semenic, Childerhos, Lauziere & Groleau, 2012)
- Lack of adoption and enculturation of BFHI as an organizational culture/philosophy or care. Including treating the Ten Steps a checklist rather than a best practice approach and lack of collaboration across perinatal units (i.e. NICU as a “separate world”) (Semenic et al., 2012).
- Lack of Human and financial resources including staff shortages, high staff turnover, lack of time to provide breastfeeding teaching and support (Semenic et al.,2012).
- Difficulty to fund the development of breastfeeding policies, and even once the policies are developed, it can be difficult to communicate and share those policies with all relevant staff members (Semenic et al, 2012).
- Implementation of staff training including lack of breastfeeding resources to complete training (Semenic et al, 2012).
- Compliance with the International Code of Marketing of Breast Milk Substitutes (Semenic et al., 2012). In order to comply with this code, facilities are required to refuse to accept any supplies of formula and feeding supplies at no cost to the facility, or at a cost that is below fair market price (Semenic et al., 2012).

Test Yourself

It is acceptable for a Baby-Friendly facility to offer free formula to bottle-feeding infants only.

A. True

B. False- Correct!

Rational: Baby-Friendly facilities must demonstrate its compliance with the International Code of Marketing of Breast Milk Substitutes by refusing to accept any free supplies of formula or feeding supplies for any infant (Baby Friendly USA, 2016).

Barriers to Implementation: Health Care Providers & Mother/Family Members

Beyond the organizational barriers Health Care Providers along with the mother and other family members can prove to be barriers to implementation of BFHI (Semenic et al., 2012).

For Health Care Providers barriers identified were:

- Inadequate knowledge of staff and skill related to breastfeeding, outdated practices among

physicians or senior staff and lack of knowledge of community resources (Semenic et al., 2012).

- Staff's attitudes toward accepting BFHI program and resistance to change (Semenic et al., 2012).
- Staff's reluctance to "push" breastfeeding and concerned about mother's feeling guilty about their feeding choices (Semenic et al., 2012).
- Overreliance on breastfeeding aids (i.e breast pumps, bottles, pacifiers, or formula) to manage breastfeeding challenges (Semenic et al., 2012).

For the mother and family members barriers include:

- Lack of knowledge about breastfeeding and antenatal preparation including informed choice of feeding preference (Semenic et al.2012).
- Mother's and family member's beliefs and practices related to breastfeeding (Semenic et al, 2012).

Overcoming Obstacles

The largest hurdle for facilities is often the economic impact of giving up free formula, but the benefits of achieving Baby-Friendly status far outweigh the economic cost of purchasing formula and feeding supplies (Semenic et al, 2012).

According to Peters (2013), customer satisfaction surveys, measured before and after the implementation of Baby-Friendly practices, consistently demonstrate increased patient satisfaction ratings to the question "I learned how to feed my baby properly". This same result is reflected in the perinatal care core measure of exclusive breastfeeding (Peters, 2013).

Establishing a strong administrative support from leadership, physician leadership and designation of a lead coordinator have proven to facilitate integration and enculturation of BFHI as an organizational culture/philosophy or care (Semenic et al, 2012).

Myths and obstacles of Baby-Friendly practice can present barriers to implementation. The most common myths are that mothers will not have a choice in how to feed their infant, hospital costs will increase significantly, and the requirement of staff education will be difficult to meet (Peters, 2013). However, organizations that have achieved Baby-Friendly status have found that these obstacles can be overcome by meeting the Baby-Friendly goals of providing consistent information to parents and staff regarding breastfeeding, keeping moms and infants together as standard of care, and changing practice to meet skin-to-skin contact and exclusive breast milk requirements (Peters, 2013).

Conclusion

Breastfeeding is the preferred feeding for almost all infants (Meek, 2013). Health care professionals need to support breastfeeding, to ensure that all infants are offered the ideal form of nutrition. In order to succeed, breastfeeding must be actively supported and promoted in the medical community and in society.

Becoming Baby-Friendly often demands a change in practice toward family-centered care (Peters, 2013). Baby-Friendly initiatives are often met initially with resistance from staff and physicians, as it requires the reversal of traditional concepts, such as sending infants to the nursery so that mothers can rest, not offering supplementation of formula until lactation is established, and using pacifiers to satisfy suckling (Semenic et al., 2012). The initiative requires that health care professionals educate mothers about breastfeeding skills, support practices such as skin-to-skin contact after birth, rooming-

in as standard of care for healthy infants, and offer supplementation only when medically indicated (Baby Friendly USA,2016).

You can make a difference by assisting your facilities in achieving the Baby-Friendly Hospital designation, as a gold standard of excellence in the care of mothers and babies. To begin this journey, visit Baby-Friendly USA, Inc. to learn more.

Resources

American Academy of Pediatrics (AAP) Resources To Support Breastfeeding Families

Your Guide to Breastfeeding

<https://www.womenshealth.gov/publications/our-publications/breastfeeding-guide/>

This popular pamphlet for mothers provides the basics of breastfeeding for your patients.

Breastfeeding Your Baby: Answers to Common Questions

<http://www2.aap.org/breastfeeding/healthProfessionalsResourceGuide.html#Families>

This pamphlet provides a brief overview of common breastfeeding questions. Available in Spanish.

New Mother's Guide to Breastfeeding (English)

<https://shop.aap.org/new-mothers-guide-to-breastfeeding-paperback/>

A basic breastfeeding 101 book for mothers. It is a good overview of the experience of breastfeeding from initiation to weaning for parents. Available in Spanish.

Nueva Guia De Lactancia Materna

<https://shop.aap.org/nueva-guia-de-lactancia-materna-paperback/>

This is the Spanish version of the New Mother's Guide to Breastfeeding, a basic breastfeeding 101 book for mothers. It is a good overview of the experience of breastfeeding from initiation to weaning for parents.

Safe and Healthy Beginnings Toolkit

<https://shop.aap.org/safe-and-healthy-beginnings-a-resource-toolkit-for-hospitals-and-physicians-offices/>

The AAP has developed and tested a variety of tools to help you to make sure that infants in your practice or hospital get off to the best start in life. The tools specifically relate to hyperbilirubinemia and jaundice prevention and treatment and breastfeeding support.

Resources for General Breastfeeding Questions from Families

There are many organizations that provide excellent information when your families have general breastfeeding questions.

Breastfeeding — Best for Baby, Best for Mom

This comprehensive Web site from the Office on Women's Health offers breastfeeding information and a breastfeeding helpline.

Centers for Disease Control and Prevention Breastfeeding Pages

The CDC has basic information about breastfeeding including the safety of vaccinating pregnant women, traveling and breastfeeding, and other helpful information about breastfeeding and disease prevention.

International Lactation Consultant Association

Visit this site to find local International Board Certified Lactation Consultants by zip code.

La Leche League International

La Leche League International offers many resources for families including breastfeeding help, breastfeeding laws, breastfeeding publications, links to local LLL leaders and groups, and more.

References

American Academy of Family Physicians [AAFP] (2015). *AAFP releases position paper on breastfeeding*. Retrieved from: <http://www.aafp.org/afp/2015/0101/p56.pdf>

American Academy of Pediatrics [AAP], (2012). *Breastfeeding and the use of human milk: policy statement*. Retrieved from: <http://www2.aap.org/breastfeeding/files/pdf/breastfeeding2012execsum.pdf>

American Academy of Pediatrics [AAP] (n.d). *Sample hospital breastfeeding policy for newborns*. Retrieved from: https://www2.aap.org/breastfeeding/curriculum/documents/pdf/hospital%20breastfeeding%20policy_final.pdf

Association of Women's Health, Obsetric and Neonatal Nurses [AWHONN] (2015) Breastfeeding. *Journal of Obsetric, Gynecologic & Neonatal Nursing [JOGNN]* 44.145-150. Retrieved from: <http://onlinelibrary.wiley.com/doi/10.1111/1552-6909.12530/epdf>

Baby-Friendly USA (2012a). *BFHI worldwide*. Retrieved from: <http://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/bfhi-worldwide>

Baby-Friendly USA (2012b). *Get started*. Retrieved from: <http://www.babyfriendlyusa.org/get-started>

Baby-Friendly USA (2016). *Guidelines & evaluation criteria*. Retrieved from: <http://www.babyfriendlyusa.org/get-started/the-guidelines-evaluation-criteria>

Baby-Friendly USA (2017). *Find facilities*. Retrieved from: <http://www.babyfriendlyusa.org/find-facilities>

Centers for Disease Control & Prevention [CDC], (2013). Progress in increasing breastfeeding and reducing racial/ethnic difference-united states, 2000-2008 Births. *Morbidity & Mortality Weekly Report [MMWR]*, 62 (5) 77-80. Retrieved from: <https://www.cdc.gov/mmwr/pdf/wk/mm6205.pdf>

Centers for Disease Control & Prevention [CDC], (2016a) *Breastfeeding report card: progressing toward national breastfeeding goals united states*. Retrieved from: <https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf>

Centers for Disease Control & Prevention [CDC], (2016b) *Diseases and conditions*. Retrieved from: <https://www.cdc.gov/breastfeeding/disease/index.htm>

Martin, C.R, Ling,P. & Blackburn, G.L. (2016) Review of infant feeding: key features of breast milk and infant formula. *Nutrients* 8(279). Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4882692/>

- March of Dimes (2014). *In the NICU: holding your baby close: kangaroo care*. Retrieved from: <http://www.marchofdimes.com/baby/holding-your-baby-close-kangaroo-care.aspx>
- Meek, Y. (2013). *Breastfeeding support and promotion.section 5: breastfeeding advocacy*. Retrieved from: <http://www2.aap.org/breastfeeding/healthProfessionalsResourceGuide.html>
- Peters, L. (2013). Overcoming obstacles to become a baby friendly hospital. *Journal of Obstetric, Gynecological & Neonatal Nursing*, 42 (s1), s38-s39.
- Semenic, S., Childerhose, J.E, Lauziere, J. & Groleau, D (2012). Barriers, facilitators and recommendations related to implementing the baby-friendly initiative (BFI): an integrative review. *Journal of Human Lactation* 28(3) 317-334.
- The American College of Obstetricians and Gynecologist [ACOG] (2016). *Committee opinion: optimizing support for breastfeeding as part of obstetric practice*. Retrieved from: <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice>
- The Joint Commission (2015). *Exclusive breast milk feeding PC-05*. Retrieved from: <https://manual.jointcommission.org/releases/TJC2015B/MIF0170.html>
- United Nations International Children's Emergency Fund [UNICEF] (2015). *Breastfeeding*. Retrieved from: https://www.unicef.org/nutrition/index_24824.html
- United Nations International Children's Emergency Fund [UNICEF] (2017). *The baby-friendly hospital initiative*. Retrieved from: <http://www.unicef.org/programme/breastfeeding/baby.htm>
- World Health Organization [WHO], (2015). *10 facts on breastfeeding*. Retrieved from: <http://www.who.int/features/factfiles/breastfeeding/en/index.htm>
- World Health Organization [WHO] (2016). *Marketing of breast-milk substitutes: national implementation of international code: status report 2016*. Retrieved from: http://apps.who.int/iris/bitstream/10665/206008/1/9789241565325_eng.pdf

Disclosure

This publication is intended solely for the educational use of health care professionals taking this course, for credit, from RN.com, in accordance with RN.com [terms of use](#). It is designed to assist health care professionals, including nurses, in addressing many issues associated with health care. The guidance provided in this publication is general in nature, and is not designed to address any specific situation. As always, in assessing and responding to specific patient care situations, health care professionals must use their judgment, as well as follow the policies of their organization and any applicable law. This publication in no way absolves facilities of their responsibility for the appropriate orientation of health care professionals. Health care organizations using this publication as a part of their own orientation processes should review the contents of this publication to ensure accuracy and compliance before using this publication. Health care providers, hospitals and facilities that use this publication agree to defend and indemnify, and shall hold RN.com, including its

Material Protected by Copyright

parent(s), subsidiaries, affiliates, officers/directors, and employees from liability resulting from the use of this publication. The contents of this publication may not be reproduced without written permission from RN.com.

Participants are advised that the accredited status of RN.com does not imply endorsement by the provider or ANCC of any products/therapeutics mentioned in this course. The information in the course is for educational purposes only. There is no “off label” usage of drugs or products discussed in this course.

You may find that both generic and trade names are used in courses produced by RN.com. The use of trade names does not indicate any preference of one trade named agent or company over another. Trade names are provided to enhance recognition of agents described in the course.

Note: All dosages given are for adults unless otherwise stated. The information on medications contained in this course is not meant to be prescriptive or all-encompassing. You are encouraged to consult with physicians and pharmacists about all medication issues for your patients.