Model Hospital Infant Feeding Policy

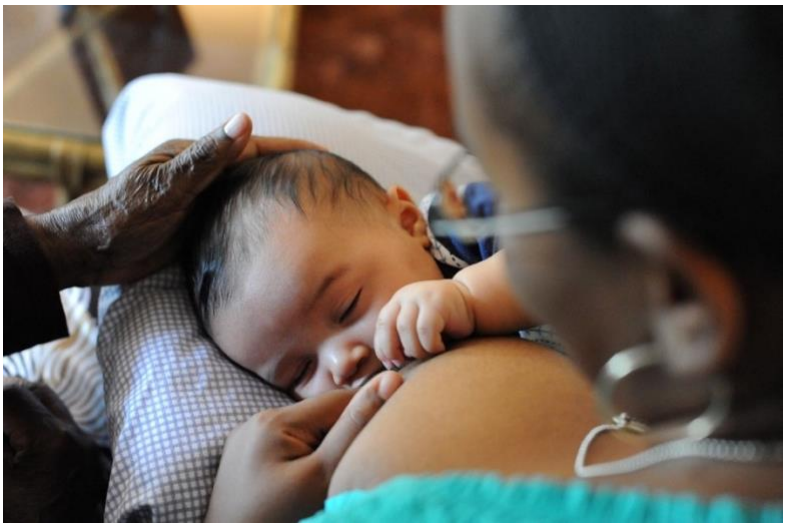

Photo credit: US Breastfeeding Committee

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Endorsements:

Model Hospital Infant Feeding Policy

Introduction

This comprehensive document outlines recommended policies intended to serve as a long-term guide that can be adapted over time to fit your facility's needs. These policies should be viewed in the context of the facility and will require a strong commitment by leadership and management to communicate, follow and implement these important practices.

Methodology

The specific policies contained in this document are based on evidence-based practices and are closely aligned with the World Health Organization's *Implementation Guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative*, the Baby-Friendly USA, *Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation, Sixth Edition*, and the Academy of Breastfeeding Medicine *Clinical Protocol #7: Model Maternity Policy Supportive of Breastfeeding*. These documents were utilized to form the basis for all steps in each category. Complete references for these documents can be found on the References page.

The Indiana Model Policy was used as a model for categorizing each of the steps and classified to indicate the progression that a facility may wish to take in developing a policy that reflects their long-term goals. There were many additional sources of model policies and implementation toolkits that were used during the development of this model policy. They are listed in the Appendix G. Input was also received from a number of hospital-based IBCLCs in the state of Oklahoma and staff from the Maternal and Child Health Division at the Oklahoma State Department of Health.

We acknowledge that although the vast majority of birthing individuals are women, transgender and nonbinary-gendered individuals may also give birth and many may want to breastfeed or feed at the chest. Throughout this document we may refer interchangeably to "mothers," "birthing individuals," or "parents."

First Steps

For facilities that are beginning to develop their breastfeeding policies and have limited resources, this content will provide a good place to start. These points will work best if initiated together.

Important Next Steps

These will replace some of the initial policy content and are more rigorous than the first steps. They will also require more staff education and staffing time but will improve effectiveness of evidence-based care and patient satisfaction.

Additional Evidence-Based Steps **These steps include more of the language that is consistent with the Baby-Friendly Hospital Initiative. While not inclusive, these will bring a higher level of baby-friendly practice to your institution.**

Recommended Implementation Strategies

1. Create an interdisciplinary team with a dedicated project leader to review and strengthen breastfeeding policies. This team should include a wide range of stakeholders who:
    - Support breastfeeding
    - Understand the breastfeeding process
    - Represent the culture and ethnic diversity of the communities served by the facility
2. Evaluate facility data relevant to breastfeeding support services on a regular basis, and, if necessary, revise policies and develop a plan of action to implement needed changes.
3. Use current, evidence-based research to examine, review and if necessary, update infant feeding policies. A good tool to use for evaluation of infant feeding policies is the mPINC Ten Steps Assessment Tool available on the US Centers for Disease Control and Prevention (CDC) website.
4. Implement new or revised policies accompanied by staff education and training and patient education materials.
5. Conduct regular auditing and monitoring to ensure that staff is adhering to the policy and determine whether any adjustments are needed.

WHO/UNICEF Ten Steps to Successful Breastfeeding (revised 2018)

CRITICAL MANAGEMENT PROCEDURES
1 A. Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.
1 B. Have a written infant feeding policy that is routinely communicated to staff and parents.
1 C. Establish ongoing monitoring and data-management systems.
2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.
KEY CLINICAL PRACTICES
3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast-milk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
8. Support mothers to recognize and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, artificial nipples (teats) and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

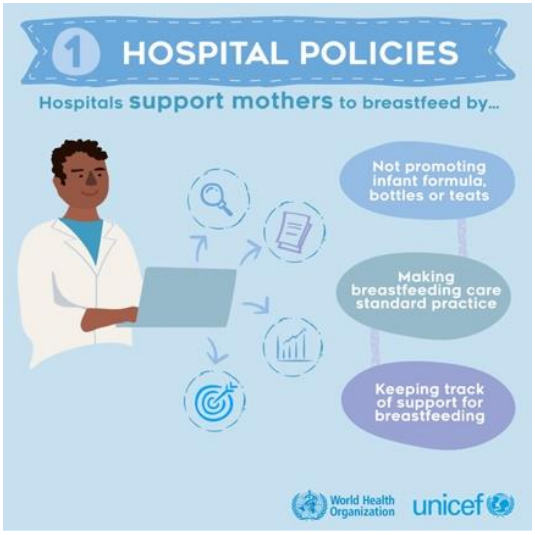
World Health Organization Ten Steps Poster available for download and use:
https://apps.who.int/nutrition/bfhi/bfhi-poster-A2.pdf?ua=1

Purpose

The purpose of the infant feeding policy is to promote a philosophy of maternal infant care that advocates breastfeeding and supports the normal physiological functions involved in the establishment of this process, to assist families choosing to breastfeed with initiating and developing a successful and satisfying experience, and to assist those unable or choosing not to breastfeed with information and support for a safe feeding experience.

Effective Date: 2022

Facility Policy and Data Monitoring



RATIONALE: Written policy assures that appropriate care is provided equitably to all patients. Policies drive practice within any healthcare facility and help sustain evidence-based practices over time.

Families are most vulnerable to the marketing of breastmilk substitutes during the perinatal time. The World Health Assembly and multiple healthcare organizations have called upon healthcare workers and systems to comply with the International Code of Marketing of Breastmilk Substitutes[1] and for healthcare workers to be protected from commercial influences that may affect practice.

By integrating the monitoring of clinical practices related to infant feeding into their quality improvement processes, facilities can identify areas where improvements in policy, compliance, and education are needed in order to improve overall care.

First Step

Review and routinely update the written infant feeding policy based on facility review guidelines and using current research as an evidence-based guide. Communicate any updates to all health care staff.

Important Next Steps

- Nursing leadership will identify staff responsible for implementation and monitoring of the policy.
- The facility does not accept free or below market value formula, nipples, pacifiers, and infant feeding bottles.
- As specified by the International Code of Marketing of Breast Milk Substitutes, pregnant women, new parents, and families will not be given marketing materials or samples or gift packs by the facility that consist of breastmilk substitutes, bottles, nipples or pacifiers, or other infant feeding equipment or coupons for the above items.
- Employees of manufacturers or distributors of breastmilk substitutes, bottles, nipples, and pacifiers will have no direct contact or communication with expectant and new mothers.
- The facility does not receive free gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufacturers of breastmilk substitutes, bottles, nipples, and pacifiers.
- A mechanism for data collection to routinely track breastfeeding and policy implementation will be in place to monitor and improve quality of perinatal care.

Additional Evidence-based Steps

- Health professionals will receive annual education and updates on the elements of the International Code of Marketing of Breast-Milk Substitutes.

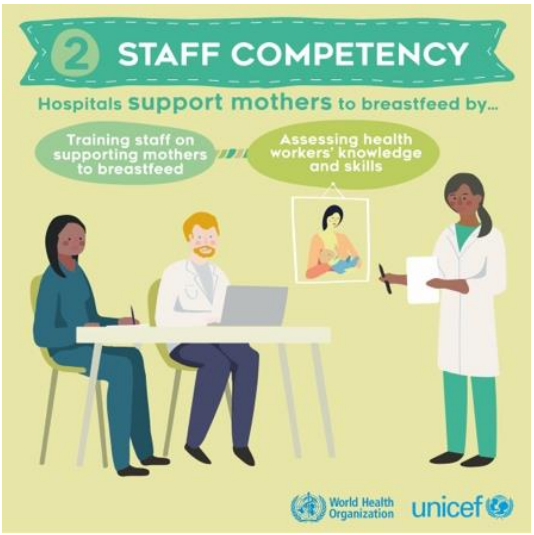
- No items displayed in the facility or provided to patients will bear the product image or logo of companies that produce breast-milk substitutes, infant feeding bottles, artificial nipples, and pacifiers unless specific to the patient's needs or conditions.

- All items that are displayed or distributed to pregnant individuals and mothers are free of messages that promote the use of pacifiers. The exception being information for safe sleep and/or SUIDS/SIDS risk reduction. That information must contain language to promote breastfeeding.

- Place posters that cover The Ten Steps to Successful Breastfeeding in all areas of the facility where families may visit and receive care. These posters will be in the language/s most understood by patients.

- A maternal child health multi-disciplinary quality improvement committee shall meet at least every 6 months for analysis of key clinical practice indicators, determination if targets are met and definition of corrective actions to improve the quality of care.

Staff Competency and Training



RATIONALE: Effective staff training is essential for provision of evidence-based care for all mothers and infants. Training allows staff to provide consistent messages to patients, to develop necessary and effective skills, and to implement facility policies. Development of these skills takes ongoing training and competency assessment.

First Step

All staff that directly care for women, infants and/or children will have basic orientation and training on the impact of breastfeeding and lactation/breastfeeding management as well as competency-based skills needed to implement the infant feeding policy.

Important Next Steps

- Staff will receive competency assessment and training as needed on the infant feeding policy within 6 months of hire and will be provided ongoing continuing education on principles of policy.
- The facility will designate at least one person who is thoroughly trained in breastfeeding physiology and management to be responsible for ensuring the implementation of an effective breastfeeding program.
- Perinatal centers will staff clinical lactation care (number of IBCLC FTEs per 1000 deliveries) consistent with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and United States Lactation Consultant Association (USLCA) recommended staffing levels.[2]

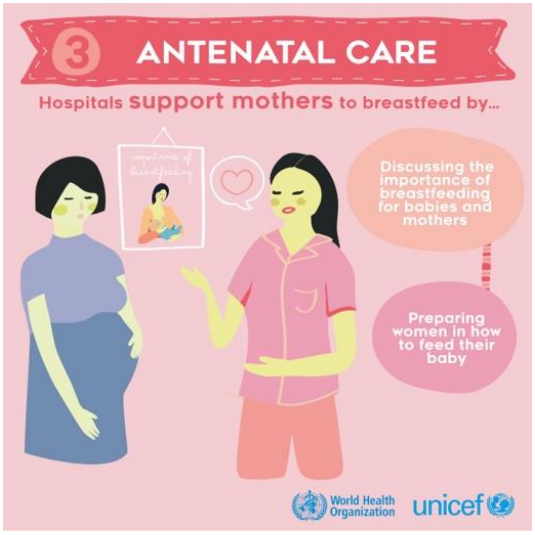
Additional Evidence-based Steps

- At least one hospital maternity staff member will be an International Board Certified Lactation Consultant (IBCLC).
- Management will designate a health professional to be responsible for all aspects of planning, implementing, verifying, and maintaining documentation of direct care staff and direct care providers' competencies.
- All staff with primary responsibility for the care of new mothers and their infants will complete comprehensive, competency-based training on breastfeeding physiology and management, with annual updates and competency verification, as well as continuing education in breastfeeding and lactation management.
- All medical providers who have privileges to provide care to new mothers and/or newborn infants will complete competency assessment and training as needed, with annual updates in breastfeeding promotion and lactation management.
- Staff will be trained to provide safe, effective, evidence-based, and patient-centered care to support breastfeeding and informed infant feeding decisions.

Resources for comprehensive competency verification information for all items in this policy:
Baby-Friendly USA, *Guidelines and evaluation Criteria for Facilities Seeking Baby-Friendly Designation, Sixth Edition, 2021*.

World Health Organization, Competency verification toolkit: Ensuring competency of direct care providers to implement the Baby-Friendly Hospital Initiative. 2020.

Breastfeeding Education in Prenatal Care



RATIONALE: Pregnancy is a key time to provide all pregnant individuals with basic information about breastfeeding. Accurate, evidence-based practical information can dispel myths and allow for true informed decision-making. This is also a time to inform families of maternity care practices that may impact and influence the success of breastfeeding.

First Step

Provide all pregnant individuals with information on breastfeeding and counsel on the importance of breastfeeding, contraindications to breastfeeding, and management of breastfeeding. [3,4]

Important Next Steps

- The facility will collaborate with prenatal care providers in the community to provide breastfeeding education and support. Establish collaboration with community-based programs in order to coordinate breastfeeding messages.

- Encourage breastfeeding unless medically contraindicated. Make breastfeeding history and breastfeeding goal part of the prenatal history in the medical record.

- Prenatal breastfeeding education shall begin with the first or second prenatal visit to avoid lack of information for those who may deliver early. Document all education in the patient's medical record.

Additional Evidence-based Steps

- All pregnant patients will receive socially and culturally appropriate support and education that at the minimum includes the following topics: [5]
    - Importance of breastfeeding
    - Recommendations for:
        - exclusive breastfeeding for the first 6 months of life
        - the risk of giving formula or other breast-milk substitutes
        - continuing breastfeeding beyond the first 6 months after other foods are added to the diet
    - Importance of immediate and sustained skin-to-skin holding
    - Importance of rooming-in
    - Breastfeeding management:
        - Early initiation of breastfeeding
        - Proper positioning and latch-on
        - Recognition of feeding cues

- Pregnant individuals and families will receive no information that promotes the use of human milk substitutes, including no information or promotional materials that contain industry logos in compliance with the International Code of Marketing of Breast-milk Substitutes.

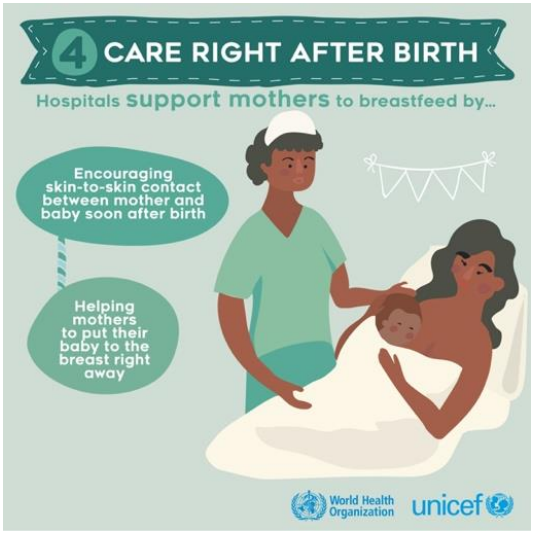
- Staff and providers will explore issues and concerns with women who are unsure how they will feed their babies or who have chosen not to breastfeed. Staff will:
    - Make efforts to address the concerns raised and educate the patient about the risks of not breastfeeding.
    - Teach the woman who chooses to formula feed safe methods of formula preparation and infant feeding.
    - Provide this information on an individual basis.

Resources:

Appendix A: Counseling to Improve Breastfeeding Practices

Appendix B: Contraindications to Breastfeeding

Care Right After Birth



RATIONALE: Immediate skin-to-skin holding and early breastfeeding are tandem practices that are proven to be beneficial for infant stabilization, early and prolonged breastfeeding success, maternal satisfaction and confidence and bonding. Skin-to-skin holding may take place regardless of the mode of birth, and when medical conditions prevent immediate skin-to-skin holding, contact within the first hour showed the same successful outcomes.[4,6]

First Steps

- Admitting facility staff will document the woman's informed infant feeding decision in her medical record, the infant's chart, and on the crib card.

- Staff monitoring birthing woman and infant will encourage and assist with early skin-to-skin holding and breastfeeding attempts as needed.

Important Next Steps

- Place healthy, term and late preterm infants with no evidence of compromise directly skin-to-skin with the mother immediately after birth, regardless of vaginal or cesarean delivery and regardless of feeding choice, when the patient is alert and stable. Complete drying, APGAR and initial assessments while the infant is on the mother's chest.

- Keep infant skin-to-skin for at least 2 hours or until after the first breastfeed unless medically contraindicated or by mother's choice.

- Transport mother and infant to recovery and/or postpartum areas with infant skin-to-skin and covered with blankets.

- Undertake safe infant positioning and continuous supervision of mother and baby while skin-to-skin to minimize the risk of Sudden Unexpected Postnatal Collapse.[7,8]

Additional Evidence-based Steps

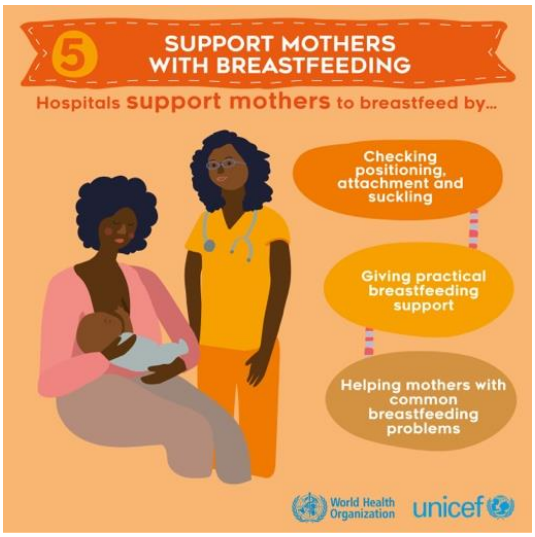
- If skin-to-skin holding is interrupted or delayed, staff shall ensure that the mother and infant initiate or resume skin-to-skin holding as soon as clinically possible.

- Postpone all routine procedures such as weight, measurements, vitamin K, and erythromycin eye ointment until after the first breastfeeding.

- Document time of initiation and end of skin-to-skin holding and first breastfeed in the medical record.

Resource:
Appendix C: Procedures for Skin-to-Skin Holding

Support Mothers with Breastfeeding



RATIONALE: While breastfeeding is known to be natural, many mothers, both first-time and experienced, benefit from practical help as they learn how to breastfeed. Breastfeeding support and counseling have been shown in a Cochrane Review to increase rates of breastfeeding up to 6 months of age.[9] Early assistance with positioning and latch may prevent future breastfeeding issues and the support from hospital staff and lactation professionals helps to build maternal confidence.

First Steps

- Nursing staff will offer each mother assistance with initial breastfeeding soon after birth and again within 6 hours of delivery. Guide the mother to help the newborn latch onto the breast properly.

- Assess mothers and infants for effective latch and breastfeeding at least once per shift.

- Mothers will be offered assistance with breastfeeding or expressing breastmilk as indicated by infant and/or mother's conditions or by maternal request.

Important Next Steps

- Maternity care staff shall address any breastfeeding difficulties (sore nipples, breast pain, engorgement, milk supply, etc.) and refer patient to the lactation consultant as needed.

- Instruct all breastfeeding mothers on the principles and techniques of hand expression.

- Instruct and assist breastfeeding mothers who are separated from their infants with initiating milk expression within 1 to 2 hours after birth.

- If supplemental feedings are indicated there should be a collaborative approach including parents, nurse, and provider. Provide pasteurized donor human milk to the breastfeeding infant if available and acceptable to the parent. Offer alternative feeding methods (syringe, SNS feeding systems, spoon, cup).

- Document each feeding in the infant's medical record. Documentation will include latch, position, and any problems encountered. For feedings not directly observed, maternal report may be used.

Additional Evidence-based Steps

- Each breastfeeding patient shall receive instruction on and be evaluated for knowledge of:[5]
    - Infant's hunger and satiety cues
    - Principles of cue-based breastfeeding
    - Goals of comfortable safe positioning and effective latch
    - Signs of effective milk transfer (intake)
        - During a breastfeed
        - By observation of output, behavior, weight and baby's general condition
    - Basics of building and sustaining a milk supply
    - Role of frequent direct milk removal in prevention of engorgement

    - Indications that help might be needed
    - How and when to access help if needed

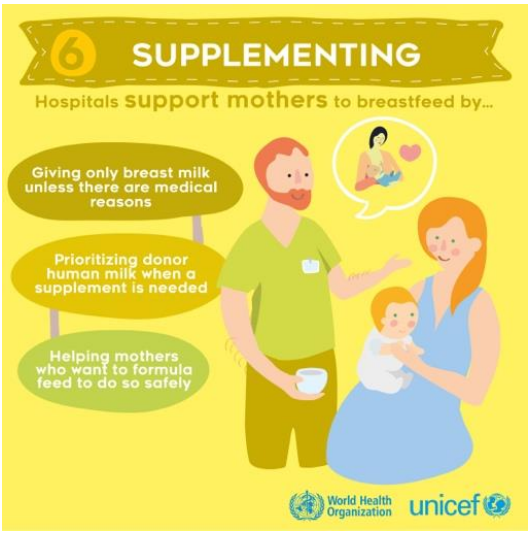
- Instruct mothers with infants in special care areas or with extended separation from their infants on methods of continued milk expression that best fit their needs that may include hand expression, use of manual and/or electric breast pumps and hands-on pumping.

- Instructions for mothers with infants in special care or with extended separation shall include:
    - expected milk volumes in the first days and weeks
    - basics of building and sustaining a milk supply
    - use of breast pump
    - assessment of flange size and suction
    - anticipatory guidance and troubleshooting
    - principles and frequency of milk removal in building an adequate supply

- All mothers with infants in special care or with extended separation from their infants shall receive assistance with obtaining a quality electric pump for the duration of separation from her baby.

<u>Resource:</u>
Appendix D: Technique for Hand Expression

Supplementing



RATIONALE: Human milk has long been recognized as the perfect food for human infants, providing not only necessary nutrients for growth and development, but also providing significant immune benefits that may last into adulthood. Therefore, human milk shall be considered the norm for infant feeding. In the first days and weeks of life, frequent time at breast and milk removal is critical for the establishment of the mother's milk supply. Any amount of artificial baby milk products given in the first days of life may interfere with the establishment of the infant's intestinal microflora and the establishment of a healthy gut microbiome. In addition, infants supplemented in the first few days of life have been found to be far more likely to stop breastfeeding completely within the first weeks of life. [11-13]

First Steps

- Do not give food or fluids other than breast milk to any breastfeeding infant unless they are specifically ordered for a medical indication or by the parent's informed and documented request.

- Support and provide education to parents making the informed choice to formula feed their infants on proper formula feeding techniques as well as care, preparation, and storage of infant formula.[5,10] Document education along with parent feeding informed choice in the medical record.

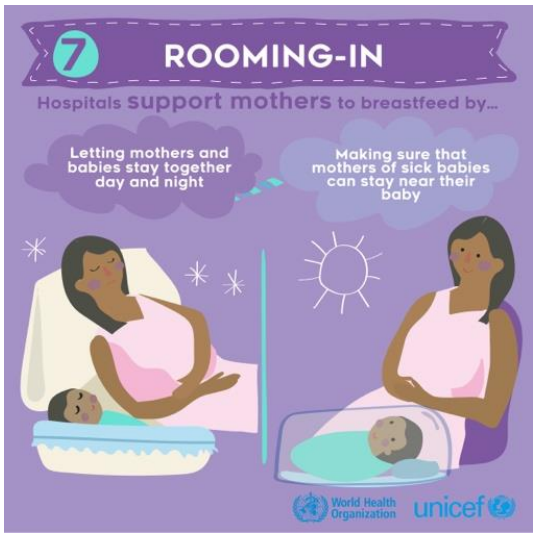
Important Next Steps

- Medical indications for supplementation will be evidence-based and documented in the infant's medical record.

- If supplementation is medically indicated, educate the parent on the possible consequences of introduction of infant formula and offer pasteurized donor human milk as a preferred alternative to formula if available and culturally acceptable to the parent. If unavailable or not acceptable, formula will be provided.

- When supplementation is indicated or chosen by the parent, offer alternative feeding devices to the breastfeeding couplet. These alternatives often allow for smaller supplementation volumes, which are more physiologically matched to the infant's small stomach capacity in the first few days of life and decrease interference with subsequent breastfeeding.

Rooming-In



RATIONALE: The practice of allowing mothers and babies to remain together in the same room continuously 24 hours a day allows families to learn and understand their infant's cues and enables responsive feeding. Cue recognition and the close proximity of the feeding parent facilitates early breastfeeding success and there is moderate evidence that exclusive breastfeeding is improved at 4 days postpartum. New mothers are often sleepy after birth and may be experiencing health issues of their own. Facilities should implement policies that encourage safe rooming-in practices.[4,7,8,14]

First Steps

- Provide education to all patients regarding the benefits of having the baby in the room with them continuously during the hospital stay. Document education in the medical record.
- Encourage all mothers and infants to remain together during the hospital stay.

Important Next Steps

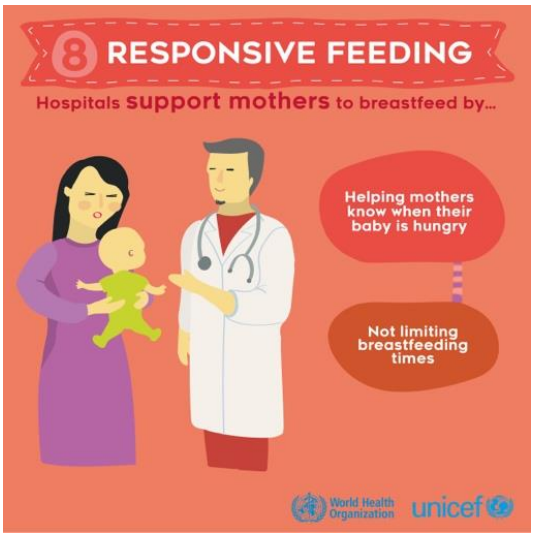
- Cluster routine care and testing of mother and infant as much as possible to avoid unnecessary interruption of mother and baby and to facilitate patient rest/sleep.
- Perform routine medical procedures for the baby in the mother's room for medically stable mothers and infants.
- Provide all families with education on safe sleep environment and practices as per current national guidelines. [7,8]
- Allow mothers with infants in the special care nursery unrestricted access to their babies.

Additional Evidence-based Steps

- All mothers and infants will room-in together, including at night. Separation of mothers and infants will only occur if medically indicated, for safety reasons, or upon mother's informed choice. Document separation reason, location, and length of time of separation in the medical record.
- If separation occurs for medical indication or safety reasons, return the infant to the mother as soon as physiologically stable. Document reason for separation and time separated in the medical record.
- If after education regarding the benefits of rooming-in, the mother requests that her infant be cared for in the nursery or a setting outside of her room, staff will return infant to parent once early hunger cues are observed. Document reason for separation, location and length of time separated in the medical record.
- Staff will support safe rooming-in practices by:[7,8]
    - Routine monitoring of maternal well-being based on individual risk assessment
    - Hourly rounding for safety observation
    - Encouraging patient to call for assistance or placing infant in bassinet if patient is falling asleep

<u>Resource:</u>
Appendix F: Safe Sleep Education

Responsive Feeding



RATIONALE: Responsive feeding encourages the feeding parent to recognize and respond to the infant's hunger cues and readiness to feed as opposed to feeding on a particular schedule. It is part of the development of a nurturing relationship between the mother and child. Responsive feeding puts no time limits or restrictions on the frequency or length of feedings and encourages mothers to feed as often as the baby wants. Responsive feeding is also known as baby-led or on-demand feeding.

First Step

Hospital maternity staff will teach mothers feeding cues and encourage mothers to feed as soon as their infant(s) display early infant feeding cues.

Important Next Steps

- Base the frequency and duration of breastfeeding on infant's early feeding cues, including but not limited to sucking noises, sucking on fist or fingers, fussiness, or moving hands toward mouth.
- Avoid time limits for breastfeeding as well as breastfeeding on each side. Infants can be offered both breasts at each feeding but may be interested in feeding only on one side per feeding during the first several days.
- If a mother and infant are separated, staff will take the breastfeeding infant to the mother for feeding whenever the infant displays early feeding cues.

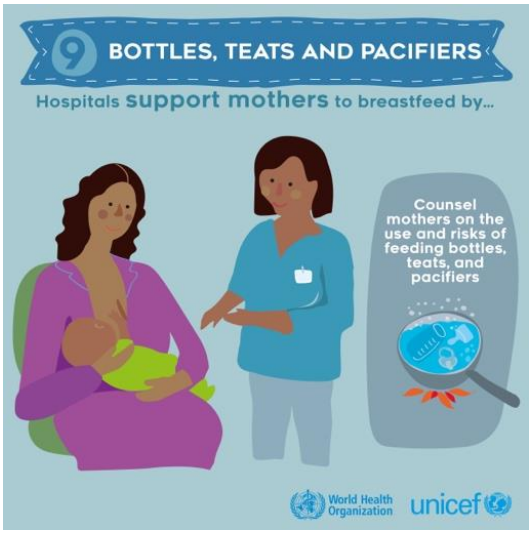
Additional Evidence-based Steps

- Provide education to all families regarding the signs of adequate intake and physiologically appropriate feeding amounts in the first days.
- In the instance of excessive crying by the infant, staff will provide complete assessment of infant and feeding.
- Provide education and resources to all families regarding crying as a form of communication for infants and anticipatory guidance regarding responsive comforting techniques.

<u>Resource:</u>

Appendix E: Comforting a Crying Baby

Bottles, Artificial Nipples and Pacifiers



RATIONALE: The use of pacifiers, artificial nipples and feeding bottles while not absolutely prohibited by current World Health Organization guidelines, may interfere with the establishment of a mother's milk supply and the infant's effective and frequent removal of milk. In addition, pacifier use may mask infant feeding cues leading to delayed feeds and compromised milk supply. Therefore, effective education and counseling of parents and extended family allows for informed decision making regarding their use. It is recognized that pacifier use is part of Safe Sleep guidance. According to the American Academy of Pediatrics exclusive breastfeeding is recommended for at least 6 months. A pacifier may be offered at naptime and bedtime once breastfeeding is firmly established. Infants who are not direct breastfeeding can begin pacifier use as soon as the family desires.[7]

First Steps

- Provide breastfeeding mothers with counseling and education regarding the possible impact pacifiers, artificial bottles and nipples will have on breastfeeding and establishment of milk supply according to the best scientific evidence available.

- Provide all families with education on Safe Sleep and Sudden Infant Death Syndrome (SIDS) risk reduction that also includes information on promotion of breastfeeding.

Important Next Steps

Offer infants who are receiving supplemental feedings alternative feeding methods to avoid use of bottles and nipples if acceptable to the parents and achievable according to providers and staff.

Additional Evidence-based Steps

- Provide parents who need or choose to offer a supplemental feed appropriate counseling and education regarding how to feed a supplement in a safe manner including physiologically appropriate amounts.

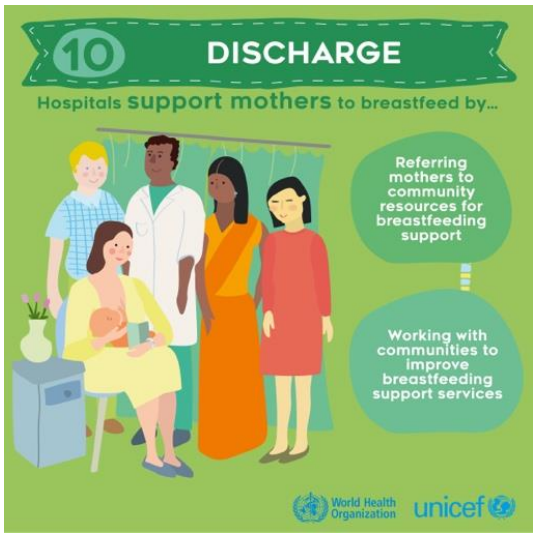
- Provide breastfeeding parents guidance and education on the appropriate time for introduction of a pacifier to a breastfeeding baby regarding SIDS prevention and based on current scientific evidence.[7]

- Provide parents education/anticipatory guidance regarding calming and soothing techniques to use either before or as an alternative to pacifier use.

Resource:

Appendix F: Safe Sleep Education

Post-Discharge Support



RATIONALE: Support to continue breastfeeding beyond the birthing facility experience is critical to long term breastfeeding success. For many mothers, their milk supply is not fully established until after they have left the birthing facility. In addition, they often are confronted by many life experiences and issues that may affect their breastfeeding experience. Available, knowledgeable community support for breastfeeding is critical to their success and well-being. Facilities that provide maternal, newborn and child health services must know about and refer breastfeeding families to a variety of support services in the community post discharge. When a family is formula feeding or mixed feeding, resources regarding optimal, safe infant feeding must be provided.

First Step

Prior to discharge, schedule all infants to see a pediatrician or other knowledgeable healthcare provider within 48 -72 hours of discharge from the facility as per current AAP guidelines.[15]

Important Next Steps

- Distribute a listing of infant feeding and postpartum resources to all families, with their discharge instructions. Individualize the list to mode of infant feeding and to be culturally and socially relevant.

- In the case where the infant is still not latching or breastfeeding well at the time of discharge, review the feeding/supplementation plan with the parents along with routine breastfeeding instructions and education. Schedule a follow-up visit with the pediatric care provider, lactation consultant or home visit nurse within 24 hours of discharge. In some cases, it may be appropriate to delay infant discharge.

Additional Evidence-based Steps

- The facility shall not distribute any discharge packs that contain infant formula, logos of infant formula companies, coupons for formula or literature sponsored by formula companies or their affiliates.

- The facility collaborates with WIC and other community breastfeeding support services including provider office staff in order to coordinate consistent infant feeding messaging and education.

References

This policy is adapted from:

Baby-Friendly USA, Inc. "Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation, Sixth Edition" Albany, NY: Baby-Friendly USA, 2021. License: CC BY-NC-SA 3.0 IGO. https://www.babyfriendlyusa.org/wp-content/uploads/2021/07/Baby-Friendly-GEC-Final.pdf

Hernandez-Aguilar, et al. ABM Clinical Protocol #7: Model Maternity Policy Supportive of Breastfeeding. Academy of Breastfeeding Medicine. BREASTFEEDING MEDICINE 13: 9, 559-574. 2018 DOI: 10.1089/bfm.2018.29110.mha. https://abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/Protocol%20_7%20-%20English%20Translation.pdf

World Health Organization (WHO). Implementation Guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization (WHO); 2018. License: CC BY-NC-SA 3.0 IGO. https://www.who.int/publications/i/item/9789241513807

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Appendix A:

Counseling to Improve Breastfeeding Practices

Guideline: counselling of women to improve breastfeeding practices. Geneva, Switzerland, World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO. https://www.who.int/publications/i/item/9789241550468

"All care providers and staff should engage in meaningful conversations that ENCOURAGES the patient and family members." (BFUSA 2018, p. 35)

ENCOURAGES – meaningful conversation guidelines
E – Empathize while listening and engaging in the conversation.
N – Be Non-judgmental by respecting each individual's experiences with breastfeeding, current infant feeding goals, and/or cultural and social considerations.
C – Confirm you understand the specific circumstances, issues and/or concerns.
O – Ask Open-ended questions to evaluate each person's understanding of breastfeeding, infant formula feeding and/or specific maternity care practices applicable to the conversation. For example, "What have you heard about breastfeeding?" "What do you know about infant formula?"
U - Use competent skills to assess any potential or current concerns or challenges.
R - Responsive care that provides anticipatory guidance [including suitable options] and/or addresses the specific concerns and circumstances.
A - Affirm successes and the desire to do what is right for the baby.
G – Give evidenced based, scientific, unbiased, and factual information in a sensitive manner that emphasizes the protections provided by breastfeeding/maternity care practices to enable an informed decision.
E – Empower each individual to make the decision that is right for her/his circumstances.
S – Support informed decisions by providing an individualized plan that encourages a mother to have a safe, responsive, caring, and nurturing relationship with her baby.

Baby-Friendly USA, Inc. "Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation, Sixth Edition" Albany, NY: Baby-Friendly USA, 2021. License: CC BY-NC-SA 3.0 IGO. Page 35. https://www.babyfriendlyusa.org/wp-content/uploads/2021/07/Baby-Friendly-GEC-Final.pdf

APPENDIX B:

Contraindications to Breastfeeding

Rare instances exist where breastfeeding may be contraindicated, either for a short period of time or completely. Each instance where there is a question or consideration to recommend that breastfeeding not occur needs to be considered individually by the health care provider and woman and follow current evidence and national guidelines.

Resources for current guidelines may include the US Centers for Disease Control and Prevention, the Academy of Breastfeeding Medicine, and the American Academy of Pediatrics.

MATERNAL CONDITIONS:

Ebola virus	Suspected or confirmed active cases. Women who have recovered from ebola virus disease may breastfeed.
Herpes virus	Do not breastfeed from breast when active herpetic lesions are present on that breast; mother can breastfeed from unaffected breast; milk from the affected breast may be used as long as the pump flange is not in contact with any active herpetic lesions.
Human Inmunodeficiency Virus (HIV)	Breastfeeding is contraindicated when artificial feeding is acceptable, feasible, affordable, sustainable, and safe. Recommendations from individual countries may vary.
HTLV I and II	Human T-cell lymphotrophic virus type I or type II
Varicella virus	Active varicella virus (chickenpox) that develops within 5 days before to 2 days after giving birth. Expressed breast milk may be given to the baby.
Brucellosis	Untreated infection as human-to-human transmission of the virus via breastfeeding has been reported.
Tuberculosis	Active, untreated pulmonary TB until no longer contagious which is considered 15 days of treatment; mother's expressed milk may be given to the infant
Certain medications	Treatment with some medications, such as chemotherapy or certain antivirals. Consult available accurate resources such as: LactMed, InfantRisk.com, e-lactancia, Hale's Medications & Mother's Milk App or book, Trash the Pump & Dump
Illicit drugs	Current use of illicit drugs. Methamphetamine, phencyclidine (PCP), heroin, and cocaine have been shown to be dangerous considering milk transfer and the prolonged presence of metabolites. Women enrolled in a supervised methadone/buprenorphine treatment program who otherwise are able to breastfeed should be encouraged to do so.

INFANT CONDITIONS:

Inborn errors of metabolism	Galactosemia
	Congenital lactase deficiency
	Phenylketonuria, maple syrup disease may be possible to breastfeed with supplementation

ENVIRONMENTAL HAZARDS:

Information and resources on a wide variety of environmental exposures including occupational chemical exposure and breastfeeding is available on the CDC website: https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/environmental-exposures/index.html

APPENDIX C:

Procedures for Skin-to-Skin Holding

All facilities should have a policy that outlines procedures for assessment, positioning, and staff and patient education surrounding safe skin-to-skin holding in the first hours after birth.

Sudden Unexpected Postnatal Collapse (SUPC) is defined as cardiorespiratory collapse of a healthy term or near-term infant who had a 5-minute APGAR score of 8 or greater within the first 7 days after birth. The most common cause of SUPC is positional occlusion of the infant's airway which can be attributed to several risk factors. Breastfeeding and skin-to-skin holding have been associated with SUPC and therefore risk assessments, education and observation of the parent and infant are critical to providing safe care for the birthing dyad.

In 2016 the American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome in their article Safe Sleep and skin-to-skin care in the neonatal period for healthy term newborns outlined specific procedures for immediate skin-to-skin care (box 1) as well as "Components of Safe Positioning for the Newborn While Skin-to-Skin" (box 2).

In addition, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) 2020 Practice Brief Number 8, Sudden Unexpected Postnatal Collapse in Healthy Term Newborns reviews suggested strategies to prevent and minimize the effects of SUPC as well as guidelines for education of both staff and birthing families. This document also provides information on 2 standardized risk assessment tools.

Resources:

Association of Women's Health, Obstetric and Neonatal Nurses. Sudden unexpected postnatal collapse in healthy term newborns: AWHONN practice brief number 8. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 2020; 49(4), 388-390.

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APPENDIX D:

Technique for Hand Expression

Hand expression of breast milk is a skill that every breastfeeding individual should be taught and comfortable with performing.

The classic video of hand expression that is utilized by many organizations and education programs in the United States is the video from Stanford Medicine and developed by Jane Morton, MD. You can access the video here: **https://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html**

In addition, UNICEF United Kingdom has a video on their website that also provides instruction in the technique of hand expression as well as a brief review of what instances it might be helpful to use hand expression. You can access their video here:
https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/breastfeeding-resources/hand-expression-video/

Lactation Education Resources has a reproducible handout containing photos and a link to Dr. Morton's hand expression video. The hand expression handout is available in English, Spanish, Arabic and Vietnamese. Go to the Resources tab on their main page and you can search for hand expression in either the "handouts for professionals" or "handouts for parents" tab.

La Leche League International has a Hand Expressing page on their website that contains detailed instructions regarding the techniques of hand expression as well as additional articles and videos on the technique and rationale for teaching all breastfeeding individuals this skill. You can access these materials here:
https://www.llli.org/breastfeeding-info/hand-expressing/

Appendix E:

Comforting a Crying Baby

Parents are often unprepared for the amount of time a newborn spends trying to communicate via crying. Below are resources that can be used for education of families either before or after birth regarding newborn crying and soothing techniques.

Jeanne Segal, PhD and Melinda Smith, MA, have an article on HelpGuide.org website entitled When Your Baby Won't Stop Crying that discusses numerous reasons for crying, coping techniques, baby's signs and attachment milestones and more. It concludes with several additional references.

The American Academy of Pediatrics sponsors a website that contains information on a variety of parenting topics: How to Calm a Fussy Baby: Tips for Parents and Caregivers

The Period of Purple Crying® is a national evidence-based program offered through the National Center on Shaken Baby Syndrome that is offered in 39 facilities across the state of Oklahoma. Patients in these facilities receive either a booklet and DVD, or a booklet and Web and mobile App. For detailed information on this program you can go to their website:
https://www.dontshake.org/purple-crying

The Children's Hospital Colorado has a helpful page entitled Calming Techniques for a Crying Baby.

Appendix F:

Safe Sleep Education

The primary resource for all safe infant sleep information is the Safe To Sleep public education campaign that began in 1994 as the Back To Sleep campaign. This work is led by the National Institutes of Health Eunice Kennedy Shriver National Institute of Child Health and Human Development in collaboration with other organizations and contains numerous professional and patient education materials and resources. website

Other helpful resources for additional information or for developing safe sleep education campaigns include:

- The National Institute for Children's Health Quality (NICHQ) website contains numerous resources including a reproducible handout: Safe Infant Sleep and Breastfeeding, Myths and Facts.
- The Centers for Disease Control and Prevention (CDC): Helping Babies Sleep Safely.
- March of Dimes: Safe Sleep for Your Baby.
- American Academy of Pediatrics (AAP) healthychildren.org: How to Keep Your Sleeping Baby Safe: AAP Policy Explained
- The Oklahoma State Department of Health (OSDH): Safe Sleep For Your Baby
- AAP Policy Statement: Moon RY, Carlin RF, Hand I; AAP Task Force on Sudden Infant Death Syndrome; AAP Committee on Fetus and Newborn. Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. *Pediatrics*. 2022;150(1):e2022057990

Appendix G:

Additional Model Policies

Several of these resources were developed prior to the 2018 revision of the Ten Steps to Successful Breastfeeding and are based on the original version of the Ten Steps.

Indiana Hospital Model Breastfeeding Policy
https://www.in.gov/health/mch/files/Hospital_Model_Policy_2013.pdf

Sample Infant Feeding Policies, UNICEF United Kingdom
https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/sample-infant-feeding-policies/

New York State Model Hospital Breastfeeding Policy
https://www.health.ny.gov/community/pregnancy/breastfeeding/docs/model_hospital_breastfeeding_policy.pdf

Sample Hospital Breastfeeding Policy for Newborns, American Academy of Pediatrics Section on Breastfeeding
https://njaap.org/uploadfiles/documents/f48.pdf

Academy of Breastfeeding Medicine Clinical Protocol #7: Model Maternity Policy Supportive of Breastfeeding
http://alabamabreastfeeding.org/wp-content/uploads/ABM-Model-Breastfeeding-Policy.pdf

Texas 10 Step Star Achiever Training Toolkit
http://texastenstep.org/starachiever-texastenstep/Star_Achiever_Ten_Step_Modules/resources-and-tools/

Arnold C, Rodriguez A, Spier P. **Providing Breastfeeding Support: Model Hospital Policy Recommendations**. 2021. California Department of Public Health, Sacramento, California.
(https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/CDPH%20Document%20Library/Breastfeeding-Model-Hospital-Policy-Recommendations.pdf)

Appendix H:

Breastfeeding Resources

Oklahoma Breastfeeding Hotline
1-877-271-MILK (6455) or text OK2BF to 61222

Academy of Breastfeeding Medicine
https://www.bfmed.org

American Academy of Pediatrics
https://www.aap.org

American College of Obstetrics and Gynecology
https://www.acog.org

American Academy of Family Practice
https://www.aafp.org/home.html

Baby-Friendly USA
https://www.babyfriendlyusa.org

Ban the Bag
https://banthebags.org

Centers for Disease Control & Prevention
https://www.cdc.gov

Coalition of Oklahoma Breastfeeding Advocates
https://www.okbreastfeeding.org

Healthy People
https://health.gov/healthypeople

Human Milk Banking Association of North America
https://www.hmbana.org

Indian Health Service Breastfeeding Site
https://www.ihs.gov/babyfriendly/

Infant Risk Center
https://www.infantrisk.com

International Lactation Consultants Association
https://ilca.org

La Leche League International
https://www.llli.org

La Leche League Oklahoma
https://www.lllok.org

LactMed Drugs and Lactation Database
https://www.ncbi.nlm.nih.gov/books/NBK501922/

National Institute for Children's Health Quality
https://nichq.org

Office on Women's Health – It's Only Natural
https://www.womenshealth.gov/its-only-natural

Oklahoma Breastfeeding Resource Center
https://obrc.ouhsc.edu

Oklahoma Indian Tribal Organizations – WIC Breastfeeding Promotion and Support
Oklahoma ITO Breastfeeding Contacts.pdf

Oklahoma Lactation Consultant Resource Guide
https://www.okbreastfeeding.org/lactation-consultant-resource-guide.html

ok-lactation-consultant-guide.pdf (oklahoma.gov)

Oklahoma Mothers' Milk Bank
https://okmilkbank.org

Oklahoma State Department of Health – Breastfeeding Information and Support
https://oklahoma.gov/health/family-health/breastfeeding.html

Oklahoma Pregnancy Risk Assessment Monitoring System
https://oklahoma.gov/health/family-health/maternal-and-child-health-service/data-and-evaluation/pregnancy-risk-assessment-monitoring-system-prams.html

The Joint Commission – Perinatal Care Measures
https://www.jointcommission.org/measurement/measures/perinatal-care/

United States Breastfeeding Committee
http://www.usbreastfeeding.org

United States Lactation Consultant Association
https://uslca.org

WIC Breastfeeding Support – US Department of Agriculture
https://wicbreastfeeding.fns.usda.gov

WIC Support – Oklahoma State Department of Health
https://oklahoma.gov/health/family-health/wic.html

World Health Organization - Breastfeeding
https://www.who.int/health-topics/breastfeeding#tab=tab_1